

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

### **Presenters:**

### ***Subject Matter Experts***

- [\*\*Aisha T. Pittman, MPH\*\*](#) - Senior Vice President, Government Affairs, National Association of ACOs (NAACOS)
- [\*\*Jackson Griggs, MD, FAAFP\*\*](#) - Chief Executive Officer, Waco Family Medicine
- [\*\*Mark Holmes, PhD\*\*](#) - Professor, Department of Health Policy and Management, University of North Carolina Gillings School of Global Public Health, and Director, Cecil G. Sheps Center for Health Services Research

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**Aisha T. Pittman, MPH**

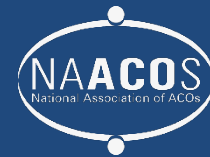
Senior Vice President  
Government Affairs  
National Association of ACOs  
(NAACOS)

# Approaches for Incorporating Rural Providers in TCOC Models



**Aisha Pittman**

# About NAACOS



406

ACO MEMBERS

8.3M

BENEFICIARY LIVES IN  
MEMBER ACOS

64%

OF ACOS ARE NAACOS  
MEMBERS

127

PARTNER  
ORGANIZATIONS



## THOUGHT LEADERSHIP

NAACOS works to advance the ACO model and promote the value of coordinated, patient-centered care through research, publications, and other forms of thought leadership.



## EDUCATION

NAACOS offers a variety of educational webinars, conferences, and other events to help ACOs stay up-to-date on the latest developments in the field and learn from experts and peers.



## ADVOCACY

NAACOS advocates for ACOs through various means, such as engaging with policymakers, participating in rulemaking, collaborating with other organizations, and communicating with the public.

*Founded in 2012, the National Association of ACOs (NAACOS) is a member-led and member-owned nonprofit helping ACOs succeed in efforts to coordinate and improve the quality of care for their patient populations.*

# Fundamental Shift to Account for Access



- Rural communities are health professional shortage areas
- Different ability to reduce costs; lower cost settings may be unavailable
- Models need to consider maintaining or improving access over cost reductions
- **Must modify core elements of TCOC models to account for rural provider challenges**

# Modifying TCOC Elements: Attribution



## Challenges

- ACOs built on primary care relationship
- ACOs with significant portion of FQHCs experience significant churn due to patient care patterns (fewer visits challenges plurality of services)
- Many rural practices do not include a physician and do not drive attribution (e.g. NP-only TINs)
- Difficulty capturing annual wellness visits
- FQHC billing at facility level makes it difficult to understand attribution

## Potential Solutions

- Rural specific attribution approaches
  - Attribution steps for certain rural providers
  - Advanced Practice Provider (APP) attribution or removal of physician pre-step in rural communities
  - Multi-year alignment approaches
- Additional data on attribution provided to participants

# Modifying TCOC Elements: Benchmarks



## Challenges

- Shared savings approaches do not account for underlying rural payment systems
  - FQHC and RHC: One-service per visit reimbursement
  - RHC: All-inclusive rate requires face-to-face visit
  - CAH: Cost-based reimbursements prevents being rewarded for lowering utilization
- The “rural glitch” penalizes ACOs for lowering costs because it removes the benefits of the regional adjustment
- Patients can be much sicker than historic risk scores indicate, therefore patients then hit caps on risk scores faster
- Coding underemphasized because it’s unnecessary in traditional reimbursement structure

## Potential Solutions

- Consider a global budget or prospective population-based payment approaches
- Lower discounts or minimum savings rate (MSR) for rural providers in risk-bearing models
- Fix the “Rural Glitch” by setting regional adjustment to what it would be without an ACO
- Adapt risk adjustment policies to not disadvantage sicker populations
  - Considerations for lack of historical coding: increase risk caps for rural populations or beneficiaries without historical access to care
  - More weight to proxies for social risk: Area Deprivation Index (ADI), dual-eligible, disabled
- Account for costs that are specific to rural communities (e.g., air ambulance)
- Develop alternative measures of success to financial benchmarks for CAHs, such as maintaining or improving access to care

# Modifying TCOC Elements: Flexibility and Support



## Challenges

- Providers need additional technical support to participate in models

## Potential Solutions

- Rural specific waivers
  - Waiver one-visit, one-service requirement
  - Make it easier to provide Hospital at Home
  - Remove face-to-face billing requirement for certain services like AWWs
- Remove MSSP's high/low revenue distinction to provide access to Advanced Investment Payments (AIP)
- CMS provide more avenues for understanding impact of TCOC policies on rural providers



# Questions

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Aisha Pittman

Senior Vice President, Government Affairs

[Aisha\\_Pittman@naacos.com](mailto:Aisha_Pittman@naacos.com)

**Listening Session 1: *Approaches for Incorporating Rural  
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**Jackson Griggs, MD, FAAFP**

