

**Physician-Focused Payment Model Technical Advisory Committee
Public Meeting Minutes**

**September 18, 2023
9:32 a.m. – 4:55 p.m. EDT
Hubert H. Humphrey Building
200 Independence Avenue, SW
Washington, DC 20201**

Attendance

Physician-Focused Payment Model Technical Advisory Committee (PTAC) Members

Lauran Hardin, MSN, FAAN, PTAC Co-Chair (Chief Integration Officer, HC² Strategies)
Angelo Sinopoli, MD, PTAC Co-Chair (Chief Network Officer, UpStream)
Lindsay K. Botsford, MD, MBA (Market Medical Director, One Medical)
Jay S. Feldstein, DO (President and Chief Executive Officer, Philadelphia College of Osteopathic Medicine)
Lawrence R. Kosinski, MD, MBA (Founder and Chief Medical Officer, SonarMD, Inc.)
Walter Lin, MD, MBA (Chief Executive Officer, Generation Clinical Partners)
Terry L. Mills Jr., MD, MMM (Senior Vice President and Chief Medical Officer, CommunityCare)
Soujanya Pulluru, MD (Independent Consultant)
James Walton, DO, MBA (President, JWalton, LLC)
Jennifer L. Wiler, MD, MBA (Chief Quality Officer Denver Metro, UHealth and Professor of Emergency Medicine, University of Colorado School of Medicine)

PTAC Members Not in Attendance

Joshua M. Liao, MD, MSc (Associate Professor, Medicine and Director, Value and Systems Science Lab, University of Washington School of Medicine)

Department of Health and Human Services (HHS) Guest Speaker

Elizabeth (Liz) Fowler, JD, PhD (Deputy Administrator, Centers for Medicare & Medicaid Services [CMS] and Director, Center for Medicare and Medicaid Innovation [CMMI])*

Office of the Assistant Secretary for Planning and Evaluation (ASPE) Staff

Lisa Shats, PTAC Designated Federal Officer
Steven Sheingold, PhD

****Via Webex Webinar***

List of Speakers and Handouts

1. Presentation: Encouraging Rural Participation in Population-Based Total Cost of Care (PB-TCOC) Models

Jay Feldstein, DO, Preliminary Comments Development Team (PCDT) Lead

Handouts

- Public Meeting Agenda
- PCDT Presentation Slides
- Environmental Scan on Rural Participation in PB-TCOC Models

2. Panel Discussion: Challenges Facing Patients and Providers in Rural Communities

Janice Walters, MSHA, CHFP, Chief Operating Officer, Rural Health Redesign Center*

Meggan Grant-Nierman, DO, MBA, Family Physician, First Street Family Health; Heart of the Rockies Regional Medical Center*

Jen L. Brull, MD, FAAFP, Family Physician and Vice President, Clinical Engagement, Aledade*

Handouts

- Panel Discussion Panelists' Biographies
- Panel Discussion Introduction Slides
- Panel Discussion Guide

3. Listening Session 1: Approaches for Incorporating Rural Providers in Population-Based TCOC Model Design

Aisha T. Pittman, MPH, Senior Vice President, Government Affairs, National Association of ACOs (NAACOS)*

Jackson Griggs, MD, FAAFP, Chief Executive Officer, Waco Family Medicine*

Mark Holmes, PhD, Professor, Department of Health Policy and Management, University of North Carolina Gillings School of Global Public Health, and Director, Cecil G. Sheps Center for Health Services Research*

Handouts

- Listening Session 1 Presenters' Biographies
- Listening Session 1 Presentation Slides
- Listening Session 1 Facilitation Questions

4. Roundtable Panel Discussion: Provider Perspectives on Payment Issues Related to Rural Providers in Population-Based Models

Adrian Billings, MD, PhD, Chief Medical Officer and Associate Professor, Family and Community Medicine, Texas Tech University School of Medicine*

Howard M. Haft, MD, MMM, Consultant and Former Senior Medical Advisor, Maryland Primary Care Program*

Jean Antonucci, MD, Family Physician, Northern Light Health (*An Innovative Model for Primary Care Office Payment Proposal*)*

Karen Murphy, PhD, RN, Executive Vice President and Chief Innovation Officer, Founding Director, Steele Institute for Health Innovation, Geisinger*

Handouts

- Roundtable Panel Discussion Panelists' Biographies
- Roundtable Panel Discussion Introduction Slides
- Roundtable Panel Discussion Guide

**Via Webex Webinar*

[NOTE: A transcript of all statements made by PTAC members and public commenters at this meeting, video recording, presentation slides, and other meeting materials are available at: <https://aspe.hhs.gov/ptac-physician-focused-payment-model-technical-advisory-committee>].

Welcome and Co-Chair Update

Lauran Hardin, PTAC Co-Chair, welcomed the Committee and members of the public to the September 18-19 public meeting. She explained that the Committee has been exploring themes that have emerged from proposals that the public has submitted to PTAC and releasing reports to the Secretary of Health and Human Services (HHS) on each theme. Co-Chair Hardin indicated that the report to the Secretary from the March 2023 public meeting on improving care delivery and integrating specialty care in population-based models would be posted within the next week, and the June 2023 public meeting report to the Secretary on improving management of care transitions in population-based models would be posted in the next month.

Co-Chair Hardin explained that the September public meeting would focus on the challenges rural providers face with care delivery and approaches to addressing them. This topic has emerged from previous PTAC theme-based discussions and in several proposals submitted to PTAC.

Co-Chair Hardin introduced Elizabeth (Liz) Fowler, Deputy Administrator of the Centers for Medicare & Medicaid Services (CMS) and the Director of the Center for Medicare and Medicaid Innovation (CMMI; the Innovation Center).

Dr. Fowler thanked PTAC members for the valuable discussions during the March and June 2023 public meetings and noted that she looked forward to the discussions on rural health. She explained that disparities in chronic diseases, disability, and access to care between urban and rural populations are the result of many factors, as will be discussed throughout the meeting. Dr. Fowler noted that low rates of physicians practicing in rural communities, Health Professional Shortage Areas in rural communities, and increasing closures of rural hospitals have exacerbated access to care challenges. She explained that telehealth may be a promising strategy to improve care and access in rural areas but may be limited if broadband is unavailable. She reflected on how technology barriers, workforce shortages, and other structural limitations have led to decreased participation in value-based care models in rural areas. Dr. Fowler indicated that supporting access to care in rural, frontier, and other geographically isolated areas is a priority for CMS.

Dr. Fowler provided an overview of current and future CMS initiatives related to rural care. She explained that CMS finalized rules for Rural Emergency Hospitals, a designation that would allow Critical Access Hospitals (CAHs) and small rural hospitals to receive enhanced Medicaid reimbursement. She noted that beginning in January 2024, the Medicare Shared Savings Program (MSSP) will provide advanced infrastructure payments to new Accountable Care Organizations (ACOs), which will help bridge entities to

join the program, particularly in rural areas. Dr. Fowler explained that CMS also administers two statutory demonstrations—the Rural Community Hospital demonstration and the Frontier Community Health Integration Project—as well as the Pennsylvania Rural Health Model, which examines care delivery transformation using hospital global budgets. She noted that CMS recently announced the States Advancing All-Payer Health Equity Approaches and Development (AHEAD) model, which focuses on state health system transformation and includes a hospital global budget component, and that the Making Care Primary (MCP) model features a strong focus on underserved communities, including rural areas. Dr. Fowler explained that earlier in 2023, CMS announced the termination of the Community Health Access and Rural Transformation (CHART) model due to a lack of hospital participation; however, CMS appreciated the feedback and lessons learned from rural providers. She expressed that CMMI looks forward to hearing from subject matter experts and PTAC members as they continue to explore opportunities to address challenges faced by beneficiaries and providers in rural areas.

