

Encouraging Rural Participation in Population-Based Total Cost of Care Models Request for Input (RFI)

The Physician-Focused Payment Model Technical Advisory Committee (PTAC) is hosting theme-based discussions to inform the Committee on topics that are important for physician-focused payment models (PFPMs). Given the increased emphasis on developing larger population-based Alternative Payment Models (APMs) that encourage accountable care relationships, PTAC has conducted a series of theme-based discussions that examined key definitions, issues and opportunities related to developing and implementing population-based total cost of care (PB-TCOC) models with accountability for quality and TCOC,¹ improving care delivery and integration of specialty care in population-based models, and improving management of care transitions in population-based models.

These theme-based discussions are designed to give Committee members additional information about current perspectives on key issues related to developing and operationalizing PB-TCOC models. This information will be useful to policy makers, payers, accountable care entities, and providers for optimizing health care delivery and value-based transformation in the context of APMs and PFPMs specifically. The theme-based discussions provide an opportunity for PTAC to hear from the public and subject matter experts, including stakeholders who have previously submitted proposals to PTAC with relevant components.

PTAC's two-day September 2023 public meeting focused on encouraging rural participation in PB-TCOC models. During the public meeting, Committee members heard from various subject matter experts, including stakeholders who have previously submitted proposals to PTAC that included components related to rural participation. Specific topics that were addressed included challenges affecting patients and providers in different types of rural areas; issues affecting rural providers' participation in APMs; lessons learned from APMs that have targeted or included rural providers; effective care delivery interventions/models for meeting the needs of rural patients and encouraging value-based care transformation in rural areas; financial incentives/payment mechanisms with the greatest potential to encourage rural providers' participation in PB-TCOC models and other types of APMs; and factors and performance measures that should be considered when measuring rural providers' quality of care. Stakeholders also had an opportunity to provide public comments. Findings from this theme-based discussion will be included in a report to the Secretary of Health and Human Services (HHS).

¹ Please see the Appendix for PTAC's definition of PB-TCOC models.

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Background:

The Center for Medicare and Medicaid Innovation (CMMI) has set the goal of having all Medicare fee-for-service (FFS) beneficiaries with Parts A and B coverage in a care relationship with accountability for quality and TCOC by 2030.² CMMI has also identified a goal of increasing the number of beneficiaries from underserved communities, including rural communities, that receive care through value-based payment models by increasing the participation of providers who serve them in these models as part of its overall objective of advancing health equity. For example, CMMI is examining model application and participant selection processes to identify and address barriers to inclusion of providers that serve underserved communities.³

Within this context, PTAC has assessed previous submitters' use of model design components related to health equity and rural populations. Among the 35 proposals that were submitted to PTAC between 2016 and 2020, eleven proposals either included or targeted rural populations. The two PTAC PFPM proposals that specifically targeted rural populations were: the *Innovative Model for Primary Care Office Payment* proposal and the *ACCESS Telemedicine: An Alternative Healthcare Delivery Model for Rural Cerebral Emergencies* proposal.

The Office of the Assistant Secretary for Planning and Evaluation (ASPE) provides an environmental scan for every proposal reviewed by PTAC so that Committee members have an understanding of the clinical and economic circumstances within which a proposed model would be implemented, as well as related resource information that can inform their evaluation of each proposal. To assist PTAC in preparing for the September 2023 theme-based discussion, an environmental scan was developed with background information on topics related to increasing participation of rural providers in the context of APMs and PFPMs.

There are a variety of definitions for determining what constitutes a rural area that are used for different purposes such as grants, public policy, and research. Some of the criteria that are used to identify rural areas include geography, population size, population density, proximity to metropolitan areas, and geographic remoteness. It should also be noted that these definitions

² Center for Medicare and Medicaid Innovation. *Innovation Center Strategy Refresh*; 2021:32. <https://innovation.cms.gov/strategic-direction-whitepaper>

³ Centers for Medicare & Medicaid Services. CMS Framework for Advancing Health Care in Rural, Tribal, and Geographically Isolated Communities; 2023. <https://www.cms.gov/files/document/cms-geographic-framework.pdf>

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and characteristics are inexact and can mean “different things to different people, organizations, and governments.”⁴

PTAC is using the following working definition of “rural area” as a starting point:

- *The Office of Management and Budget (OMB) identifies metropolitan areas as counties with 50,000 or more people, and rural areas as counties with fewer than 50,000 people.*
- *The U. S. Department of Agriculture’s Rural-Urban Continuum Codes (RUCC) can be used to further identify differences in rural counties based on population size and proximity to metropolitan areas.*

Additionally, PTAC is using the following working definition for rural providers:

- *Rural providers are providers, including independent practitioners and other types of providers, that are physically located in rural areas.*
- *Additionally, PTAC is aware that some rural communities have access to providers that are located in urban or suburban communities.*

These definitions will likely evolve as the Committee collects additional information from stakeholders.

PTAC Areas of Interest:

PTAC is particularly interested in innovative approaches for addressing the needs of patients in rural communities and encouraging the participation of rural providers within the context of value-based care. Particular topics of interest include identifying and addressing challenges that affect rural providers’ participation in APMs, effective care delivery interventions/models for meeting the needs of rural patients and encouraging value-based care in rural areas, and designing financial incentives to encourage increased participation of rural providers in PB-TCOC models and other types of APMs.

PTAC seeks to build upon the insights of stakeholders and use those insights and considerations to further inform the Committee’s review of proposals and recommendations that the Committee may provide to the Secretary relating to this topic. PTAC also seeks additional information on stakeholders’ experiences related to improving management of care transitions

⁴ Rural Health Information Hub. *What is Rural?* January 27, 2022. <https://www.ruralhealthinfo.org/topics/what-is-rural>

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in population-based models. Therefore, PTAC requests stakeholders' input on the questions listed below.

Please submit written input regarding any or all of the following questions to PTAC@HHS.gov. Questions about this request may also be addressed to PTAC@HHS.gov.

Questions to the Public:

- 1) What definitions of “rural” areas are the most relevant for identifying the needs of rural patients, providers, and health care systems within the context of population-based total cost of care (PB-TCOC) models?
 - a) What definitions are the most effective in identifying rural areas and distinguishing among different kinds of rural areas?
 - b) How should rural providers be identified and defined? What are the types of health care providers that serve rural communities (including non-rural providers whose catchment areas include rural communities)?
- 2) What are the characteristics and health care needs of rural Medicare beneficiaries (demographics, chronic conditions, practice patterns, other factors)?
 - a) How do the health care needs of rural beneficiaries differ from those of other types of beneficiaries?
 - b) What social and other risk factors are unique to rural populations, as compared to other geographies?
- 3) What are the characteristics and care delivery needs of rural providers (e.g., practice size, specialty, care delivery and coordination infrastructure, etc.)?
 - a) How do these characteristics and needs vary for different types of rural areas (e.g., rural areas with higher or lower population density; rural areas that are closer to urban areas versus rural areas that are more isolated; rural areas that do not have a lot of providers versus rural areas that have providers but do not have a lot of competition; rural areas in different geographic regions)?
 - b) How does the availability of health care system-related infrastructure vary depending on the type of rural area?
 - c) How does care delivery vary across gradations of rurality? What flexibilities are needed to operationalize different approaches across varying rural settings? What are the most important factors that require flexibility across rural settings?

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- 4) What major programs, payment mechanisms, and other policies have sought to assist rural health care providers in serving rural communities and patients?
 - a) How have these programs, payment mechanisms, and policies been implemented and sustained among rural providers?
 - b) What has been the impact of these programs and models that assisted rural health care providers on the providers' health care systems and on patient outcomes?
 - c) What additional programs, policies, and payment structures are needed to address rural health challenges?
- 5) What are the major barriers that affect rural providers' participation in APMs?
 - a) What specific APM eligibility criteria affect rural providers' participation in APMs (e.g., attributable population size, facility type, facility size, or health information technology [HIT] infrastructure requirements)?
 - b) How can rural providers' lack of external support for their contracting, quality assurance monitoring, data analytics, and data sharing activities be addressed to facilitate their participation in APMs?
 - c) Should there be a focus on specific types of rural providers in APMs (such as independent practices, Critical Access Hospitals [CAHs], or Rural Health Clinics [RHCs])?
 - d) What issues affect the participation of Federally Qualified Health Centers (FQHCs) and Rural Health Clinics (RHCs) in population-based models? What issues affect the participation of solo practitioners in population-based models?
 - e) Are there additional barriers that affect rural safety net providers' participation in APMs?
- 6) What care delivery interventions are the most effective in encouraging value-based care (VBC) transformation in rural areas?
 - a) What strategies do these interventions or models include (e.g., telehealth services, remote monitoring, patient education and self-management, use of community paramedicine or community health workers [CHWs], use of freestanding emergency departments [FSEDs], or screening for and addressing health-related social needs [HRSNs], etc.)?