Chief Executive Officer  
Waco Family Medicine



# Rural Health Reimagined: A Collaborative Approach to PB-TCOC Models & Funding

Jackson Griggs, MD, FAAFP  
CEO, Waco Family Medicine  
September 18, 2023



# TEXAS

- Largest rural population in the nation: 4.7mm
- 177 of 254 counties are rural (70%)
- \$21.2 billion in goods GDP

	Rural Texas	United States
Below FPL	15.8%	11.6%
Adults lacking HS diploma	18.3%	8.9%
Food Insecure Families with Children	23.4%	12.5%

US Census, RHlhub, USDA, UTHealth

# Bum Steer?

- Take underfunded systems
- In resource poor populations
- Cast a vision of access & quality
- Add some new work
- And fund less



New York Post, 1946

**SELF-ACTUALIZATION**  
reaching full potential

**ESTEEM**  
respect • freedom

**BELONGING**  
family • friendship

**SAFETY**  
employment • health

**PHYSIOLOGICAL**  
water • food • shelter

## Maslow's Hierarchy

Maslow, A.H. Psych Review, 1943.



**HEALTH EQUITY**  
patients • community

**QUALITY**  
outcomes in aggregate

**INTEGRATION**  
health ecosystem • SDOH

**FINANCIAL SECURITY**  
reliable funding

**OPERATIONS**  
basic infrastructure

## System Hierarchy

# PMPM



# In a Nutshell

- Don't build a high-rise until you fix the foundation
- Determine desired outcomes, then identify leaders whose values yield desired outcomes
- Invest heavily in realized successes
- Tailor model to population, then iterate
- Protect precious human capital