Dr. Fowler posed several questions on which CMMI hopes to gain insight during PTAC's public meeting:

- How should rural be defined for the purposes of CMMI? What kind of providers should count as rural?
- What should CMMI prioritize in a care delivery model for rural populations?
- What are the changes to payment that would interest rural providers, and what flexibilities would they require to take on value-based care arrangements?
- What are some of the factors holding back rural providers that have not participated in value-based payment models?
- How can quality of care be reliably measured in rural areas, given lower patient volumes in rural settings?

Dr. Fowler thanked PTAC for the opportunity to learn about how to address the disparities in health care in rural areas, which will inform CMMI's future innovations in rural health care.

Co-Chair Hardin thanked Dr. Fowler for her remarks and reviewed the meeting agenda, which will explore the following topics:

- Challenges facing patients and providers in rural communities
- Approaches for incorporating rural providers in model design
- Provider perspectives on payment issues related to rural providers
- Incentives to increase rural provider participation
- Successful interventions and models for encouraging value-based transformation in rural areas

Co-Chair Hardin referred audience members to the [background materials](#) and explained that the discussions, materials, and public comments from the September public meeting will inform a report to the Secretary of HHS on how to encourage rural participation in population-based models.

Co-Chair Hardin reminded stakeholders that PTAC accepts proposals for physician-focused payment models (PFPMs) on a rolling basis. She noted that PTAC offers two proposal submission tracks, allowing flexibility depending on the level of detail that is available regarding payment methodology. She referred stakeholders to information on how to [submit a proposal](#).

Co-Chair Hardin invited Committee members to introduce themselves and their experience with rural health care delivery. Following Committee member introductions, Co-Chair Hardin shared that three Committee members served on the Preliminary Comments Development Team (PCDT): Jay Feldstein

(Lead), Jim Walton, and Joshua Liao. She introduced Dr. Feldstein, who presented the PCDT's findings from the [background materials](#).

Presentation: Encouraging Rural Participation in Population-Based TCOC Models

Dr. Feldstein delivered the PCDT presentation. For additional details, please see the [presentation slides](#), transcript, and [meeting recording](#) (18:40-53:38).

Dr. Feldstein provided an overview of the objectives of the theme-based meeting and noted that PTAC has deliberated on the extent to which 28 proposed PFPs met the Secretary's 10 regulatory criteria. Eleven of the 28 proposed PFPs either included or targeted rural populations. Dr. Feldstein discussed the variety of definitions for determining what constitutes a rural area. He noted that PTAC's working definition of a rural area is based on the Office of Management and Budget's (OMB's) definition, which identifies rural areas as counties with fewer than 50,000 people, and the U.S. Department of Agriculture's (USDA's) nine Rural-Urban Continuum Codes (RUCCs), which further identify differences in counties based on population size and proximity to metropolitan areas. He explained that PTAC's working definition of rural providers is providers that are physically located in rural areas. He also noted that patients in some rural areas have access to providers located in urban or suburban communities.

Dr. Feldstein presented a map illustrating the geographic distribution of rural areas by RUCC, noting that 15 percent of the U.S. population live in rural areas, and 63 percent of U.S. counties are designated as rural areas. He presented two tables to show how rural areas vary based on population size and proximity to metropolitan areas and how these characteristics also vary by geographic region. Dr. Feldstein noted that rural areas are not uniform and may face different challenges. He explained that effective care delivery models, financial incentives, and payment methodologies may vary depending on the type of rural area and type of provider.

Dr. Feldstein noted that rural providers differ in the services they offer and resources to which they have access. Different provider types also have different coding and billing practices which may make measurement and reimbursement more difficult, such as, related to statutory requirements or to the provider's relationship with a nearby hospital or integrated delivery system.

Dr. Feldstein explained that research has found that, compared with non-rural counties, rural counties have lower income, higher uninsured populations, older populations, decreasing life expectancy, fewer primary care providers (PCPs) and specialists, lower broadband access, and lower Medicare Advantage (MA) enrollment.

Dr. Feldstein presented data showing higher age-adjusted death rates for rural compared with urban counties. He explained that the greatest disparities between rural and urban death rates for the 10 leading causes of death in the U.S. were in heart disease, cancer, unintentional injuries, and chronic lower respiratory disease.

Dr. Feldstein presented a graphic depicting the overlapping issues affecting rural health care systems, settings, providers, and patients. He provided an overview of some of the challenges experienced by rural health care systems, settings, and providers, including complex patient populations, higher rates of uninsured and publicly insured patients, lower patient volume, lower earnings, workforce shortages, higher workload, challenges building economies of scale, and less health information technology (HIT) infrastructure. He noted that compared with non-rural areas, rural areas have fewer PCPs and specialists.

Dr. Feldstein discussed issues related to workforce shortages in rural areas and suggested strategies for addressing rural workforce challenges through the use of telehealth. Dr. Feldstein also discussed the challenges related to implementing HIT and data analytics for rural providers and provided recommendations for addressing HIT infrastructure challenges in rural areas.

Dr. Feldstein noted that rural providers participate in Alternative Payment Models (APMs) at a lower rate than their non-rural counterparts, and physicians participating in advanced APMs in rural areas are most commonly in primary care specialties. Dr. Feldstein provided an overview of challenges affecting rural providers participating in and transitioning into APMs, including financial resources and risk management, data and HIT, staff resources and capabilities, and design and availability of models.

Dr. Feldstein provided an overview of the financial risks and challenges faced by rural providers in population-based TCOC models, including attribution, panel size, validity of outcome data given limited HIT infrastructure and smaller populations, ability to take on risk, relevant performance metrics, and quality performance measurement.

Dr. Feldstein discussed the types of care most difficult to provide in rural areas, approaches to addressing the needs of rural communities, and effective strategies to drive value-based care transformation in rural areas. He explained the financial and quality incentives that promote value-based care transformation among rural providers.

Dr. Feldstein noted the challenges affecting rural providers' ability to measure performance, including low case volumes, staff and resource shortages, and limited staff with experience performing data analytics and using the results to inform quality improvement efforts. He noted that rural patients tend to be disproportionately affected by health conditions, making performance comparisons between rural and non-rural settings difficult.

Dr. Feldstein reviewed strategies to address challenges related to measuring the performance of rural providers. These strategies included ensuring that measures appropriately assess the performance of rural providers, considering measurement differences between rural and non-rural providers, and identifying alternative measures related to retention of rural providers. He provided examples of quality measures used in APMs that target rural providers.

