PTAC MEMBERS PRESENT

LAURAN HARDIN, MSN, FAAN, Co-Chair
ANGELO SINOPOLI, MD, Co-Chair
LINDSAY K. BOTSFORD, MD, MBA
JAY S. FELDSTEIN, DO
LAWRENCE R. KOSINSKI, MD, MBA
WALTER LIN, MD, MBA
TERRY L. MILLS JR., MD, MMM
SOUJANYA R. PULLURU, MD
JAMES WALTON, DO, MBA
JENNIFER L. WILER, MD, MBA

PTAC MEMBERS NOT PRESENT

JOSHUA M. LIAO, MD, MSc

STAFF PRESENT

LISA SHATS, Designated Federal Officer (DFO),
Office of the Assistant Secretary for
Planning and Evaluation (ASPE)
STEVEN SHEINGOLD, PhD, ASPE
Opening Remarks

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

Welcome and Co-Chair Update - Overview of Discussion on Encouraging Rural Participation in Population-Based Total Cost of Care (TCOC) Models Day 1

PTAC Member Introductions

PCDT Presentation - Encouraging Rural Participation in Population-Based TCOC Models

Panel Discussion: Challenges Facing Patients and Providers in Rural Communities

- Janice Walters, MSHA, CHFP; Meggan Grant-Nierman, DO, MBA; and Jen L. Brull, MD, FAAFP

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

- Aisha T. Pittman, MPH; Jackson Griggs, MD, FAAFP; and Mark Holmes, PhD

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

- Adrian Billings, MD, PhD; Howard M. Haft, MD, MMM; Jean Antonucci, MD; and Karen Murphy, PhD, RN

Committee Discussion

Closing Remarks

Adjourn
**CO-CHAIR HARDIN:** Good morning, and welcome to this meeting of the Physician-Focused Payment Model Technical Advisory Committee, known as PTAC. My name is Lauran Hardin, and I am one of the Co-Chairs of PTAC along with Angelo Sinopoli. Since 2020, PTAC has been looking across its portfolio to explore themes that have emerged from proposals received from the public over the years. After each theme, the Committee releases a public report to the Secretary of HHS\(^1\) with its findings. In March we had our public meeting on improving care delivery and integrating specialty care in population-based models. We plan to post the report to the Secretary on our website in the next week. A listserv will go out announcing the posting of that report.

We also plan to post the June report to the Secretary on improving management of care transitions in population-based models in the next month.

Rural providers face challenges with care delivery and approaches to address them,

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\(^1\) Health and Human Services
particularly in relation to population-based model participation, and this theme has come up throughout the previous PTAC theme-based discussions and in several submitted proposals. We know that this topic is also of interest to the Innovation Center at CMS.

And before our first presentation of the day, we're very honored to have opening remarks from Dr. Liz Fowler, the Deputy Administrator of CMS and Director of the Center for Medicare and Medicaid Innovation. Dr. Fowler previously served as Executive Vice President of Programs at the Commonwealth Fund and Vice President for Global Health Policy at Johnson & Johnson. She was Special Assistant to President Obama on Healthcare and Economic Policy at the National Economic Council. From 2008 to 2010, she also served as Chief Health Counsel to the Senate Finance Committee Chair where she played a critical role in developing the Senate version of the Affordable Care Act. Thank you so much and welcome, Liz.

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

DR. FOWLER: Lauran, thanks. It's so nice to be here. Dr. Sinopoli, nice to you and all the rest of the PTAC members and also note that we've got a number of CMS Innovation Center folks who are eagerly listening in the audience to the presentations today.

I just want to thank you for the invitation to provide some opening comments this morning, and it's great to be back for the third quarterly meeting of 2023. The first two quarterly meetings this year were very rich discussions, and the Innovation Center has been tracking closely a lot of these discussions, the specialty care integration meeting in March and then as you noted, the transitions of care meeting in June.

Both of those meetings brought together deep subject matter experts who provided excellent thought-provoking presentations. And I expect these discussions on rural health to be more of the same.

We know people in rural communities have a higher prevalence of chronic diseases
like diabetes and COPD², as well as higher rates of unintentional injury and disability compared to their urban counterparts. And we also know that access to care is a particular challenge in rural communities. These disparities and access challenges are linked to many different factors that speakers over the next two days will explore. For example, only 12 percent of physicians practice in rural communities, and more than half of health professional shortage areas in the U.S. are in rural areas.

And over the last decade, many rural hospitals have closed, particularly in states that have not expanded Medicaid, and this has exacerbated the challenges around accessing care. Greater use of telehealth services, a promising way to improve care and access in rural areas while positive, may be limited if broadband access isn't available.

And finally, technology barriers that limit telehealth uptake, workforce shortages that have impacted providers and health systems across the country, but are particularly acute in rural areas, and other structural limitations have all led to

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² Chronic obstructive pulmonary disease
decreased uptake in value-based care models in rural areas.

Supporting access to care in rural frontier and other geographically-isolated communities is a priority for CMS. And we're working across the Agency to think about and how to address these challenges. Last year, CMS finalized rules for Rural Emergency Hospitals, a designation that would allow Critical Access Hospitals and small rural hospitals to convert to REH³ status and receive enhanced Medicare reimbursement. And starting in January 2024, the Medicare Shared Savings Program will provide advanced infrastructure payments to new ACOs⁴, and we hope that this will provide a bridge for entities to join the program, particularly in rural areas among practices and providers.

Current and past models and initiatives at the Innovation Center also represent an extension of the CMS commitment to support rural health. We continue to administer two statutory demonstrations, the Rural Community Hospital Demonstration and the

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3 Rural Emergency Hospital
4 Accountable Care Organizations
Frontier Community Health Integration Project, FCHIP. We also lead the Pennsylvania Rural Health Model or PARHM, which started in 2017 and will continue through 2024, which is exploring the feasibility of care delivery transformation in the context of hospital global budgets. We have heard some hospitals have commented that the global budget hasn't funded all of their hospital transformation activities, but the model has been a catalyst to accelerate existing and build new community partnerships.

And then two weeks ago, we announced the States Advancing All-Payer Health Equity Approaches and Development, or AHEAD model, which focuses on state health systems and transformation and also includes a hospital global budget component. This model is open to Rural Health Clinics and Critical Access Hospitals.

Additionally, the new primary care model we announced this summer has a strong focus on underserved communities and particular outreach and focus on community health centers, and we hope that those providers and practices and organizations who serve beneficiaries in
underserved areas, including rural areas, will be coming into the model.

And as some in the audience may know, in March 2023, we announced the termination of the Community Health Access and Rural Transformation, or CHART model, due to a lack of hospital participation. CHART was intended to innovate payments, increase access, and improve the quality of care and health outcomes in rural communities. While we were disappointed at this outcome, we also appreciate what we learned from our rural partners about this model and why the outcome wasn't what we wanted or expected.

As the CMS Innovation Center continues to explore opportunities to expand our work to address the challenges faced by beneficiaries and providers in rural areas, we look forward to hearing from all of the speakers that PTAC has invited to this meeting. In particular, I know we have a handful of them who are participants in some of our models and welcome them as well.

I'll close with a few general questions that CMMI is hoping to learn over the next couple of days. First, our teams are...
challenged by the many definitions of rural. How should it be defined for purposes of CMMI? What kind of providers count as rural? And which ones shouldn't count and why? And second, what should we prioritize in a care delivery model for rural populations? Third, what are the changes to payment that are interesting to rural providers, or what flexibilities would they need to take on value-based care arrangements? For rural providers and practitioners that haven't been engaged in value-based payment models, what are some of the key factors holding them back? And finally, given lower patient volumes in rural health care settings, what does this mean for measuring the quality of care? How can we reliably measure the quality of care in rural communities?

We are very grateful for the efforts that went into developing the presentations over the next couple of days and look forward to learning more from all of you on how to solve the disparities in health care experienced in rural communities. We're eager and excited that our partnership with PTAC will help inform future innovations and actions in
rural health care.

So I'll stop there and turn it back over to you, and thanks very much for the chance to be here.

* Welcome and Co-Chair Update — Overview of Discussion on Encouraging Rural Participation in Population-Based Total Cost of Care (TCOC) Models Day 1

CO-CHAIR HARDIN: Thank you so much for joining us, Liz. We really appreciate your engagement and partnership and look forward to working with you over the next couple of days.

For today's agenda, we will explore a range of topics, including 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 providers' participation, and successful interventions and models for encouraging value-based transformation in rural areas.

The background materials for this public meeting, including an environmental scan, are online. Over the next two days,
you'll hear from many esteemed experts. We've worked very hard to include a variety of perspectives throughout the two-day meeting, including the viewpoints of previous PTAC proposal submitters who addressed relevant issues in their proposed models.

I also want to mention that tomorrow afternoon will include a public comment period. Public comments are limited to three minutes each. If you would like to give an oral presentation tomorrow, but have not registered to do so, please email ptacregistration@norc.org. Again, that's ptacregistration@norc.org.

The discussions, materials, and public comments from the September PTAC public meetings will all feed into a report for the Secretary of HHS on how to encourage rural participation in public population-based models.

The agenda for today and tomorrow includes time for the Committee to discuss and shape our comments for the upcoming report. Before we adjourn tomorrow, we'll announce a Request for Input, which is an opportunity for stakeholders to provide written comments to the
Committee on improving care transitions.

Lastly, I'll note that, as always, the Committee is ready to receive proposals on possible innovative approaches and solutions related to care delivery, payment, or other policy issues from the public on a rolling basis. We offer two proposal submission tracks for submitters, allowing flexibility depending on the level of detail of their payment methodology. You can find information about how to submit a proposal online.

* PTAC Member Introductions

At this time, I would like my fellow PTAC members to please introduce themselves. Please share your name and organization and if you would like, feel free to describe any experience you have with our topic.

First, we'll go around the table, and then I'll ask our members joining remotely to introduce themselves. I'll start.

I'm Lauran Hardin, a nurse and Chief Integration Officer for HC2 Strategies. I spent the better part of the last 20 years designing care management models under all of the ACO, BPCI\textsuperscript{5} value-based payment initiatives

\textsuperscript{5} Bundled Payments for Care Improvement
and was a founding member of the National Center for Complex Health and Social Needs that partnered with states, communities, health systems, designing models to meet the needs to underserved populations and deeply working now in California with the Medicaid 1115 waiver, building connected communities of care deeply in rural areas. Angelo.

CO-CHAIR SINOPOLI: Thank you, Lauran. Angelo Sinopoli. I'm a pulmonary critical care physician by training. Spent a lot of my career in an organization called Prisma Health, where I built and developed a large clinically-integrated network there that served about 1.2 million patients across two-thirds of South Carolina. We had 5,000 providers in that network and obviously, in South Carolina I’ve spent a lot of -- had a lot of patients in rural, very rural areas, as well as urban areas, and so I had a diverse experience there taking care of those patients.

Most recently, I'm the Chief Network Officer for UpStream, and looking forward to the next few days. Jay.

DR. FELDSTEIN: Good morning, everyone. My name is Jay Feldstein. I'm
originally trained as an emergency medicine physician. I practiced emergency medicine for 10 years and then spent 15 years in the health insurance world in government and commercial programs. And in the last 10 years, I've been the President of the Philadelphia College of Osteopathic Medicine, turning out primary care physicians in both urban and rural settings.

DR. WILER: Good morning. I'm Jennifer Wiler. I'm the Chief Quality Officer at UCHealth out of the Denver Metro area, one of the largest health care systems in the Rocky Mountain region. I'm also co-founder of the Health Systems Care Innovation Center where we partner with digital health companies to grow and scale their solutions to improve patient care. I'm a tenured professor at the University of Colorado School of Medicine and an emergency physician by training and co-author of an Alternative Payment Model that was considered by this Committee.

DR. WALTON: Good morning. My name is Jim Walton. I'm a general internal medicine physician. I started my career in Waxahachie, Texas, in private practice and transitioned to develop rural health centers in Ellis County
and then transitioned as a Medical Director of Baylor Community Care for about two decades.

(Inaudible due to sound system failure.)

DR. WALTON: Back to the programming, I served as the Baylor Healthcare Systems Chief Equity Officer and then transitioned into the CEO of a large primary care ACO in Dallas, Texas, serving both urban and rural patients in Medicare and Medicaid and commercial ACO contracts.

DR. KOSINSKI: I'm Dr. Larry Kosinski. I am the founder and Chief Medical Officer of SonarMD, a value-based company that for the last 10 years has been my focus. We bring risk-based, value-based solutions to gastrointestinal specialists in the commercial space.

Of note is the fact that SonarMD was the first PTAC recommended physician-focused payment model back in 2017. I look forward to the next two days.

DR. LIN: Good morning. My name is Walter Lin. I'm an internist and founder of Generation Clinical Partners. We are a group of providers based in the St. Louis-Southern
Illinois area that cares for the frail elderly in senior living organizations such as nursing homes and assisted living facilities.

DR. BOTSFORD: Good morning. I'm Lindsay Botsford. I'm a family physician in Houston, Texas, and a medical director with One Medical. After 10 years in teaching residents and medical students, I shifted to Iora Primary Care, where we started caring for older adults on Medicare in full-risk payment models, and continued to serve as the medical director for our practices in Texas.

DR. PULLURU: Good morning. My name is Chinni Pulluru. I'm a family physician by trade, most recently, Chief Clinical Executive and Vice President of Clinical Operations for Walmart Health, where I powered the expansion of Walmart Health clinics, as well as the integration of their national telehealth platform and the transformation to value-based care across the enterprise. Prior to that, I served as Chief Clinical Executive for DuPage Medical Group, now called Duly, and their subsidiary medical services organization leading the value-based care service expansion, as well as physician engagement. Thank you.
DR. MILLS: Good morning. I'm Terry Lee Mills. I'm a family physician, and I'm Senior Vice President and Chief Medical Officer at CommunityCare, a regional health system-owned provider health payer in Oklahoma. We operate in the Medicare Advantage, commercial, and marketplace exchange space where for 30 years we've offered total cost of care, quality directed, capitated models in all three of those markets.

I came up through medical group leadership in a variety of integrated health systems leading primary care transformation, including operating in a whole variety of CMMI innovation models over 25 years.

CO-CHAIR HARDIN: Thank you so much, everyone. And now we'll turn to our first presentation.

So three PTAC members have served on the Preliminary Comments Development Team, or PCDT, which has worked closely with staff to prepare for this meeting. Jay Feldstein was the PCDT lead with participation from Jim and Josh. I'm thankful for the time and effort they put into organizing today's agenda. I think you'll find it sets a very great
foundation for our discussion today.

We'll begin with the PCDT presenting some of the findings from their analysis. Additional background information materials are available on the ASPE PTAC website.

PTAC members, you'll have an opportunity to ask the PCDT any follow-up questions afterwards. And now I'll turn it over to Jay.

* PCDT Presentation - Encouraging Rural Participation in Population-Based TCOC Models

DR. FELDSTEIN: Thank you, Lauran. I'd like to just thank staff of ASPE and NORC for their hard work and support and my fellow PCDT team members and the PTAC Committee for their contribution and support.

Myself and Jim and Josh have a special affinity and commitment to rural health care, as all three of us have practiced and are committed to rural health care. Jim practiced rural health medicine in Texas. We actually opened a medical school in rural South Georgia with a population of 15,000 people. I know Josh is committed, as well, to rural health care in the state of Washington, so this is
really an exciting topic for all three of us
and for all members of the PTAC Committee.

So over the next two days, what
we're looking to do is to examine challenges.
The first one will be advancing the slides and
reading them at the same time; facing patients
and health care providers in rural communities;
identify care delivery models that are
effective in addressing patient needs,
improving outcomes, and encouraging value-based
transformation in rural areas; explore options
for encouraging participation of rural
providers and population-based total cost of
care models, and other Alternative Payment
Models; and to identify financial incentives
and mechanisms to increase participation of
rural providers in Alternative Payment Models.

Rural providers face unique
challenges and have been less likely to
participate in Accountable Care Organizations
and other population-based models. The Centers
for Medicare & Medicaid Services and the Center
for Medicare and Medicaid Innovation have
developed several models and programs designed
to encourage value-based transformation of
rural areas. PTAC has deliberated on the
extent to which 28 proposed physician-focused payment models met the Secretary's 10 regulatory criteria. Eleven of these proposals either included or targeted rural populations. And the goal for this meeting is to better understand these challenges and lessons learned from models and programs that have sought to address them.

As part of the overview, we'll explore the definitions of rural care, challenges affecting rural patients and providers, challenges affecting rural participation in Alternative Payment Models, innovative approaches for supporting rural value-based care transformation, and lessons learned about rural participation in Alternative Payment Models.

There are a variety of definitions for determining what constitutes a rural area. Definitions are used for various purposes such as grants, public policy, and research. Criteria include geography, population size, population density, proximity to metropolitan areas, and geographic remoteness.

PTAC is using the following working definitions for this presentation. The Office
of Management and Budget 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 has nine Rural-Urban Continuum Codes or RUC Codes that can be used to further identify differences in rural counties based on population size and proximity to metropolitan areas.

PTAC is using the following working definition of rural providers. Rural providers are providers, including independent practitioners and other types of providers that are physically located in rural areas. PTAC is aware that some rural areas also have access to providers that are located in urban and suburban communities. The key takeaway here is how do we define them, how do we measure their success, and how ultimately do we reimburse them in payment models?

When we look at geographic distribution by rural access by RUC Codes, you can see that 15 percent of the U.S. population, or close to 46 million lives, are people in rural areas. Sixty-three percent of U.S. counties are designated as rural areas. And
some counties include both rural and non-rural areas. If you look at the scale, non-rural or cities at 1 are representing by the rose-colored geographic areas. And as we get to dark blue, they become more rural with 9 being the most rural areas in America.

Rural areas vary based on population size and proximity to metropolitan areas. Half of all rural counties have 2,500 to 19,999 residents, and a third have less than 2,500 residents. Half of all rural counties, 48 percent, are not adjacent to metropolitan areas. The bottom line is rural areas are not monolithic; therefore, effective delivery models, financial incentives, and payment methodologies may vary depending on the type of rural area and the type of rural provider. Rural areas with a shortage of providers may experience different challenges compared to rural areas with low patient volume or insufficient competition among providers, relative to having sustainable financing, measuring performance, and being able to participate in APMs\(^6\).

There are regional differences among

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\(^6\) Alternative Payment Models
rural providers as well according to population and adjacency to metropolitan areas. Nearly half of all rural counties in the West North Central region have less than 2,500 residents, and nearly two-thirds of all rural counties in the West North Central region are not adjacent to metropolitan areas.

I want to highlight on this slide the Mid-Atlantic states, New Jersey, New York, and Pennsylvania. The percentage that is completely rural or less than 2,500, urban, non-metro population are RUCC counties 8 and 9, are less than 9 percent. Not adjacent to a metropolitan area which are RUC Codes 5, 7, and 9 is 20 percent. Now compare that to the West North Central. Forty-nine percent have areas of less than 2,500 population bases, and 64 percent are not adjacent to a metropolitan area. So there's tremendous variation across the country.

There's also tremendous diversity among rural providers. Rural providers differ in the services that they offer and statutory requirements. Some rural providers have special payment rates and methodologies created by statute. For example, Critical Access
Hospitals provide 24-hour emergency care services, whereas Rural Health Clinics may be limited to providing a specific type of primary care. And rural health care centers and Critical Access Hospitals are not paid by service codes, so they are not accustomed to coding and billing as the same way as other providers, which makes measurement and reimbursement sometimes difficult.

Additional differences between rural and urban areas, compared to non-rural counties, rural counties had lower income on average, less than $9,000 per average per capita in the U.S., and Americans living in rural areas are more likely to live below the poverty level. There are higher uninsured populations. Rural areas have larger proportions of adults under the age of 65 without insurance. It's an older population, 17.5 percent of the rural population is 65 and over, compared to 13.8 percent in urban areas. And most importantly, there is decreasing life expectancy in rural counties. We'll explain in more detail the life expectancy differences in later slides.

Compared to non-rural counties,
rural counties had fewer primary care providers, 37.9 versus 52.9 per 100,000 people; fewer specialists, 46.5 specialists per 100,000, while urban areas have 146.4 per 100,000. And a theme that will come up during the course of the presentation is reduced broadband access. Less than 70 percent of rural households have access to high-speed internet compared to 85 percent of households in large metropolitan areas. In fact, when we were doing research for this theme-based discussion, some potential subject matter experts in rural areas could only be reached by phone or fax because it had no internet access.

And there are lower Medicare Advantage enrollment in rural areas compared to metropolitan areas. That has basically quadrupled since 2010, and now there are close to a million Medicare Advantage beneficiaries living in rural areas.

Just a graphic of the adjusted death rates by the urban-rural classification in the United States over the last 10 years, and you can see that there's a discrepancy between rural death rates and urban death rates. More importantly, when you look at age-adjusted
death rates for the 10 leading causes of death by urban-rural classifications, the greatest discrepancies in death rates are in heart disease, cancer, and chronic lower respiratory diseases.

When we look at an overview of issues affecting rural health care systems, settings, providers, and patients, obviously, there are going to be economic, social, and environmental challenges, accessing federal resources, poverty, lower health literacy, and educational attainment. On the patient side, there's higher rates of obesity, substance use, and chronic disease, complications due to less health insurance and access, higher rates of unintentional injury, more older adults.

In the provider setting, there's lower patient volume and provider revenues, more publicly and uninsured patients, complex patient populations, workforce shortages, and an aging workforce and higher workload burnout, as well as limited transportation options for patients and insufficient ancillary health care services. When we look at the intersection between patient issues and provider issues, lower income affects both. There's a mismatch
between infrastructure for broadband access, health information technology, provider mix, which is reflected in a lack of specialists, and a lack of community-based organizations and resources, and patient complexity.

Rural doctors are seeing urban-level disease with rural-level resources. Rural patients' higher rates of obesity and substance abuse, as well as a higher proportion of older adults with limited access, leads to a decrease in services and specialists with poor health outcomes. And the challenges providers face with addressing the needs of complex patient populations, while having limited support staff because of workforce shortages, often leads to a higher workload and burnout rate.

Rural health care settings, lower patient volume frequently results in inadequate income streams necessary for providers to sustain their practice, which forces them to shut down. The unstable finances also limits their ability to participate in APMs and population-based total cost of care models.

Let's look at some of these in greater detail. Complex patient populations, rural areas tend to have higher rates of
behavioral health conditions, substance abuse, and older adults, as well as higher disease burden, compared to non-rural areas. A higher rate of uninsured and publicly insured patients under the age of 65 were 2.5 to 4 times more likely than the urban peers to be uninsured. And rural hospitals have a 20-percentage point higher rate of Medicaid patients.

Lower patient volumes can affect financial viability and reduce reliability and validity or performance measurements results and impact providers' ability to participate in CMS-quality programs. Forty-seven percent of rural hospitals have 25 or fewer staff beds, and over 100 rural hospitals closed between January of 2013 and 2020. Eleven rural hospitals have closed in 2023, and over 600 rural hospitals are at risk of closure for this year.

Rural PCPs tend to make five percent less than their urban counterparts. Now the Consolidated Appropriations Act of 2021 established Rural Emergency Hospitals as a new Medicare provider type to address the large number of rural hospital closures during and

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7 Primary care providers
prior to the COVID-19 public health emergency. Rural Emergency Hospitals are required to provide emergency and observation services and may provide other outpatient services based on the needs of the community. They received enhanced Medicare payments for certain outpatient services and an additional monthly facility payment.

Workforce shortages, patient-to-PCP ratios in rural areas: 40 PCPs per 100,000 compared to 53 in an urban area. Higher workloads, challenges building economies of scale due to limited financial resources in rural areas can challenge technological integration and other innovations and less health information technology [HIT] infrastructure. Rural areas experience lower HIT adoption rates due to limited financial resources and inconsistent broadband access. Approximately 43 percent of rural health care centers report that costs for health information technology improvements prevents their participation in ACOs.

Compared to non-rural areas, rural areas have fewer PCPs and specialists per 100,000. When we look at the specialists, 46
per 100,000, as compared to 146 in non-rural areas, with a large discrepancy in cardiovascular disease. There's only 1.1 per 100,000 in rural areas compared to 4.27 in non-rural areas. Whether this fact is causative or an association for the increased death rates seen in rural areas for cardiovascular disease remains to be seen; gastroenterology specialists, .47 per 100,000 compared to 2.93; and neurosurgery, .17 per 100,000 versus 1.3 in non-rural areas.

So what are some of the opportunities for addressing rural workforce challenges? Well, due to the workforce shortages in rural communities, there's increased provider burnout and turnover. There's increased difficulty with recruiting and retaining providers, and there's limited access to health care training and education in rural areas for ancillary staff. Some of the strategies for addressing rural workforce challenges through the use of telehealth, ACOs can provide resources to support telehealth. They can help share financial risks and can be cost effective and help rural providers adopt higher-value telehealth applications, bonus
payments to rural health providers to develop their telehealth infrastructure, incentives for rural providers to increase the proportion of telehealth visits and funds to provide rural patients with access to necessary telehealth technology, cell phones, facilities with tablets, and again, increased broadband access.

In terms of giving rural providers, they encounter challenges when implementing and using health information technology and data analytics. They have a lack of financial resources. Again, 43 percent of rural health centers reported costs for health information technology improvements prevented their participation in ACOs, and many providers lack training on data analysis and decision support systems, as well as having the support staff help to use health data information. And patients may not engage in health information technology due to a lack of broadband access or low digital literacy.

Some of the strategies for addressing this infrastructure challenge are funding for health information technology infrastructure, providing technical assistance and value-based incentives for health
information technology engagement.

Rural providers tend to participate in APMs at a lower rate than their metropolitan and non-rural counterparts, and physicians participating in advanced APMs in rural areas were most commonly in primary care specialties, family practice, and internal medicine.

Again, the challenges affecting rural providers to participate are financial resources and risk management. They lack the capital to finance the up-front cost of transitioning to APMs. They're averse to financial risk or lack reserves to cover potential losses. And they treat too few Medicare patients to justify investments in APMs, and lower patient volumes result in less predictable spending patterns, heightening the financial risk. They're less able to control the cost of care because patients are often referred elsewhere for tertiary care. And their lower patient volumes render less predictable spending patterns.

They are unable to conduct data analytics or financial modeling needed to provide value-base care. The complexity and
cost of EHRs\textsuperscript{8} or lack of high-speed internet hinder EHR adoption. And the lack of EHR interoperability and staff training, as well as weakness of health information exchange between providers inside and outside the community, just are continued challenges for the adoption of data and health information technology. And again, staff resources and capabilities, they lack staff members capable of managing the transition to or participate in APMs. There's a lack of capital to manage building a population base, team-based approach for care coordination and case management, and a general overall lack of awareness of APMs.

Again, the design and availability of models, there are limited APM options due to models' participation restrictions, whether geographic or provider type in volume, a lack of nearby ACO or models appropriate for providers in rural shortage or underserved areas, economies of scale, and the potential need for low-volume adjustments. They struggle to adapt to changing model rules and regulations.

The challenges faced by rural

\textsuperscript{8} Electronic health records
providers for total cost of care models are attribution panel size, validity of outcome data given limited information technology, infrastructure and small populations, the ability to take on risk, relevant performance measures, and quality performance measurements. For example, small panel sizes limit rural providers' ability to calculate reliable and valid performance measurement results.

Types of care that are most difficult to provide in rural communities include lack of post-discharge follow-up due to workforce availability and transportation issues; decreased access to mental health and substance abuse disorder treatment; fewer gastroenterologists, general surgeons, radiation oncologists, and other specialists; and limited access to ancillary service providers from health care diagnostic testing and dialysis.

Some of the approaches to address the needs of rural communities include audio and video visits, including telehealth, co-location of health care services, leveraging pharmacists as care providers, increasing value-based payment models in rural hospitals,
and coordination with community-based organizations supporting nutrition and housing, et cetera.