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- b) What role do aggregators play in supporting rural providers' transformation to VBC? How does aggregators' dissemination of best practices for providers across disparate rural areas differ from their dissemination of best practices for non-rural providers?⁵
 - c) What has been the experience regarding the development of primary care medical homes (PCMHs) in rural communities? What are examples of effective approaches that providers, Accountable Care Organizations (ACOs), integrated delivery systems and payers have developed for providing patient-centered care in different types of rural communities? What are some lessons learned and best practices for expanding patient-centered care in rural communities?
 - d) What types of care are the most difficult to provide in rural areas (e.g., home health care; hospice and palliative care; behavioral health care; alcohol and substance use disorder services; reproductive, obstetric, and maternal health services, etc.)? What strategies can specifically target these types of care for improvement?
 - e) How does intervention effectiveness vary by setting (e.g., acute care hospital versus physician office), provider type (e.g., primary care versus specialty care), and other provider characteristics (e.g., organizational structure, mission, ownership)?
 - f) How does intervention effectiveness vary by type of rural community (e.g., population size, population density, isolation, provider capacity, region, etc.)?
 - g) How can care delivery interventions address specific barriers faced by patient populations residing in rural areas (e.g., lack of access to care, lack of health care coverage, distance and lack of transportation, provider shortages, lack of communication or trust, etc.)?
 - h) What non-medical interventions and social services can help address rural patient populations' needs? What role should rural providers play in supporting these non-medical interventions?
- 7) How do rural-specific issues affect social determinants of health (SDOH), health-related social needs (HRSNs), equity, and behavioral health (e.g., mental health and substance abuse disorders)?

⁵ "Physician aggregators are companies that bring together multiple physicians and medical practices under one umbrella organization. The aggregator typically provides a centralized platform or centralized services for managing the administrative and operational functions of the participating practices, including technology, resources, contracting, human resources, and marketing, etc." Source: Vim. Physician Aggregator Business. <https://getvim.com/glossary/physician-aggregator-business/>

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- a) What are examples of effective approaches that providers, ACOs, integrated delivery systems, and payers have developed for addressing SDOH, HRSNs, equity, and behavioral health in rural areas?
 - b) What measures of behavioral health (e.g., suicide rates and prevention, stress, substance use, etc.) are needed to evaluate rural quality of care?
 - c) What other kinds of measures are needed to evaluate rural quality of care (e.g., transportation, housing, financial status, availability of 24/7 access to services, etc.)?
- 8) How do rural-specific issues affect care coordination, specialty integration, and care transition management?
- a) What approaches have hospitals, integrated delivery systems, academic medical centers, ACOs, CAHs, and independent practices used to improve care coordination in rural communities? Which of these strategies have been the most effective for improving care coordination in rural communities?
 - b) What disparities exist in care transition management for rural patient populations? What are some approaches (e.g., swing beds) that can improve care transitions for rural populations?
 - c) What alternative care settings can be leveraged for rural populations (e.g., emergency medical services and ambulance transports to treat patients in place or transfer patients to alternative, non-ED destinations, etc.)?
- 9) What kinds of resources have been effective in assisting in the development of health infrastructure to support VBC among rural providers?
- a) Do rural providers and patient populations have differential uptake of telehealth services and modality than non-rural providers and patient populations? If so, why?
 - b) How would telehealth expansion benefit rural providers and the populations they serve? What are some potential unintended consequences of telehealth expansion (e.g., can it worsen disparities in access to care in some settings)?
 - c) What approaches have integrated delivery systems, ACOs, and payers used to address infrastructure issues in rural areas?
- 10) What kinds of resources have been effective in assisting in the development of the rural health workforce, including ancillary providers?
- a) How does the availability of primary care and specialty providers vary depending on the type of rural area?
 - b) How can APMs support the development of the rural health workforce?