Dr. Feldstein explained that several CMMI models have used a variety of payment mechanisms in models that targeted or included rural populations. He highlighted lessons learned from these models, including: 1) establishing longer on-ramps for rural practices interested in model participation; 2) developing APMs that specifically target rural settings; 3) identifying suitable risk-adjusted quality measures; 4) providing risk protection caps on risk exposure; 5) extending bonus payments for new advanced APM participants; and 6) decreasing qualifying participation thresholds for rural providers operating under APMs. Dr. Feldstein highlighted rural providers' performance in the ACO Investment Model (AIM), Maryland's Total Patient Revenue (TPR) global budget program, and the Pennsylvania Rural Health Model.

Dr. Feldstein discussed the MSSP's inclusion of rural providers, including, lessons learned from rural participation, and the development of the Advance Investment Payments (AIPs), a new MSSP payment option that aims to encourage the formation of ACOs in rural and underserved areas by offering up-front and quarterly payments to fund infrastructure and promote equity.

Dr. Feldstein highlighted areas of focus for the public meeting, including challenges facing patients and providers in rural areas, provider perspectives on rural participation in population-based TCOC models, measurement of rural providers' performance in APMs, approaches to incorporate rural providers in model design, incentives to increase rural providers' participation in population-based models, and successful interventions and models to encourage value-based care transformation in rural areas.

In response to a question from Angelo Sinopoli, PTAC Co-Chair, Dr. Feldstein noted that the PCDT had not found any data that differentiated outcomes between independent and employed physicians.

Panel Discussion: Challenges Facing Patients and Providers in Rural Communities

- Janice Walters, MSHA, CHFP, Chief Operating Officer, Rural Health Redesign Center
- Meggan Grant-Nierman, DO, MBA, Family Physician, First Street Family Health; Heart of the Rockies Regional Medical Center
- Jen L. Brull, MD, FAAFP, Family Physician and Vice President, Clinical Engagement, Aledade

Co-Chair Hardin moderated the panel discussion with three subject matter experts (SMEs) offering their perspectives on challenges facing patients and providers in rural communities. For additional details, please see the transcript and [meeting recording](#).

Panelists introduced themselves and provided background on their respective organizations. Full [biographies](#) and [panelist introduction slides](#) are available.

- Janice Walters noted that she has led the Pennsylvania Rural Health Model (PARHM) since 2018, including creating the Rural Health Redesign Center Authority and the Rural Health Redesign Center Organization. The Authority oversees the PARHM, and the Organization is a not-for-profit that oversees rural health projects in other states. Ms. Walters emphasized the importance of preserving access to care through rural hospitals, which employ most of the primary care and specialty physicians in many rural communities. She explained that the PARHM includes work on substance use disorder and peer recovery. She also noted that the Rural Health Redesign Center oversees the Rural Emergency Hospital Technical Assistance Center, which assists hospitals in determining whether conversion to a new provider type called the Rural Emergency Hospital (REH)—a new CMS designation that allows rural hospitals to focus on outpatient needs—is appropriate for their communities. Ms. Walters explained that rural communities are disproportionately older and sicker, and have higher rates of disability, food insecurity, and “deaths of despair.” She expressed that such disparities would be much worse without access to rural hospitals and to primary and specialty care. Ms. Walters noted that many of the same social issues exist in both urban and rural communities; however, the solutions are much different for rural areas due to the lack of infrastructure. She summarized by observing that policy solutions should be aligned across the rural health care continuum and that there need to be incentives to pay for the type of care that should be delivered in rural communities. For additional details on Ms. Walters' background and organization, see the [panelist introduction slides](#) (pages 4-7).
- Meggan Grant-Nierman explained that she was a family physician at First Street Family Health, a rural private practice. She explained that First Street Family Health participated in the Comprehensive Primary Care (CPC) initiative, the CPC Plus (CPC+) model, and the Primary Care First (PCF) model, as well as the Medicare Shared Savings Program (MSSP), but that the practice no longer participates in value-based care. While the practice was successful during CPC and CPC+, the prospective payments from PCF and funding from Aledade was not sufficient to financially support the practice, and the practice was sold to Heart of the Rockies Regional Medical Center, a Critical

Access Hospital (CAH) and network for Rural Health Clinics. Dr. Grant-Nierman discussed some lessons learned from her participation in value-based care initiatives as a rural provider:

- Proactive, coordinated, team-based care improves the experience of both patients and providers, and rural practices are poised for success because of the familial nature and connectedness of rural communities.
- Rural communities lack the workforce and wraparound support services necessary to be effective in value-based care models, and the increased payroll expense for staffing outweighs the financial return of participation in value-based programs.
- Gathering and reporting reliable data is an issue for rural providers, both because they do not have access to high-quality electronic health record (EHR) systems, and their small populations warp their cost and performance metrics, which in turn affects the ability to be paid. Artificial intelligence (AI) and technology have the potential to assist in addressing this issue.
- Rural health care systems are not equipped to fund the increased investment required to participate in value-based payment models or to take on downside risk.
- The periodic and inconsistent nature of funding under value-based payment models is difficult for small rural providers that often operate with little cash on hand.
- Dr. Grant-Nierman noted several suggestions to make rural participation in value-based care more appealing:
 - Provide financial support to help rural health care systems collectively afford access to higher-quality EHRs and timely, accurate data analytics.
 - Provide collaborative funding across communities to bring together health care ecosystems and encourage community development to address the social determinants of health (SDOH) of rural communities.
 - Emphasize multi-payer alignment that includes private payers.
 - Include resources to support emergency medical services, long-term care, public health, and social services.
- For additional details on Dr. Grant-Nierman’s background and organization, see the [panelist introduction slides](#) (slides 9-11).
- Jen Brull introduced herself as the Vice President for Clinical Engagement at Aledade, which helps independent PCPs form ACOs that are geographically disparate to take on risk. Prior to her current role, she practiced family medicine in a rural area and participated in value-based care initiatives. Dr. Brull discussed her takeaways from her experience as both a rural provider participating in value-based care models and her work helping other providers do the same:
 - The “rural glitch” puts rural providers at a disadvantage because their own patient population makes up a significant market share due to the way regional benchmarks are set. Benchmarking works differently for urban providers.
 - Investment in access is needed for community and specialty resources.
 - CAHs and Rural Health Clinics (RHCs) have been excluded from innovative models due to the complexity of the models. Integrating rural health care systems into value-based models would facilitate rural provider participation.
 - Models should offer advance pay options for rural practices, to create the infrastructure needed to participate in value-based care.
 - Policy makers should connect with rural health care professionals and subject matter experts to better understand the challenges that rural providers face in participating in value-based care.
- For additional details on Dr. Brull’s background and organization, see the [panelist introduction slides](#) (pages 13-14).

Panelists discussed the barriers to and potential solutions for effective care coordination in rural areas.