Strategies included in effective models that drive valued-based care in rural areas include promoting behavioral health care services, supporting and encouraging care coordination across providers, improving specialty integration, and expanding care networks or performing new entities.

Financial incentives to drive value-based care transformation among rural providers include providing startup funding for incentive coordination of care, provide a fixed, up-front payment regardless of patient volumes to increase access to care and specialty care, quality incentives to drive value-based care transformation among rural providers, payment tied to performance on quality measures, adjust Medicare fee-for-service payments based on performance against a set of quality measures relative to their peers' performance because performance impacts future payment adjustments.

Challenges affecting rural providers' participation and performance measurement: low case volumes place
limitations on the calculation of reliable and valid performance measurement results. Several CMS value-based programs exclude providers from public reporting based on low care volumes; staff shortages, as well as limited funds and other resources; limited staff with experience performing data extraction analysis, as well as using measurement results to inform quality improvement efforts. And rural patients tend to be disproportionately impacted by health conditions, making performance comparisons between rural and non-rural settings difficult. Measures should not be used to evaluate rural providers' performance; for example, measures of cost should be used with caution because some rural providers do not have access to lower cost treatment options or may encounter higher supply chain costs compared to non-rural providers.

Strategies to ensure that rural-relevant measures appropriately measure the performance of rural providers would be to tailor performance measures to the type of rural provider health care services offered, modify measurement approaches for rural providers, use risk adjustment to account for
differences in risk factors within and across rural patient populations. You need to consider how measuring the success of rural providers might differ from measuring the success of non-rural providers. One example would be emergency department utilization because EDs\(^9\) are a critical source of after-hour care in rural markets, so reducing ED utilization may not adequately reflect value-based care transformation in rural markets, and again, potentially identifying other measures related to retention of rural providers in APMs and shared savings.

Examples of quality measures used in prior APMs that target rural providers include inpatient and ED visits for ambulatory care-sensitive conditions, hospital readmissions, ambulance transports, patient experience with care, primary care and behavioral health integration, influenza vaccination, screening for depression, follow-up plan and rate of adults with preventative care visits, care coordination and care transitions, and substance abuse -- use of pharmacotherapy for opioid use disorder, use of opioids at high

\(^9\) Emergency departments
dosage in persons without cancer, and risk of continued opioid use.

The National Quality Forum [NQF] Measure Applications Partnership Rural Health Work Group suggested that rural-relevant measures should be NQF-endorsed, resistant to case volumes, and address care transitions.

Now what are some of the lessons that we've learned from CMMI models that targeted or included rural participants? Several CMMI models have either targeted or included rural participants. The models used a variety of payment mechanisms, including pre-paid shared savings, per beneficiary per month payments, global budgets, fee-for-service payments, and population-based payments, bundle payments, and performance-based payments.

Specific lessons learned include establishing longer on-ramps for rural practices interested in APM participation, developing APMs that specifically target rural settings, identifying suitable risk-adjusted quality measures, providing risk protection caps on risk exposure, extending bonus payments for new advanced APM participants, and decreasing qualifying participation thresholds.
for rural providers operating under APMs.

Some selective lessons learned from CMMI models relevant to opportunities for rural provider participation include the Frontier Community Health Integration Project, or FCHIP, Demonstration where increased payments for Part B ambulance transports and telehealth origination services increased patient satisfaction with telehealth. The Vermont All-Payer ACO Model provided up-front funding and limited downside risk. It was noted that different attribution mechanisms may be needed in rural communities to achieve scale. The Pennsylvania Rural Health Model, which was a creation of the Rural Health Redesign Center Authority, helped foster relationships among participants, payers, and partners, and although global budgets provided stable cash flow, participants and payers found it challenging to monitor global budgets.

Preliminary Medicare per member per month spending is below the national average for rural hospitals, 80 percent of participants improved avoidable utilization, and 83 percent improved their hospital acquired condition reduction scores. The Rural Community Health
Demonstration showed that rural community hospitals may need support to update older capital infrastructure, and the Next Generation Accountable Care Organization model serving rural areas used care management strategies such as telephonic engagement and embedded care management staff.

Additional learnings include the Community Health Access and Rural Transformation model or CHART, which attempted to increase financial stability for rural providers through new reimbursement processes that provided up-front investment and predictable capitated payments and removed regulatory burden by providing waivers that increase operational and regulatory flexibility. Unfortunately, this model was withdrawn this past year due to the feedback from model stakeholders, as well as lack of hospital participation.

The Medicare Care Choices Model was actually for palliative care, which increased funding for transportation, allowed outcomes between rural and non-rural beneficiaries to be equal for end-of-life care.

The Maryland All-Payer Model:
hospital leaders who are more rural or in economically disadvantaged areas reported that they would not be able to attract or retain enough hospitalists and certain types of specialists if they did not employ those physicians.

And the Accountable Care Organization Investment Model [AIM], which included up-front payment of shared savings, encouraged ACOs to form in areas with greater health care needs and less access to accountable care. And as of 2020, 14 of the 47 AIM participants remain in the Medicare Shared Savings Program, and the ACOs remaining in the program were larger and served less rural markets.

So in summary, the experience with rural providers' performance in APMs showed that the ACO investment model decreased spending, and maintained or improved quality of care in rural and underserved areas. Maryland's Total Patient Revenue model, which was a global budget for rural hospitals, led to reductions in outpatient utilization, but not inpatient utilization. And earlier results of the Pennsylvania Rural Healthcare Model stated
earlier, show that preliminary Medicare PMPM spending is below the national average for rural hospitals. In addition, 80 percent of participants improved utilization, 83 percent improved their hospital acquired condition reduction score, and 100 percent maintained the CMS admission rates.

The Medicare Shared Savings Program inclusion of rural providers, this program has been going on since 2012, is a voluntary program that encourages groups of doctors, hospitals, and other health care providers to come together as an ACO to give coordinated, high-quality care to the Medicare beneficiaries. Participants must have at least 5,000 attributed Medicare fee-for-service patients and agree to participate for at least five years. FQHCs\textsuperscript{10}, RHCs\textsuperscript{11}, and CAHs\textsuperscript{12}, are eligible to join in ACO and/or the MSSP, and FQHCs, RHCs, and some CAHs are also eligible to become their own ACO under an MSSP.

As of January 2023, 467 CAHs, or approximately 35 percent of all CAHs, and 22,040 RHCs, approximately 51 percent of all

\textsuperscript{10} Federally Qualified Health Centers
\textsuperscript{11} Rural Health Clinics
\textsuperscript{12} Critical Access Hospitals
RHCs, were participating in an MSSP ACO.

Some of the lessons learned with the Advanced Investment Payment, AIP, and a new MMSP payment option is that rural ACOs participating in MSSPs were less likely to switch to a two-sided risk than urban ACOs, and some of the ACOs remaining in the AIM serve less rural areas.

CMS is offering a new payment option, the Advanced Investment Payment, to encourage ACOs to form in rural and underserved areas. The AIP offers eligible ACOs an up-front payment of $250,000 and two years of quarterly payments to build the infrastructure needed to succeed in MSSP and promote equity by holistically addressing beneficiary needs, including social needs. The AIP will be recouped from the ACO’s shared savings. If there are no shared savings, as long as the eligible ACO continues to participate, monies will not be recouped.

So what we've tried to do today with our presentation is to set the table for the next two days and to focus on the challenges facing patients and rural providers in rural communities, what the provider perspectives on
issues related to rural provider participation in population-based models, the challenges with measuring rural providers' performance in APMs, some of the approaches from incorporating rural providers into population-based total cost of care model designs, incentives for increasing rural providers' participation in population-based models, and successful innovations and learnings and models for encouraging value-based transformation in rural areas.

We look forward to a great discussion over the next two days and great panels and great subject matter experts. Thank you.

CO-CHAIR HARDIN: Thank you so much, Jay. Jay, Jim, and Josh, excellent work. We really appreciate all of this foundational research and work on summarizing this really important topic.

I'm going to turn it briefly to Angelo for one question. Committee members, if you can hold your questions until we have our broad discussion later in the day. Angelo.

CO-CHAIR SINOPOLI: Yes, so I'll echo what Lauran just said. Congratulations to you and the other PCDT members. It's just an
amazing amount of work that had to go into this and an amazing summary that's going to really set the stage, not only for the next couple of days, but I think for next year's work, so really good, and congratulations on that.

I only had one clarification. So early on in your slides, as you were describing the rural environment, there was a specific use of the word independent physician. And so I wondered if there's any data or differentiation between an independent physician or a physician that may be employed by a local delivery system or yet a distant regional health care delivery system which provides them resources. Is there any data that discriminates between those?

DR. FELDSTEIN: In terms of the ratio of PCPs per 100,000?

CO-CHAIR SINOPOLI: Outcomes.

DR. FELDSTEIN: Not in terms of outcomes. We haven't been able to find anything yet.

CO-CHAIR SINOPOLI: Thank you.

CO-CHAIR HARDIN: I want to thank you all again very much. We look forward to diving into more discussion.

At this point, we're going to take a
break until 10:30 a.m. Eastern. Please join us
then. We have a great lineup of presenters
today. Our first panel discussion is on
challenges facing patients and providers in
rural communities. We'll see you at 10:30.

(Whereupon, the above-entitled
matter went off the record at 10:25 a.m. and
resumed at 10:33 a.m.)

* Panel Discussion: Challenges Facing
Patients and Providers in Rural
Communities

CO-CHAIR HARDIN: Welcome back.
We’re excited to share with you our next
session with some esteemed panelists. We want
to thank Jay and the PCDT for starting us off
with a great summary and evaluation of the
foundational information that we’re really
interested and focused on today.

And now I’m excited to welcome our
first panel. At this time I ask our panelists
to go ahead and turn on your video if you
haven’t done so already. In this session we’ll
have three esteemed experts to discuss
challenges facing patients and providers in
rural communities.

After each panelist offers a brief
overview of their work, I’ll be asking them questions. PTAC members, you’ll also have an opportunity to ask our guests follow-up questions, so be capturing those as we go through the presentations.

The full biographies of our panelists can be found online, along with other materials for today’s meeting. I’ll briefly introduce each of our guests and their current organizations and give them a few minutes each to introduce themselves.

First, we have Ms. Janice Walters, who is the Chief Operating Officer for Rural Health Redesign Center. Janice, welcome.

MS. WALTERS: Thank you so much, and thank you for this opportunity to be part of this very important discussion today. I certainly count it a privilege to be here and offer insights into our work supporting rural communities across the country, as well as using my talents to be able to help and support those communities.

So just a little bit about myself. Obviously you can read my bio, and I have been leading the Pennsylvania Rural Health Model work specifically since 2018, which also
included the creation of the Rural Health Redesign Center Authority, as well as the Rural Health Redesign Center Organization.

The Authority allows us to do work specific in Pennsylvania overseeing the Pennsylvania Rural Health Model. And then the organization is a not-for-profit, and we oversee work being done in other states specific to rural. So I’m giving my insights in the topic at hand today that the challenges faced by rural communities across the country.

You know, while our work really is focused on supporting hospitals, we also understand that in many rural communities, those hospitals actually employ a predominance of the physicians. And so ensuring that access to care and rural hospitals remain open is really fundamental to ensuring and preserving the health care access, not only for important hospital care, but primary care and specialty care.

So some of the programs that we oversee, it’s obvious the Pennsylvania Rural Health Model, which was highlighted in the prior session. Heard a little bit about that program, as well as its outcomes. Supporting
about 1.3 million Pennsylvanians with ensuring access to care through keeping the rural hospitals open.

Within that work, we’re doing some specific work around substance use disorder, peer recovery expansion, and using peer recovery. And we can talk a little bit more about that as we go through some of the Q&A session.

We also are overseeing the Rural Emergency Hospital Technical Assistance Center. So that’s the new CMS designation that allows hospitals, rural hospitals to become just outpatient hospitals serving outpatient needs of communities. Our organization is actually overseeing the technical assistance to help hospitals across the country as they identify whether that is right for their communities or not.

And then we also are doing some work in the northern border region providing technical assistance to hospitals really with the goal of ensuring access to care remains in these communities.

If we go on to the next slide. So regarding disparities and some of the issues
that we see within the communities that we serve, obviously there’s common trends. So our organization, currently this number changes daily as we work with organizations really across the country.

But we support about 2.6 million rural residents. And so looking at that demographic data across the country really does identify some of the challenges that we have specific to providing care in rural communities and helping those communities specific to the people that reside in them.

And so certainly our data shows that, you know, populations at least where our organization exists and is providing services do have a lot of health disparities. They tend to be older and sicker, which certainly we’ve heard that before. But certainly we have that data to show, and we can dig into this in a little bit more detail throughout the Q&A section.

But certainly we have higher disability rates in the communities that we serve, food insecurity. A lot of those social lists, as well as higher deaths associated with chronic disease, as well as deaths by despair.
And so some of the key takeaways that -- I’ll wrap up my opening comments here, but some of the key takeaways that we certainly see within our work supporting rural communities is if you think about the work of hospitals, as well as professionals, doctors, and providers, these outcomes that we have on the slide in front of you today are with some health care services already in these communities.

Can we imagine how much worse these outcomes would be if we no longer have primary care or specialty care in these rural communities? And again preserving and oftentimes keeping the hospital open is how we preserve the professional providers in these communities as well.

So also data as shown indicates that many of the same social issues exist in urban and rural communities, but rural solutions must be vastly different due to the lack of infrastructure that exists to solve the problem, such as transportation, food insecurity, et cetera.

And then certainly I’m a big believer that there needs to be policy reform.
And it’s needed to align incentives across the rural health care continuum in order to create reasonable and pragmatic solutions to these problems.

So it really does need the whole health care continuum from professional services to hospital services and then post-acute. And really I would say incentivizing and paying for the type of care that we want to see delivered in these rural communities.

So again, thank you. I count it a privilege to be here today and really look forward to the conversation. And I will turn it back to the moderator, Lauran. Thank you.

CO-CHAIR HARDIN: Thank you so much, Ms. Walters, really looking forward to diving in with questions.

Next we have Dr. Meggan Grant-Nierman, a family physician with First Street Family Health and the Heart of the Rockies Regional Medical Center.

Meggan, please go ahead.

DR. GRANT-NIERMAN: Hi there, thank you very much. Thank you very much for inviting me to the meeting. I don’t necessarily consider myself an esteemed
panelist, as somebody said earlier, but I am really humbled to be asked to share my experiences.

So I’m going to bring the perspective of a rural family practice physician in private practice who has been and now will no longer be doing value-based care. So I entered the profession with a strong desire to join private practice and to do -- provide a full -- to provide full-spectrum family medicine with surgical OB\textsuperscript{13} in rural Colorado.

And I was blessed to find a professional home at First Street Family Health at Salida. It’s a private practice that had been in business for 74 years, since 1949. And I’ve worked there for 11 years.

When I joined in 2012, First Street had just been selected as a pilot practice for CPCI, the Comprehensive Primary Care Initiative. And so my practice of medicine has been informed by value-based care since the beginning.

As many of you probably know, CPCI

\textsuperscript{13} Obstetrics
evolved to CPC+\textsuperscript{14}, which evolved to Primary Care First. And our practice transformed quickly and effectively, and we were pretty -- very successful really in meeting all the quotas and metrics and milestones through these programs.

However, as Primary Care First came along, we looked really hard at that pro forma, and under the very best of circumstances, we knew we would lose money by being part of Primary Care First.

We considered abandoning value-based care at that point and becoming a rural health clinic. But culturally and emotionally, we were committed to the value of care that we believed in and a lot of the hard-earned, hard-fought methods we developed. And so we carried on, hoped for the best.

At that point, the Aledade’s exquisite marketing for MSSP ACO enablement organization found us, and so we signed up for them in addition to Primary Care First, with the idea that if we got a little prospective money from Primary Care First, some money on the back end from Aledade, we could make enough money from the valuable work we were doing to

\textsuperscript{14} Comprehensive Primary Care Plus
hopefully make it through.

And that, now we fast forward one short year, our practice of 75 years is closed. Our building is sold to the hospital. And I’m now employed by the hospital at Heart of the Rockies Regional Medical Center, which is our Critical Access Hospital and network for rural health clinics, and whose leadership team is aggressively opposed to participation in any value-based payment model.

So this month has proven a very pivotal professional moment for me. So lessons that I would like to bring that I have taken away from our experience in the last decade of value-based care participation is, one, it is good and valuable work, and patients are better for the coordinated care and the proactive management.

Capitalizing on team-based care and highly functioning teams really improves the joy of practice for a physician or provider and improves outcomes.

And rural practices are poised to be very successful in a lot of ways in providing value-based care because of the familial nature and the connectedness of rural communities.
There are a lot of things about being rural that make doing this value-based care work natural and easy, in my opinion certainly. So yes, yes, yes.

And rural communities also struggle to want to engage in, to be able to succeed. We lack the available support workforce in a wraparound to support services that are necessary to be maximally effective.

And the increased payroll expense necessary to staff the value-based work, if you can find the employees to do it, outweighs the financial return of participation in the value-based programs.

The other -- the second challenge is that our data chasm is very real thing. Rural facilities overall in my experience have very dysfunctional, inexpensive EMR\textsuperscript{15} systems, both hospital and clinic. So gathering and reporting data is very difficult.

And also when you have a small population, when you’re reporting data metrics, it takes one or two outliers to completely blow up your stats and change your ability to get paid. And so that’s a statistical issue that

\textsuperscript{15} Electronic medical record
we run into.

And then I think downside risk contracts are not something rural health care infrastructures can afford to take on. It’s hard enough to justify the increased overhead that it takes just to break even in a value-based model. So to be a downside risk is somewhat of a struggle.

I think it’s my belief that AI\(^\text{16}\) and technology may be a huge game changer for this in this space in the future in terms of good data collection and meaningful data. But that’s yet to be proven I think.

And then the other thing that is a struggle is the inconsistent bonus funding streams that come in value-based models. Chunks up front, monthly chunks, and then chunks of money at the end. Incomes are not predictable and sufficient to help rural and small clinics or hospitals make the monthly payroll.

Because as you guys know statistically, so many rural health care infrastructures are operating with what, 30 days’ cash on hand. They’re on the line every

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16 Artificial intelligence
day. So if you have to employ a bunch of people to do the value-based work and not get paid for 18 months for who you just employed, that kind of inconsistent funding stream makes it difficult in rural communities to do that.

I have some pie-in-the-sky dreams and suggestions of what might make rural participation in value-based care a little more appetizing. And one is a model for financial support to help rural health care systems maybe collectively afford access to higher-quality EMRs and data dashboards that are timely and accurate. And then collaborative arrangements and funding sources that I think the gal before me mentioned that help fund across the whole community, organization, and health care ecosystem in the whole county in some places that braid funding from different departments to help rural economic development in education, so that the system itself can support serving social determinants of health and growing health within the community.

I mentioned earlier thinking hard about downside risk and how that precludes involvement from rural organizations. I think it’s important to remember multi-payer
alignment is important, not just Medicare-Medicaid, but we need our private payers to actively be part of the conversation and financially be part of the conversation of value-based care.

And also just to an earlier point, resources to help support the part of the medical neighborhood that includes like EMS\(^\text{17}\), long-term care, public health, social services, et cetera.

That’s a lot, thank you very much.

CO-CHAIR HARDIN: Thank you so much, Dr. Grant-Nierman. You are an esteemed expert, and I know everyone is going to be really interested in asking you more questions.

Lastly we have Dr. Jen Brull, a family physician and Vice President of Clinical Engagement for Aledade. Welcome, Jen, please go ahead.

DR. BRULL: Thank you. I appreciate the opportunity to speak with you all.

I am currently Vice President of Clinical Engagement at Aledade, which is a company that helps independent primary care physicians form ACOs that are geographically

\(^{17}\) Emergency medical services
disparate and that take on risk in a significant way.

Prior to that, my life involved being a rural full-scope family medicine doc for 22 years, in Plainville, Kansas. And I participated in value care with that hat on also. I certainly, my heart goes out to Meggan, because I know how that feels to be in a place and a space where you have limited power to make change.

Aledade’s stats are on the slide. I won’t spend much time talking about them because what I really want to share with you is on the next slide, please, Amy.

So as I think about both from my perspective as someone who did rural primary care in an Accountable Care Organization and from someone who is in an organization trying to solve for this, because many of our practice partners are in rural areas, I’ve thought of five things that I think if this group could do and could solve for, we would make significant progress. You’ll definitely hear echoes of Janice and Meggan’s comments in what I have to say.

The first one is to solve something
that we’ve coined the rural glitch. So rural clinicians who participate in Accountable Care Organizations are significantly disadvantaged from their urban counterparts because they make up a significant market share of the way that regional benchmarks are set.

They’re literally being compared against themselves in many cases. So regional benchmarking does not solve for them in the way that it does for urban counterparts. Solving for that glitch in the math is really important as we think about being able to differentiate the performance of rural positions and their urban counterparts.

The second thing, I’ll echo Meggan, we need to invest in access. And by access I don’t mean that rural primary care physicians don’t understand what their patients need. They do. Frequently, though, they lack the community and specialty resources for the patient populations they’ve identified, or those resources are significantly underfunded.

I can’t tell you how many times someone has said -- told me about a resource to help me find community resources like Aunt Bertha and, you go online, you enter your zip
code, and it will give you resources in the plentifuls that are three and four hours away from the patients you are serving.

When you are working with social drivers of health, it is almost impossible for those same patients to achieve transportation to the resources that are being promoted for them.

Third, include CHCs\textsuperscript{18} and Rural Health Centers. I was excited to come in at the end of your last conversation and hear about AIP, which sounds like a move in this direction. That is wonderful.

But CAH hospitals and Rural Health Clinics have been left out traditionally of some of these innovation models because they’re complex, and it’s difficult to imagine how they might integrate into the work that you are doing.

When you instead flip it so that you find a way to integrate them in all models, I think that will be a tremendous benefit, and you may see less resistance and hesitation to being involved in accountable care.

Fourth, advanced pay. Again, AIP is

\textsuperscript{18} Community health centers
exciting here. Meggan mentioned resources are a big deal. When you’re trying to do value-based care, you frequently need to expand your staff to be able to do that. And you need money to do that. And many times without a significant cash on hand, it’s really challenging to envision how you can make that happen and keep your doors open.

Being able to do it, we have these pay models like AIM, and being able to make it easy to access for rural providers will make a huge difference.

And then finally, I love what you’re doing here today. And I think that continuing to connect to rural subject matter experts is going to be critical as you design systems that might support them.

So many times I think policymakers and administration officials have not well understood the challenges and barriers that rural clinicians face in their everyday life, let alone their journey to become an Accountable Care Organization or to deliver value-based care.

And so when you seek out the understanding before you write the legislation,
I think it’s a great place to be. So thank you very much for letting me be here today, and I look forward to answering your questions.

CO-CHAIR HARDIN: Thank you so much, Jen. I really want to compliment each of you. Your presentations built on each other very well and have set a wonderful foundation for us.

Committee members, there’s an opportunity for you to ask questions. If you’d like to pose a comment or question, please tip your nametag up. In the meantime, I’ll start us off with a question.

I’m really interested in your perspective on what the barriers are to effective care coordination in rural areas. And what strategies or innovations are you seeing as actually improving care coordination?

I was intrigued by some of the things you were saying about looking at blending and braiding funding and looking at this as a county-wide approach. So would love to hear your thoughts about that.

And Janice, why don’t you start us off.

MS. WALTERS: Yes, thank you for the
question. So certainly some of the barriers, as my esteemed colleagues and subject matter experts have already stated, it really is the lack of infrastructure and resources.

So I had to smile when Jen made reference to Aunt Bertha. And you know, the idea that there’s a plethora of resources out there. And in rural communities, there really aren’t.

So lack of -- you know, we call it community benefit organizations or some of these other infrastructures that really need to be present in order to meet the needs of the communities.

And so often even within our program, certainly we -- our payment model within the Pennsylvania Rural Health Model really is asking our hospital leaders to change how they typically viewed and really come to start serving as the convener in that community to bring the health care continuum together.

And so given their position within most of these communities as either, you know, one of the largest either employers or health care organizations to say, you know, we’re not asking you to solve the problem by yourself,
but help serve as the convener to pull organizations together.

What we see is the infrastructure’s not there. And so you know, the barriers of even, so funding, it all comes back to funding. I’m a health care – health care’s actually my third industry. I started in manufacturing, I was in communication, and now I’m in health care. And I really believe, just going to back to basic business principles, we get what we pay for.

And so those investments just, the funding has not been there. And so I truly do believe too in rural. One of the challenges that we face within CMMI directly is we know that by statute, they have to produce savings or improved quality for the same cost, but yet there’s not enough I would say funding in health care alone.

So you do have to figure out how to bring in these other revenue streams from our community perspective. So you know, there’s a lot of despair at whether it’s USDA\textsuperscript{19} grant funding or, you know, mental health, at least in the state of Pennsylvania, mental health

\textsuperscript{19} U.S. Department of Agriculture
payment is a separate payment stream.

Then you’ve got health care, you’ve got dental, we’ve got vision. Then you’ve got funding for other community benefit organizations. But how do we build a system that everybody aligns for the improved health of the community? And bring those funding sources together.

So I don’t know that I have anything new to share beyond the barriers, because I think we all recognize that the barriers that exist, a lot of it does come down to funding.

But in terms of innovative solutions, I can tell you within the work that we’re doing, we are seeing hospitals invest in care management strategies that typically have been done thinking of primary care.

But how do we bring, you know, that care management for the people that are using the emergency rooms as their primary care? There needs to be able to -- somebody step in and allow for that care coordination.

So you know, innovative strategies that I have seen, a lot of our hospitals are investing in care coordination strategies versus discharge planning. Discharge planning
has really been the work of the hospitals up until this point. Now they’re truly investing in care management, care coordination.

Using peer recovery specialists within our emergency rooms. So again, trying to intercept where the need is and identify, okay, how do we invest in a different type of infrastructure that’s certainly our payment model we believe allows for that? Because it’s no longer looking on volume, but it really is looking on value.

And then you know, social determinant of health screenings. I’m a big proponent of data. And I completely echo the sentiments of my colleagues: data is greatly lacking within the rural infrastructure. But really, you can’t fix a problem if you don’t know the problem exists.

So simple things like doing social determinant of health screenings for certain populations that come into the emergency room or into the hospital. They’re taking very pragmatic approaches to say what can we do within the confines, what resources do we have available.

And I would say starting with very -
- you know, use data to identify pragmatic solutions that can be done without maybe a lot of additional funding. However, additional funding is needed if we truly want to move the dial.

So that’s how I would answer that question.

CO-CHAIR HARDIN: Thank you so much, Janice. Meggan, we’d love to hear from you.

DR. GRANT-NIERMAN: So yeah, I guess when I was thinking through this question, my mind went to the concept of a little bit with care management, but also with transitions of care. Is that somewhat we can talk about at this juncture?

CO-CHAIR HARDIN: Definitely.

DR. GRANT-NIERMAN: So the idea of TCM²⁰ to transitions of care management from a primary care perspective, that’s something that our clinic worked to do pretty well. And I think with support from some of the data structures from -- data dashboards from Aledade that we used, we were able to improve on that.

But in rural, I think sometimes transitions of care can be easy in some ways.

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²⁰ Transitional care management
For example, if I admit my patient from the clinic to myself in the hospital, I see them in the hospital, and I discharge them back to myself in the one hospital in town. That’s kind of easy.

But a lot of our patients get sent out. They get flown out to Denver, they got flown out to Colorado Springs. And so those are the transitions that are a little bit more tricky.

Back to data, the ADT feeds that can go into our HIEs, health information exchanges, that can be helpful. But truthfully a lot of small clinics, small practices, small hospitals can afford to access or choose not to afford to access the rural health HIEs appropriately.