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- 11) What are examples of promising APMs and model design components that include or target participation by rural providers?
- a) How can participation in APMs and PB-TCOC models potentially impact rural providers' ability to address rural health challenges?
 - b) What have been some lessons learned from Medicare Advantage Organization and ACO participation in rural communities?
 - c) How do the lessons learned vary for models that have been more rural-focused versus models that included participation of rural providers?
 - d) What have been some lessons learned based on the experience of FQHCs and RHCs participating in the Medicare Shared Savings Program?
 - e) What financial incentives were provided in these models? Which of these financial incentives were the most effective?
 - f) Did participating providers offer other person-centered activities (for example, transportation assistance; food and meals; building access to and subsidizing technology, such as broadband internet; affiliation with larger systems or networks; workforce shortages, and staff recruitment and retention)?
 - g) What financial incentives and model design features are needed to support rural providers' participation in PB-TCOC models?
 - h) What have been some effective approaches for determining patient attribution in models targeting or including rural providers?
 - i) What have been some effective approaches for overcoming challenges related to panel size in models targeting or including rural providers?
 - j) What have been some effective approaches for addressing issues related to benchmarking and risk adjustment in models targeting or including rural providers?
 - k) Does the effectiveness of various types of APMs and model design components in encouraging the participation of rural providers in value-based care vary depending on the type of provider or the type of rural community?
 - l) Is it likely to be feasible for rural providers to be able to participate in population-based total cost of care models with accountability for quality and total cost of care? Why or why not? What components will be needed to encourage rural providers' participation in these models?

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Where to Submit Comments/Input: Please submit written input regarding any or all of the following questions to PTAC@HHS.gov. Questions about this request may also be addressed to PTAC@HHS.gov.

Note: Any comments that are not focused on the topic of rural participation, APMs and PFPs, and efforts by physicians and related providers caring for Medicare FFS beneficiaries, or are deemed outside of PTAC's statutory authority, will not be reviewed and included in any document(s) summarizing the public comments that were received in response to this request.

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Appendix: Working Definitions Related to Population-Based Total Cost of Care (PB-TCOC) Models, Rural Areas and Rural Providers

PTAC is using the following working definition for population-based models.

Population-based models are models that include the entire patient population served by a given accountable entity or a broad subset of the patient population served by an accountable entity (e.g., Medicare-Medicaid enrollees).

PTAC is using the following working definition for PB-TCOC models.

A population-based total cost of care (PB-TCOC) model is an Alternative Payment Model (APM) in which participating entities assume accountability for quality and TCOC and receive payments for all covered health care costs for a broadly defined population with varying health care needs during the course of a year (365 days).

Within this context, a PB-TCOC model would not be an episode-based, condition-specific, or disease-specific specialty model. However, these types of models could potentially be “nested” within a PB-TCOC model.

Additionally, PTAC is using the following working definition of TCOC:

Total cost of care is a composite measure of the cost of all covered medical services delivered to an individual or group. In the context of Medicare Alternative Payment Models, TCOC typically includes Medicare Part A and Part B expenditures, and is calculated on a per-beneficiary basis for a specified time period.

Within this context, some examples of existing population-based models/programs that include components that are relevant for the development of PB-TCOC models include:

- *Advanced primary care models (APCMs)* that promote the use of Advanced Primary Care, an approach that enables primary care innovations to achieve higher quality care and allows providers more flexibility to offer a broader set of services and care coordination.
- *Accountable Care Organization (ACO) programs* where physicians or health systems assume responsibility for TCOC associated with a patient population.

While some existing APMs may include shared savings with upside risk only, PTAC anticipates that PB-TCOC models will include glide paths for allowing providers and organizations to gradually assume more downside financial risk over time.

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PTAC is using the following working definition as a starting point:

- *The Office of Management and Budget (OMB) identifies metropolitan areas as counties with 50,000 or more people, and rural areas as counties with fewer than 50,000 people.*
- *Because rural areas are not monolithic, the U. S. Department of Agriculture's Rural-Urban Continuum Codes (RUCC) can be used to further identify differences in rural counties based on population size and proximity to metropolitan areas.*

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