- Problems include lack of infrastructure and resources; infrastructure and community partnerships are needed to connect patients to community resources. Hospitals can play a role in connecting community organizations to the health care system.
- Current models do not provide sufficient funding for rural providers to invest in care delivery infrastructure. There is not enough funding from health care alone, so that models are needed to align funding streams across health care systems, dental, vision, mental health, and community benefit organizations.
- Beyond discharge planning, hospitals are investing in care management strategies, care coordination, and using peer recovery specialists to help manage the care of frequent emergency department (ED) patients.
- There is a lack of data on SDOH in rural areas, a need that can be addressed simply through screenings for certain populations that come into the ED or hospital.
- Care transitions can be easy in rural areas, for example, where the same provider sees a patient in the hospital as in the clinic, but often, can be difficult when patients are transferred to hospitals far outside the community or to a long-term care facility.
- Small rural practices cannot afford to use admission-discharge-transfer (ADT) feeds or health information exchanges (HIEs) effectively, for example, when they must hire staff to identify when patients are admitted to or discharged from long-term care facilities, or out of town hospitals.
- There is a lack of wraparound services that could help patients stay in their home, particularly when resources such as pharmacies are far away.
- Effective discharge planning for clinics requires significant time and effort from nurse care managers, which can be too expensive for rural practices.
- Dedicated care coordinators embedded within clinics can ensure that patients receive the services they need from the community. There must be a sustainable source of revenue to support this work.
- Practices can take advantage of community-based grants and resources designed to facilitate communication and coordinate resources, for example, through a city planning grant.
- Telehealth services can reduce barriers of access to care, supported by funding streams and the greater access to devices that support telehealth.

Panelists discussed characteristics of rural communities where value-based care has been successful, despite the barriers.

- Successful rural health care systems have lower barriers than other rural areas. For example, if there are enough PCPs in a community, the system will have greater capacity to take on the work of value-based care than a community with a PCP shortage, and where there are great collaborations between the hospital and the community physicians, there is a supportive environment.
- Aledade tries to identify practices that will need fewer additional resources to succeed in value-based care but also partners with under-resourced practices where there is greater room for improvement. There are CMS data available to help identify practices that deliver great value-based care, for example, related to the number of annual wellness visits, the transitions of care, and the readmission rate.
- Risk-based models better incentivize value-based care; however, some practices may need to start with non-risk bearing status before moving to bearing risk in a model.
- Commitment to innovation by local leadership is crucial to facilitating care transformation.

- Providers will not join value-based arrangements if their current payment structure is more profitable. For this reason, her organization’s assessment begins with the math and whether value-based care has enough incentives to lead to a more sustainable path.
- Cost-based reimbursement is a decreasing revenue source for CAHs as Medicare Advantage (MA) participation increases. Hospitals cannot be profitable if their reimbursement is based on cost and there needs to be a way to pay them for value.

Panelists discussed their recommendations for future payment models to transform care in rural communities from cost-plus reimbursement.

- Currently, rural providers rely on billable services to stay financially solvent, which does not serve the best interests of the community. Payment arrangements need to align incentives for delivering quality health care while ensuring that hospitals and local physicians can continue to operate in their communities.
- Global budgets are more effective than ACOs, as most ACO frameworks are still based on volume. Global budgets are a predictable payment mechanism that allow providers to serve the best interests of their community without worrying about their financial solvency.
- Hospitals may be wary of ACOs because being part of an ACO may decrease patient volume and, therefore, revenue at their particular facility. Focusing on the common goal of improving the health of the community can foster productive partnerships, but organizations also need to be financially aligned to avoid a financial downfall for the hospital. For example, while a hospital may have reduced inpatient volume as part of an ACO, it will benefit from switching to a primary and preventive care focus with programs such as fall prevention programs, preventive imaging, and urgent walk-in care.
- Cohesive incentives are needed across the medical ecosystem. Payment structures can incorporate or braid funding sources from federal agencies other than HHS and private insurance to invest in the whole community. For example, there could be a requirement that a portion of shared savings from an ACO program be reinvested in community structures and supports, such as emergency medical services (EMS), long-term care, or public health services.

Panelists discussed the definition of “rural” and the variety of rural environments.

- There is a difference between rural and frontier. In frontier areas, patients are hours from the nearest specialist or hospital, while in rural areas, providers may be closer, for example, less than an hour away. There are likely important differences between rural and frontier when risk stratifying patients.
- It is important to recognize the spectrum in differences between distance in miles and distance in time. For example, 45 miles in a flat geography would take 45 minutes, but 45 miles through mountains could take hours. Considering proximity to emergency services, key specialty services, and primary care, rather than defining rural in terms of population size, should inform how degrees of rural health care services are classified.
- A standard definition for rural will be important for developing future models, particularly all-payer models. For example, in Pennsylvania, some hospitals were deemed rural from the state perspective but not from a federal perspective, which could create an issue in terms of qualifying for a program.

Panelists discussed pooling measurement data to alleviate the outliers than can influence performance metrics in medical service areas and counties with low populations.

- Aggregating patients across geographically disparate populations can reduce the effect of outliers in performance measurement. There should be a balance between data used to measure performance and data used to improve performance.
- Organizations such as Aledade can help small practices assess data to improve care delivery and work on multi-payer contracts so that practices are also benefitting from their value-based work (and not just the payers).
- Performance measures should be relevant to rural health care systems and less likely to be impacted by small numbers of patients. The identification of rural-relevant measures is as important as being able to aggregate and pull the data.
- Early alignment with common, standardized performance metrics alleviates the administrative burden for both program operators and clinicians.

Panelists discussed how to fully leverage PCPs to fill in gaps where specialty care may not be accessible in the community, to support value-based care.

- There is a need to develop additional types of primary care extenders, who are crucial to address the needs of rural areas—for example, addressing the transportation issue through mobile integrated health, working with rural technical schools to train staff who can support PCPs, and exploring paramedicine programs to build out a better clinical team in light of the short supply of PCPs.
- Developing alternative types of provider career paths and helping providers to practice to the full extent of their license could help address the provider shortage in rural areas. Payment policies should adequately reimburse these provider types.
- Some residency programs teach family practice physicians to have a higher scope of practice or a full spectrum of care, but this level of practice often leads to burnout. In order for a shrinking population of PCPs to provide more types of care, they need more community supports and reduced administrative burden, and over time, culture change.
- Ensuring a sufficient supply of primary care specialists is important, rather than shifting the scope of practice, which in turn relates to reimbursement. PCPs stand to benefit from value-based care models because they are involved with every aspect of a patient’s care. Advance and predictable payments in value-based care will make primary care a more desirable specialty in both urban and rural areas.

Ms. Walters discussed the use of mobile services to fill gaps in care delivery in rural areas.

- Mobile integrated health solutions represent an opportunity to fill in service gaps, but adequate reimbursement is needed to fund these services, as well as state and federal policy for workforce development.

Panelists discussed whether the health care market can help solve some of the issues faced by rural health systems.

- The marketplace incentives must be aligned with rural providers and patients.
- The marketplace needs to emphasize quality care over volume of care.

Listening Session 1: Approaches for Incorporating Rural Providers in Population-Based TCOC Model Design

- Aisha T. Pittman, MPH, Senior Vice President, Government Affairs, National Association of ACOs (NAACOS)

- Jackson Griggs, MD, FAAFP, Chief Executive Officer, Waco Family Medicine
- Mark Holmes, PhD, Professor, Department of Health Policy and Management, University of North Carolina Gillings School of Global Public Health, and Director, Cecil G. Sheps Center for Health Services Research

Co-Chair Sinopoli moderated the listening session with three SMEs on approaches for incorporating rural providers in population-based total cost of care (PB-TCOC) model design. Full [biographies](#) and [presentations](#) are available.

Aisha Pittman presented on modifying TCOC elements to better integrate rural providers in PB-TCOC models.