And so there is a struggle that we found of really unless they’re across the street from us, and we admitted them to ourselves, is really figuring out timely ADT feeds and triggers to let us know when our patients are being admitted or discharged from various places.

Long-term care facilities don’t

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21 Admission, discharge, and transfer
often feed in ADT data in the same way. So as a small clinic, it’s hard to hire yet another full-time equivalent to chase down who’s being admitted where, when, and how, and how do we capture them to transition them back.

For the most part, when we do succeed at doing that, the other struggle comes into, as was alluded to earlier, just the lack of the wraparound services necessary in the rural community to receive them safely so that they can stay home. Timely home health. Sometimes pharmacy ability to get your meds once you get home.

In the community where I grew up, the pharmacies are an hour apart from each other. So most people have a 30-40-minute drive to a town with a pharmacy. So getting meds when you get home in a rural community, sometimes that falls through the cracks.

So the support services to catch them when they land at home and help them safely stay at home can be a big part of the struggle.

I think that our community rural Critical Access Hospital, they discharge planners who do one token phone call, 48 hours
of discharge to be sure that the patient still has a pulse, and then they say follow up with a PCP and call it good. I think that’s about as much as we have from the hospital side for care management in that way.

From the clinic side, we had nurse care managers who would bulldog these patients, hunt them, find them, call them, chase them down to try to manage their care, which worked well for us, but also as was mentioned earlier, that’s an expensive overhead that was unsustainable to be able to provide that good care.

So I don’t know if that’s a good -- if that answers the question well.

CO-CHAIR HARDIN: Thank you so much, Meggan. And Jen, we’d love to hear from you on this question.

DR. BRULL: I think I have the benefit of sort of seeing across about 1,500 practices that we partner with at Aledade. And I think we’ve seen three ways that people are successful in care coordination, including transitions of care.

The first way is, as Meggan referenced, an embedded person in the clinic
whose role is care coordination. Whether that’s a nurse or a social worker, but someone whose job description includes the list of tasks of making sure that patients receive the services in connections like they need when they’re available within the community.

That faces the challenges of the practice needs to pay that person, and there needs to be a sustainable source of revenue to support that person’s work.

The second way I think that we have seen success is when practices partner with their communities and are taking advantage of community-based grants and resources that are designed to communicate and coordinate resources.

So for example, if you have a city planning grant or a health-wise county grant that are working, you can oftentimes partner to make those resources more transparently available and accessible to your patient population.

That relies on the presence of grant funds and visionary people within your community that are doing this kind of work so that you’re not trying to do it yourself.
The third way I think that we’ve seen success is through the use of telehealth and teleservices. So not all services that patients need at the time of discharge or in any other care coordinating setting are available in a telehealth platform. But when they are, and the primary resources here are in the mental health arena, so counseling services or access to mental health providers.

This tends to work pretty well because people don’t have to leave their homes, and fortunately, there are fewer barriers now about people having devices that are accessible to be able to do telehealth type supports. And now funding supports that for the people providing that care, which means that there is a revenue stream for doing so.

So I’m not going to downplay at all the barriers that Janice and Meggan presented, I think they are very real. And I can tell you that as a practicing clinician, I absolutely saw those every day.

And I think there are some bright spots and some ways that if we amplified those bright spots, so funding in advance for people in the clinic, grant streams for people in the
community, and continued payment for telehealth. I think that those are places we can amplify where there’s some good things happening and spread that.

CO-CHAIR HARDIN: Thank you so much, Jen.

Jim, I’ll turn it to you.

DR. WALTON: Yes, thank you. I think Jen and then probably Janice, I was going to try to see if you both would comment on this. When we looked at the data, we see some bright spots in the rural communities, and we understand that rural health care isn’t 100 percent broken. That is in some places in rural America, it’s working, and especially in value-based care.

But on average, we see the results to be suboptimal in that by and large, when you compare rural versus non-rural areas, we see that the rural areas aren’t making the kind of progress that we hoped for with regards to value-based arrangements.

And I was curious about I guess a couple questions that kind of crossed my mind, and I think Jen, you just kind of touched on it a little bit.
But maybe there could be a little bit more exploration here, which is what are the -- what do you think are the differentiating factors that create bright spots within rural America when the story sounds so dire?

And on the Aledade question, or even Janice, in your organization, do you do assessments before you go into a community, and what are you looking for that would help you predict success between one rural community and another as you choose to work with these organizations in order to kind of create forward progress?

DR. BRULL: Sounded like you were pitching that to me first, so I’ll take a stab at it. And what I understood you to say is when we see bright spots, why are they bright spots? And what sort of evaluation do we do or could we do to find those bright spots as we’re looking for successful places?

So I think the answer to the bright spots question is that all the barriers that Janice and Meggan and I have presented are lower in those places, as a starting place. So we all see places where there are enough
primary care physicians to serve the community. That means there’s a little bit of capacity to take on this new work of value-based care.

We see places where there are great collaborations between the hospital and the community physicians, between the community and the hospital that really mean that there’s a chemistry there and a supportive environment that make it a fertile place for this to grow.

And some of that is not very predictable in the data, but you might see the data and be able to find that in the community that’s there. I think that’s hard when you think about it. So how do we predict that.

I can share with you Aledade absolutely looks for places where -- and I wouldn’t say where we think people will be more successful, but where we will need fewer or more resources to support the work of value-based care. And we don’t exclude practices because they’re not high performers. We just see them as opportunities for a larger delta.

And so yes, there is data you can look at. There’s lots of data from CMS that is available to help you spot where things are happening well, where practices are delivering
what looks like great value-based care. You know, how many AWVs have they done, how many transitions of care have they done? What does their readmission rate look like?

All the things that I think we all know to look at or point at a community that is doing better, whether intentionally or through good luck. And most of the time it’s very intentional.

Having said that, we love partnering with any independent primary care practice, and when we see places where people are maybe not as far along on their value-based care journey, maybe they haven’t had the opportunity to be involved or be in CPCI or any of these other initiatives, although that’s getting to be a smaller group of people, we just see that as an opportunity where people may need to enter the world of ACOs in a non-risk-bearing status.

And they may need a year to get those muscles built and be ready to move to risk. Being in risk is certainly a better proposition from our perspective because it incentivizes and rewards the work of value-based care much more strongly than not being in risk. But some folks just aren’t quite ready
for that, right as they start.

CO-CHAIR HARDIN: Would any of our other panelists like to comment?

MS. WALTERS: Sure. So I’m happy to jump in here and add a couple thoughts as well. So I’ve had a little bit more time to process the question than Jen did, but I think I can attribute the success of what we’ve seen to a couple of things.

So the first is leadership. And does, you know, the local leadership in these communities recognize the need for change? And so I will say at least in the Pennsylvania, the Pennsylvania Rural Health Model Program, it was all voluntary. You know, the leaders that came to the table certainly I would say were visionary, and they recognized the need for change.

So certainly, you know, as we talk to a lot of hospitals, talk to over 30-plus, 40 hospitals, 18 of which came to the table, I would say it was more innovative leadership recognized that there needed to be a change and wanted to be part of that change, wanted to be part of the test.

There were a few that came out of
desperation that they knew this program was probably the only way that their hospital might stay open. But even so, recognized the current paradigm fee-for-service was not going to yield them, you know, longevity for their organization, but really leadership.

And I would say the forward-thinking nature of leadership wanted to be part of the new mousetrap or the solution.

The other thing, it’s a very pragmatic, does the math work? So we want folks to go into value-based, but if that value-based arrangement doesn’t produce a better result than what the current paradigm is, why would they change? So Meggan gave that example where she really wanted to be part of this, but the math didn’t work.

And so in terms of assessments, whether it was in the Pennsylvania program or what we do within the Rural Emergency Hospital space, we start with does the math work? We certainly educate what is the new potential opportunity. But then the next step is does it produce a better result than what you’re currently having right now?

Is there the opportunity for
improvement, is there enough incentive in that value-based work that actually leads to a more sustainable path?

To go back to a comment that I think it was Jen made about the Critical Access Hospital, I think that’s one of the issues that we currently see, that Critical Access Hospital, you know, cost-based reimbursement.

That piece of the pie for many states is getting smaller and smaller because we see Medicare Advantage, you know, that there’s an increase in Medicare Advantage, which is actually decreasing the opportunity under cost-based reimbursement for the Critical Access Hospital.

And the other thing that I like to say about critical, it was great, but it still keeps folks at cost. Even for that piece of the pie, the best they’re going to do is actually costs are now slightly less than costs with sequestration.

So how does even in value-based, the hospitals that chose to participate in our program for that Medicare book of business, it’s still cost-based reimbursement. How do you ever get to where it’s -- you can, you
know, have a profit margin if you always come back to cost.

So the incentives have to produce a better result in order for a leader to actually embrace, the math has to work. So a very pragmatic approach. Does the new paradigm offer something better than the current?

So again, leadership, we do a financial assessment to say the math works. And then I think there has to be a commitment to transformation.

So at least within the Pennsylvania program, in exchange for that global budget, that predictable payment, we ask them to make a commitment. What are you actually going to put to writing that you will commit to transform?

So it’s one thing to say we’re moving to value-based, it’s another thing to actually be held accountable for that commitment. And so thinking about the hospitals and even in the Rural Emergency Hospital space, you know, who’s coming to the table.

Obviously the math has to work in order for them to even consider the new designation. In the Pennsylvania program, it
was does the math work, do we have leadership that’s committed to making the transformation?

And I do believe that’s what’s yielded the results that were shared in the prior session where most of our -- you know, it is favorable. The Medicare member per month spent is still less than the national average, and we have seen avoidable utilization decrease. The right care being provided in the right setting. And our quality indicators are, you know, are being maintained.

So that’s how I would answer that question. Thank you.

CO-CHAIR HARDIN: Thank you so much. Lee, I’ll turn it to you next.

DR. MILLS: Thank you, Lauran.

Well, Meggan, my heart certainly goes to you. I’m so sorry you’re having to go through this. But thanks for your commitment and getting up each morning and serving your community the best you and your partners can.

I’m fascinated by your all’s experience, you and Jen particularly, of going from walking the walk on a value-based payment journey with your patients from a practice perspective, now larger to a system perspective
and trying to implement that from small to large.

And so from a perspective of this wrinkle you brought out about it’s hard to get facilities who are often the employers, if not the physicians directly, the assets you need to connect the dots in a community, all those employees. This wrinkle you brought out that it’s hard to get leaders of cost-plus reimbursed facilities to see that there’s any squeeze for them, if you will, there’s no juice.

So from an alternate payment mechanism perspective, I would love to hear your all’s advice. What would you recommend that we can pass onto the Secretary that has worked in changing the trajectory? If you had the federal policy magic wand, how would you pay in rural communities differently to change the trajectory of these health systems?

MS. WALTERS: Well, I’m willing go first. So I truly do believe that we get what we pay for. And I think the Pennsylvania program is testament to that. That we are paying our hospitals a global budget. The intent was predictable.
You know, as was brought out in the prior session, that has proved to be challenging. But that all comes back to the current methodology. And I do believe there’s opportunity to refine methodology.

But if we truly want to engage facilities on this journey, we have to align the incentive that actually allows them to do that, especially in rural communities.

So having been a former rural Critical Access Hospital, you know, finance leader for the organization, as much as I wanted to like not have people presenting in the emergency room because they didn’t need to be there, the reality is, is that rural provider needs every billable service in order to stay open.

They can’t afford to naturally do what’s in the best interest of the community when you need billable services just to keep your door open. So if we truly want to engage rural hospitals on this journey, we need to align the incentive that actually allows them to do that.

So one of my participant CEOs, when he came to the program and signed on, he said I
feel this program for the first time actually brought me to the table as a partner in this journey, versus being treated as a cost center with everybody trying to keep their patients out of the hospital.

I’m now at the table as part of the partnership, and no longer -- if I actually keep people out of my hospital because they don’t need the care, and they’re getting good quality of care, and they’re generally healthier, I don’t have to worry about payment for that. I’m suddenly incentivized to help reduce avoidable utilization.

And so it’s allowed them -- and then you give them the data that they need to identify who’s coming into their hospitals that don’t need to be there, suddenly there’s the incentive for them to hire the care manager, to keep the patient out of the hospital. Because they no longer have to fear their revenue stream is going to be hurt because of it.

Now, you know, there are controls in our program that we don’t just want them going someplace else. So we do have to monitor that a little bit, that the patients are truly getting the care they need, not being turned
away. And they’re not going someplace else, but they actually are being healthier.

So to me it’s aligning the incentive of how do we actually want these rural hospitals to operate, recognizing we have to keep the asset in the community. Because on the flip side of that, if we don’t do something, we’re not going to have rural hospitals left.

And again, that’s going to have a domino effect, because oftentimes they’re employing the primary care, the specialty care. So we want to make sure access to care remains in the community, and I fully believe you do that by fundamentally changing how rural hospitals are paid.

I’m obviously a proponent of global budgets, because even ACO frameworks are built on volume. Most ACO frameworks, there’s a volume consent -- incentive. So if I have the magic wand for something to come out of CMS, it would be allow global budgeting more broadly to rural hospitals across the country.

Because it really does allow them to do what’s in the best interest of their community without having to worry about keeping
their doors open because there’s predictability of payment. And then for Critical Access Hospitals, there has to be some way to actually get paid for value. Because the Critical Access Hospital as it stands today still comes back to cost.

So even if they do reduce avoidable utilization for that Medicare fee-for-service book of business, they run their cost report, they get paid cost. It’s got to be a cost plus a value type of incentive.

DR. BRULL: I’ll add. So having worked in a rural community with a Critical Access Hospital, and when we joined an Accountable Care Organization in 2015 for a 2016 start year, the board, who are wonderful people and are collaborative, were scared to death that we were going to close their hospital because of joining an Accountable Care Organization and reducing the need for patients to be in their hospital.

And that felt very scary for them. Which, even though we are in a small community and all friends, it made them feel very defensive. The way that we got to an immediately better place was to align not on
payment but on values, which is you are here, and we are here because we want our community to be healthier.

The work of accountable care and value-based care is designed to make our community healthier. And as soon as we got to an aligned incentive, then we could have conversations about how to make sure that it did not result in a financial downfall for the hospital.

And the way that we framed this in our community is there’s no doubt through numerous studies that what patients need more of is great primary and preventive care. Hospitals can be part of primary and preventive care.

And instead of focusing on revenue from heads in beds, if instead we focus on revenue that is on primary and preventive care, helping our community be healthier with things like fall prevention programs and preventive imaging and preventive services and urgent walk-in care instead of ER\textsuperscript{22} care, if we can flip the book of business for the hospital to that side-- and we love for them to be in that

\textsuperscript{22} Emergency room
side, it’s not a competition, it’s a collaboration. Then they could see how they can both deal with their cost-based reimbursement and be part of the solution for a healthier community.

I’m going to plus one, though, to Janice’s comments that we need to think more about how rural hospitals, particularly Critical Access Hospitals, can be part of cost-plus value. Because that’s still a sticking point.

CO-CHAIR HARDIN: Meggan, did you want to add comment as well?

DR. GRANT-NIERMAN: I guess just simply to agree with the idea of having cohesive incentives across the medical ecosystem.

And in our experience just day-to-day, we would work very hard to keep a patient from having to go through the emergency room and get them over to the hospital for maybe an infusion in the infusion center to avoid an ER visit. And the nurse at the hospital would say, uh, you should just go to the ER. And then do everything we just did.

And it’s because of those misaligned
incentives. And so kind of global as the incidence across the medical neighborhood is certainly important.

And then payment structures that look at braiding funding from other federal organizations outside of HHS and insurance so that we can invest in the whole community. I’m not for sure of the details, I’m not fully educated on this.

But I believe some of the ACO programs have a requirement where a certain percentage of shared savings needs to be -- is required to be reinvested into the community for the health of the community. Is that correct to people’s understanding?

And so if there was a requirement from the money that is saved to the payers, that a certain amount of that can then be reinvested to community structures and supports, such as EMS, long-term care, public health services, so that the community can better strive to succeed in the health of the community. I think that can be pretty helpful.

CO-CHAIR HARDIN: Thank you so much, Meggan.

Angelo, I’ll turn it to you.
CO-CHAIR SINOPOLI: Yes, so again, thank you all for participating in this today. Obviously rural health care is a big issue nationally, and it’s a big issue for PTAC and CMMI. And hopefully we can come out of this in the next few days and over the next few months with some specific recommendations and programs to address rural health care.

I think one of the very basic questions that we’ve been wrestling with is what is the definition of a rural community and rural health?

And as we’ve looked at the data, it doesn’t come across as clear that there’s one single definition, that there’s a spectrum of rural environments, from those that have a little bit more resources to those that have very little and they’re across the more -- a different kind of geography.

So I’m curious to hear from each one of you how you think about rural as a definition of a rural environment and how you would help us define that. And if you agree that there’s a spectrum of rural environments and how you would help define those. So maybe if we could start out with Meggan on that.
DR. GRANT-NIERMAN: Yeah, I’ve recently learned to better understand that there is a huge variation in how people interpret rural. My interpretation of rural is somewhat similar to maybe what Dr. Brull experienced in Plainview, is what others might consider actually frontier as opposed to rural hospitals that are 40 minutes away from another rural hospital.

So absolutely there’s a huge discrepancy of physicians and patients who live two hours from the closest cardiologist and three or four hours to closest labor and delivery, which would probably be considered more frontier. But that’s the reality of where I grew up and never thought otherwise.

That’s definitely legitimately rural and frontier. And then we have small Critical Access Hospitals in parts of the country, in the Southeast, for example, that are wailing and gnashing teeth because 40 miles away a hospital closed, and God forbid we drive 45 miles to the next health care. To me that’s a luxury, that’s lovely, to drive only 45 miles.

So absolutely frontier and rural are two different things. I think that would be an
interesting opportunity when we look at risk-stratifying health populations for value-based, population-based dollars, is maybe a zip code and distance from health care services-related risk score that automatically helps stratify those differences.

Because rural that is 50 minutes away from Boston is not the same rural as Plainview, Kansas. It’s just not. And so the resources, the finances, and the logistics are just not the same.


DR. BRULL: Yeah, when you asked the question, the phrase that came to mind is like you know one when you see one. And that doesn’t help you at all.

I think Meggan’s comments resonate with me in terms of there is a spectrum. And I think it’s important to recognize the spectrum, because people who are an hour from Boston are still an hour from Boston, they’re not in Boston. And their challenges are different than those who live in Boston suburbs and those who live in Salida, Colorado, or Plainview, Kansas.

And so I think recognizing the
spectrum is something I would advise. I will
double down on Meggan’s comments that I think
there are some key drivers that you could
evaluate.

And some of that is distance in
miles and some of that is distance in time.
Because 45 minutes in Kansas is -- I mean 45
miles in Kansas is 45 minutes. Forty-five
miles in Colorado might be a couple of hours if
you’ve got some mountain passes to go through.

And so one of the things I would do
is recommend that you identify things like
where is the closest emergency services? Where
is the closest key specialty services, not
necessarily every specialty, but some of the
most important ones to primary care-sensitive
conditions?

Where is the closest obstetric
services? We have a lot of obstetric deserts
in the United States. And then how far are
those in miles and time to patients?

And I think that that, more than
population, is going to tell you who needs to
be considered and classified various strata of
rural health care services.

CO-CHAIR SINOPOLI: Great, thank
you. And now Janice?

MS. WALTERS: Yeah, I don’t know that I have a lot new to offer, other than to echo Jen’s sentiment that it has to be about time as well. Because when you’re dealing with mountainous terrain, mileage does not show that as it relates to going over mountains in the state of Pennsylvania. And to the point of mileage, a map only tells a portion of the story.

So certainly that has proven to be a challenge in our current program. We use a state-based definition of rural. And so within the Pennsylvania, within the state of Pennsylvania, we had a definition of any county that had less than 284 people per square mile was deemed rural.

And I know when you’re talking frontier, that’s a huge amount of population. You know, we’ve certainly heard that. But that did create some issues in terms of qualifying for the program. We had hospitals in the state that were deemed rural from a state perspective but not from a federal perspective.

And so certainly definition is something that would need to be solidified.
And I would also encourage to get other stakeholders at the table to ask this question, especially if you’re looking for all-payer types of programs.

Because it’s one thing to come up with a definition for a Medicare program, but if we’re asking, you know, all payers to come to the table, they certainly are more apt to want to pay a global budget to one type of rural hospital versus another type of rural hospital that in their mind might be more urban. But because of the county, the demographic of the county, the hospital is deemed eligible.

So I do think there’d be broader stakeholders that we would get -- should get their voice into that question, especially if we are asking for all-payer types of programs.

CO-CHAIR SINOPOLI: Great, thank you all, appreciate it.

CO-CHAIR HARDIN: Chinni, I’ll turn it to you.

DR. PULLURU: Good morning, everyone. And thank you, Meggan, particularly, for your passion and all of the sort of commitment that you’ve displayed. I know
having been in multiple VBC23 transformation roles, this is really hard. And you’ve spent a lifetime doing the right thing for your patients, and so thank you to all of you panelists.

The question I have and would love to hear from Jen and all of the panelists is when you think about measurement and data pooling for risk, I know one of the struggles is really on how rural populations, particularly RUCC 9 populations, have such few eligible participants that it really, you know, one or two outliers can throw the data off.

So I would love to hear your thoughts and recommendations around how you would envision data pooling around medical service areas and counties.

DR. BRULL: Thank you. I’ll bet there are other folks who can speak to this more eloquently than me, but I’ll tell you two thoughts that come to mind.

The first is in MSSP and in other innovation spaces in general, rural folks are aggregated, and I think that’s very wise because yes, if Jen Brull with her 200 Medicare
patients has an outlier in cost, it’s going to sink the whole boat. But if Jen Brull is a member of an ACO that has 10,000 Medicare patients, the one that I have that is an outlier won’t sink the ACO’s boat.

So globally I think thinking about larger denominators is a good thing for rural folks. And anything you can do to make it easier to aggregate lives across geographically disparate populations is wonderful, which I think we’re in that space.

When I think about specific metrics and measures and things like blood pressure control and A1C control and some quality metrics that we’re working on, certainly you’d like to be able to provide people with feedback of their performance. And the more direct feedback and transparent feedback you can give, the easier it is to improve performance, both in the quality and in a cost-based environment.

So I think that there’s a balance in that space between providing performance data and using that data in an individual sense to determine performance. And there’s a difference between someone who has 200 patients and 100 percent, you know, 100 of them are out
of line for performance versus one of them is out of line for performance. And I think you can treat that data differently.

I think the other thing that happens, helps is something that Meggan said earlier, which is if you can align across all payers, then you grow your patient population and your denominator from a couple of hundred Medicare patients to a couple of thousand all-payer patients.

And that makes a huge difference when you’re looking at outliers. Because you’ve just grown your denominator, but it’s the same person providing care to all of those people.

DR. GRANT-NIERMAN: I would like to agree with Jen for sure. We’re not -- I hope this doesn’t come off as like the Aledade celebration presentation, but we worked with Aledade just for one year, and their dashboard is awesome for providing meaningful feedback and to aggregate a bunch of data.

So working with that organization was really helpful for us as a small practice. And then having enable the organization create, at least start with the contracts of more
multi-payer alignment so that we’re doing the hard — putting all the work in for the Medicare dollars, and all the private payers are just benefitting and just getting richer from our hard work.

But actually having them recognize and value the value-based work too was super helpful, so I definitely want to agree with that.

When you were talking about data pooling as in aggregate pooling, O-O-L, or pulling as in pulling data? I heard that two different ways at the initial question.

DR. PULLURU: I was thinking about aggregate pooling.

DR. GRANT-NIERMAN: Got it, okay. And I’ll let the next person talk at that point then.

MS. WALTERS: Yeah, the only thing I would add to what has already been stated is really the identification of rural-relevant measures.

So I do know that’s one of the things that within our Pennsylvania program, you know, some of the metrics that were originally identified to measure outcomes. You
know, we realized that they were necessarily rural-relevant.

And so we spent a lot of time working in partnership with CMMI to come up with metrics that we did feel were rural-relevant. And maybe less likely to be impacted by small numbers. So the identification of the measure I think is as important as then being able to aggregate it and pull it.

So also coming up with metrics. A quality program, and I think one of my colleagues has already said that, you know, I think value-based is an opportunity to what are the metrics that we want everybody within a program using and standardization of that.

Because it also helps not only from a program administration perspective, but also, you know, the clinicians that are on the front end.

So many times, being a former health care finance leader, I felt I was chasing the dollar, I was trying to chase the carrot. And in these small facilities where we know resources are already strapped, we didn’t have the time to chase the carrot.

And so if you standardized that
where everybody is pulling in the same direction, it’s already been said before, alignment, getting everybody to agree on what the outcome is that we’re looking for and how we’re going to be measured against that and get that alignment at the beginning.

It makes the whole value-based journey a lot less arduous for everyone involved if we all agree on what the most important outcomes are that we’re trying to measure at the beginning.

DR. PULLURU: Thank you.

COORDINATING CHAIR SINOPOLI: Larry.

DR. KOSINSKI: Well, first of all, I want to commend Jay and the PCDT for compiling such a fantastic set of SMEs\textsuperscript{24} for this session. There certainly is tremendous experience in the three of you.

All three of you present a very significant statement around the problem with access. And that access not only has to do with distance and time, it also has to do with do you have available personnel to provide the services?

And we can’t possibly put together

\textsuperscript{24} Subject matter experts
value-based structures if half of your patients are leaking out to out-of-network specialty sites that are 50 miles plus away.

So my question, and I don’t think we’ve -- I heard you address this, how do we fully leverage the primary care base that we have there? Jay eloquently presented the fact that the disparity between the PCPs in rural versus the PCPs in non-rural, although it is less, is significantly less disparate than that for the specialist.

I’m a gastroenterologist, so I keyed in on his GI number, and there’s six times as many gastroenterologists in the non-rural area as there are in the rural area. Which begs the question of training and broadening the expertise of the primary care.

My colleagues in GI will probably not want me to say this, but we need to be training PCPs to do colonoscopies more. And we need to train dentists to do more than just crowns. They need to do some endo and some oral surgery.

So we can’t build value-based care unless we have the pieces there to perform the care. So what are the three of you seeing done
to expand the PCP abilities and raise them to a higher level of their performance than we’d see in a more urban environment?

MS. WALTERS: So I’m happy to go first on this one. I can tell you we fully and firmly believe that in order to address the needs in the rural communities where we’re present is we need to develop additional types of primary care extenders.

So we certainly know that transportation is a huge issue in rural communities. So how do we develop other types of resources in the communities that can, I’m going to say stretch the primary care that’s already there through concepts such as mobile integrated health?

So are there ways that through protocols, and we can develop other folks to support that care team and using, for example, some mobile integrated health strategies, working with technical schools in these rural communities. Can we develop additional, I’m going to say hands and feet of the primary care provider that would be working in partnership with them to expand that knowledge in the rural community?
So one of the things we’re exploring is the use of mobile integrated health solutions, broader peer medicine type programs. How do we build out a better clinical team? Because none of -- you know, the primary care shortage. The ability to recruit a primary care doctor to rural America, that challenge is not going to go away in the near term.

But we also know one of the things I believe, again having lived rural my whole life and having watched the demise of my community is, you know, how do we bring some economic alternative career paths, et cetera, to start addressing the economic issues in a lot of these communities?

And is there a way to develop alternative types of providers of, you know, whether it’s the community health worker, paramedics, EMTs\(^\text{25}\)? How do you develop other types of care and allow them to practice at the full extent of their license to bring additional primary care to the community and make sure from a payment policy perspective that payment is there to allow for these other types of providers to be paid and address the

\(^{25}\text{Emergency medical technicians}\)
need that way?

So that’s how I would say we’re viewing this within the Pennsylvania program and some other, you know, within the REH spaces there’s the opportunity to develop other types of care. Providers to extend and partner with the primary care that already exists in that community to meet the needs.