- The one-size-fits-all approach will not help to accomplish CMS' goal of having all traditional Medicare beneficiaries in a clinical relationship responsible for TCOC and quality. Rural and non-rural providers differ in how they are paid, the populations they serve, and the challenges they encounter.
- New TCOC models should be developed, and existing TCOC models should be adapted to target rural providers. Models should focus on maintaining or increasing access to care, not necessarily on reducing costs, because some of the lower cost of care settings might not be available.
- Ms. Pittman discussed challenges rural providers face participating in TCOC models, as well as opportunities to improve TCOC models to increase rural provider participation.
 - ACOs are built on a primary care relationship, yet many rural practices do not include a physician and for this reason, do not contribute to attribution. In addition, Federally Qualified Health Centers (FQHCs) experience significant patient movement or churn, which would make it difficult to maintain attribution from year to year, and facility-level billing can make attribution through an ACO or specific providers more difficult. Solutions include creating rural-specific attribution approaches, such as Advanced Practice Provider (APP) attribution for a rural area or examination of multi-year approaches of alignment. In addition, obtaining data on attribution can help ACOs better understand how and why providers align to the ACO.
 - There are challenges related to benchmarks. Shared savings approaches do not account for rural payment systems that may limit reimbursement to one service per day. In addition, if most of a hospital's costs are fixed, under cost-based reimbursement, there are limited opportunities for spending reductions. Further, risk adjustment may need to be adjusted for rural populations that historically have not had significant coding documentation. Solutions to address these challenges include considering global budget or prospective population-based payment approaches, lowering the discounts or minimum savings rates for rural providers in risk-bearing models, adapting risk-adjustment policies to not disadvantage sicker populations, accounting for costs that are specific to rural communities, and developing alternative measures of success to financial benchmarks for CAHs.
 - Rural providers typically need technical support to participate in models. Solutions to address this challenge can include using waivers in models that are specific to rural providers, such as waiving the one-visit, one-service requirement; making it easier to provide Hospital at Home services; and providing more avenues for understanding the impact of TCOC policies on rural providers.

For additional details on Ms. Pittman’s presentation, see the [presentation slides](#) (pages 3-9), transcript, and [meeting recording](#) (0:45-12:05).

Dr. Jackson Griggs presented on a collaborative approach to PB-TCOC models.

- In Texas, value-based care has translated into underfunded initiatives with additional responsibilities for providers, without addressing the unique challenges of providing health care in rural areas.
- Maslow’s hierarchy of needs can be applied to the way clinical systems operate. The goal is to have a health care system that offers equitable health care to all segments of the population. Achieving health equity first requires basic infrastructure, financial security, integration within the broader health and social ecosystems, and quality outcomes in aggregate.
- Foundational investments tailored to specific rural demographics are necessary before providers can expect to achieve a high level of performance, while safeguarding providers from burnout risks associated with clinical practice and with systems change.
- Lessons learned from initial experiences of their FQHC in a hospital-based ACO in MSSP suggest the limits of value-based care in serving patients with a disproportionate burden of chronic illness, mental health conditions, substance use disorder, and health-related social needs associated with their rural circumstances. The hospital-focused approach can overlook opportunities for quality, equity, and cost reduction, and benchmarking in an underfunded region is counterproductive.
- Three changes are needed: a front-end investment in infrastructure, a glide path to TCOC, and meaningful, properly incentivized measures.
- A value-based hub-and-spoke model anchored in a community health center could allow health centers to form strategic partnerships and widen their services. The hub could include an FQHC-anchored ACO in PB-TCOC contract models. The spokes could include rural areas within an FQHC service area interested in participating. State and national agencies would finance, including nontraditional funders to invest in SDOH.
- A primary care-centered approach would provide a direct route to achieve population health and health equity, as it is intrinsically holistic, relationship-based, community-focused, and integrated using interprofessional teams that are patient-centered. The tailored approach of primary care creates trust, which is important.
- An interprofessional primary care team is crucial to ensure quality outcomes while preventing provider burnout, especially with fewer physicians.
- A TCOC model should be grounded in the FQHC framework because FQHCs embody principles of justice and frugality, collaboration, and accountability, in addition to funding from several federal programs.
- Both structural and programmatic resources should be considered and aligned, with existing rural systems bolstered.
- Through CMMI, CMS could allow FQHCs to spearhead discussions on a tailored MSSP model for rural areas. At the same time, non-expansion states should be given incentives to prioritize FQHCs in TCOC strategies through 1115 waivers.
- If MSSP is designed for rural populations, it should be simple; revolve around primary care; use existing resources for CAHs, FQHCs, and local mental health authorities; and emphasize initial investment in rural health infrastructure.

For additional details on Dr. Griggs’ presentation, see the [presentation slides](#) (pages 11-44), transcript, and [meeting recording](#) (12:10-24:40).

Dr. Mark Holmes presented on patient attribution in rural areas.

- Most attribution schemes were designed assuming fee-for-service (FFS) data flow, but recent modifications have been more flexible.
- Attribution does not necessarily inhibit rural provider enrollment.
- The cost of non-prospective payment system (PPS) payment structures attributed to providers may be higher, making cost savings challenging for organizations with beneficiaries seeing rural providers. Payment structures for some types of rural providers can be difficult to fit into the FFS system.
- Other challenges in rural settings may be more important than attribution, such as the ability to manage financial risk and infrastructure, as well as the infrastructure to manage utilization.
- Payment models depend on the attribution of beneficiaries to one provider. A key design requirement built into models is that provider payments must align with the PPS system. If the reimbursement data do not align with the PPS-based attribution model, the providers cannot be included. In the past, it has been common to make these providers ineligible to participate in the model, which has been a typical story for rural areas.
- Using Taxpayer Identification Numbers (TINs) for attribution may not work for rural providers. MSSP is built on a TIN infrastructure, yet RHCs, CAHs (under Method II billing), and FQHCs bill through CMS Certification Numbers (CCNs). One solution seen in the 21st Century Cures Act is to include rural providers in an attribution method by assuming that all services provided at RHCs and FQHCs are primary care services that qualify the visit for attribution. This solution bundles providers at the CCN level. Another approach would be to attribute based on the population, for example, as Vermont has done with Medicaid.
- There is selection bias in rural areas, where local hospitals have a lower income Medicare base compared with the population overall, reflecting challenges related to transportation.
- Coding is substantially different in rural and urban settings. Hierarchical Condition Category (HCC) scores are lower for patients who see rural providers, which may reflect risk, as well as less complete coding in rural areas, where billing may not depend as much on coding.
- Lower patient volume means lower financial liquidity in rural areas, because a practice's fixed costs are spread over fewer patients. This could be alleviated by including multiple payers to increase the base of patients.
- The higher cost of care in rural areas influences referrals. Providers providing care in a bundled payment model are incentivized to keep care in an urban setting because the cost of care will be lower compared to a rural setting.

For additional details on Dr. Holmes' presentation, see the [presentation slides](#) (pages 46-53), transcript, and [meeting recording](#) (24:45-36:27).

Following the presentations, Committee members asked questions of the presenters. For more details on this discussion, see the transcript and [meeting recording](#) (36:38-1:18:34).

Presenters discussed what they would prioritize in future models for rural health care.

- A greater percentage of the overall spending on health care should go to primary care, particularly in rural settings. Different rural areas have different levels of readiness to move toward risk-bearing value-based care models.
- Models should include more up-front investments for rural providers.
- Policy makers should ensure that TCOC models have an adequate budget and account for differences in risk for benchmarking, such as, differences in patient populations.
- Financial sustainability may be more challenging in rural areas compared with urban areas. For example, for post-acute care, providers in rural settings may be more expensive than in urban

settings. Some payment models recognize the greater challenges in rural areas, yet the benchmarks present barriers that do not acknowledge rural provisions.

Presenters discussed leveraging the Area Deprivation Index (ADI) as a proxy for social risk and the prospects for differentiating communities within the definition of rural by combining risk that reflects both diagnostic and social considerations. Presenters also discussed recommendations for HHS to collaborate with federal departments to stack funding streams for rural areas to improve health and health equity.

- The U.S. Department of Agriculture (USDA) has several economic development approaches, including loans. Up-front costs could be funded through grants or loans. The U.S. Centers for Disease Control and Prevention (CDC) is forming an Office of Rural Health and looking for long-term sustainable funding.
- Policies should avoid using a two-track system that lowers the benchmark for populations with more needs. Models should balance the two competing interests of creating achievable benchmarks and advancing health equity.
- Although the ADI is a useful tool to assess social risk, efforts should be made toward using patient-reported social risk factors. In the ACO Realizing Equity, Access, and Community Health (REACH) model, the ADI is used to adjust the benchmark, but this budget-neutral approach is not sustainable more broadly.
- Urban health care systems have made significant investment in optimizing coding, while rural providers do not have the infrastructure to maximize coding and will not spend their resources without seeing a clear return on investment (ROI).

Presenters discussed considerations for measuring quality among rural providers and how performance can be linked to payment.

- Quality measures should be moved toward patient-centered metrics. This can be achieved by measuring accessibility and responsiveness to patient needs, preventive screenings, timely interventions, hospital readmissions, and the integration of primary care, behavioral health, and oral health into social services and care. Performance measurement should include measures of disparities in outcomes and examine disaggregated data by subpopulations.
- To assess whether a model is effective, policy makers should measure whether the model helps to retain access to care in rural areas, not necessarily assessing access at the provider level.

Presenters discussed how to address the challenge of small beneficiary populations in rural areas.

- Use of patient-reported measures, such as the Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS) survey's satisfaction measures, allows for a larger denominator compared with measures such as, control for people with diabetes. Measures of access, satisfaction, and integration can be more informative in rural areas compared with measures of quality or cost because quality and cost can be highly variable in rural areas.
- The ACO model allows providers to remain independent but share actuarial risk across a larger group of providers. ACOs use more individual quality metrics than what are used at the population level, to assess individual provider trends and inform provider payments based on performance.
- The number of beneficiaries will be larger for large FQHCs that have multiple sites in smaller communities. However, rural health care settings need front-end investments to build relationships and develop the HIT to gather data.

Presenters discussed where they would prioritize investments if more funding were put into primary care.

- The vision for the interprofessional primary care team has not been realized because of a lack of funding for health professionals outside of traditional medical providers such as, community health workers, nutritionists.
- Investments should be made for the HIT and the infrastructure factors that affect rural settings, such as having enough revenue to pay competitive market rates to rural providers.
- If an investment is provided through a population-based prospective payment, primary care should have the flexibility to address a broader set of services such as addressing social needs.
- Funding should be directed toward forming community partnerships or partnership cultivation, to address patient needs and to ensure that resources are available.

Presenters discussed existing successful rural models.

- Models tend to work well when they have global budgets and are integrated to include inpatient, outpatient, and post-acute services. They also function most effectively when multiple providers are highly coordinated.
- The ACO model works for rural providers; however, there is a desire to move toward global budgets. The Maryland TCOC Model stabilized payment to rural providers.
- The Federal Office of Rural Health Policy provided examples of collaboration among rural providers. Collaboration between a CAH and an FQHC resulted in improvement in cash on hand and net margins for both entities.

Presenters discussed whether telehealth could be an attribution model embedded into a TCOC model.

- It is important to be explicit about who benefits from telehealth and recognize that the benefits of telehealth may depend on tele-specialty (for example, tele-psych). The ramifications of telehealth are not yet clear for rural providers or for considering impacts on different populations.
- In addition to limited broadband access, uptake in telehealth may depend on other factors, such as a lack of trust in the medical system. Some patients prefer in-person visits with physicians they know rather than through a screen with a provider they have never met in person.
- Policy makers should consider opportunities to waive the current telehealth requirements in FFS and expand the use of telehealth in value-based models. Lessons learned about telehealth during the COVID-19 Public Health Emergency (PHE) can be applied to other value arrangements.
- Meeting with patients in their homes via telehealth can offer providers a different perspective on patients' circumstances. For example, when meeting with the patient in their home via telehealth, a provider might learn that a patient's heat was cut off.

Presenters discussed innovations in addressing issues related to transportation.

- Uber Health, a ride-sharing program, may be one way to bring more remote rural populations into the health care setting; however, the clinic must cover the cost. This cost could be included in PB-TCOC payment structures.
- Social connectedness is often higher in rural communities, but transportation solutions may rely on volunteerism, which is difficult to scale.
- Community paramedicine is a potential solution where an EMS truck that is not being used for emergencies can be used to help with house calls.

Presenters discussed ideas on how to encourage successful urban ACOs to incorporate rural practices.

- Addressing attribution and benchmarks will help to encourage urban ACOs to bring rural providers into the model. Rural areas can also form their own ACOs to manage risk so that they do not have to be connected to an urban ACO.

- It can be an incentive for large urban systems to work with high-performing rural ACOs to include high-value services in the system.

Presenters shared additional thoughts and insights not previously mentioned during the listening session.

- The term “rural” can be defined in different ways. Frontier and Remote Area (FAR) codes could provide an alternative way of thinking about rural health care, as the codes relate to access. The definition of rural will vary depending on the setting and the service provided.
- Policy makers need to establish consistent definitions of rural in order to measure and compare the performance of rural health care providers.

Roundtable Panel Discussion: Provider Perspectives on Payment Issues Related to Rural Providers in Population-Based Models

SMEs

- Adrian Billings, MD, PhD, Chief Medical Officer and Associate Professor, Family and Community Medicine, Texas Tech University School of Medicine
- Howard M. Haft, MD, MMM, Consultant and Former Senior Medical Advisor, Maryland Primary Care Program
- Karen Murphy, PhD, RN, Executive Vice President and Chief Innovation Officer, Founding Director, Steele Institute for Health Innovation, Geisinger

Previous Submitter

- Jean Antonucci, MD, Family Physician, Northern Light Health (*An Innovative Model for Primary Care Office Payment Proposal*)

Co-Chair Sinopoli moderated the panel discussion with four subject matter experts (SMEs) offering their perspectives on challenges facing patients and providers in rural areas. For additional details, please see the transcript and [meeting recording](#).

Panelists introduced themselves and provided background on their respective organizations. Full [biographies](#) and [panelist introduction slides](#) are available.