DR. GRANT-NIERMAN: I can comment just a little as well. So I did my residency training at Via Christi, which is one the handful of programs in the country that do train their residents to do full spectrum family medicine procedures with the intention that they go to rural Kansas, rural Colorado, Africa, you know, and do mission work.

And so there are a few training programs that train family practice docs to have the higher scope of practice.

And in my experience of watching the classes of residents that go through, everybody grabs the bull by the horns. We’re going to learn all the things and do all the things for everybody everywhere. Nobody lasts that long doing that because saying we should have the family docs do the scopes, which back in the
day they did, many people have.

And eventually that’s been burnt out because you can’t do everything well in an environment where in a court of law you are not going to be able to defend yourself against a GI doc.

Do you know what I mean? Like the medical-legal neighborhood of that, having them do all the things, is really great, and it’s also very risky. And it’s not very sustainable with quality of life.

So I definitely agree that allowing physicians who can be trained to do a higher scope of practice is a great goal. There are residency programs that do that, but those residency programs have a hard time fighting to maintain that training from the specialists at that level to be willing to train FPs\(^\text{26}\) to do it. So there’s a struggle.

And then when they get out there, they realize that it’s not compatible with life to do the scopes, the deliveries, the C-sections, the ER, the hospitalization, all the clinic, all the social determinants of health, solve the housing crisis. Don’t forget to

\(^{26}\) Family physicians
check on them at home because EMS can’t pick them up. You may need to go and pick up their prescriptions because we don’t have pharmacy.

So in the same breath that we say we need to support primary care, all of the solutions all come down to we should ask primary care, teach primary care to do that. Let’s add that to what they’re doing.

So we’re kind of squishing from both directions, and in the middle saying oh, by the way, we’re going to financially squeeze you and put you at risk too, by the way. So I’m hearing a lot of interesting forces and potential solutions that as a primary care doc feel like a squeeze, a pull, and a push in every direction.

So I agree that extending and getting support networks within the community, if that was possible to take off some of the burden of doing things that physicians don’t necessarily need to be doing. Being very mindful of not adding more administrative burden to participate in value-based care. Computer clicking boxes for the sake of clicking boxes. Treating a payer and a computer and a dashboard instead of a patient.
That’s things that we’re adding to physicians as well in rural communities, and then we’re wondering why they aren’t sticking around. We have to be really mindful to pay attention to all the things we’re going to add and ask of the already shrinking workforce.

Because what we’re seeing is primary care docs are saying I’m done with medicine, or I’m done with the payers. I’m going to direct primary care. I’m removing all of this. I’m getting back to my patient, thank you, goodbye.

So I agree that family medicine docs can deliver babies and do C-sections. I do that currently. They can do scopes.

But to say that all the things can be done by the PCP when there aren’t enough of them is a hard -- that will take decades of culture change, medical-legal malpractice change, financial change, reimbursement change before that’s I think going to be a reality again.

I’m hopeful. I don’t mean to sound negative Nancy, because I really am hopeful, and I love doing full-spectrum care, and I don’t ever want to stop delivering babies and working in the hospital. I’m not going to stop
doing that.

But across the community, residents aren’t trained to do that. Residency programs are disincentivized to train residents to do that. And the medical community is actually not welcoming to that kind of full-spectrum provision of care from family medicine in most parts of the country.

DR. BRULL: I want to amplify just a little bit of what Meggan said, which is I absolutely think family physicians are capable of providing expanded services, with the caveat if there are enough of us. Which means that you get more lifting up than pressing down.

And there is a shortage of primary care specialists in rural communities, just like there’s a shortage of gastroenterology specialists in rural communities. And so I don’t think the solution is shifting the work of various preventive services, colonoscopies being the example we’re talking about, but there are just hundreds of them, to the primary care specialist.

I think it’s more about ensuring that there are a sufficient quantity of primary care specialists to serve the population of the
United States, urban and rural. We just feel the gap harder in the rural areas because there aren’t as many of the other specialties to take care of the other parts of the patients in those areas.

And to me that comes down to reimbursement, which I think you all are working to solve. I think value-based care is the space for primary care to benefit from.

We are the folks who are looking at people’s total and comprehensive cost of care. We are involved with every organ system, with every transition, with every part of people’s lives when they are needing a health care system.

And so I think the more that we are able to make a path forward to do advanced payments, do predictable payments in value-based care, we will make primary care specialties more desirable as a specialty to pursue for students who are graduating from med school, we’ll increase the population of primary care specialists throughout the United States, which will in turn increase the population of primary care specialists in rural areas.
In addition, there are some really nice incentive programs. And many places, Kansas is one of those states where you can go to med school for free if you’re willing to give four years of your time back to a rural area.

And if we had enough of that going on, even if we have a different population of physicians coming and going in rural areas. The problem is once somebody leaves, there’s not usually somebody in line to take their place like there is in an urban area.

And so we just, we need to increase those programs that pay primary care well and that make it attractive for them to spend some time in a rural area, just like they might spend some time in Denver or Kansas City. Thanks.

CO-CHAIR HARDIN: Thank you all so much. We have about five more minutes left. Jay, I’ll turn it next to you.

DR. FELDSTEIN: Thanks. Janice, you touched on my question briefly. You know, one of the -- we’re not talking about dentistry and dental care today, but mobile dental care has used to fill the gaps, because there’s a
tremendous, you know, there’s no access for
dental care in rural America, let’s just call
it what it is.

And they’ve used mobile services to
fill the gap. So I’m curious for each of you,
what’s your experience been with mobile
services to fill some of the gaps we’re talking
about in health care delivery for rural
America?

MS. WALTERS: Yes, so I’m happy to
take lead on that. So not in this current
role, but when I was the financial leader for a
Critical Access Hospital in the state of
Pennsylvania, we actually did introduce mobile
clinics within our Rural Health Clinics.

And so that’s how we began
addressing the need of lack of dentistry within
our service area, was to do mobile clinics and
bringing them into the Rural Health Clinics.

Generally, as I administrate, you
know, the programs that the Rural Health
Redesign Center has been privileged enough to
manage, we really do believe there’s a huge
opportunity to do mobile integrated health
solutions. Anything from social determinant of
health screenings, you know, taking -- as
physician extenders can go into the home and begin doing some of this.

Even things like prenatal. We have a colleague that we work with who has experience doing even prenatal work and doing some of that through mobile integrated health. Certainly we’re not going to be delivering babies.

But what are the opportunities that if we develop the right workforce? Because that also, that addresses some of the transportation barriers.

So we do have examples of where this type of program is working and certainly looking to replicate that. But understanding that policy changes will probably be needed. Again, reimbursement at the federal level to make sure that their reimbursement.

So for example, one of CMMI’s programs was the ET327, which, you know, it was a reimbursement, alternative reimbursement model that would allow EMS systems to get paid through responding. Unfortunately in a lot of these rural communities, traditional Medicare is getting smaller and smaller.

27 Emergency Triage, Treat, and Transport
But we really need policies that do allow for EMS to be reimbursed, not only when they transport somebody to the hospital, but when they go out and do this type of in-home, making sure the reimbursement is there.

You know, the use of community health workers, at least in the state of Pennsylvania, all of that has been grant-funded to date. And so allowing the policy, both at the state and federal level, to make sure that there’s payment for these services is also going to be a big piece. And then also the workforce development.

So we think it’s a very viable strategy. But it’s again getting education, you know, your technical schools as well as your workforce, you know, labor and industry to the table. As well as policy then to make sure that there’s payment for these types of services when they are delivered in the rural community.

CO-CHAIR HARDIN: Jen and Meggan, did you want to comment briefly?

DR. BRULL: I’ll just give -- I’m solidly nodding my head to Janice’s comments.

DR. GRANT-NIERMAN: I don’t have
much experience with mobile delivery systems to have a -- have much to say.

CO-CHAIR HARDIN: Jim, I think we can fit in your question then, if you make it brief. So we have about three more minutes.

DR. WALTON: Yeah, my question is really such a big question. It’s about can the market solve this problem, which is -- it sounds to be like that the all-payer model, particularly as an example, might be a destination that we might want to look toward as a solution to help make progress.

Can the marketplace be motivated to do this, in your experience?

DR. BRULL: I’ll give my one-liner. Not until the marketplace has the same incentives that we do. Not until saving money makes you more money than putting a head in a bed or getting a dollar for making a widget. Like, we have to change the alignment of the marketplace before they’re going to help us solve this problem.

MS. WALTERS: And I would echo that. That would be we get what we pay for, and until we change, fundamentally change the incentives. So I do think we need to compete on something
And so I do think the marketplace can, if we change what we’re competing for, which is high-quality, improved care, value-based.

So my answer would be yes, if we get the right incentives and compete on something different.

DR. GRANT-NIERMAN: I would agree I guess with what the other two gals have said, but I’m also -- just want to spit out the curious nature of what the market is showing us right now. Which is the overwhelming investment from private equity, venture capitalists, the vertical and horizontal integration that is going absolutely haywire and bonkers, because there is billions of dollars being made by people who are not providing health care, taking away care from the patients who we claim we care about serving.

And so I think the market is speaking loudly and doing a lot of crazy and wild things. In America, it’s probably a little bit more urban than rural at the moment where a lot of the money is.

But I think it’ll be curious to see
what the market does when Walmart now is the provider of health care in rural Florida and Arkansas, I think that’s where they’re already starting. Or Intermountain Healthcare takes care of all of the health care in this part of the country. Like, there are big market forces at play really quickly, really scary.

So I think that it’ll be really fun to watch the train wreck.

CO-CHAIR HARDIN: I want to thank each of you so much for this very, very valuable discussion. It’s been really interesting, and I know we could asking you questions for another hour at least.

But you’ve helped us cover a lot of ground during this session, and you’re welcome to stay and listen to the rest of the meeting as much as you can.

At this time we have a break until 1:00 p.m. Eastern. Please join us then. We have great lineup of additional guests, and our first -- in addition to this first listening session of the day.

So we’ll see you back here at 1:00 p.m. Eastern. Thank you.

(Whereupon, the above-entitled
mattered went off the record at 11:58 a.m. and resumed at 1:00 p.m.)

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

**CO-CHAIR SINOPOLI:** Welcome back, Angelo Sinopoli, one of the co-chairs of PTAC. I’m pleased to welcome three experts who have experience with how payment features can encourage some of the innovations we’ve been discussing earlier today.

You can find their full biographies posted on the ASPE PTAC website along with their overview slides. I’ll briefly introduce our guests and give them a few minutes each to share an overview of their key takeaways.

First we have Ms. Aisha Pittman, a senior vice president of government affairs with the National Association of ACOs, NAACOS. Aisha, welcome.

**MS. PITTMAN:** Good afternoon, everyone. Thank you so much for having me. If you go to the next slide, just a little bit about NAACOS. We are an association that represents more than 400 ACOs, an MSSP,
Medicare Share Savings Program, the ACO REACH\textsuperscript{28} model, and then other CMMI models. And our members are also engaged in risk value arrangements with other payers.

We really appreciate PTAC’s interest in examining the barriers to rural provider participation in total cost of care models. I think, if we are to ever reach CMS’s goal of having 100 percent of traditional Medicare beneficiaries, in a clinical relationship responsible for total cost of care and quality, we really need to think about how we bring more participation to rural providers, including Federally Qualified Health Centers, Rural Health Centers, and Critical Access Hospitals.

So if we go to the next slide to get into some of our recommendations, we’re really thinking about this from the perspective of how can we bring more rural providers into the existing ACO models which are strong total cost of care models.

Ultimately we really have to recognize that rural providers are fundamentally different in how we pay them, the populations they serve, and the unique

\textsuperscript{28} Realizing Equity, Access, and Community Health
challenges. The one size fits all approach has not worked, and we need to adapt existing total cost of care models or create new models targeted towards rural providers.

I think efforts to bring rural providers into total cost of care must account for access. And so we have to really build everything from maintaining or increasing access to care. And potentially that also means having a lower focus on reducing costs.

Because ultimately some of the lower cost care settings might not be available. If we think about the lack of specialty care, urgent care, and post-acute care. That’s a unique challenge that you might not have in other areas.

So for example, in the absence of an inpatient rehab facility, the care may need to be delivered in a Critical Access Hospital. That represents a lack of an opportunity for a rural community to lower costs that might be available in other cities.

So from here I want to go through, if we’re using the ACO as a chassis for increasing rural provider participation, what are some of the opportunities to improve the
current models for rural providers?

So on to the next slide, wanting to first think about attribution, so ultimately ACOs are built on this primary care relationship. If we think about some of the providers in rural settings, this creates several limitations.

So one being that many rural practices do not include a physician and therefore don’t drive attribution. We hear from our members with significant penetration in ACOs, but they lose a lot of attribution just because they have several NP\textsuperscript{29}-only TINs\textsuperscript{30}. And the current construct for attribution in ACOs is all based around a primary care visit.

So needing to think about that a little bit differently, if we look at, for example, Federally Qualified Health Centers, a significant portion of their -- they have a lot of patient churn and so therefore can’t maintain attribution from year to year.

Additionally the billing at the facility level makes it difficult to understand when are attributing beneficiaries to your ACO

\textsuperscript{29} Nurse practitioner
\textsuperscript{30} Tax identification number
and through which providers?

Some potential solutions in this area are to create rural-specific attribution approaches. So does that mean one of the things would be attribution steps for certain rural providers so you could have, say, an advanced practitioner provider attribution just for rural communities, looking at multi-year approaches of alignment in attribution to account for the churn that the rural providers tend to see?

If a patient’s only having a visit occasionally, then they might not attribute to the ACO from year to year. So how can we expand that and look at more years?

And then just additional data is one thing that we strongly heard from our members, being able to better understand how and why providers are aligning to the ACO.

If we go to the next slide, I wanted to talk about benchmarks and the challenges that exist there. So FQHCs, RHCs, and Critical Access Hospitals all operate under unique billing and reimbursement conditions which present challenges to the participation in total cost of care models.
We think about FQHCs and RHCs. They are limited to being reimbursed for one service per day. So this creates a scenario where the FQHCs can deliver multiple services per visit, but they’re only getting paid for one service.

This has led to a climate where clinicians are often picking and choosing what services they provide patients. And then sometimes the patients have to come back for additional services.

This just creates a challenge in when you want to think about how you redesign care delivery because of the restrictions of the existing payment system.

I think another example for FQHCs and RHCs is they are prohibited from providing the annual wellness visit and any chronic care management in one day. They tend to provide these things both in one day, but it doesn’t get captured in billing. And so it becomes difficult to really assess what type of care that they are providing.

We think about a Critical Access Hospital. They’re paid under a cost-based reimbursement system. So 90 percent of their costs for fixed and opportunities for spending
reductions are limited.

If you reduce the number of admissions to a Critical Access Hospital in a particular year, you’re still going to have the same amount of payment. And so that is immediately in conflict with the concept of shared savings. And so it has to think about a different paradigm shift to be able to account for those payment systems.

Another challenge with regard to benchmarks is around the risk adjustment approaches. So in the existing payment systems for these settings risk adjustment is -- there’s no incentive to focus on risk adjustment.

And so when these providers attribute beneficiaries to an ACO, the beneficiaries typically seem lower risk. Therefore, they have a lower benchmark. And then there are caps on how much a risk score can increase within an ACO. And so you quickly hit those caps once you have the incentive in the ACO to focus on coding and risk adjustment.

It’s just under-emphasized because of the historical approach for reimbursement in those settings. And so you have to think about
are there ways to adjust risk adjustment for these populations that historically don't have significant coding documentation.

Some potential solutions in this area, you know, when we’re thinking about total cost of care, this is where we might need additional models. So thinking about global budgets or prospective population-based payments, those are options that are really attractive to rural providers.

I think, when CMMI was considering the CHART model that was going to be a rural-based population model, there was some interest in that. I think timing prevented, and mandatory Medicaid participation prevented that from moving forward.

I know with the recently announced AHEAD model that would be a global budget focus. That is something that can address some of those overarching payment challenges in rural settings.

Some other things to think about are lowering the discounts of minimum savings rates for rural providers in risk-bearing models, just recognizing that you might not be accounting for the historical costs in the
current benchmarking approach. And so their ability to create additional savings is limited.

In terms of the risk challenges I mentioned, adapting risk adjustment policies so you do not disadvantage sicker populations, this could be things like accounting for the lack of historical coding. So you could increase the risk caps for rural populations or beneficiaries without historical access to care.

And also as, I think is a hope, is to bring in more social risk factors over time to improve the risk coding methodology.

There also have to be some considerations for specific costs that are unique to rural communities. You know, I heard an example from one of our members that they had two needs for air ambulance in a year. And because of that significant cost, it was going to cause them to exceed their benchmarks for that particular performance year.

That is something that is much harder to account for. And so we need more outlier approaches so that we’re not penalizing the ACOs for these minor changes of care.
And then I think additionally is thinking about alternative measures of success to financial benchmarks. So is it that, instead of saving cost constantly, maybe it is that you’re reducing your trend over time.

And then if I go to my final point around flexibility within the models on the next slide, I think one of the things we overarchingly hear is that providers need additional technical -- rural providers need additional technical support to participate in models.

Things that our members have raised is that the waivers tend to be a one size fit all approach as well, so thinking about waivers in models and that are specific to rural providers.

So for example, for the FQHCs in rural health communities, waiving the one visit/one site requirement, making it easier to provide Hospital at Home, removing some of their face-to-face billing requirements for certain services, like the annual wellness visits and then, I think, providing more avenues for rural providers to understand the impact of the total cost of care policies on
those providers.

I just described three settings, the FQHCs, Rural Health Centers, and Critical Access Hospitals, where they are, to date, participating in ACOs. But when they’re asked to seek support of how their payment system interacts with the ACO, it’s really hard to get answers, so having much more of a focus of how, and more detailed information from CMS for how those providers can meaningfully participate in any value-based care model.

And that sums up my comments. Thank you so much for your time.

CO-CHAIR SINOPOLI: Great presentation, thank you, Aisha. Jackson?

DR. GRIGGS: Hello. I’m really honored to visit with you today and really appreciate the opportunity. I’m particularly honored to be included in the discussion with Aisha and Mark Holmes. These guys are truly subject matter experts. I’m just boots on the ground in central Texas. So I’m going to speak fairly generally.

But I want to start, next slide, with Texas. Texas holds the distinction of having the largest rural population in the U.S.
with over 70 percent of its counties housing fewer than 50,000 residents.

Rural Texas is economically vital though. It produces an impressive 50, sorry 21 billion in annual goods. But the region’s beset by challenges, high rates of poverty, educational shortfalls, food insecurity, which intensify health challenges.

Next slide. So here in Texas we’ve re-purposed a maritime term to fit our cattle industry. A bum steer in Texas signifies a deal that doesn’t deliver as expected. So rural health systems see the move to value-based care in that light.

So value-based care translates to underfunded initiatives that pile on responsibilities without truly addressing the unique challenges of rural Texas health care.

Next slide. So to illustrate my main argument, I’m going to use Abraham Maslow’s familiar hierarchy of needs that was first described in 1943. This hierarchy, you know, starting from basic physiological needs ascends to self-actualization. But you’ve got to satisfy each level before progressing on.

So next, clinical systems operate in
a similar fashion. The end goal is a health care system that offers equitable health care to all segments of the population. But reaching that summit of health equity first demands foundational infrastructure followed by financial stability.

Because how can rural health systems envision delivery reform to achieve health equity when they’re just trying to pay their nurses a fair wage, and bankruptcy is constantly nipping at their heels?

With financial security, then integration within the broader health and social ecosystems can be achieved. And once integrated, then we can arrive at true quality in aggregate. But of course, in aggregate doesn’t mean that health equity, a situation which everyone in society has the opportunity to thrive, has been achieved.

Health equity is a national moral imperative. But for medicine in particular, health equity is intrinsic to our core bioethic of justice. So it’s critical that we invest sufficiently to get there. So how do we create systems in underfunded communities to achieve health equity?
Next, so my aim in this model is to present a conceptual framework, obviously not to offer precise financial calculations. What’s crucial is recognizing the need for foundational investments before assuming capacity of higher-level performance.

Next. In a nutshell, I’m suggesting that foundational investment’s necessary before there can be expectations of high performance. And such investments should be rooted in proven methods, and tailored to specific rural demographics, all while safeguarding our already overburdened health care professionals from the burnout risks associated with clinical practice and systems change.

Next. More about us, our FQHC resides in the heart of Central Texas through – so our service area is McLennan County and the city of Temple, but the patients from 14 counties seek our services.

Next. This depicts that region there.

Now, next, in the same region several Rural Health Clinics and Critical Access Hospitals are managing to stay operational on a shoestring.
Next. But if we zoom into that same area, we find numerous small communities, each housing less than 2,000 residents, spread across an area that exceeds the size of the state of Delaware.

Next. A staggering 73 percent of our FQHC patients live below the federal poverty level with a third lacking any form of insurance. And of course, in Texas, Medicaid has not been expanded, and FQHCs have also missed out on the state’s 1115 waiver benefits. And this creates dire challenges.

And in light of these constraints, patients drive long distances in a centripetal pattern to see us. Patients carrying a disproportionate burden of chronic illness, mental health conditions, substance use disorder, and health-related social needs associated with their rural circumstances.

Next. Could value-based care help with this? Well, what we’ve learned from our initial experiences in a hospital-centric ACO, with a traditional MSSP, well, it would suggest no. It can’t.

A hospital-focused approach misses numerous opportunities for quality, equity, and
cost reduction. Benchmarking based on an already underfunded region is counterproductive. And superficial changes are seductive distractions when scarce funding has made your imagination for significant delivery reform rather cachectic.

So to boost participations, three things are needed: a front-end investment in infrastructure to allow rural health care sufficient buffer to take risks associated with delivery or reform, a glide path to total cost of care, and meaningful measures that are properly incentivized.

Next. So this then brings me to a nascent idea. I was asked to consider what it might look like to create an APM leveraging the assets of an FQHC. So I’ll try to describe that here. Remember how I mentioned a minute ago that our patient flow is centripetal? Well, what if we made the model centrifugal? What if we met the patients where they were in a tailored, community-focused model?

Next. There are 1,400 community health centers in the United States, each with a designated service area. In rural settings, expanding these areas often isn’t viable due to
lack of economies of scale.

But in a value-based hub and spoke model anchored in a community health center, that could pose potential solutions. It would allow health centers to widen their service footprint by forming strategic partnerships, aligning with HRSA\textsuperscript{31}'s vision and CMS objectives.

Potential ACO partners would include kind of obvious players, FQHCs, rural hospitals, local mental health agencies, while local allied contributors would consist of various interested community parties.

Next. The rationale for a primary care centered approach is straightforward. Why a primary care centered? It’s the most direct route to achieving population health and health equity.

Next. Moreover, the primary care approach is intrinsically holistic. It's relationship-based, community-focused, tailored, and integrated using interprofessional teams where the patient is at the center.

Next. And that tailored approach

\textsuperscript{31} Health Resources and Services Administration
creates trust, which is a really big deal in Texas.

Next. And rural regions grappling with health care professional shortages, an interprofessional primary care team isn’t just ideal, it’s indispensable. A team approach ensures quality outcomes while preventing burnout of the precious few physicians available.

Next. Now why ground a total cost of care model in the FQHC framework? Well, for starters, FQHCs already embody principles of justice, and frugality, collaboration, and accountability. They also bring tangible benefits like the Medicaid PPS\(^{32}\) rate, the FTCA\(^{33}\) coverage, and the 340 B program.

Next. So if these are all of our constituent pieces, let’s conclude by discussing how to piece together a locally tailored FQHC anchored hub and spoke model collaboration.

Next. Division structure as concentric circles, with the ACO at its core, supported by the aforementioned allied

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32 Prospective Payment System  
33 Federal Tort Claims Act
contributors in the immediate periphery, and more
distally supported by state and national agencies playing imperative roles in financing, you might even also consider USDA or other non-traditional health care funders for SDOH\textsuperscript{34} investments.

Next. Since there’s little to no risk tolerance within rural health care, and I mean even in the investment of existing staff time and resources, much less downside contractual risks, there needs to be a clear, simple glide path to progression.

Next. Heeding NASEM\textsuperscript{35}’s insights both structural and programmatic resources should be considered and these should be goal-aligned.

Next. Prioritizing structural resources means bolstering existing rural systems so that they can confidently embrace population-based total cost of care frameworks.

Next. And Congress' role includes sufficiently funding HRSA to support rural health care. And subsequently HRSA, via your

\textsuperscript{34} Social determinants of health
\textsuperscript{35} National Academies of Sciences, Engineering, and Medicine
primary health care and the federal Office of Rural Health Policy, should allocate unprecedented new funds for rural initiatives.

CMS through CMMI should pave the way for FQHCs to spearhead discussions on a tailored MSSP model for rural communities. And concurrently, CMS should incentivize non-expansion states to prioritize FQHCs and total cost of care strategies through 1115 waivers.

And then finally, my last slide, next, is -- oh, sorry, one back, is programmatically -- we’ll get this right here. There you go, perfect. That’s very good.

So programmatically, if an MSSP is designed for a rural population, it should be simple. And it should revolve around primary care. It should utilize existing resources for Critical Access Hospitals, FQHCs, and local mental health authorities. And it should emphasize initial investment and rural health infrastructure. Thanks so much.

CO-CHAIR SINOPOLI: Thank you. That was a great presentation also, Jackson. Just to reassure you, we do value the input from front-line providers that are out there doing the work.
And lastly, we have Mark.

DR. HOLMES: Great. Thank you for inviting me here today. I look forward to sharing my thoughts. So I was charged with discussing, focusing on attribution.

Next slide. And so I’m going to put the highlights up front. My key takeaways here are that, starting off first, most attribution schemes have a design assuming -- it says PPS, it really should have said fee-for-service data flow.

Although recent modifications have been more flexible, and based on that, a second point, I don’t think there’s a lot of evidence -- I should put it this way, I don’t think attribution, per se, is a major factor inhibiting rural provider enrollment.

There’s certainly some thoughts. And I think what Ms. Pittman outlined in particular, I think, are a couple issues to be considered. But I think if we had this discussion five years ago, it would be a pretty different point I would make on this. But I think some of the recent changes have addressed that. And we’ll get into that a little more in a minute.
The third point is that the cost of non-PPS payment schemes that are attributed to providers may often be higher, which makes cost savings more challenging for those with beneficiaries seeing rural providers.

And I want to stress that last part there. I’m saying beneficiaries seeing rural providers which is different from rural providers. And Ms. Pittman outlined a number of these CAH, cost-based Medicare upper payment limit as it relates to Rural Health Clinics.

But I think, as we talk about this in particular, the notion of different payment structures for some types of rural providers mean that it can be really challenging to fit that in a fee-for-service type setting that we normally think of value-based payment models being built on.

And then finally, other challenges in rural context, such as the ability to manage financial risk in infrastructure, and the infrastructure to manage utilization, may be more important than attribution per se.

It's always interesting to go last on a panel, because I’ve been -- certainly circumstances where the first person raises
points, and I’m, like, oh, I’m going to say something totally different. But I think 80 percent of what Dr. Griggs and Ms. Pittman have covered are aligned with my message as well. So that’s a great sign.

I can go through the next slide relatively quickly since this is a recap that we’ve sort of covered. We saw the data on the far left which is sort of the Notre Dame colors that GAO\textsuperscript{36} likes to use. It’s contrasting rural and urban participation on the left along with a number of challenges that inhibit participation in ACOs. And we’ll talk about some of these. And some of them have certainly already come up so far today.

Next slide. So just a quick review for attribution and that payment models generally depend on the attribution of beneficiaries or members, depending on whether we’re thinking of private or public systems, to one provider.

And I’m using provider in a very general sense here. It might be grouped around a TIN, it might be a system, it might be a clinic, it might be an individual health

\textsuperscript{36} Government Accountability Office
professional. But for the purposes of this, it’s not really critical.