- Adrian Billings introduced himself as a rural family and community medicine physician. He also serves as the Chief Medical Officer and Associate Professor of Family and Community Medicine at Texas Tech University School of Medicine. Dr. Billings merged his private practice in rural southwestern Texas with an FQHC to expand his impact and services to include behavioral health, pharmacy, and dental services. Dr. Billings explained that he has provided health care across a variety of specialties to meet the needs of medically under-resourced areas of the Texas-Mexico border, and he has served in academic leadership roles to connect more resources to his rural communities. Through his experience, he shared that rural areas lack support services and financial resources, specifically social workers, specialist positions, and care management infrastructure. He recommended that value-based payment models design incentives that encourage academic health centers to collaborate and share their resources with rural health care organizations. He noted that his collaborations with academic health centers allowed the expansion of services within the FQHC and the launch of the rural residency program in partnership with the FQHC and CAH. Dr. Billings concluded with specific recommendations for academic health centers to use financial incentives to recruit medical students and trainees to rural communities and to encourage them to stay and practice in the community. Financial incentives could also be used to provide education about value-based care for students, trainees, and providers in rural areas. For additional

details on Dr. Billings' background and organization, see the [panelist introduction slides](#) (pages 16-18).

- Howard Haft introduced himself as a primary care internist, who has delivered primary care in rural settings for over 30 years. He also served as a state health officer and then senior medical advisor of the Maryland Primary Care Program (MDPCP). The MDPCP includes two-thirds of eligible primary care practices in Maryland, 17 of which are located in rural counties. Dr. Haft shared that the foundation of health care—specifically primary care—is about caring for the social and environmental needs of a community, in addition to the physical needs. He referenced recommendations from the National Academies of Sciences, Engineering, and Medicine (NASEM) report on implementing high-quality primary care through use of HIT and hybrid payments (FFS and population-based) to address equity issues. Dr. Haft noted that the main barrier to achieving equity for rural communities is insufficient funding in both rural health and primary care. In current value-based models, small rural providers are expected to take on the financial risk, which is not feasible or sustainable given the lack of infrastructure and resources. There is an opportunity for rural providers to benefit from the flexibility of population-based payments that do not carry risk, such as care management fees. However, Dr. Haft noted that these payments are not large enough to affect long-term innovation, which would require addressing the social needs of patients and expanding the scope of primary care, such as integrating behavioral health care. Regarding quality and performance benchmarks, Dr. Haft shared that it would be useful for models in rural settings to award performance improvement, not just achievement of a benchmark. He also explained that the benchmark should be expanded beyond one group or type of patients. For additional details on Dr. Haft's background and organization, see the [panelist introduction slides](#) (slides 20-22).
- Jean Antonucci introduced herself as a PCP in rural Maine. She shared that, as a solo PCP in a rural setting, she was able to provide quality care despite the stereotypes and limitations of rural practice. She participated in an ACO model, a Patient-Centered Medical Home (PCMH) model, and a Health Homes program through her state's Medicaid agency; however, her participation was short-lived due to hospital politics, administrative or regulatory burdens, or lack of benefit for the patient population. Dr. Antonucci explained that many of the rules and regulations involved with participation in government-run models and programs are barriers to progress. For example, meaningful use standards required the purchase of a new EHR system that did not work as well as her previous system. Dr. Antonucci also shared that she submitted a primary care-focused PFPM proposal to PTAC, which incorporates risk-based capitated payments in the context of SDOH. She emphasized that primary care practices should not be expected to take on this financial risk. She also explained that tools and resources for addressing SDOH are needed, or screening is fruitless. Dr. Antonucci also stated that technology, such as access and ability to effectively use smartphones, as well as affordable and available transportation, are significant barriers for her patient populations. For additional details on Dr. Antonucci's background and organization, see the [panelist introduction slides](#) (pages 24-25).
- Karen Murphy introduced herself as a registered nurse and current Executive Vice President, Chief Innovation Officer, and Founding Director of the Steele Institute for Health Innovation at Geisinger Hospital. Dr. Murphy has worked as an ICU nurse, a hospital CEO, on Dr. Haft's team on MDPCP, and as Secretary of Health at the Pennsylvania Department of Health. In this latter role, she collaborated with CMMI in developing the Pennsylvania Rural Health Model (PARHM). In her current role at Geisinger, she serves primarily rural areas in Maryland. She emphasized the importance of social accountability in the delivery and business of health care. She noted that the role of both federal and state governments is to protect vulnerable populations, which includes rural communities. Dr. Murphy shared that her thinking has evolved since working on PARHM to encompass a more holistic view of health, which means including the social determinants of health

and behavioral health in medical care. Taking a holistic, big-picture view would enable models to consider the predominant needs of each rural community or region. She reiterated that rural providers cannot take on the financial risk of current payment models and that payment models for rural areas should be aligned across settings and should prioritize sustainability. For additional details on Dr. Murphy's background and organization, see the [panelist introduction slides](#) (pages 27-28).

Panelists discussed their perspectives on the ideal payment model structure in a rural environment to incentivize the care delivery activities that would have the largest positive impact.

- Rural providers need to be paid more to incentivize innovations and collaborations, such as hiring social workers or behavioral health care providers within primary care and establishing rural residencies.
- Academic health centers need incentives that encourage social accountability to their rural communities. This would direct investment in recruitment, education, and training of the rural health care workforce.
- Value-based care models should not penalize rural providers based on pre-existing disparities in health, social needs, and immigration status in the populations they serve.
- In the *Innovative Model for Primary Care Office Payment Proposal*, the medical practice first assesses the risk of patients according to burden of disease. Capitated payments would be risk-adjusted such that providers serving minimal-risk patients would be paid less per patient than providers serving the highest-risk patients. The additional funds paid out to providers serving high-risk patients could be used to invest in care coordination, for example.
- Value-based care models should consider that many patients expect 24/7 comprehensive care, and models must be substantial and sustainable to adequately meet patient needs.
- Studies have found that \$60-65 per patient is necessary to provide comprehensive care that includes social needs support. This is much more than what is being compensated in the marketplace and is partially due to the chronic underfunding of primary care.
- Increased funding for primary care should be multi-payer.
- With some reforms to the physician fee schedule, models could use a hybrid payment that includes infrastructure payments adjusted for risk and social vulnerability, in addition to FFS payments.
- Capitated payments and global budgets can work for rural areas if they do not have the risk contingency.
- Increasing reimbursement of primary care, paying for infrastructure improvements, and aligning payment models with community needs are necessary for the success and sustainability of rural health care systems.

Panelists discussed the unintended consequences of not improving the value-based approach for rural markets and recommendations for new policy approaches.

- Anything that further disincentivizes rural health care payment risks the closure of more rural hospitals and clinics, thereby reducing access to care. Even less access to care results in increased morbidity and mortality for rural populations, further widening health disparities between rural and urban areas.
- Increased investment is vital to the survival of rural areas and cannot happen without accountability.
- The struggles of rural providers are the first indication of foundational problems with the country's health care system. When rural health care systems fail, this erodes the bedrock of the larger health system. Urban health care systems and academic health systems cannot fill the gap.

- To save primary care, the backbone of rural health care, investment, tools, time, and fewer rules and regulations are needed.

Panelists discussed their perspectives on ambitious policies to solve the issues with rural health care and, in the absence of new policy approaches, marketplace strategies.

- Investing in rural health care goes beyond social justice or accountability. Important resources are produced in rural America, and so a threat to rural health care is also a threat to the overall economy.
- Investing in rural health care is also important for urban and suburban residents who might vacation in rural areas and need access to high-quality care.
- Current culture and society do not value primary care. Changing this culture takes a long time and requires large-scale efforts.
- To encourage large-scale change through domestic policy, focus on the decrease in life expectancy and overall quality of life overall in rural areas. Because the United States does not have a unified health care delivery system, policy makers are limited in improving the health of the nation with the country's fragmented system.
- The problems with primary care and rural health care are bipartisan issues and should be addressed with complementary federal and state approaches.
- For a federal approach, the action plan that the Office of the Assistant Secretary for Health (OASH) produced for HHS is a starting point.

Dr. Haft discussed his perspective on the politics related to the privatization of Medicare versus the creation of a national health plan.

- MA plans are insufficient for primary care and most do not adequately follow a hybrid payment model that employs both FFS and capitation. There are too many MA plans in the marketplace, and they often focus on maximizing profit, while ignoring value and equity. MA prioritizes fiduciary responsibility to the board and CEO rather than to the patient.

Panelists discussed how to structure increased payments to rural providers and how to allow rural providers to participate in value-based care without taking on financial risk.

- Current value-based care models often include downside risk, which is challenging for rural providers to absorb, but value-based care models can be effective through upside risk.
- In rural health care, providers cannot cut costs because they are still not meeting the needs of their patients. The process of delivering health care in rural areas needs to be sustainable through investing in infrastructure and better appropriated through evaluating the needs of each community.
- Rural providers want to have access to the same tools and resources for their patient populations that urban providers have access to.

Panelists discussed the shortage of PCPs across the states and practical solutions.

- One solution is to pay for care teams to provide primary health care in communities. Thus, the increase in funding and investment does not go solely to PCPs and other advanced practice providers, but to coordinated team-based care through global capitation or risk-adjusted payments. This may include hiring more non-physician providers that can fill gaps in behavioral health care, care management, and HIT.
- Simplifying the billing and coding processes, which are time-consuming and costly for small practices, could help alleviate burden on PCPs and free up time to focus on patients.

Panelists discussed their perspectives on improving incentives to train PCPs to practice in rural areas and to recruit more students from rural areas into medical school.

- Two important predictors of practicing medicine in a rural area include growing up or having a significant life experience in a rural community, and having exposure to rural areas during medical school and/or residency.
- Creating multidisciplinary academic health centers in rural areas could provide opportunities for rural students to matriculate into social work, medical, or dental training programs, for example. This would help build a foundation for team-based care, which provides the best patient care and is lacking in rural areas.
- Fifteen percent of the U.S. population is rural. Thus, 15 percent of matriculants into health care training programs should be from rural areas. Hybrid or distance learning programs can be used in rural areas without training centers to enable students to maintain connections to their communities. More investment in the rural public education system in general may be needed for future health care providers and their families to stay in rural communities for the long-term.

Panelists discussed licensure expansion in rural areas.

- There is an opportunity to expand the scope of practice in pharmacy.
- Rural health care has the same number of regulations as urban health care with significantly fewer resources. To facilitate license expansion in rural areas, regulations need to be reduced and be appropriate for rural areas.

Committee Discussion

Co-Chair Sinopoli opened the floor to Committee members to reflect on the day's presentations and discussions. The Committee members discussed the following topics. For additional details, please see the transcript and [meeting recording](#).

- Significant capital investment is required for rural providers to implement the infrastructure, team-based care, and primary care needed to succeed in value-based care.
- It is important to ensure the survival of rural hospitals and primary care. Rural hospitals, though often small, are important centers of health care and crucial to recruiting PCPs and specialists to the area.
- Care models should preserve access to acute care and specialists to keep communities healthy. Models should focus on maintaining community health through partnerships.
- Innovative care models leverage community resources, such as paramedicine, community health workers (CHWs), and mobile clinics.
- The current focus on quality measurement, particularly TCOC, is an issue. Quality measures should focus on process measures, such as access to care.
- There is an opportunity to protect human capital and create a sustainable, interprofessional, interdisciplinary workforce.
- The distinction within the definition of rural and frontier requires different incentives and payment models.
- Policy makers must listen to the concerns of rural providers and work with them to provide support.
- Interdisciplinary primary care teams should be key to care delivery models.
- Measures should evaluate care integration, patient experience, provider burnout and retention, network promoter scores, and access to care.
- There should be investments across federal agencies to address communities disproportionately affected by increased morbidity and mortality.

- The health care system is not addressing the underfunding of primary care quickly enough, and MA is becoming the dominant public payer.
- Practice transformation must happen before payment reform to inform how payment models are designed.
- There is a pay disparity between PCPs and specialists, particularly considering the value PCPs provide to population health.
- Current value-based care models do not work in rural settings. In particular, there are issues related to attribution, lack of infrastructure, and benchmarks.
- PTAC should address how to design payment models to support innovative, team-based care delivery tailored to rural settings in its report to the Secretary.
- The challenges faced by all providers to report on quality and performance measures are magnified for rural providers. Rural areas lack the infrastructure to address the challenging reporting requirements for value-based models.
- All-payer models may circumvent the issue of attribution, especially in rural areas.
- Policy changes, such as reducing telehealth restrictions, relaxing meaningful use standards, and excluding outliers, may offer rural providers the flexibility needed to participate in APMs. Some of these interventions may need to occur across all payers to have an impact on rural participation.
- There are different types of rural areas, each requiring tailored solutions to health care delivery transformation.
- Prospective payments and a longer “on-ramp” to value-based models may help rural providers make the infrastructure investments needed to succeed in APMs.
- Attribution may need to look different for different types of rural areas.
- Entities such as academic centers and multispecialty groups, usually based in larger cities, could have a role in pooling rural areas into more urban or suburban areas to ease the attribution challenges inherent in rural areas.
- Medically underserved and rural areas are part of the country’s geopolitical polarization and instability. Access to quality health care is an important element of geopolitical stability.
- Policies should make Medicare FFS more “uncomfortable” and value-based care arrangements more attractive to providers.
- Unified definitions, such as a standard set of measures and standard definitions of factors such as race and ethnicity, are needed for rural practices to be able to manage within APMs.
- Policies should encourage all-payer participation.
- Significant investment is needed in HIT.
- The payment structures for the facilities that provide a large portion of rural care (RHCs, FQHCs, CAHs) inhibit them from participating in CMMI models, which has impeded innovation in rural areas.
- Rural and frontier areas face similar challenges, but those challenges are more severe in rural areas.
- Access is often defined by time and distance from a practice; however, practice resources are more important to network adequacy.
- Rural providers are often “competing against themselves” to achieve benchmarks, since they sometimes provide the vast majority of care to the community, which makes it difficult to show improvement.
- There should be a way to exclude outliers in quality measurement.
- There is a need for coordination and integration in rural communities.

- Some specific policies that should be considered include removing the face-to-face requirement for telehealth; waiving the one-visit, one-service for FQ billing; increasing access to Hospital at Home programs; and examining patient attribution approaches.
- Tertiary health centers are not equipped to support rural communities when hospitals close.
- A model that supports rural health care could be budget-neutral.

Closing Remarks

Co-Chair Sinopoli adjourned the meeting.

The public meeting adjourned at 4:55 p.m. EDT.

Approved and certified by:

//Lisa Shats//

12/4/2023

Lisa Shats, Designated Federal Officer
Physician-Focused Payment Model Technical
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Date

//Lauran Hardin//

12/4/2023

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Date