A typical rule is that the beneficiaries assigned to the provider with a plurality of E&M visits or payments for the year with some sort of tiebreaker there.

So generally it’s what, you know, who did the patient, did the member, did the beneficiary see, and where did they get the preponderance of their care, and how do we measure that?

But the key design requirement built in that is that provider payments, and really more accurately data, but a primary source of a lot of our data comes from payments, is that it has to align with a PPS or, again, fee-for-service system.

So, if you’re not submitting payment reimbursement that’s in that system, you’re losing that ability to align them. And Ms. Pittman really explained that much better than I can in the context of some of the elements that she raised. Particularly, Federally Qualified Health Centers is a great example.

So if the reimbursement data do not support this type of model, then those
providers cannot be included. And so a common approach in the past has been to say, well, we don’t know what to do with them, so we’re going to leave them out, which is a pretty typical rural story.

And there’s an example there, the Oncology Care Model exempted Rural Health Clinics, Federally Qualified Health Centers, Critical Access Hospitals in Maryland as well, and just saying we don’t know what to do, so they’re not going to be eligible to participate.

And so there’s a lot of interest, of course, in saying okay, this isn’t sustainable if we want to have the value-based payment, Alternative Payment Models on as broad a provider-base as possible. So we need to come up with new approaches.

Next slide. So MSSP is built on it, so taxpayer identification number, or TIN. I deal mostly with hospitals, and so think in CCNs\textsuperscript{37}. And this is how we think about providers.

But providers that have a large presence in rural areas, such as Rural Health

\textsuperscript{37} CMS Certification Numbers
Clinics, Critical Access Hospitals, particularly Method 2 where what we would normally think of as Part B service is billed through the hospital. And Federally Qualified Health Centers bill through CCNs not TINs. And so a logic that’s built on TINs is stuck from the beginning and has no place to go.

And so there were fixes to this. As an example, the 21st Century Cures Act, along with others, have added these to qualified providers by saying all right, well, we can’t see exactly what the care is that you got from RHC and FQHC. So we’re going to assume that they’re all primary care services. And so therefore any visits to an RHC or FQHC we’re going to deem as a primary care service and qualify that for attribution.

That’s probably, well, the extent of my expertise, such as it is, probably says it’s not clear that’s unreasonable, but was the fix in order to include those providers into an attribution method.

Now it bundles those at the CCN level. So if you have multiple Rural Health Clinics under one CCN, as you might if a provider-based RHC, for example, under one
hospital, then that would be bundled under one. Again, we can have discussion about whether that’s appropriate.

Another similarity of that would be Vermont’s approach for Medicaid, as we covered earlier, where they addressed the fact that, for example, with Medicaid churn, looking at attribution based on last year wasn’t going to work as well.

What happens if I have a beneficiary who has never gotten primary care services? That’s going to be a challenge. And so they’re attributed based on population base.

I don’t really have another place to put this, but I’m going to raise it here as well in that -- can you go back a slide, sorry, Amy -- is that we also need to think about bypass and selection.

And so what I mean by that is certainly in the hospital literature there are multiple studies that have shown, as a rural resident, I have two options. I can get my health care locally, or I can go and get it from a larger facility, typically in a non-urban setting.

And we know that lower-income
Medicare beneficiaries are more likely to get their health care locally, whether that’s transportation needs, or transportation limitations, or other challenges that make it harder to go those farther distances.

So what that means is that at the hospital level you have a lower-income Medicare base than you do based on the population. And if those same principles hold in a primary care setting, it would be the same sort of story here, that if I don’t have a car, I don’t have choice where to go. And so there may be a disproportionate level of lower-income at the local level.

Okay. Now, Amy, you can move forward. So Ms. Pittman raised this point as well in her challenges, that coding is substantially different in rural and urban settings. Hierarchical condition categories, which we use for risk adjustment, generally the scores are lower for those who see rural providers. Again, I’m choosing my words carefully there.

This may be an accurate measure of risk, but it also may be that rural providers do not code as completely as urban providers,
generally. And Aisha got into that fairly well.

The call-out on the right-hand panel there is from a study that RUPRI\textsuperscript{38} out of, well, a rural health value consortium of RUPRI and Stratus Health out of Iowa put together where they did sort of an in-depth analysis of one particular rural ACO. And they also outlined challenges with coding.

And, you know, if you go to one of these, well, larger facilities have more ability to really train their coders to understand coding, the ramifications of long-term coding. But if you’re someone whose billing doesn’t depend on that, you’re just not going to be as complete with that.

Next slide. Other considerations, and really all of these fit under the larger bucket of it all comes back to volume, and my sort of approach to most of rural health is that volume is king.

And we can read these in depth here, but basically most of these come back to the idea that with fewer lives, members, beneficiaries, patients, whatever you want to

\textsuperscript{38} Rural Policy Research Institute
call those benes, you’re often going to have lower liquidity.

You’re spreading your fixed costs, which includes not just direct costs for technology and infrastructure. But also harder to understand costs such as expertise, and the time to invest, and understanding what these models look like, are spread over fewer people.

And mention again that broadening the base across multiple payers may be helpful. And we heard that earlier as well from Janice.

Last slide, dealing with referrals and costs, and I mentioned this earlier as well, in that when you’re looking at -- and there was an allusion to it earlier, that for many types of services, care is going to be higher, if not much higher cost in rural areas.

And so what that means is that, for not just rural providers but also urban providers, who are looking at, I would use the word steering patients, and whether, let’s suppose I’m a rural bene, I get my care in an urban hospital. My post-acute, I have the option to stay 50 miles away from my family or go to the rural place which might be 20 percent higher cost.
You know, from a total cost of care standpoint, the provider providing that care in the bundle is going to be incentivized to keep it in their urban low cost setting. We have a study to look at that. This particular citation is from GAO.

So, I'm at my 11 minutes. Sorry for being over. And thank you for your time today.

CO-CHAIR SINOPOLI: Great presentation, Mark. Three really good presentations just loaded with information.

So we're going to move to some questions now. And PTAC members, if you have questions, if you'll flip your name cards over, I'm going to start out with a couple of questions, and then look to the PTAC members to chime in. They've been asking a lot of great questions earlier today.

So earlier today Liz Fowler was here, and she actually gave us some ideas of things that she was curious about. And I like the idea that one of you mentioned about building a foundation before we build the skyscraper.

And so I'm interested to hear from you all very specifically, what few things
would you prioritize as we change our models in regards to looking at rural health care? What would you prioritize, and why would you prioritize those?

And so maybe if I can start out with Jackson on that one.

DR. GRIGGS: Well, you know, I’m going to quickly defer to my colleagues on what the levers are. But, you know, just in the NASEM implementing paper the argument was made that we just need more of the percentage of the overall spend on health care to go to primary care.

And I think that is particularly important in rural settings. I think that how that happens, how we get more dollars to flow into rural primary care, you know, well, I think that it’s going to be dependent on whether we’re talking about rural and far West Texas or rural Massachusetts.

I mean, there’s going to be different levels of readiness to move towards something that’s risk-bearing and could acquire more of the shared savings, for example.

So I think that how those dollars flow is probably more of a question for someone
with a little more familiarity with what the different levels are.

CO-CHAIR SINOPOLI: Great, thank you. Aisha?

MS. PITTMAN: Yes, I’ll say two things. I think one is more up-front investments for rural providers. I think we all documented just the technical challenges. And we’ve seen that come into place in MSSP, but I think we need to think about it globally across any potential model.

And the second thing would be just ensuring that any total cost of care model has the right adequate budget. So I mentioned things about accounting for differences that we see in risk, differences in that the patient populations.

There’s a lot of debate currently around how much is regionally versus nationally weighted if you’re defining a benchmark. So I think if you set it more regionally, it can address some of the challenges that we see with benchmarks and their impact on rural providers.

CO-CHAIR SINOPOLI: Great, thank you. And Mark?

DR. HOLMES: Yes, in addition to
those points, I think I’m going to expand on Aisha’s last point in particular in thinking about the benchmarks. There’s price standardization as a common approach for looking at this. So, for example, for post-acute care in rural, providers may be more expensive than in urban settings.

To the extent that those are included in the benchmarks, and recognized that we as a society have made a decision, and recognized that financial sustainability may be more challenging in rural areas, and have designed some payment methods that recognize that, and yet that offers often a barrier for meeting benchmarks that are not aware of those rural provisions.

COCHAIR SINOPOLI: Thank you. Jim?

DR. WALTON: Thank you. Great presentations, I appreciate all the input. I think the Committee benefitted a lot from what you guys have shared with us.

I wanted to pick up on a theme that I’ve been thinking a little bit about, and wanted to ask you guys what you think about it,
which is, Mark, you brought up the HCC\textsuperscript{39} risk scoring. And we've heard about this earlier today, that there's reasons why rural providers may not focus on that as a strategy as much as urban providers in value-based care.

My question just kind of circulates around this idea that what about the social risk, what about Area Deprivation Index as a proxy for social risk, and that an interplay, if you will, with the ADI of a community with diagnostic coding risk to identify communities, or differentiate different communities within the rural definition, that may have more combined risk, both diagnostic and social.

And the follow-on question to that would be which federal departments would you recommend HHS collaborate with to stack funding streams for the motivated rural areas to address their vision for improved health and health equity?

DR. HOLMES: I'll tackle that first, I guess, and I think others can weigh in. So I'll do the second part first, simply because I remember that question better, other federal agencies. I think USDA has a number of

\textsuperscript{39} Hierarchal condition category
economic development approaches, and particularly from a loan standpoint.

And I’m very sympathetic to Ms. Pittman’s point about the up-front costs. I’d love to see that as a grant or recognized within the program. But loans may also be another mechanism.

USDA tends to focus on larger facilities such as hospitals and the like. But that may be an important avenue. CDC\textsuperscript{40} has an Office of Rural Health that they’re standing up now. They’re looking for, it’s my understanding it’s a long-term sustainable funding.

And I think, when you think about public health, and social needs, that’s a great partner right there at the CDC to really leverage the exciting work that they’ve been pushing into this as of late. Those would be the two that I would start with, the federal agency standpoint.

The first question, see, I knew I would forget, can you remind me, Jim? Sorry.

DR. WALTON: Yes. The idea of leveraging the Area Deprivation Index --
DR. HOLMES: Yes, thank you.

DR. WALTON: -- as a proxy for social risk and somehow combining it with the HCC scores to get a better, maybe more clear view of the risk of a population within different rural areas.

DR. HOLMES. Yes, I think that’s a very compelling case. The thing that always makes me pause with these models is you have to be really careful to not have a two-track system. And by that I mean say, oh, if we get 40 percent for low income, that’s just as good as getting 60 percent for high income. And it makes it seem like we’re lowering the benchmark and is sort of antithetic to health equity.

So finding a model that recognizes there may be additional challenges with social needs, if you don’t have transportation, it’s harder to get you your follow-up care, but not setting a benchmark lower for populations with more needs, just coming up with a model that balances those two competing interests.

MS. PITTMAN: I’ll just elaborate on that. And I think ADI is a sort of tool that we have that we could use in leverage today. But ideally, you would want to, like, use
patient reported social risk factors to incorporate over time. And I know there’s efforts by the agency to encourage better collection of that.

On the ADI, just some lessons we’ve learned from its use in REACH is it needs to be regionally adjusted. If you’re just using national ADI, you are going to, in any benchmarking approach, disadvantage urban communities that also have other challenging needs.

And then beyond that, I think the challenge that we see in REACH is that ADI is used to adjust the benchmark up or down. So those with -- I forget whether -- some have a lower benchmark and others have a higher benchmark.

I think there’s a recognition that for vulnerable communities, it’s just additional money needs to go in. And you should be lowering the benchmark of other providers to give it to different ones. So it needs to be -- the budget neutral approach that’s used in ACO REACH is not something that would be sustainable more broadly.

CO-CHAIR SINOPOLI: Any others want
to comment on that before we move on?

DR. GRIGGS: I think this is probably apparent to everyone, but in terms of coding, you know, we’ve got big urban systems, you know, hospital systems that are billions in budget who have a whole workforce that’s dedicated to optimizing coding. And then you’ve got, you know, Rural Health Clinics and FQHCs that just don’t have any infrastructure to maximize coding.

So it’s sort of the -- I think it’s, so I don’t know literature well enough to be able to articulate where the evidence is at sort of the national level, but based on personal experience, you know, we’re just not able to spend our resources without seeing a clear ROI⁴¹ there.

And I think that’s the key. It’s that this is sort of the argument to simplify, simplify. It’s when we’re engaging rural health communities that have dilapidated infrastructure, you know, there has to be a very clear, if you do A, you will get B. And here’s the timeline for the investment before you’ll see a return on that investment.

⁴¹ Return on investment
Because everybody is just peddling as fast as they can already without the capacity to see why we would add more staff in order to improve coding, unless there’s some clear return on that.

CO-CHAIR SINOPOLI: All right, thank you.

So given what we’ve heard from you all and we’ve heard this morning, what considerations should be made when we are thinking about measuring quality in rural providers? And what performance measures would you consider most appropriate for rural providers, and how can rural providers’ performance most appropriately be linked to payment?

And we’ll start out with Jackson.

DR. GRIGGS: Well, I think that we need to move all of our quality-based metrics towards patient-centered metrics. And I think that that poses its own challenge sort of across urban, suburban, rural environments.

But I think specific to rural environments, you know, the accessibility, responsiveness to individual needs from the time an individual needs an appointment to when
they can achieve that appointment, what is the length of time there?

Again, I think from a patient-centered standpoint, the effectiveness of communication with an emphasis on clarity and empathy, capacity of a therapeutic plan to incorporate the patients’ unique values, obviously preventative screenings, timely interventions, hospital readmissions, I think all of those things could be potential metrics, integration of primary care, behavioral health, oral health, into social services, into care, and the degree of integration.

I mean, I think that that we’ve got to include measures of disparities in outcomes. How close are we getting to health equity by looking at disaggregated data, by subpopulations, particularly race subpopulations?

Those are some thoughts on how do we move towards more patient-centered measurements particularly in rural settings.

CO-CHAIR SINOPOLI: Great, thank you. Aisha, can you address that?

MS. PITTMAN: Yes, I would just concur with everything that Jackson just said
in terms of how do we assess providers in a particular model? I think more globally, if we’re assessing if a model or an approach is working, we would also want to look at measures of access, so not necessarily assessing access at the provider level, but does the model help retain access in communities that are at a threat of losing access to care?

CO-CHAIR SINOPOLI: Great. And Mark?

DR. HOLMES: I think both Aisha and Jackson have covered it very well. I have nothing to add.

CO-CHAIR SINOPOLI: Perfect, thank you all. Any other questions from PTAC members?

If not, so I’ll pose the question, how do we get past the small number of benes issue, which is obviously a common issue in small practices in the rural areas.

And I’ll start with Mark on that one.

DR. HOLMES: So the approaches that we’ve just discussed, I think, get us a long way there, so something that’s patient-reported, for example.

From a hospital setting, for
example, one of the few quality measures that is consistently available at a hospital level is HCAHPS satisfaction, so looking at patient reported satisfaction, anything that’s based on broad-based was probably going to get us farther along than something like control for people with diabetes, which is going to limit your percentage of eligibles pretty quickly or the denominator.

This has been a standard challenge, a long-standing challenge. And I think there’s a reason it remains out there, in that the solutions aren’t super palatable. And it’s all going to entail compromise.

Statisticians will tell you, oh, here’s an opportunity for a Bayesian model, with shrinkage, but it’s really hard to tell a provider, yes, you got 15 out of 15 right, but we’re going to call that 87 percent, because that’s closer to the mean.

And so we really have to deal from an accountability and transparency standpoint, something that people can understand when you’re talking about putting dollars at risk or

42 Hospital Consumer Assessment of Healthcare Providers and Systems
any sort of financial incentives as well.

So I think there’s another reason why measures of access, satisfaction, integration, that were just previously outlined, are far more compelling than some of the more traditional quality or cost which is going to be highly variable if you get one area ambulance, one broken femur. All of a sudden your total cost is out the window.

CO-CHAIR SINOPOLI: Yes. And I think part of my asking that question was to also address the actuarial risk with such low numbers which you did. So appreciate that.

And so I’ll move to Aisha for the same question.

MS. PITTMAN: I mean, I think in terms of the actuarial risk, we have approaches that work if we look at, like, an ACO model that allows providers to remain independent but share actuarial risk across a larger group of providers.

And then I think what happens in there is they’re using quality metrics that are different than what you assess at a population level. They get to more individual metrics in terms of how they shift or reward individual
provider level care.

I think the small N is always going
to be a challenge to getting to individual
provider level care. And if we look at things
like access to more population health metrics,
you need to access those from a larger group of
aligned providers, which is essentially what
the ACO model does.

CO-CHAIR SINOPOLI: Jackson?

DR. GRIGGS: Yes. I just think it’s
really difficult when we’re talking about
FQHCs, and Rural Health Clinics, and
particularly traditional Medicare. I mean
those numbers are just really, really small for
those populations.

So if you have larger FQHCs, I mean,
again, just working through this in my head,
thinking about that kind of hub and spoke
model, if you have larger FQHCs that can have
multiple sites in smaller communities, again,
you get to potentially numbers that work.

You know, obviously, like Aisha
said,
the ACO tries to account for that, but that ACO
ends up having, again, for a Medicare
population, ends up having to rely heavily on a
lot of front-end work, building the relationships, maintaining the relationships.

The HIT, which we haven't gotten to in rural environments, is just terrible. I mean, there's just no sophisticated health information technology workforce or systems base in rural environments to gather the data.

So I think all that says there's got to be front-end investment like we started with in order to get the collaborations built, the HIT developed, and even the technical assistance in developing a properly fit ACO when there are so many MSSP options to sort of select from.

So all that's got to be kind of baked into any initiative to get rural health up to play.

CO-CHAIR SINOPOLI: Okay. I like that. And so going back to my actual first question, if we put more money into primary care, and we're paying for up-front costs, what do you all consider the most important thing that you want to make sure that money goes to?

Obviously putting more money into primary care, not necessarily go into their biweekly paycheck, but what are they using that
money to invest in? What do you think are the
top three priorities that we need to make sure
they’re focused on with that money?

Again, start out with Jackson again.

DR. GRIGGS: So the vision for the
interprofessional primary care team has not
been realized in large part because there’s not
funding for health professions outside of
traditional medical providers.

So if I had community health
workers, if I had social workers who were on my
team, if I had nutritionists who could join me
and help, life coaches, I mean, there’s a whole
array, promotoras, doulas. There are proven
strategies that we just can’t pay for right
now.

So I think that staffing the
interprofessional primary care team is one of
those top three. Then I think data reporting
infrastructure, and so health information
technology would be a key second.

And then just back to my, kind of,
Maslow’s hierarchy, there are so many
infrastructural things, you know, we’re one of
the larger FQHCs, we have 62,000 patients, and
we just can’t retain nurses, because we can’t
pay market rates, you know?

I mean, we’re competing with big hospital systems that have had big mergers of huge economies of scale. And we’re competing for the same stuff. So there’s a lot of just basic infrastructural things that with more dollars flowing into primary care we could address just to stabilize our basic operations.

MS. PITTMAN: Yes, I would, this is Aisha, concur exactly with what Jackson said. And then also one thing additional is just increased investment in primary care.

And then particularly if you’re doing that as a population-based perspective payment, you can get rid of some of the constraints of being limited to providing services that are simply in the CPT\textsuperscript{43} book and addressing a broader set of services. And I think this is the way that we’re going to be able to address social needs a little bit better as well.

DR. HOLMES: Yeah, I like that. And so I’ve written down Jackson’s interprofessional care teams, I think, being critical. But as we heard earlier, if there’s

\textsuperscript{43} Current Procedural Terminology
no social organizations that can address those needs within 50 miles, you’re kind of stuck.

So I call this partnership cultivation. I’m not sure exactly what that means, but helping, working with the community to help address those needs and make sure those resources are there. Identifying someone who’s food insecure is helpful, but less so if you can’t say, well, here’s where to go next.

CO-CHAIR SINOPOLI: Good, thank you. So can any of you identify rural models out there that have been demonstrated to work well? And can you cite those and give us some insight into those?

DR. HOLMES: I think the evidence is we have tends to be those that are more integrated, so system-based looking. I’m going to try not to identify any specifics, but those that are really cross-services, systems that include inpatient, outpatient, post-acute, something that looks closer to a global budget type setting where you don’t have the incentives that have been identified over the last five hours, I guess, four and a half hours at this point.

Because the fact of the matter is
that, for many rural services, it is hard to compete financially because of that volume. And so if we can find a model that recognizes we, as 340 million Americans, have decided that we’re willing to help support those rural places, because we think health care is a right, and as I’m driving down I-80 in the Midwest, I hope that there’s a hospital there in case I have accident.

Now again, that’s antithetic to most of what we’re talking about here, so all that is to say, the original question was, oh, where does it work best? And those are places where you have multiple providers usually, you know, acting as one. That often is something that could be as formal as one dominant system.

CO-CHAIR SINOPOLI: All right, thank you. Aisha?

MS. PITTMAN: Yes. I think, elaborating, I agree with that point about seeing where you can implement global budgets, that’s something that we’ve heard from our members. While, you know, they could say that the ACO model works for rural providers, I think I brought to the table a lot of the things where we would want to see it shifted.
Those shifts in an ACO model work, but I think also there’s a desire to think about global budgets and the advantage of global budgets being that they’re all-payer, and that the model's not just limited to just Medicare fee-for-service, but it’s across the board.

And I think one of the things where we’ve seen it's been successful in that approach for rural providers is in the Maryland model in stabilizing payment to rural providers.

CO-CHAIR SINOPOLI: All right. Jackson?

DR. GRIGGS: I don't have examples like Aisha and Mark, but there was a paper that the Federal Office of Rural Health Policy put out that was titled a Guide to Rural Health Collaboration. 2019 is the date on that.

And they gave some practices that were working in terms of collaborating between rural agencies, one of which I just illustrated in the appendix of my slides. It happened to be with a Critical Access Hospital and FQHC, that demonstrated some improvements in cash on hand and net margins for both entities once
they began to collaborate.

CO-CHAIR SINOPOLI: Perfect, thank you. Chinni, do you have a question?

DR. PULLURU: Thank you to our panel. This question is, to start out with, for Mark and obviously also the rest of the panel. I want to hear your thoughts as well.

When we talk about, you know, what I’m hearing through this discussion is basically that in a systems-based sort of perspective payment or population-based, interprofessional primary care teams should be incentivized. And access, Aisha had mentioned access as well for a possible quality metric.

When you take the three of those together, one of the things that’s been floated is a solution in providing access care and good care to rural-based populations is telehealth. So I'd love to hear your thoughts on how telehealth, whether it be removing barriers and restrictions, or it could be an attribution model if embedded into sort of a total cost of care.

DR. HOLMES: That's a great question. Thank you for that.

So for years we’ve been saying the
promise of telehealth, and it wasn’t until March 2020 that we really started seeing it get utilized. Of course what we saw is that urban -- I’m being careful, I think it’s urban beneficiaries ended up using telehealth more than rural which, I think, kind of surprised some people but is really consistent with what we talked about with broadband barriers and the like, for example.

So one thing, and this is an opinion, I’ve not found any studies, and I continue to look for this, I think when we talk about telehealth, we have to be really explicit about who's benefitting. And by that I mean as a resident beneficiary.

You know, I love telehealth. When my son broke his toe on the beach, I was able to hold the phone over it and get a consult within 20 minutes when nothing around me was open.

That was great for me. But as telehealth becomes more accessible, I’m not sure what that means for care that used to go locally to the rural. So if, for example, in that case, my trade-off was go to the ED, the urgent care that's just down the road, instead
I connected with someone, I don’t know where this telehealth unit was based, that was care that was now being delivered at an urban setting.

So if we’re talking about rural providers, I think we still don’t know yet what the ramifications of that are. I think we’re just starting to see the data come in. If we’re talking about rural beneficiaries and rural patients, I think it seems pretty clear that telehealth is a net plus.

And I want to also separate, let’s call it, what, rural specialty, so things like telepsych, or sorry, telespecialty, so telespecialty, so telepsych, I think, is a very different ball game. If there’s nothing with -- if I cannot find a mental health professional within an hour of me, but I can connect to something locally, yes, that’s great. And I can get access to it.

But I think it’s a, what, triple edged sword. I’m an economist, so I always say on this hand and on the other hand. But there might actually be three hands in this case, just being mindful of what it is that -- the multiple ramifications of telehealth and how it
impacts different populations, I think, need to be thought out carefully.

DR. PULLURU: Jackson?

DR. GRIGGS: Yes. I think it's a question of if you build it, will they come?

And while I whole heartedly agree with Mark that there’s a broadband issue in rural populations that would have to be addressed, then there is, in addition to what's the best fit for telehealth in terms of clinical practice, this issue of trust. You know, what’s shocked me during the pandemic was how evidenced medical interventions became polarized along the political spectrum and how the trust in the traditional institution of medicine eroded very, very quickly.

I think that when we’re thinking about rural populations, we have to apprise the culture of the different ruralities. Again, I mentioned before, you know, West Texas versus Massachusetts rural might be very, very different.

I know that telehealth, as a one size fits all, I don’t think if you build it, they will come. I know in our community, we’ve had, well, we’ve had telehealth up since --
think it was April in 2020. We’ve just seen very sluggish uptake.

And people were very quick to return to their primary care clinician but have been, despite all of our promotion and marketing to try to make it as easy as possible, particularly the aging population just has not had a large uptake in — so, there's some medical skepticism.

There's some erosion of trust in the industry of medicine. But I certainly trust this doctor who I know. They’re my family doctor. Of course, I trust Dr., you know, Smith. But seeing a stranger on a screen, there’s just layers of kind of cultural barriers, I think, for a lot of rural populations.

DR. PULLURU: Aisha?

MS. PITTMAN: The only one quick point I’ll add to Mark’s point of we didn’t really see telehealth use until 2020, and I think while there have been telehealth waivers available in any sort of model test, it has not been expansive of — permitted during the public health emergency.

So I think it just — in thinking
about how different communities will utilize telehealth, we also have to think about how it’s restricted and where we want to waive the current fee for service requirements and really open up telehealth in the context of value models.

Those concerns about fraud and abuse are really mitigated when you’re responsible for a population and are going to ensure -- and for cost and equality you’re going to ensure that they’re going to have in-person visits when necessary and utilize telehealth as available.

And we just haven’t had that in the models to date. So I think we can take lessons learned from the pandemic, and apply that in any sort of value arrangement.

DR. HOLMES: Yes. I’d just add on that sometimes telehealth can help with things that you couldn’t get otherwise. There’s a narrative I heard, which we always have to be careful with that, but someone talking about a telehealth with one of their patients. And they were bundled up in a jacket and a blanket.

And they’re like, what’s going on?
Like, well, my heat was cut off two days ago.

Oh, you might not have picked that up in office visits. So, the ability to sometimes get a different perspective on circumstances that may be affecting health care is maybe enhanced in a telehealth setting.

DR. PULLURU: Thank you.

CO-CHAIR SINOPOLI: Yes, thank you.

Lauran?

CO-CHAIR HARDIN: I'm going to ask a tiny question, but I think it's interesting, and it's repeatedly come up, related to rural. So I think a lot about transportation. So, we've talked about hubs, we've talked about telehealth. But I'm curious what each of you are seeing or if you have seen innovation in really solving for transportation.

I work with many rural counties in design, more for Medicaid populations, but I've seen some interesting things there emerge. And then I personally, when I'm not traveling, live on a farm in Appalachia.

And there is an underground railroad for getting people to health care that occurs in the mountains where people know who to call. And that's how you get fast enough to an
emergency room that can treat you, or to pain
management, or other things. So it just has
made me reflect interestingly.

So the question is have you seen
innovation in solving for transportation? And
what has that looked like outside of the
telehealth?

DR. GRIGGS: I'll be real quick. We
just started using Uber Health, the ride
sharing program. And I think that that may
offer us, you know, some potential ways in
which to bring some of our remote rural
populations in to see us.

However, we're eating that cost
right now. I mean, if we were moved towards
population-based total cost of care, global
cap, you know, obviously that would be part of
the spend. But right now it's something we're
just eating.

DR. HOLMES: I love Lauran's story.
To me this is -- we want to think about rural
with an asset-based lens, and there aren't many
assets that we can leverage. And one of those
is the social capital. Social connectedness is
often much higher in rural communities. And
you've given a perfect example for that.
Whether it’s built around, you know, the school, or the house of worship, or whatever, I think that’s a great opportunity. But of course, you’re leveraging a volunteerism base which is more difficult to take the scale. So I think that’s important to address. The micro-transit that Jackson had mentioned I’ve written down as well.

And then a third would be community paramedicine where if I have an EMS truck that’s "not doing anything," basically, at a time, then I can use that for house calls and can address a lot of this interprofessional care as well.

So I think that’s not technically addressing your transportation, Lauran, in the sense that it’s not getting the patient out. But in many ways it may be better. Because once again, I get up there, and I can see sort of what’s going on in this setting.

CO-CHAIR SINOPOLI: So, I have one last question, kind of reflecting back on the comment Aisha made. So I’m just curious, and I think we’ve talked about it over the course of the day with all of the support that we’ve talked about giving rural primary care
practices, but just thinking through.

So what would encourage a well-performing urban ACO to want to incorporate a rural practice, knowing that their infrastructure costs are going to be higher, and their outcomes are going to be lower? How would you see that being structured so that they would be incorporated into a larger ACO or a larger pool of patients?

So I’ll start out with Aisha on that.

MS. PITTMAN: I think it gets to the type of community service that we already see urban and rural combined depending on, you know, particularly some of the larger health system ACOs, so just how they saw a broader net of patients.

And I think if we address some of the things like attribution and the benchmarks, they’ll be more encouraged to bring those providers into the model.

I think there's also something to be said for rural communities banding together to manage risk across them. So it doesn’t necessarily have to be connected back to an urban community. We see that as well, that
multiple rural communities come together to form ACOs.

CO-CHAIR SINOPOLI: Any other comments on that question?

DR. HOLMES: Sometimes hospitals will do this to get access to high-value services. I’m not sure that’s a strategy we want to encourage, but the idea being if I, as an urban, I think, a large urban system can work with a rural ACO that’s high performing, and I can figure out a way to get some of those high-value services, cardiology, orthopedics, for example, to come to my system, that could be an incentive.

But that’s an economist talking. I’m not sure that’s really the kind of thing that we want to leverage. But that might be one driver.

CO-CHAIR SINOPOLI: Got it. Jackson, any comment about that?

DR. GRIGGS: No, thanks.

CO-CHAIR SINOPOLI: So, before we close, any issues that we’ve not covered today or any insights that you all want to share with us at the end of this?

DR. HOLMES: I think the only thing
I would mention is the definition of rural community came up both from Dr. Fowler, as well as you, Angelo. I think you mentioned this in the previous session.

And I think there are multiple places to draw the line for what is rural. I’d say one thing that did not come up was a FAR code, which is a -- I forget what it stands for, but it’s basically, as you might expect, how far is this zip code from a large city kind of thing. And that might be an alternative way to think about some of this. Because that really gets at access.

But no matter where you draw the line, there’s going to be one of these rural communities that’s going to look least rural. And so I do a lot with rural definitions. A lot of people I talk to say I drive by a cow on my way to work. That must mean I’m in a rural community. I’m like, no --

(Laughter.)

DR. HOLMES: -- you know. We need to think about it more than that. But it’s going to vary depending on the setting. And so if I’m getting my radiation oncology treatment,
what probably matters more than anything is how far I’m driving every day for five weeks in a row for that.

If I’m, you know, getting an infusion, and probably it’s going to be, do I have a sufficient number of people in my community to support an oncologist? So it’s going to depend on the particular service which always means that there’s no great answer.

CO-CHAIR SINOPOLI: Perfect. Any other comments?

DR. GRIGGS: Just the fact that, in order to be able to measure performance of rural communities when it gets better to just judge how we’re going to fund, you know, this kind of programmatic intervention versus that one, we’ve got to get the definitions down. And so I agree, I’m glad you mentioned that, Mark.

CO-CHAIR SINOPOLI: Perfect. Good. So, thank you all. This has been another great session. It was very informative. It’s going to help us create a great document to send to the Secretary.

And so I think that we’re going to break at this point, and you all are welcome to
stay and listen to as much of the next meeting as you would like. We’d certainly love to have you stay on and listen. But right now, we’ll go ahead and take a break until 2:40.

All right. Thank you.

(Whereupon, the above-entitled matter went off the record at 2:19 p.m. and resumed at 2:40 p.m.)

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

CO-CHAIR SINOPOLI: Welcome back.

When planning this meeting, PTAC wanted to prioritize hearing from those with frontline experience managing care transitions within value-based care.

To that end, we invited four experts from across the country for this next panel.

You can find their full biographies posted on the ASPE PTAC website along with their slides.

At this time, I ask our panelists to go ahead and turn on your video if you haven't already.

After all four have introduced
themselves, our Committee members will have plenty of time to ask questions.

First, we'll hear from Dr. Adrian Billings who is the Chief Medical Officer and Associate Professor of Family and Community Medicine at Texas Tech University School of Medicine.

Please go ahead, Adrian.

DR. BILLINGS: Thank you very much for the introduction. Buenas tardes.

My name is Adrian Billings, and I have been a rural family and community physician for my entire 17-year career, primarily, first, in private practice in the same community in rural southwestern part of far west Texas.

And merged my private practice with a Federally Qualified Health Center as a way to try and expand my impact and improve services beyond primary care and try and debut behavioral health services, pharmacy, as well as dental health services.

And so, I've been the Chief Medical Officer of this Federally Qualified Health Center for the past dozen-plus years in a very medically under-resourced area of the Texas-
Mexico border with a high HPSA\textsuperscript{45} score of 19 and high Maternity Care Target Area score of 21.

And have been very, very much involved in hospital medicine as well, practicing out of a Critical Access Hospital, admitting my own patients for medical reasons, as well as for obstetrical reasons and have delivered babies in these settings.

We've also debuted a rural family medicine residency with Texas Tech.

And academically, I'm serving as their Associate Academic Dean of Rural and Community Engagement also as a way to try and leverage more resources out to our rural communities within our health science center service area.

Next, please?

So, that's the perspective that I bring.

And I won't go into detail on this first bullet point. I was able to attend a little bit this morning Dr. Feldstein's excellent introduction to the rural health care disparities that you all have already heard.

But, you know, I just want to

\textsuperscript{45} Health Professional Shortage Area
highlight that I recognize, as a medical student rotating in rural communities, as a resident when I went back to the rural community where I ultimately ended up serving my career at, I knew that there was a paucity of services from a medical standpoint, no social workers, you know, very few specialist physicians, lack of care management.

What I under recognized was the lack of business and financial wherewithal as well and those resources.

And so, I haven't heard anything with regards to that. And I just do want to point out that, in addition to all of the health care disparities and the under-resourced disciplines that are a paucity in our rural areas, I just want to also encourage that we think of it from a business standpoint and a financial standpoint.

How can we best support those people who really hold the financial purse strings?

And I think when we're thinking about value-based care, that will be a discipline that is going to be so important to enable those of us who are clinicians to continue to provide the care that we do.
And I think I always practiced with the humility that I did not have nor did my community nor did my health care organization have all the knowledge nor all the resources that we needed to care for our patients, that our patients deserved.

And so, it was really only through collaboration with primarily academic health centers that we were able to expand our services within the Federally Qualified Health Center and debut the rural residency program in partnership with a Critical Access Hospital and the Federally Qualified Health Center.

And now that I'm wearing an academic hat, and that's my role is to try and leverage resources out to these rural communities.

I have the understanding now that really, these publicly supported academic health centers really should have the responsibility and the social accountability of wanting to take care of the neighborhoods and the areas around these academic health centers.

And in my bias as a rural physician, I really feel that it's these rural communities that need the most help, certainly.

So, I think my other point would be,
any financial incentives that could be given to academic health centers to encourage leveraging of their resources out to these rural communities is important.

And on the other hand, on the flip side of the coin, also, anything that could be encouraged from a payment model to encourage these rural health care organizations to collaborate as well would, I think, go a long way in standing up more services and more access to care in these rural communities.

Next, please?

And so, really, it's, you know, these financial incentives for sending and accepting students and trainees that, hopefully, plant roots and, ultimately, stay.

And I can tell you that, as a rural physician, I, at least, you know, need to learn more about value-based care. And I think that also extends to the entire health care discipline within rural communities.

So, any partnership with larger, urban organizations that can hold our hand and walk us through the value-based care and getting us on board would be very, very helpful.
So, thank you so much for this opportunity.

CO-CHAIR SINOPOLI: Great, thank you.

So, next, we have Dr. Howard Haft, a consultant and former Senior Medical Advisor of the Maryland Primary Care Program.

Welcome, and go ahead, please, Howard.

DR. HAFT: Thank you very much. It's an honor and a privilege to be here today.

And I am, as you said, a primary care internist going on 50 years of experience now. At least 30 of those years have been delivering primary care in rural settings.

I also served as a state health officer, state health official.

And during my watch, I served as the initial Executive Director and helped form the Maryland Primary Care Model as part of the negotiation we did over many years with wonderful colleagues at CMMI.

That model is one that continues even after I left state service and under great continued leadership.

And it really encompassed almost
two-thirds or two-thirds of all eligible primary care practices in Maryland.

The model included practices in 17 rural counties. Maryland is one of those hybrid states that is both rural, urban, and suburban. But a majority of counties in the state are considered rural.

And, you know, I am now, I think, understanding that, after almost a 50-year career, I'm coming back to find the real joy in serving people in rural communities. And I'm looking forward to, after all this journeying, finding where I started again and only really recognizing it for the first time.

Let's have the next slide, please.

So, I want to just first get a little bit of artwork in. This is Norman Rockwell, a painting that he did as part of his series in Americana that appeared in the Saturday Evening Post over many years in the '40s and early '50s.

But this is a picture that Norman painted, actually, of himself and his family being cared for by Dr. George Russell.

I think it really goes back to the roots of, why are we doing this now?
I think this was a picture that Norman painted, not for the cover, but kind of a piece that he really wanted to talk about what Dr. Russell meant to his community.

Because it's a rural community in Arlington, Vermont, that he said, when Dr. Russell came there, really changed everything in the community.

Dr. Russell cared for the physical needs of the community, but also identified social needs and environmental needs, provided transportation when people needed to get to go to specialists, did vaccinations, started public health nursing, really said, I have a fiduciary responsibility to this community that I serve.

And in turn, the community supported Dr. Russell.

So, this is really the roots of health care and primary care. And really, the foundation, I think, in which all health care should be delivered, on the strong foundation where there's a clear fiduciary responsibility of the primary care provider, the internist, the family physician, to care for those people that they serve.
You know, I say this and then, I think that the NASEM report in implementing high-quality primary care in 2021 really described how it could be done now in the current context with health information technology and hybrid payments that are both fee-for-service and population-based, and addressing equity, and said all the right things about that.

I was just really not disappointed and shocked, but I think went back to reality when I heard earlier today one of the presentations, one of the presenters, it was Meggan Grant-Nierman talk about how this system has really failed her in rural health, how they embraced a lot of the things that were happening, but there was just insufficient funding.

And I think that's at the heart of the problem that we have, is that we have insufficient funding.

We know that rural healthcare providers are called upon to do more, you know, with their patients, all the things that you've heard all through the day today.

Their patients are sicker. They're
older. They have transportation issues. There's, you know, the lack of connectivity.

And still, we don't recognize we don't pay primary care enough to begin with. We know that they're 4 to 5 percent of the total spend.

But this is even more of an acute problem and a serious problem in the rural settings where it actually costs more to provide that care, and they're actually getting paid less, the GPCIs\textsuperscript{46} are less, the ability to engage in these programs is less.

And then, as I think one of the other presenters said earlier on, we're doing this, but at the same time, we're saying, we'll give you a little bit more money, but we want to put you at financial risk for that money.

Now, that's so, so painful. And one of the things that I heard during my time in the Maryland Primary Care Program loud and clear from all providers, but particularly from the rural providers, we don't have enough now to build infrastructure.

If you give us a little bit of money and you put us at risk for that, what happens

\textsuperscript{46} Geographic Practice Cost Index
if we don't score as well as we can? And then, you're taking away our infrastructure again?

So, one of the take-home messages from us is that, for me, is that we have to start by recognizing and paying our primary care providers more.

How we deliver that to them, I think, is a matter of the art of regulation and policy and manipulation of the payment systems within ACOs or otherwise and clearly, with some value-based payer -- value-based payment systems.

And let's be careful about putting small individual rural providers at risk, but primary care providers, probably in general, at financial risk.

Financial risk really, you know, implies, you know, and I'll end here for this slide, really implies actuarial risk, as you heard before. And that requires large numbers. It requires sophistication in taking that risk.

And that's not what providers have to begin with, and it's not what they signed up to do to begin with.

Let's go on to the next slide.

So, a couple of key takeaways: rural
providers really benefit from the flexibility offered by the non-visit-based population-based payments such as Care Management Fees.

In the Maryland Primary Care Program, I think they, largely, the providers, and particularly the rural providers said, we can really do a lot with the Care Management Fees that are provided that are really risk free, Care Management Fees.

We can implement a lot of things in care management and building out this team-based care that's been described as really important, and we know it's really important.

But it's probably still not enough. It still falls short of being able to build a full boat of what we are asking people to do in terms of addressing equity and the social needs of patients and behavioral health integration and all of the other things that primary care could do if it was funded well enough.

Quality benchmarks were talked about earlier also. And I think they really don't need to be so much adjusted because that can cause a, you know, if you lower a benchmark, actually may cause less equity rather than closing -- bringing greater equity.
But I think we can recognize that we can pay for achievement or improvement, as well as achievement.

Improving towards a benchmark, if you make sufficient adjustments, should be as valuable as achieving the benchmark, particularly in rural settings.

One of the things that I -- that was a take home message to me also, and this is, I think, going to be really important going forward, is Medicare Advantage begins to really usurp traditional Medicare.

So, many states, it's 50, 55 percent, others even higher.

It really cuts down the number of beneficiaries who could be funded through the, at least the Medicare or CMMI APM models.

And if there's a narrow restriction that the funding that goes to them, which is going to be smaller and smaller, can only be used for that small group of patients, it really hamstrings the providers in saying, with this small amount of money, there's probably little that I can do for these patients.

But perhaps there's something that we can do if we spread this out over all of our
patients for a single initiative.

But it's been very tightly benchmarked to just to be used for one particular patient -- one particular group of patients.

Now, hopefully, we'll see in the future all-payer models that will make those kind of issues go away.

But right now, the limited payments that come with some of the APM models really, particularly when they're pigeonholed to one particular patient type, makes it really difficult to institute at the practice level of a real program.

So, I think I'll just stop there and be happy to address issues during the question-and-answer period.

CO-CHAIR SINOPOLI: Great, thank you, that was actually very helpful.

So, next, we have Dr. Jean Antonucci, a family physician with Northern Light Health and previous submitter to PTAC.

Welcome, Jean, and please begin.

DR. ANTONUCCI: Hi, I've had lots of technical troubles being a rural provider, can you hear me?
CO-CHAIR SINOPOLI: We can.

DR. ANTONUCCI: Oh, that's delightful, okay.

So, I'm sort of staring at you so I don't misinterpret that and thank you for calling me an expert, that was very sweet.

I am a rural primary care provider out in Maine. I've been here for 33 years.

And so, I think I'm here for two reasons, to try and be useful to you. One is that I do have extensive experience being a solo primary care provider and working with small providers all over the country a little bit.

I've worked in many settings, but the best was my own practice.

I think that a few things, one is, small practices are somewhat in this country like Vitamin C. There's a myth that they are cottage industries and disconnected and can't afford EMRs.

And yet, the data from folks like Casalino says that we do very good care.

I had an EMR before lots of people.

And so, I want to tell you that some of the programs and payments and program things
I was in, I saw every patient the day they called and on time for many years.

And I did PCMH\textsuperscript{47} and was Level III. And I was in a few programs. We had an ACO, and it started out fairly sweetly and then, basically stopped.

There was politics, and the hospital fired the guy who was bringing us together trying to do some good work. And I never heard from him again.

One day, I Googled him, and they said, oh, but we meet every month. Well, no one was telling me anything about it.

I mean, it was just a failure from my end, except once a year when they wanted my data.

I was in a program called a health homes project run through the state Medicaid. And there were lots and lots of strings attached. And I really wanted to be in that project because they had a community, a care team, which I wanted for my patients.

And then, it turned out it didn't make any difference. And there was a little extra money, but lots of us, I think, left that

\textsuperscript{47} Patient-Centered Medical Home
project because of the hoops we had to jump through.

I did do NCQA\textsuperscript{48}, as I said, PCMH. And I can tell you also, you know, I've been listening most of the morning to what I've been listening to all morning.

And I think there's a very big disconnect. There's a lot of good thoughts about what to do for rural providers and pay us and such, but it is a lot of other regulations and rules we're up against.

And so, Meaningful Use is a good example because I had a great EMR that did things my big fancy EMR where I'm employed cannot do now.

For instance, it had a plain old tickler reminder system. That's one reason I got it. And now, I have to keep that on paper to make sure a test was done, that I got results, that I told the patient the results.

To me, that is a hallmark collection of primary care. And so, I can't do that.

And when I did Meaningful Use, I had to get a different EMR because mine didn't meet Meaningful Use, although it was great.

\textsuperscript{48} National Committee on Quality Assurance
And then, the Government sent my $11,000 to someplace I hadn't worked for years.

And so, it's not just payments we're up against.

I have also been paying through a program that's a little similar to the proposal that I submitted. And that's the second reason I am here.

I heard you could submit proposals, so I did. You know, I'm not slick or polished, I'm kind of direct and sometimes blunt because I've been out here doing this work for a long time.

But I submitted a proposal and came to PTAC. And the feedback I got from my three-person committee was, this was so innovative we weren't quite sure what to do with it.

And I would urge anyone who hasn't read it to read it, because some of the prior speakers today were talking about how do we measure risk? And how do we incorporate social determinants of health?

And I did all that because I used somewhat innovative methods.

And I -- my method for payment was capitation based on risk. And I did get one
small payer.

If we can do the next slide, please? I forgot all about my slides. Next slide, Amy?

I did get one payer to pay me that way. And because you had to run a low overhead practice, I did very well on that.

I know that it would take a lot for some practices to learn capitation.

So, I do think out of the box about a lot of things just because of what I've lived.

And I thank you, Dr. Haft. I don't think that primary care practices except little ones, especially little ones, should be doing risk.

The risk we take is when Mom calls us at 3:00 in the morning, and their little one has a fever of 103. That's the risk I take every day.

I should not be taking insurance risks. I should be paid fairly. And I think the states should be having primary care czars as the NASEM report suggested.

And to join us all together, the hospitals are a real problem for small practices. That's why I open up and close my
practice.

I think I might have interrupted my own self, which I do a lot.

I would say two things. I think value-based care, I'm sorry, I think it's the latest Kool-Aid. And I think it's trying to fit a round peg into a square hole.

It was Uwe Reinhardt at Princeton who said, it's the prices. I can't control prices, I can't even control a lot of prices you think might be under my care by going to one hospital I send my patients to for their MRI.

I seem to have lost my examples.

I have patients that are trying to get on the portal last week so they didn't have to deal with the terrible phone system.

And I look at their phone, and I say to them, I can get you on the portal, you have a smartphone. And they would say, no, I don't. They don't even know they have a smartphone. So, a lot of technology barriers out here.

So, in conclusion, I have to tell you, I now work for a big system. I only work part-time. And what I do now is MAT⁴⁹, Suboxone.

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⁴⁹ Medication-assisted treatment
I take care of recovering drug addicts. I take care of an incredibly difficult population. It's a lot of fun when I get there.

Every one of them has been abused. They have terrible places to live, and screening for housing trouble doesn't do me any good. I was taught as a resident, you don't screen for something you can't do anything about.

We give them food. They -- even if I have a place for them to go, I send them to the dental school for dental care, it's two and a half hours away. And even if they have a car, they tell me they won't drive there, that's too scary.

So, I'm trying to paint a picture for you about a lot of things we're up against out here. It's not just payments, although I'm a big believer in capitation for primary care.

And I use some tools through How's Your Health and the What Matters Index.

And I'll just conclude with that before Amy yells at me for talking too long.

I have to tell you, Amy and Heidi have been wonderful to me today. The barriers to get audio and visual at the same time today
have been very difficult out here.

And so, the thing I would close with is a tool I use, and it's what I see. And I think probably every working physician sees this, even if they don't know they see this.

What our patients lack is confidence. They have no ability to solve problems. This is a huge problem when taking care of them.

And so, none of these measurements that we have or metrics really matter a lot to some of my patients. The What Matters Index [inaudible].

And then, I would only throw in, I think a metric, it should matter, and what you should measure is whether the patients carry a medication list. I used to give them all medication lists.

So, I'd say a lot of different things. I do have a lot of experience and hoping I can be helpful to you today. Thank you.

CO-CHAIR SINOPOLI: Thank you, Jean, that was great. Appreciate all that insight and experience.

So next, we'll go to Dr. Karen
Murphy who's Executive Vice President and Chief Innovation Officer, as well as the Founding Director of the Steele Institute for Health Innovation at Geisinger.

Karen, please go ahead.

DR. MURPHY: Thank you, it's a pleasure to be here today to address the group and also such esteemed panelists. So, I'm thrilled and can't wait to hear the discussion.

So, just a little bit of background so you know where my comments are grounded.

I started my career out as a registered nurse. I worked in an ICU for 10 years, and I always say, I'm not that smart. I never would have been able to do the things that I did if I didn't work in that ICU and understand the importance of not only medical care, but also taking care of patients and their families.

So, when I'm -- I've worked in a hospital in northeastern Pennsylvania. My last position there, I was CEO.

Then went on to CMMI, had the wonderful pleasure of working with Howard's teams in Maryland with the Maryland model and also with the state innovation models.
And prior to coming to Geisinger, I was Secretary of Health for the Pennsylvania Department of Health where I worked with the team there and CMMI on developing the Pennsylvania Rural Health Model.

For those of you that are aware of Geisinger, Geisinger -- not aware of the details of Geisinger, so we take care of patients, we manage care, and we also research, educate, and innovate.

And I would remark that most of our clinical assets at Geisinger are in rural communities. So, I have the honor to continue that work when I came to Geisinger.

Next slide, please?

So, as was stated before, I know that you've covered deeply, and as our panelists have talked about, the rural health care in crisis and why. So, I'll let that go because I'm sure by now we have the background enough.

We've also talked about Alternative Payment Models.

But I really want to take a minute to talk about the future and a couple of things that we have said here before, and I've been
thinking about rural health now for almost 10 years from a policy perspective.

And I think the most important thing that Howard and Adrian and Jean have alluded to is the social accountability.

If we really want to address the needs in rural communities, we have to get serious about it, and we have to do it in a way that invests in rural communities.

We are going nowhere without investment.

And from a federal government and a state government perspective, the role of government is to protect the vulnerable. And rural communities represent the vulnerable populations in our country.

So, I'm a firm believer, I think we can do it, I just think we have to do it in a much more holistic way than perhaps I was even thinking about, I'd be the first to say, in 2015 when we start the discussion on the Pennsylvania Rural Health Model.

What I mean by a holistic approach is everything that Jean just talked about it, not only the medical care, but the social determinants of health.
And medical care, not only the medical care, it's not acceptable for individuals in rural communities to travel two and a half hours for health care that could be delivered adequately and appropriately in the rural community.

And whether that's through leveraging digital technology or whether that's through partnerships with larger centers.

You know, to take a day off from work to go to the doctor is just not acceptable.

So, when I talk about a holistic model, what I'm talking about is I would propose if I was designing a model today, I would propose a holistic model looking at the community that we're serving.

So, there are, you know, really, there's about four or five prototypes that every rural community would fit in. Some are more challenged than others.

But looking at a holistic community, I think, is so critically important because, rural communities are really -- health care is the physicians are really intertwined very much with the rural hospitals.
So, I think we really have to take those two together, not isolate, look at this payment model and look at the rural hospital model. I think we have to look at it together.

I think the second point that has been made, I do not believe until we get a sustainable -- a financially sustainable model developed for rural communities that we can ask rural providers to take risks.

The numbers are too small. The stakes are too high. And we don’t have the model right. So, why would you design, you know, a payment model that has risk in it? I did it, so I take full responsibility.

But having learned and thinking about moving forward, I think we have to select the model that -- the models or model that can be sustainable, implement those for a period of a long runway because you're not going to get anybody to agree to transform substantially if there's not a long runway.

And really work at improving that while we meet the behavioral health needs, the social needs, and the medical care.

So, I could go on forever, but I'll stop there.
CO-CHAIR SINOPOLI: Great, thank you.

So, again, I'll remind the PTAC members to flip their cards over if they have questions.

And I have a couple of questions here, but we'll look to PTAC to ask further questions.

So, we'll focus on a few things that have already been discussed a lot today, but just interested in this group's perspectives also.

And so, when you're really getting down to specifics in terms of what a payment model would look like in the rural environment that would incentivize those things I just heard all four of you talk about.

And realizing that rural providers can't take capitation. They can't take global risks, those kinds of things, is what I'm hearing.

What would that structure look like? And what would the payment model look like?

And if you're infusing more money into the rural provider environment, again, help us prioritize, what would that money go
for? What are the most important three things to begin with to drive changes and outcomes in the rural environment? And what would those things be? And I'll start with Adrian first.

DR. BILLINGS: Yes, thank you for that question.

And I'll try and be brief, but rural providers need to be paid more. It has been shown that we do more with less because of payment.

And we need to be incentivized for innovations of collaborations. Because for small practices or small communities, we need to be incentivized for bringing in social workers, students.

Bringing in behavioral health care work for integration of behavioral health within primary care.

We need to be incentivized to establish rural residencies.

On the other hand, academic health centers also need to be incentivized to have more of a rural impact and a rural footprint.

We have too few rural academic health centers out in our rural communities of need. We need to open more rural academic
health centers that are multi-disciplinary in nature.

It's not just the physician that's needed, it's the rural labor and delivery nurse. It's the rural social worker. It's the MA. It's everything from the associates degree level to the terminal degree level that is severely lacking in rural health care workforce, and some of that is economics.

And if value-based health care is going to financially penalize our rural providers because we're taking care of sicker patients with less access to care, they're showing up later in our offices because we just don't have the capacity to take them.

On the U.S.-Mexico border, we're taking care of a large amount of immigrant population, for the first time, we're seeing them.

And if we're going to be penalized for that because we're just willing to take care of them, and we want to take care of that population, we have to figure out.

Rural is not urban and, I agree very much that more investment is needed in rural
health care, including, you know, more knowledge.

It's not just money, but it's really more resources and more knowledge and more enabling our calling and our mission to provide increased access to multi-disciplinary health care.

Thank you.

CO-CHAIR SINOPOLI: Great. All right, Jean?

DR. ANTONUCCI: Yes, thank you.

So, I'm going to tell you exactly how to pay us and maybe it needs some tweaking. But because I submitted a proposal, I'm going to tell you what's in it.

You take six months and assess the risk of cases by burden of disease. I used a tool called How's Your Health. And we were to be paid by capitation. Capitation has to be both adequate and you have to limit -- the patient population. You can't just take lots of money and sit down with your feet up, of course.

But the way, I got what I proposed was the very low risk patients, to pay physicians a dollar a day, two dollars a day
for medium-risk patients, and three dollars a day for high-risk patients, 365 days a year.

That amount of money even at one dollar a day, which is what I did, with one payer for all my patients worked well for me because I was good with low overhead.

But if you do the math for the number of patients, 1,500 in a panel and many of them are high-risk or medium-risk, that brings a lot of income into a practice.

And the physician gets to decide what to do with that money. Almost all of us would hire someone to call the people who were in the ER or just saw a consultant. I used to do that, but I ran out of time.

That's the real definition of care coordination, to act on it.

Hey, you know, Lauran, do you know why you went to the cardiologist? Do you know what he said? Did he give you any new medicines? Is it the same as what you have? Do you know what happens next?

And I used to do that until I ran out of time and money.

And why did you go to the ER? You didn't know you could call me? That kind of
stuff. And there could be bonuses. I wrote it all in my proposal.

I understand that simple isn't easy. I'm not [inaudible] an expert on a lot of things. But I have lived by this and I will put it out there as a very valid experiment to try, a dollar a day, two dollars a day, and three dollars a day.

Not my original idea, I stole it from someone. I encourage us to think about something like this.

CO-CHAIR SINOPOLI: Perfect.

And what I'm hearing from both of you so far is that those monies would be redirected toward care coordination, team-based care, those kinds of support systems is what I'm hearing.

So --

DR. ANTONUCCI: So, I think that you should give some to the physicians. Though I have to say, the people who design projects don't always realize it's my patient.

And if you have to live by it, think about what are the hoops you have to run through?

I just would say that we have to put
Cheerios on our tables, and we came out of school with massive loans. And so, we should get a little of it.

But I think we all recognize we just really wish we had services to give patients. Thank you.

CO-CHAIR SINOPOLI: Got it. All right, Howard?

DR. HAFT: Probably, it's the important money question that you're asking. I think it starts with saying, what do you want to get from rural health providers? Particularly primary care providers.

If you, as the consumer, I'm not talking about the payers now, what is it the consumer wants?

And I think the consumer wants someone that will be there to take care of them 24/7 and provide the comprehensive services, the things that Barbara Starfield described in the Four Cs. And I think that's enduring.

Well, what's the question, what does it cost to provide this team-based care that includes behavioral health integration, that attends to the social needs of patients, and care management and all those other things in a
way that is substantial and sustainable?

And you know, I'm not going to put a dollar amount on that, but other people have said, you know, I saw this one time in a micro-simulation study, and it was a little north of $62 per person per month to provide the social needs, supports that are necessary.

Parents and others have the PCMH kind of, you know, team-based care, $60, $65.

So, all those numbers together well, well, much higher than anything that we've seen now in the marketplace, but also reflects the fact that, you know, primary care providers are getting three or four or five percent maybe of the total health care spend out of this $3 trillion dollars that we have. There's a lot of head room there.

I know that 21 states have already said, we're going to do something about that. We're just going to study what primary care is getting paid. It's a percentage of the total spend.

And at least six or seven states have said, we're going to set a target of 10, 12 percent, and we're going to get there.

So, two or three times what they're
But your question specifically is, okay, we've got to put more money in the system, how do we give it to them?

And the answer to that is, you can't give it piecemeal. You can't say, okay, Medicare, you're going to do a good job, and you're going to give them $80 per beneficiary per month, whatever that number is. But none of the other payers do. That doesn't get you there.

Or Medicaid, you're going to go up by 10 percent. That doesn't get you there. It has to be a multi-payer. It has to, ideally, be an all-payer delivery of care.

Then, how you do it once you get all the payers together, but you can't do it piecemeal, it doesn't make sense, and it doesn't get you there.

And after you get all the payers together, you figure out what it costs to deliver this service, this care that you need, and I would include Jean's comment about, you have to pay primary care more or nobody's going to want to do it.

And if you don't pay them more,
nobody does it, you're also dead in the water. Right?

So, you have to include that. You have to pay the providers more if they're at the bottom. They don't need to be at the top of the pay scale, but it wouldn't be bad. But they need to be somewhere near the middle of the pay scale anyway. So, you need to factor that in also.

And then, deliver it. I mean, you know, the NASEM report did a nice job. They looked at the data and said, you know, you give some infrastructure payments, things that you can't really count for in fee-for-service, although I would say, now that the, you know, the PFS[^51] is going to announce it, the fee schedule could include payments for population-based care.

So, that is a possibility. I think that's been recommended in some of the letters on the PFS. We'll see how that pays out.

There could be a lot of tinkering with the -- that could be done currently with the CPT codes right now, that there's 8,000 of them. They could be trimmed down considerably.

[^51]: Physician Fee Schedule
and separate out the E & M codes from the procedural codes, and perhaps it would put more money in the E&M codes that have already been, you know, undervalued for, you know, for the last 40 years.

You know, maybe, you know, have some more technical expert panel that might add some, you know, some additional information as you're doing now on top of what the RUPRI does, with less self-interest just to bolster the fee schedule. That's one way that we can improve that.

But then, in terms of value-based care, once you get the fee schedule right, you know, having a hybrid payment of some infrastructure capitated risk adjusted, social vulnerability adjusted together with strong fee-for-service payments that are appropriate at an appropriate level.

I think it's a beautiful way to enhance the system. But you've got to get the money right and then you figure out how to deliver it.

How do you - trying to deliver it when you don't have the money right, doesn't
get you anywhere.

CO-CHAIR SINOPOLI: Great, right, thank you. And Karen?

DR. MURPHY: So, I agree with everything that has been said before.

I guess I would start with, I do believe capitation, global budgets work for rural communities. I think the issue is they just can't have risk.

So, you could do a global budget and readjust that global budget as you move forward in a holistic way. I think we just have to take risk out of the equation.

I also agree with my colleagues to say that there has to be investment in primary care because the reality is, the rural communities have a very difficult time recruiting specialists because of numbers.

So, I mean, there's just not enough numbers sometimes to support rural physicians.

And I think the other piece is that the infrastructure now for acute care has gotten so sophisticated that I think it's very hard to have an ICU without a pulmonologist being on call. You know, that kind of critical infrastructure.
So, I think the primary care doctors, without a doubt, have to be paid, again, social accountability. What we're talking about is part of the government that we just have to figure that out, it has to be different for rural.

I think the other piece is investment. You know, I've visited rural hospitals that had three floors of empty beds, but they were set up as an acute care facility.

And the reason why sometimes the charges are higher is because they're just trying to sustain themselves.

And again, we're sustaining a bad model that is no longer relevant to rural communities. But they don't have cash on -- you know, they don't have 365 days of cash on their books to be able to take out and do major infrastructure supports.

And I think if we are going to look at a model that is primary care-centric and recognize that we're not going to have a lot of specialists, then we have to provide as many support services for those primary care physicians through an appropriately designed rural hospital or health center, whatever it
may be, because they can't do it alone.

And then, lastly, I know that Howard has talked about this, but I do think there has to be not only incentives, but it must be, that if you have rural communities, you're a large academic medical center in large urban areas, if you have in your market, if you have a rural area, then you must figure out a way to deliver care there, particularly specialist care.

So, get the vans with the mammograms. Get the, you know, be able to do procedures in -- you don't have to do that every day, but let's take a look at how we can do, not only telehealth, but actual physical care within the community, specialty care. Not every day, like I said, but on a basis where we serve the needs of the community.

And I think that is -- I think to -- if we had those three investments that looked at the needs of the community and designed the system accordingly, I think we'd be a lot further along than we are now.

CO-CHAIR SINOPOLI: Great, great. Great insight, appreciate that. Jim?

DR. WALTON: Thank you all for being with us today.
I've sat most of the day, and the testimony of the SMEs has kind of been one of those sobering moments where you realize that things are -- could be bad. Right? I mean, that's what I'm hearing.

And I reflect back on a time that was similar where the United States did two things in the same decade that they did very well.

They were addressing threats, one was a domestic threat in the '60s, which were around the coverage of Medicaid and Medicare, the creation of those two sentinel things occurred in the '60s.

At the same time, the United States built a space program because of an international -- a perceived international threat.

And so, we've illustrated, I think as a nation, that the ability to walk and chew gum at the same time or the ability to perceive threat and to kind of work to mitigate that.

One of the -- I have two questions for the panelists.

The first one was, and it's around this notion of threat which is, what are the
potential unintended consequences that you see of the -- if there's a persistence of the value-based direction we are on now when we compare rural to non-rural markets?

And are there any significant, serious enough -- are any of them serious enough to drive new policy approaches, from your opinion, from your point of view?

And then, I'll wait for your answer then I'll ask the second question.

DR. BILLINGS: This is Adrian Billings.

I think, you know, anything that further disincentivizes rural health care payment runs the risk of more rural hospital closures, more rural clinic closures, and less access to care.

And our patients -- our rural patients foregoing care in an urban specialized environment because of the lack of access to having paid time off or having daycare for their child when they're sick to go access care.

Or the unfortunate issue where one of my patients -- two of my patients driving back together were killed after seeing a
specialist in a head-on rural, two-lane undivided highway.

So, it's really lost lives, more morbidity, more mortality, that worsening delta between life, mortality, and just comfort level between our rural and urban population.

So, again, I think rural, just more investment is needed, more access is needed.

And we just -- we want to provide evidence-based care. We want our rural zip codes to not be a risk factor for our patients' lives and the health of our patients' lives.

But in order to make that a reality, as you said, we need to make rural health care a moonshot opportunity by both our state and federal governments and our insured, both our Medicaid insurers and our commercial insurers, they have an investment and a role to play as do our academic health centers.

Thank you.

DR. MURPHY: And, Jim, the only thing that I would add is, it is a threat. It is a real threat for the United States in terms of survivability of health care in rural communities. So, it is a threat.

And I would go back to the emphasis
that I made on no risk. That doesn't mean that it wouldn't be value-based.

So, you could do value-based care without risk. And we did it -- we've done it forever in Medicare that they require certain levels of quality and monitor outcomes.

So, it's not that we would just push the investment to the rural communities without accountability. They would -- physicians and hospitals would be accountable for making sure that the care that we've invested in is really delivered in a high-value way to our patients.

DR. HAFT: I'll just add to the urgency here for, you know, policy response.

And that I think that, you know, the rural health care providers, particularly the primary care, rural health care providers are the canary in the coal mine.

So, I think -- and then, I think they are seriously threatened right now. And we'll lose -- we stand to lose substantially, that safety net of providers and hospital systems from afar can't take up the slack for that.

You know, I think that in that -- when that falls, it's just a matter of time for
further loss of the moving in closer to the urban and the academic centers.

But you don't -- we don't want a system built -- you know, I'm part of an academic medical center myself, so I'm not going to bash them in any way, shape, or form.

But I know that the hospitals and the academic medical centers cannot be the center part of our health care delivery system.

It's not a foundation. It's the dessert. We need the main course, and the main course is primary care. That's the foundation that we need to build on.

And if we don't invest in the foundation, then you know what happens to buildings when they have crumbling foundations.

So, I think there is some real urgency.

There are no -- there's not been any reduction in HPSAs and MUAs\textsuperscript{53} in the last 20 years.

DR. WALTON: Jean?

DR. ANTONUCCI: Yes, I think the question is, if we continue down this road with value-based payments, what will happen in rural

\textsuperscript{53} Medically Underserved Areas
primary care, is that the question?

DR. WALTON: Yes.

DR. ANTONUCCI: Okay.

And the others have said it well. I can't hear Dr. Haft well, but fortunately, I've already read his article with Dr. Berenson recently. And we're all on the same page.

Primary care providers are not so much burnt out as they have been burnt. They're sick of being called providers, and nobody will even change and say physicians.

And so, yes, you're just going to lose more and more.

We're held together in primary care right now by the DOs and some nurse practitioners.

Fewer and fewer MD graduates will go into primary care, and there are more of them.

So, I think, yes, we have to think outside that box. Most -- I'm a blunt talker -- most of us see this as just one more fad going by, one more piece of waste to shovel. And that's why we need teams.

So, we need payments, but it's not just payments, it's not just money. We need tools that work and time to do our work. We
don't have tools to do our work, and we have rules and regulations that interfere.

So, if you want to save primary care, there’s a big picture to look at.

DR. WALTON: I guess sometimes I think about this, that if we take a step back and look at history, there were certain forces that galvanized enough people at one point in time to say, hey, maybe we should have a policy that is a moonshot, whether that was the creation of Medicaid or Medicare or building a rocket that would go to the moon and come back.

And so, I was thinking about, well, what would be serious enough, you know, what information could we surface here that would be actually serious enough to warrant someone to think about something bigger than tinkering around the edges?

And so, the way I -- my brain works, I think I would pose it this way.

And the second question really is, in the absence of new policy approaches, what might the risk be, from your perspective, panelists, with current marketplace aggregation strategies of primary care services in rural markets?
Where do you see that leading us?

Because that's really what is filling in the blanks, oftentimes, in the absence of a solution that would pay primary care physicians more.

And as a primary care doctor -- as a primary care physician, I've heard this conversation for a few decades that the solution to our problem is to pay primary care physicians more. But that hasn't happened.

So, there hasn't been enough compelling evidence to create a vision or a concern or a perceived threat to change it.

And so, maybe the marketplace's response that is by aggregating primary care resources in rural communities might have unintended consequences that we -- that you can see that we, as a Committee, need to elevate to the Secretary of Health and Human Services and the Executive Branch of the government.

I'm just curious if maybe you've thought about that and what you would -- what you might think -- how you would respond to that question?

DR. BILLINGS: I think beyond just the social justice merit of investment in rural
health care, our nation, and even our world's food, fiber, and fuel is produced in rural America.

And so, this is a threat to our overall economy.

You know, why is this of interest to an urban resident? Someone who's going to spend their entire life of working in an urban area, it's because when you choose to vacation as so many did during the heights of the pandemic and come out to rural America.

And you get in that motor vehicle accident or you have a myocardial infarction or you have a stroke or you have a three-month-old with a fever in the middle of the night, you want, in a rural area, you want to be able to go to a facility in a rural community and receive evidence-based care whenever it's needed, and oftentimes, life-saving care.

So, I think, you know, the -- it's really vital for our nation and our world's economy to sustain rural health care because of the food, fiber, and fuel that is produced in the rural areas of our country.

DR. ANTONUCCI: I think that it is unlikely anything will happen. And the same
things are being written, as you said, for decades.

I, and during COVID, things were pretty interesting with how people talked to us.

I think if you want to change things, first of all, you stop saying things like, how do we maximize coding and HCC codes to make our patients look sicker to get paid more?

But I think the only thing that might shake up the country and make -- because I hear you saying, how do we get a moonshot? How do we, you know, get Rosie the Riveter back to work? And you know, all these kind of national things.

This is not a country that has ever wanted primary care. We have a culture that is in a certain way.

And I think if primary care went away, people might miss it after a while.

I've often felt we should strike, but I don't think the country's very interested in primary care.

And so, if there were great leadership somewhere to help us, that would be
nice. But this is not a country that wants primary care, doesn't see the value of it and change of culture takes a long time.

DR. HAFT: So, I think your question that you asked is really at the heart of how do we bring about broad-based change?

And I think as a domestic policy issue, we have to say the country is sick, and it's getting sicker.

We're living shorter now after five decades or six decades of increasing our life span, we're seeing a shorter life span over the last three years, not just due to COVID.

And it's more acute, and again, the canary in the coal mine is the rural areas where people are sicker yet. Their life expectancies are lower yet.

And the policy question is, is this what we want for our $3 trillion investment? Do we want to continue to invest so that we can get sicker and sicker and die younger and younger and have shorter lives?

And the answer has got to be no. And then, it's got to lead us to, well, let's do something. Where's the moonshot here? What do we do about it?
Where is the Lyndon Johnson to say -- to take, you know, the, you know, a divided Congress and say, let's do something about this because we all win with making the health of this nation better.

It's something I think everybody can get behind, and everybody wants to be healthier and live longer.

So, I don't think any constituents, red or blue, are going to say no, I don't do -- I don't want that. I want to die younger, and I want to be sicker.

So, it is -- I think it has been the hallmark of something that could be done in a bipartisan way.

You know, cancer moonshot is a good -- great idea, one group of diseases. But that's not the whole thing, that's doing a disease or a condition at a time.

We need to really rebuild the system. And honestly, we don't have a health care delivery system in this country.

Most economically developed countries in the world have a health care delivery system. We have a fragmentation of wonderful, different organizations that can do
glorious things, but don't work together with any kind of theme that supports kind of the health of the nation.

So, I'll get off of that soapbox and pass it on to someone else.

DR. MURPHY: I think I was going to say the same -- I'm optimistic. And the reason I'm optimistic is because of all the issues that we said is the gravity of the situation.

It is we've got to do something as a country like everybody said.

But I think the advantage here, I would emphasize Howard's point, there's not a lot getting done in a bipartisan way. This is a bipartisan issue.

Every -- most state and federal government representatives, congressmen, senators, they all have -- most of them have at least a part of their district or their geography that they cover in rural communities.

So, it's not a red victory or a blue victory, it's a victory.

And I think that is there -- I think, to your point, Jim, of what would I say to, you know, Secretary Becerra is, this is something that you could really -- this is
something that we could do through regulation, legislation, and really move the federal approach and also the same approach with the states.

So, I think we can't emphasize enough that we shouldn't let the opportunity go by thinking that, well, you just can't get, you know, you just can't get anything done.

I think that -- I think rural communities and rural health primary care physicians are critically important right now. And I know -- I'm sure that the federal government and state governments feel the same way.

DR. HAFT: If I could add one other thing to this conversation.

I understand that the Assistant Secretary of Health has produced an action plan for HHS. And I think it's still in the process of going through the approvals.

But that would be a delightful way to move forward and move that to advance all of these issues with having a cohesive action plan for the entire agency.

Just as another thought.

CO-CHAIR SINOPOLI: Great, thank
you, that was a great, great discussion.

So, Larry, it looks like you have your card up?

DR. KOSINSKI: I've been enjoying listening to all of you and have jotted down some statements that have stuck with me from all of you.

And you know, Karen's statement that we're going nowhere without investment.

The four of you have made it very, very clear that we have to put our money where our mouth is, and we have to pay for this if we want it.

CMS is not paying enough for value. I think Howard said that.

And I'm really struck with Jean's one dollar per day, because that is so far less than any concierge practice is getting today.

God bless you, that's -- that keeps my optimism going.

But I had two questions, and I think one was for Adrian and one was for Howard.

I think Adrian answered mine already. I was intrigued by his statement about the academic medical centers should leverage their strengths to help the rural
If you want to say something more on that, that's fine.

But where I really want to go with my question here is with Howard, because you really struck something with me when you brought up MA\textsuperscript{54}.

This is a fear that, and again, we're falling into probably political waters here, one side of Congress would like everything to be under MA, and Medicare to be totally privatized.

And the other side would like to assure that all beneficiaries are receiving what they should be receiving.

And we're at a push and pull here now, and we can see where the trend is going.

So, Howard, I'd like you to expound a little bit on your statement.

You mentioned the word foundation. And I always think about that condo building in Florida that fell and killed 90 people.

And there were inspectors that were inspecting it. And there was a board that was supposed to be responsible for it.

\textsuperscript{54} Medicare Advantage
But the skeletal infrastructure fell apart, and it was the people who lived in the building who were hurt.

And my fear with MA is that, unless we have foundation and infrastructure -- foundation and structure -- inside these entities, the beneficiaries are the ones that are going to ultimately lose, and I think they already are.

But I'd like to hear you expound on your statement.

DR. HAFT: Yes, I will.

I think, you know, that there certainly was value in some of the MA plans.

And you know, and the studies that have been done show that it's questionable quality. You know, they've taken very large amounts of profit over the course of the recent years.

There's been issues, you know, with, you know, selective recruitments and other things.

But that's not the issue to my mind. I think those things can be fixed.

CMS can put regulations and guardrails in to fix that.
The question is really, do we want to have 300, 400 MA plans, each with a different payment scheme, each paying primary care and other providers in a different way as part of our overall strategy going forward?

It may look good to privatize from the top down, but we're, you know, what we're doing is, it would give, you know, the nation's largest or second largest entitlement, we're commercializing it and taking it out of any kind of public control.

And so, that's an issue. But the bigger issue is, when I look at, you know, from a practice level, which I'm happy to say I'm back in, you know, I've been practicing again now and enjoying taking care of people in a rural setting, just a delight.

But I look at the comparison to participate. The practice that I'm with participates in a state plan, the Maryland Primary Care Program.

And it has very defined payments, and it has even equity payments, there's hard payment that we ginned up over the last few years for people who are in high ADI areas, who have high HCC scores.
But what happens when those beneficiaries choose to go to Medicare Advantage, one or another of the Medicare Advantage plans that have come into the region, the practice loses all of that benefit.

They lose the capitation. They lose the equity payments. And they get whatever they can negotiate with the Medicare Advantage Plan which is either, you know, a point above or a point below whatever fee-for-service is.

Very few -- and I've looked at this in some detail and written about it, very few of the MA plans actually are adhering to what the NASEM report would say in terms of, let's provide hybrid payments and, you know, mixed fee-for-service and capitation.

They're doing basically what insurers did, you know, years ago. We're going to negotiate, get the best rates we can for us for our profit because they're for-profit entities.

To me, that's an issue. And harkens back to this other issue. First, it fragments the number of payers that a primary care has to deal with.

It reduces their ability to get real
capitation that can support a whole program.

But it also, then, puts more of the money out of kind of this fiduciary responsibilities need to my patient and puts more into, now, I've got some, you know, somebody else, a fiscal intermediary who has -- their fiduciary responsibility is to their Board and their CEO.

And I don't think that's where the fiduciary responsibility in health should be.

So, I have a -- and I think, again, there could be good MA plans. I don't think making the whole Medicare, you know, traditional Medicare turning it, as it looks like the trajectory is now, to all Medicare Advantage is going to benefit primary care in any way, shape, or form.

Sorry about that.

DR. KOSINSKI: No, you answered it well.

Adrian, did you want to add anything to yours, or did you cover that earlier?

DR. BILLINGS: I will cede my time.

Thank you.

CO-CHAIR SINOPOLI: Any other Committee or any other participants want to
make a comment about that?

No? All right, then, Walter?

DR. LIN: I want to just add my thanks for our subject matter experts being with us today. It's just a really rich, informative discussion, sometimes provocative. So, thank you for that.

You know, I think a clear and resounding theme throughout not just this session, but the prior ones today has been need to pay rural providers more.

They take care of sicker patients. They do more with less. The patients have less access. We need to pay rural providers more.

And I think we've heard that loud and clear. And I'm not sure that any of us would necessarily disagree with that.

But there have been several questions from Committee members around how to distribute that payment and how best to use that payment, assuming that we can get it.

I have actually two questions, if the Chair and Chairwoman would so indulge me.

One, you know, I'm actually intrigued by this statement, we should allow rural providers to participate in value-based
care without risk.

That just seems like a very oxymoronic, if you will, concept to me.

How can we allow providers to participate in value-based care without risk?

That's my first question.

DR. MURPHY: So, maybe I was the loudest on no risk.

I think the reality here is all the problems that we've stated, there is no way that rural communities with physicians or hospitals are going to survive without a change of payment structure.

So, again, I think I go back to the social accountability in terms of we have to make investments in these communities in primary care and the support systems that surround them.

Why I say you can do value-based care without risk, and we do it all the time now, I mean, we do it, you know, in value-based arrangements that have upside risk. Right?

So, you can -- if you lower the total cost of care, you can benefit. But if you lose, you don't have to pay.

So, I think by now, since 2010, when
we've been doing and designing all of the value-based models is that there is a way to create value. Right?

Value doesn't have to -- value does not have to answer risk. It has to answer a value question.

So, to me, it certainly can be designed to create value.

I think the second piece is risk just doesn't work because it's not that we're overspending in rural communities, we're misappropriating what we are spending.

So, it's just not a system designed for sustainability.

So, for payers to say they have to reduce their costs in rural communities, no, because we're still not meeting the needs of the communities.

We have to decide what the needs of the community are and pay appropriately for the way we've all discussed, with enhancements to primary care and investments into the community's health infrastructure.

So, I have no doubt that we can create value-based systems without risk.

And you know, we've tried to do the
risk deal in rural communities, it doesn't work. The numbers are too small. The financial picture in rural communities of both primary care physicians, whatever specialties are left, and rural hospitals are all dire.

They don't -- they cannot take risk in the current system.

DR. BILLINGS: And I think, just a point of clarification that I want to make with regards to paying rural providers more.

I think, you know, what we mean is, we all want the tools of our trade that our urban providers have, our urban patients have the privilege of having access to.

Every rural clinician wants the tools of the trade to take care of the patients so there's not a discrepancy in care received in a rural facility versus that in an urban facility.

So, when -- I think you're hearing us say that rural providers need to be paid more. What we mean is, we want that investment to give us the tools of the trade that our patients deserve and our rural clinicians deserve to have to be able to offer that to improve rural public health.
DR. LIN: I appreciate that. I appreciate those responses, and I do agree that probably a lot can be achieved through shared savings.

I guess, in my mind, I think about risk as a mechanism by which we can achieve certain desired outcomes through the increased payments and kind of direct funding toward that goal as opposed to maybe some less desirable outcomes.

But I kind of see what you guys are saying now.

My second question, kind of on a related note is, you know, I think there's been a strong sentiment within the panel of paying primary care providers more.

And you know, as a primary care provider, I'm in agreement.

But I do want to touch upon this point because I think there is a shortage of primary care providers, not just in rural areas, but kind of across the nation. It's just really hard to find them and probably even harder to get them to move out to some rural areas.

And so, I guess paying them more
might be one solution.

Some of our other panelists have discussed maybe paying for non-physician providers as an idea.

So, for example, paying for nurses or social workers. I think someone mentioned a doula earlier in the other session, and patient care ambassadors.

Why not have kind of, instead of increasing the payments for PCPs, increase payments for non-physician, non-NP, non-advanced practice providers to encourage their services to take away responsibilities from the PCP's plate that don't need their level of training so that the PCPs can actually practice at their full level, full scope?

DR. HAFT: Dr. Lin, I think you're exactly right. I think that's where the intention is in the NASEM report and others. It's not to pay providers to care for people, it's to pay for teams to provide health for communities.

And, you know, pay for -- this notion of paying more is not just, we're going to put more, as somebody said, more money in the, you know, in a biweekly paycheck of
primary care providers.

It's really about, as you kept hearing here, giving the necessary resources to get the job done, to do the work that's asked to be done, which includes caring for social needs and behavioral health integration, care management, and having the HIT tools to do that.

So, that's where the -- it is all about teams and being able to make that investment, but not -- I don't think it's individually to now we're going to start paying nurses more and hope they'll go to a rural area or pay a social worker more and hope they don't go to a rural area.

I think it's about building those teams that all work together as one and have this kind of this global capitation or risk adjusted payment per beneficiary per month or patient per month or per year, however you want to carve that.

But it's enough that infrastructure pays for the whole team or whatever the team is that you want.

You know, you may say, we don't need social workers, we just need community health
workers.

Whatever that is that, you know, that you're asking providers to deliver, you need to pay enough to actually deliver that, and includes all of those other people, MAs and front office staff, and billing people and all those other things that go into the bundle.

But it's not just -- it is clearly not just what you're going to pay the provider.

DR. ANTONUCCI: Dr. Lin, I think that Dr. Haft is partly right, but somebody else has to manage that team now, don't they? Who's going to send out those people?

And it takes me back to this value-based issue about risk. Risk should not be money, the risk is care and how we measure care.

And I think -- I guess I'm answering 3,000 questions ago, but no physician out here really thinks that any of these metrics really can be measured accurately and matter to most of our patients.

And so, I really have to speak about, we don't just need more payment, we need restructuring of payment.

And also, we could use a few doulas
or social workers or community health care
workers, but they have to have the physicians
to run the team.

And I don't think we have to have
teams. So, I think it's kind of a peripheral
question, with all due respect.

I think we have to look really long
and hard about redesigning how we get medical
care to patients and, yes, might include some
of those other things.

I think we spent a lot of time in
Alaska, and I saw community health workers who
had six weeks' worth of training. But the
doctor went to the waiting room every morning
and called every one of them.

And so, you can't have one without
the other. And that, the value, the risk is
poor care. The risk isn't around money.

That's how I see it.

DR. LIN: I'm sorry, Dr. Antonucci, did you say, just so I make sure I heard you
right, did you say you don't think we need to
have teams?

DR. ANTONUCCI: Okay, now, I didn't
hear you. Did I say we don't need to have --

DR. LIN: Teams? Did you say that
or did I mishear? Do we need to have teams or not?

DR. ANTONUCCI: Yes, I think we're having -- payments? We need to pay physicians more, but I think we keep saying that sentence. And I don't think that's the right sentence to say.

We need to pay them differently, and they do need to get paid more.

But I think as long as we keep saying, we need to pay primary care more, we're not going to get anywhere because we've been saying that for a long time.

And it does get political because some of it's a zero sum game with CMS and RVUs. Right?

And so, the radiation oncologists have to be paid less if we get more. And it becomes messy.

So, sure, we need to make more, but we need to make money differently also.

A tiny example is, where the doctors have to submit an incredibly complicated timecard for every 15 minutes' worth of work we do.

55 Relative value units
Coding for billing costs my small practice $10,000 a year.

You wouldn't have to give me any more money if you could do it in the coding for billing game. I'm not submitting any counter form.

And you have -- if you're paying me, you have every right to expect I provide value. But why do I have to do it the way we do it now and that wouldn't cost any more money if you've got all those timecards for every 15 minutes' worth of work?

DR. MURPHY: I think of one point that I'd add about teams that makes them critically important is that we have to do the math.

And the math in the country on physicians, primary care physicians and nurses and advanced practitioners to cover the needs of the country, the math doesn't work to say, well, we're going to have one, we're not going to have the other.

We need to -- I believe that we need team-based care. And I think that we can do a lot more with team-based care than we maybe did in the past.
But I think that the shortage of primary care physicians, the shortage of all those other professionals that I talked about, the math doesn't work unless we stretch to include team-based care because we just can't deliver care like -- I would say like when we had supply, adequate supply across the country.

DR. LIN: Thank you.

CO-CHAIR SINOPOLI: Chinni, you have a question?

DR. PULLURU: Yes, just listening to all of you, you know, I think about physician training and family medicine particularly training and looking at the vast majority of training organizations are still family medicine residencies and other primary care residencies are still in urban areas.

And so, any thoughts to how we could better sort of incentivize more physicians and other types of providers to come to rural areas to practice, you know, people besides training?

You know, there's obviously loan repayment and other things, too.

But would love to get, you know, you guys are in the trenches, I would love to get your thoughts on that.
DR. BILLINGS: Thank you for that question.

In the medical literature, in the medical student and resident physician literature, Shipman, et al, who used to be at AAMC, put out the 2019 Health Affairs manuscript that showed declining matriculation of rural students into medical school.

The two biggest factors for a physician that prognosticates a future, predicts a future of rural practice is, first, being from a rural community or having a significant life experience in a rural community.

The second biggest factor is having some rural exposure during medical school and/or during residency.

And so, that gets to the point that I made earlier is that we need more multi-disciplinary academic health centers in those communities of need, in those rural communities of need, much like the teaching health center program for Federally Qualified Health Centers of standing up graduate medical education programs within primary care disciplines within

56 Association of American Medical Colleges
FQHCs that are both urban and rural.

There needs -- in my view, the investment that is needed that really builds access to care is that pathway and that pathway program of having rural academic health centers and enabling rural students to have an opportunity to matriculate into health care training programs whether it be in social work or whether it be in medical school or dentistry.

All of those teams, we -- I think we can all agree that the best patient care is delivered in teams. But that is what is lacking in rural communities.

I can't tell you how often I have done the work of a social worker. My receptionist has tried to do the work of a social worker because that discipline has not been present for me in the past 17 years of my entire rural practice.

And the best way to build that team is enabling our rural high school students to have an opportunity to go to undergraduate school to do -- be successful and to get into a health care training program and building more dual-credit programs in rural high schools and
building up the rural public education system.

And bringing that from the perspective that rural school board trustee, as well as the father of three rurally educated sons, two of which are pre-med right now and hope to be rural physicians.

But we have to enable these rural students to give them information, to give them a pathway.

And you know, if 15 percent of our population is rural, you can we all agree that maybe 15 percent of your matriculates into our health care training programs should be from rural communities?

And then, how can we get them back home? Or how can we keep them at home via distance learning so they never have to leave their rural community and they don't grow roots in an urban area?

So, more investment in the rural public education system K-12, more enabling of rural students, and again, pushing out our health care training programs into our rural communities.

CO-CHAIR SINOPOLI: Perfect, good.

DR. PULLURU: Thank you.
As a follow-up to that, and just if you'll humor me, any thought to, you know, as much as we've heard, yes, invest in primary care, invest in, you know, physician-based team model leadership.

Any thought to scope of licensure expansion, particularly in rural areas in order to allow for more access?

And especially if value-based care payments were tied to utilization of multi-disciplinary teams?

And I'll throw it out there for everybody.

DR. HAFT: Yes, I'll make a brief comment on that.

One, I think, you know, some scope of practice expansions is, you know, is always a turf battle issue.

But I think there’s one clear place where there's a great opportunity, and that's with pharmacists, you know, to be able to expand their services, you know, with, you know, and provide more care.

They already are doing more in terms of vaccinations and things. But they're, you know, wonderfully trained, certainly manage
medications very well and other things. So, that's one area.

I think, in general, having everyone work to the highest level of whatever their license, their certificate is a first good first step. Because we don't even do that now. And then, looking carefully at, you know, where expansions can be done. And then, fight the political battles.

Because, you know, it's so antithetical, but even in places where there are shortages of health care providers, there's still a battle that wants to keep one group of providers from being able to expand their services to serve the community because of encroachment on services.

So, we need to get over that a little bit and then, expand.

But I think one great place would be with pharmacists.

DR. MURPHY: I think I'll add to that, Howard.

And not only for scope of license, but we also have to look at the regulations.

Essentially, rural health care has
as many regulations as their urban counterparts that have 10 times more resources dedicated to manage those regulations. Right?

So, even things like requirements to sit on committees. When I was Secretary of Health in Pennsylvania, I had a hospital come to me and say, I don't have enough physicians to populate the committees that I need to have.

And we want our advance practice nurses and physicians assistants to be able to feed into those committees so that we can meet the necessary criteria.

And to Howard's point, there was, you know, there was pushback. I mean, not -- I thought it made perfect sense if you don't have, you know, if you really don't have the resources, then you have to extend the resources you have.

But I think we have to, again, I think we have to take a look at when we're talking about a very holistic approach, and that's an example of what would be included in the holistic approach.

Let's see what we can do to maximize the resources we have.

CO-CHAIR SINOPOLI: Great.
I want to thank the panelists today for another great panel today with a lot to think about and lots of great information for us.

And so, again, just can't overemphasize how much we appreciate the time you've dedicated to this.

And so, that concludes our time for this session, and we're going to take a 10-minute break and be back in 10 minutes. Thank you.

(Whereupon, the above-entitled matter went off the record at 4:10 p.m. and resumed at 4:22 p.m.)

* Committee Discussion

CO-CHAIR SINOPOLI: Everybody want to take a seat? We're about to get started. Okay, welcome back.

As you know, PTAC will issue a report to the Secretary of Health and Human Services that will describe our key findings from the public meeting on encouraging rural participation in population-based total cost of care models.

We'll now take some time for the Committee to reflect on what we've learned from
our sessions today.

    We'll hear from more experts tomorrow, but wanted to take some time today to gather our thoughts before adjourning for the day.

    Committee members, I'm going to ask you to find the potential topics for deliberation document that's tucked in the left front pocket of your binder.

    To indicate that you have a comment, please flip your name tent.

    And I'll ask, who would like to start? And I'm probably going to go around the table and ask people for their input.

    No volunteers yet, so, I'll ask Jay, what are your thoughts of today?

    DR. FELDSTEIN: A lot of thoughts for today, but obviously, I think the overwhelming theme is the requirement for capital investment for infrastructure of team-based care and primary care and everything that encompasses, not just primary care physicians.

    I think the other aspect, which we heard, but we didn't spend a lot of time on is the fact that, you know, rural communities are ecosystems.
And you know, primary care doesn't exist in a vacuum.

And as well as we have to ensure the survival of primary care physicians and team-based care, we've got to ensure the survival of rural hospitals.

Not necessarily meaning they need to be 50 or 100 beds and inpatient.

And I think just, you know, what is a hospital in a rural setting in today's world?

Maybe, you know, it's critical access. It's an emergency - Rural Emergency Hospital, whatever it is. Maybe it's a micro-hospital, you know, with five or 10 beds.

But you know, they're economic engines for these rural communities. It's very difficult to recruit a primary care physician without a hospital. You sure are not going to recruit specialists without a hospital.

And a hospital takes on a health care center where, outpatient services, surgical services, whatever they may be.

But somehow, we need to work that into this report because one cannot exist without the other.

And, you know, if we lose another
100 to 150 rural hospitals this year, we're going to even have bigger problems with rural health care.

So, we need to work that in in some way to the report.

CO-CHAIR SINOPOLI: Jen?

DR. WILER: I agree with those comments. And there were a couple things that I took away. The first dovetails a little bit on Jay's comment.

I was struck by, in our first panel, the comment around aligning incentives in other rural communities, is that one singular focus could be keeping the community healthy.

And in order to do that, it's preserving access to acute potentially inpatient care and specialists. And it's creating a care model that focuses on improving the health of the community with partnerships.

And so, really reverse-engineering what we think of as payment models that focus on decreasing total cost of care.

And that there's some innovative care models that can happen if we leverage the assets that are in those communities like paramedicine, working with, you know, community
health workers, and expanding scopes of practice, the idea around mobile clinic, just some really innovative care models.

And thinking about how do we help subsidize and incent that innovation and care delivery?

The other thing that, again, then relates to that is, we heard over and over that the current focus on quality measurement, and particularly, that total cost of care is problematic.

And that our quality measurement and programs need to incent process measures like access to care.

And that there's a real opportunity around protecting human capital and creating a sustainable workforce.

And Chinni asked a great question of our most recent panel around how to create that inter-professional interdisciplinary workforce.

And I think there's a real opportunity for us to continue to, as we move into our experts panels tomorrow, to understand a little bit better what that workforce strategy might look like.

And the last thing I'll comment on
is, I was also struck by the differentiation within the definition of rural versus frontier, and that those are very different archetypes and they are different care models and require different incentive payment models.

CO-CHAIR SINOPOLI: Great. Jim?

DR. WALTON: Yes, I think there was some discovery around the definition of rural from a time and distance. I thought that was very, very helpful.

I also got a sense that there was a little bit of a disconnect between what these brave, courageous, tenacious people are doing out in the rural area caring for people.

And the disconnect between the social contract that has been struck with them about what's going -- how the nation is going to support them in accomplishing their goals.

So, that leads to me this kind of -- I have this just, I was telling Jen, it was like this kind of wash over me moment where like these people, without question, that spoke with us today were sounding an alarm. It has been a while since I heard that alarm, in a way that made me think that there is a perceived domestic threat to the core infrastructure or
the core fabric of our country.

    And we're here listening to that. We're on the frontline. We're in the Committee. We're in the room when it happened, to take a line out of Hamilton.

    And so, you think a little bit like there's a population health race kind of like analogous to the space race, that there's a threat, it's domestic. There's an infrastructure thing.

    We've got our SMEs are telling us that they're ringing the alarm.

    And so, we, as a Committee, can certainly be forthright in communicating that in writing to -- in our report to the Secretary.

    I was struck by this idea, and I think, Walter, you brought it up, this idea of there's a social contract, but there's also social accountability.

    There's a need for, if we make a contract from the government to the provider or communities, that there needs to be accountability back.

    And I think you hit the nail on the head with that.
I was -- Jackson Griggs and I have talked a couple times, and the interdisciplinary primary care team just makes kind of like the most sense as far as what key factor -- this is what Dr. Fowler asked.

What key factors should be financially included to increase participation?

Interdisciplinary primary care teams funding, that would be kind of like, so you start to address intrinsic motivation of human beings, and particularly providers, instead of just thinking about it through the lens of extrinsic motivation, which is always thought of as money.

It's like I just need for you to pay me a higher salary.

When in reality, I think what I heard from a number of those speakers was, no, what we really need are the tools to do our job so that we can be successful and fulfill this as human beings.

I think there was a big comment about changing the measures, period. And I think Liz asked that question, too.

What to measure that -- we didn't talk too much about how to measure it, but we
did talk about what to measure, which is, I think you bring this up, Jen, which is, you know, measuring -- how much integration are you getting done?

How are the patients responding? What's the burnout rate? Tell me what your net promoter score is from your provider network, let alone your patients?

How are you doing on transformation of increasing access to care?

And I think the labor retention issue is enormous and should be rewarded for those organizations that find a path to that.

Finally, and I'm going to just -- I'll stop because I can't go on and on.

I was struck by this idea that the thing that they were describing that was necessary to do this work well would be the requirement of multiple agencies or departments within the federal government stacking their investments and focusing on communities that are disproportionately being affected by increased morbidity and mortality by virtue of whatever those elements are.

You know, just the -- just infrastructure, history, culture, lack of a
cool place to live, the weather's bad, who knows.

    But I think this idea that it's going to take a concerted leader somewhere to pull together the entire federal government's assets that affect health.

    And examples that I wrote down were, you know, the Education Department, the Labor Department, USDA, Transportation Department, Economic Development, and we could just go on and on and on.

    But all of those entities have funding and have missions that are health-related, even though they're targeted and siloed inside their specific area.

    So, I think there's something to be said about this agency-level action plan that at Health and Human Services that basically tries to incorporate the assets that could be brought to bear for solving some of these rural problems.

    CO-CHAIR SINOPOLI: Great, great summary. Larry?

    DR. KOSINSKI: Well, we heard a lot. We heard over and over and over again that primary care is underfunded. There's no
question about that.

But I felt like I was listening to a climate change conference.

And I'm listening to the people who are passionately screaming at the top of their lungs, we've got a problem here, guys. Why is nothing being done?

And at the same time, the temperature's getting hotter and the hurricanes are getting worse and everything and nothing's getting done.

And so, leadership can't exist in a vacuum. Something will fill it up.

And I feel like after listening to this, we are leading from behind, from far behind.

And we've already got Medicare Advantage taking over 50 percent of Medicare. And as was said, there's 300 plans, and the poor primary care doc is sitting there getting beat up by each and every one of them.

And how about the patients? They don't know what to pick or what to do.

We don't need payment reform, what I heard was, we need practice transformation.

We need a model. We need to define
what is the model of care that should be
followed before you can figure out what you're
going to pay for, you've got to figure what you
should have.

And so, we heard socialist
statements, and I think they're totally
appropriate. If you're compensating an
academic medical center 250 percent of RBRVS\(^\text{57}\),
and you're paying a primary care doctor RBRVS,
maybe there's an obligation to those -- from
those centers that they should be doing
something to make sure care is being provided.

Why do we have specialists making a
million dollars year to take care of healthy
patients and do elective procedures? And you
have primary care doctors that are taking care
of ill patients for a tenth of that?

It just, to me, I'm struck with the
gravity of this situation, the fact that CMS is
leading from behind, and leadership is in a
vacuum right now, and we do need a moonshot.

I think Jim's right, we need a
moonshot. We need to make some -- CMS needs to
take some drastic measures to change this. And
we can't just have a 10-year plan.

\(^{57}\) Resource-based relative value score
By the time those 10 years go by, Medicare Advantage will be 90 percent of the population.

CO-CHAIR SINOPOLI: Alright, thank you, Larry. Walter?

DR. LIN: You know, I'll keep my comments short.

I think probably the -- one of the biggest takeaways for me from today's sessions has been the fact that value-based care as currently conceived in the United States does not work in rural settings.

You know, and I think that was -- I kind of knew that, but I think there were, actually the problems run much deeper than I had understood.

You know, the problems around attribution, around lack of infrastructure, around benchmarks, this whole concept of the rural glitch that was spoken about.

You know, I think, you know, how do you attribute patients to a PCP when there aren't PCPs taking care of patients often, there aren't primary care physicians taking care of patients because their care is being directed by advanced practice providers?
You know, so, I think that was a kind of a big ah-ha.

I'll just end with saying that, after today's session, I feel like our task as PTAC and our report to the Secretary will hopefully address redesigning or developing payment models to support innovation and team-based care delivery models tailored to rural health care.

You know, this idea that Larry just mentioned about, you know, how do you pay for something where you really don't know what the carryover model looks like I think resonates with me.

And I think we have to figure that out, but we also have to figure out the payment models that can support the development of these team-based multi-disciplinary models.

CO-CHAIR SINOPOLI: Perfect, thank you. Lindsay?

DR. BOTSFORD: Yes, lots of good points already shared.

I think maybe the thing I'll add is, you know, we've heard in previous conversations in this group and other listening sessions touch on the challenges that physicians and
groups have and reporting on a variety of quality and performance measures.

And you know, I think that seems to be magnified even more in rural areas.

I think some of the costs we see in all places just around the variety of payers and masters people have in reporting to get payment, whether in value-based care arrangements or otherwise.

And our rural areas are the least positioned in terms of data, resources to throw at the problem, et cetera.

So, hearing some of the conversations about attribution and how do you think about, you know, aggregating is one way to do it, but would rural areas be a place to see, you know, these all-payer interventions so that you overcome some of those requirements of small ends and attribution?

And could this be a way to solve problems that all communities are facing with some of these?

But ease that burden on rural communities first.

So, I think, as we think about what flexibilities do rural providers need to
motivate participation, you know, we heard things suggested like decreasing telehealth restrictions, meaningful use cited as some of the things that were barriers to EMR selections.

The ability to exclude outliers, and where can you get infrastructure investments?

But it doesn't seem like focusing just on the Medicare population, much less Medicare Advantage is going to be enough.

I think some of the interventions in payment are going to have to cross payers to enable rural participation.

There's only so much investment that'll overcome it otherwise.

So, I think I'll end there because I think the other big themes around primary care infrastructure were emphasized multiple times already.

CO-CHAIR SINOPOLI: Perfect, thank you. Chinni?

DR. PULLURU: Wow, what a day, right?

So, there's a bunch of things that I feel came out and are just so important.

So, the first is that people
articulated there are different archetypes of rural. And I think we should really think about that.

You know, if you look at the RUCC codes, you know, is there a way to sub-segregate those codes into different archetypes and have different solutions for each one of those that is a part of a policy? And so, I think that's important.

The second thing we heard is that, they don't have a lot of money and they need more money. Very simple, right?

So, perspective payment attached to potentially different things. But one of the things that they screened was that they needed tools.

And so, you know, I think back to some of the things that have happened in health care that we have used to transform.

You know, Jen brought up some of the meaningful use stuff and the conversion to EMR. Those were retrospective payments, but what about prospective payments in order to be able to pay for tools and have those payments go for tools? Right? So, that's what I heard.

The third was really around
attribution and how attribution is just negatively impacted in rural areas because of population density.

And so, thinking about maybe within those archetypes, how do we think about attribution to a larger pool of patients and get better balancing of risk?

And I know, this may be a longer glide path so people have upside only for a longer period of time while they build that infrastructure.

The fourth thing I heard was about access and specialty integration, not having access and not having specialists.

This ties to the fifth thing I hear, which was urban and rural. And you know, I practiced for a long time in suburban Chicago.

And you know, part of being -- being part of the academy there, we had a lot of academy representatives on our Board and whatnot that were from downstate.

So, I got a front row seat to downstate Illinois, and Springfield, and surrounding, you know, areas.

And I always thought, if you brought the best of what Chicago had: the academic
centers, the multi-specialty groups, and they took some responsibility, accountability in return for some of their value-based care or you pooled those to suburban areas or to those rural areas, you know, Hattiesburg and some of these places where some of my colleagues came from. And I heard that today between urban and rural.

So, I think that's really an important thing that could enable practice transformation, another thing that one of my -- one of our colleagues said here. So, you know, a lot of really good things.

I'm optimistic that we've done enough things in healthcare that have moved the needle, that if you go back and look at history, you can craft a future here, taking little tidbits of lessons we've learned.

The Primary Care Medical Home Model might work really well in one of the archetypes. Right? So, I'm optimistic.

And then, the last thing I'll say is, you know, I do feel that we need to probably highlight this disproportionately, even though 15 percent of people live there, live in rural areas, medically underserved
areas and rural areas produce -- they're a large swath of this country.

They produce a lot of our resources, like they said.

But they also are the underpinnings of some of our geopolitical polarization and instability.

And so, I think, you know, health is humanity and, therefore, people not having access to health care, it is a huge thing for people.

And so, if we don't solve for this, I think we continue to have a country of haves and have nots and thems and us's, and that's a problem.

DR. MILLS: Appreciate that, Chinni.

I took several themes from all of this and at times, I harken back to something that we've said at a prior meeting, which was, we really need to think carefully about how to make it increasingly uncomfortable to practice in fee-for-service medicine.

But then, I really got in touch with that -- the flip side of that is, it -- we must also simultaneously make it increasingly comfortable to practice in value-based
practice.

And we heard our rural colleagues saying that's not happening. All they're getting is, it's impossible to practice in any economic situation almost.

So, I was struck that there were some themes that came out of this which is, for our rural practice brethren population, it's, you know, critical factors are unified definitions.

You know, I'm struck that there's, you know, just CMS programs use at least three different definition sets of race language ethnicity data that's impossible for payers and big practices to manage, much less small rural practices. And that's something that policy internal Medicare can take a lead on.

A standard defined metric set. I mean, there's 2,500 measures. I don't know we need to make up more measures, we need to use the measures we have now better and in a unified fashion.

In almost every facet, we hear a plea for more multi-payer involvement. And I represent, you know, a payer, worked for a payer that's involved in both Medicare
Advantage and exchange and commercial space.

And we're happy to participate, but I think it is going to take some policy and federal leadership to lead the way and put enough carrot and stick involved that private payers who are often as big as the agencies making the carrots and sticks decide they want to participate.

Usually your provider affiliated or provider owned payers are always willing to go with the unified community measure set. It serves everybody's needs.

And then, a plea for data, there's just needs to be more assistance. And if there's a moonshot anywhere, it's a moonshot around this health data ecology that's the power utility for the health care system that we keep hearing picked up in different strains at almost every meeting.

So, I was struck with that.

And then, some -- I've got four pages of comments, but just some comments I'll pull out.

I was struck certainly by a rural payment structure issue that the -- a large portion of rural care is provided by Rural
Health Clinics, FQHCs, and Critical Access Hospitals.

And their payment structures are such that they almost never match up and let them participate in any of the innovations that have happened in the last 20 years.

And past that, not only is it, you know, hard to explain to your Board of Directors how your cost-plus reimbursement's going to marry up against this, and they never fit together and so, you just never really get the light to go forward.

Most or many CMMI models exclude all of those rural health care facilities. So, essentially, we've lost 20 years of innovation that have been happening in other markets which is really a dearth of, I think, knowledge that we need to figure out how to close.

I was struck by some rural definition issues that have been previously mentioned, especially this difference between rural and frontier can't paint with a wide brush. They're very, very different with the same types of needs, but an order of magnitude difference in severity being, you know, 40 miles from a larger area versus truly ultra-
rural.

I thought there were really good comments about, and I'm intimately familiar with Medicare's approach to and exchange approach to access defined as time and distance from the practice.

But yet, it's actually not the time and distance from the practice that make network adequacy, it's actually the amount of resources available to that practice.

And so, this concept that time and distance of certain key assets and care of a population, whether that's -- what was mentioned was OB and cardiovascular and oncology services. And those are really smart, as those are, you know, three of the top five cost buckets for our population. So, I thought that was interesting.

And then, similar to this idea of using Medicare's policy leadership to just streamline definition -- functional definitions of things like race, language, ethnicity.

Just there's different definitions of rural across different programs.

And so, what makes you rural and qualify for one program may not qualify for a
different rural program.

   It seems like we can -- there's no
   perfect definition, but we're all served by
   just picking one and going with it at some
   point in time.

And then, lastly, there were two
metric things that I pulled out.

   One is this idea of this rural
   glitch. And that just -- my data geek is
   saying that would just infuriate me that if I
   was a rural provider and my dataset is being
   used to measure my delta versus the community
   but my practice is 72 percent of the community,
   I'm competing against myself and can never show
   meaningful change.

   Somehow that's got to be fixed. And
   that's, again, within policy leadership to
   figure out how to do that.

And then, the last piece I'll bring
out and then turn it back to the Chair is, this
guidance over the reality that you've got a
population and a pilot, two outliers, you've
got, you know, one mom who's in a car wreck and
delivers a 26-year-old preemie, and your
measures are just destroyed for the year, and
there's no recovery.
There's got to be a way to exclude outlier white swan events in a measure set. And that -- the science is there, we would be able to figure that out and put that into practice.

So, that's what I pulled out from today. Thank you.

CO-CHAIR SINOPOLI: Thank you. Lauran?

CO-CHAIR HARDIN: Excellent comments.

Just a couple of layers, whether you're looking to the lens of Medicare, Medicaid, commercial insurance, social determinants of health, health equity, there's a crying need for coordination and integration into one ecosystem in rural communities.

We heard great examples of a hub and spoke model connected to an FQHC, hospitals operating as conveners and connectors, and utilizing the diverse resources to really pull people together.

But the need to share services and really look at what is a best practice connected ecosystem heading towards health was really an interesting theme today.
A couple other things. I heard a few very specific policy recommendations that I thought were interesting.

So, removing the face-to-face requirement for telehealth, waiving the one visit, one service for FQ billing, and also increasing access to Hospital at Home, as well as looking at the ability for attribution to advance practice providers or eliminating the physician as a pre-step in rural health were all interesting policy recommendations.

A lot of rich dialogue and really looking forward to what else we bring out tomorrow.

* Closing Remarks

CO-CHAIR SINOPOLI: Perfect. So, thank you all.

So, I'm just going to have a couple of closing comments. And I really want to emphasize what Chinni and Jay said from my experience.

Spent most of my career in a large system that had two separate, large academic medical centers, each one of them surrounded by rural health for miles around, serving 1.2 million patients.
And I can tell you that even though those rural areas may have only had 15 percent of the population we're talking about, that that 15 percent, if they did not have those rural hospitals and had to move to those more tertiary health centers for care, those tertiary health centers would have collapsed.

They cannot -- in fact, we spent most of our time trying to figure out how do we unload the academic health centers and move those out to the rural health centers for more primary care kinds of issues because the ER was always backed up. The hospital was full. The tertiary patients couldn't get into the tertiary referral centers because of that. Fifteen percent is a lot of patients.

And so, I think this warrants more attention than a 15 percent number might come across as. This is a major national problem.

And so, I just want to emphasize the importance of this discussion.

So, thank you all, it's been a great, great day today. Kind of an overwhelming amount of information, but very good.

So, any other comments from the
Committee members or otherwise before we adjourn?

DR. KOSINSKI: I forgot to say --

CO-CHAIR SINOPOLI: Go ahead.

DR. KOSINSKI: This could be budget neutral. This doesn't mean we have to have new taxes, new spending. This could be budget neutral if the model is what you're paying for, and you restructure how people are getting paid.

CO-CHAIR SINOPOLI: Yes, I agree.

* Adjourn

Good, well, thank you all and we'll re-adjourn tomorrow.

(Whereupon, the above-entitled matter went off the record at 4:55 p.m.)
CERTIFICATE

This is to certify that the foregoing transcript

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Before: PTAC

Date: 09-18-23

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