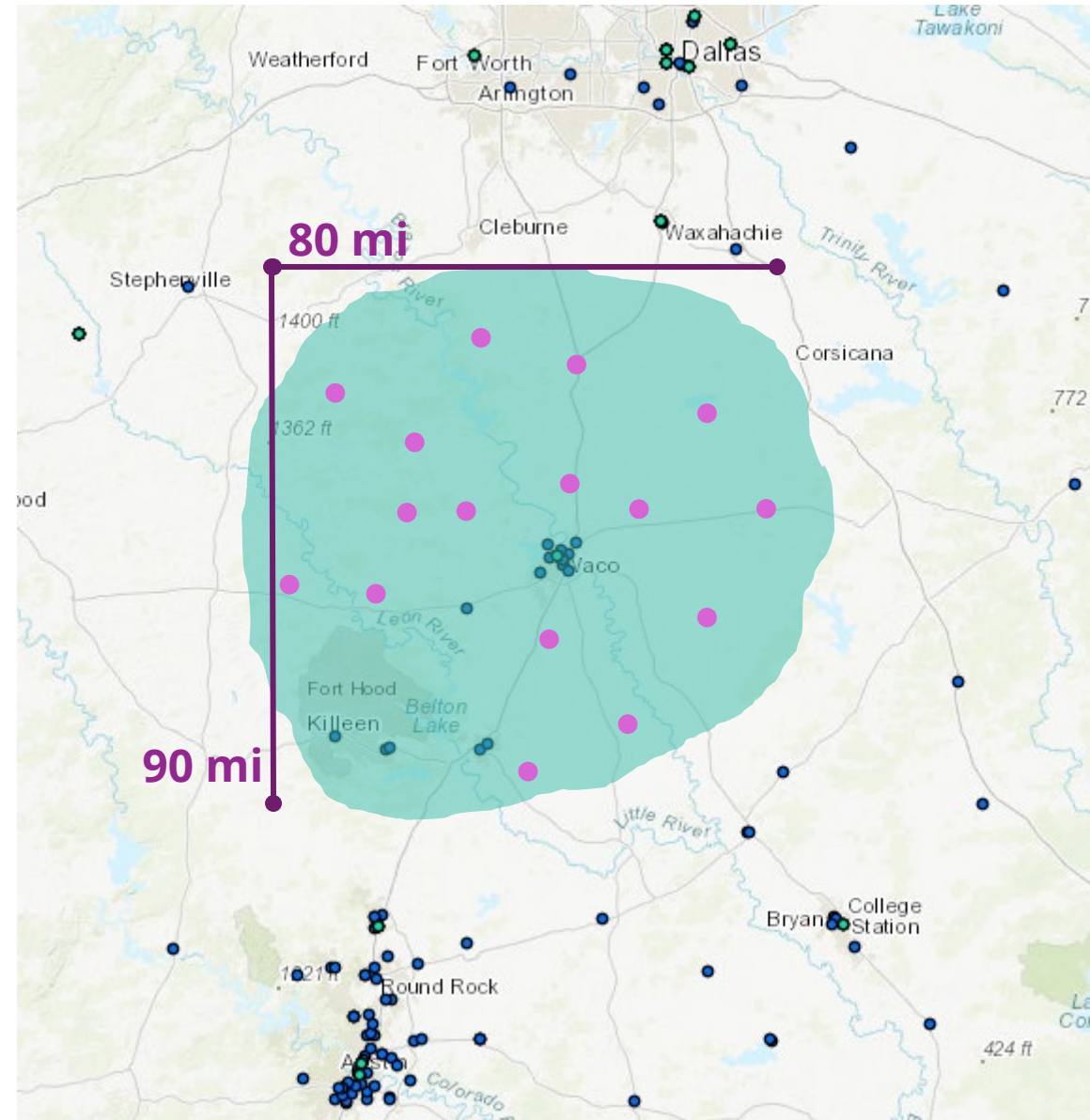






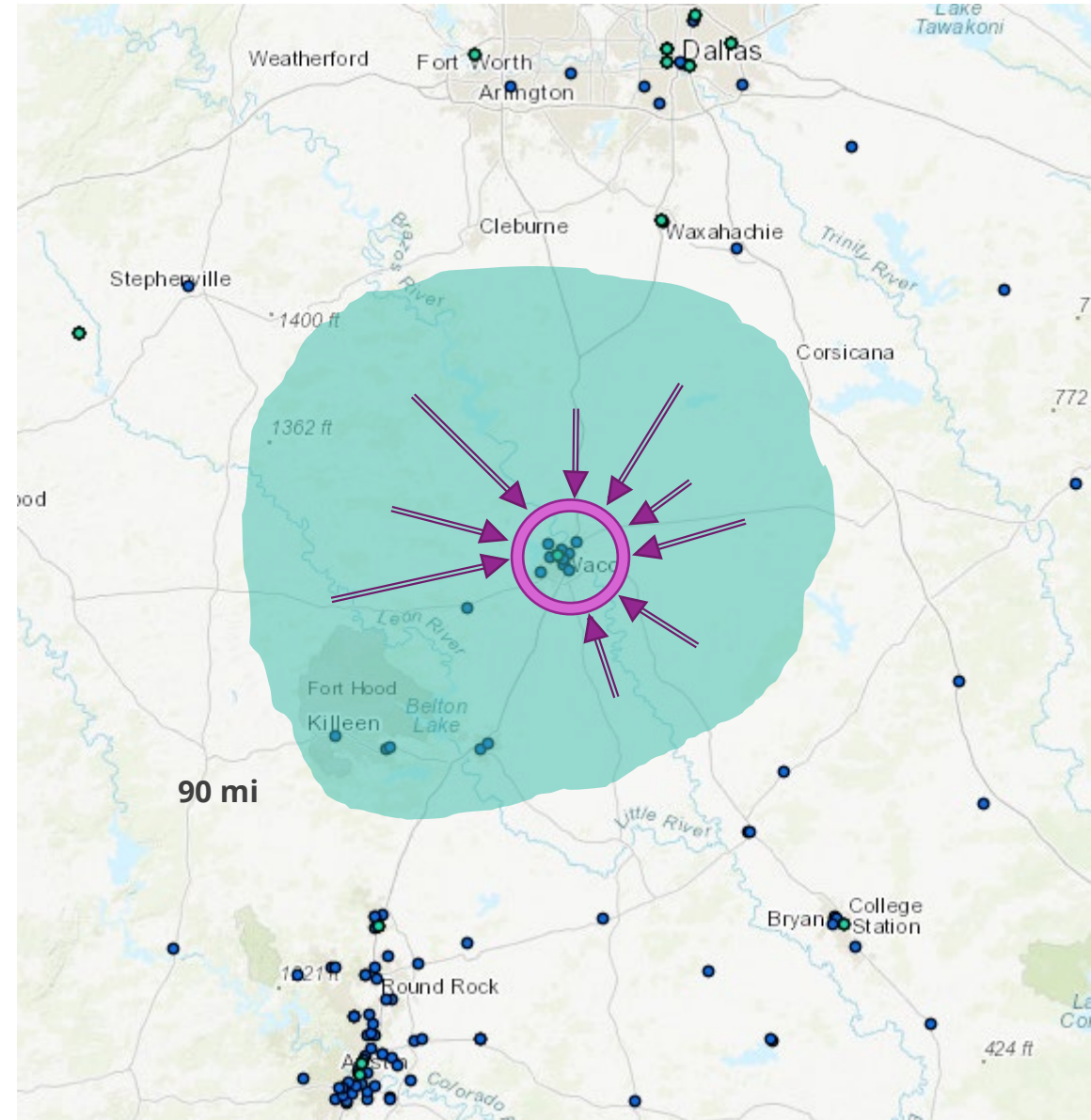
## Municipality: Population

- Mexia: 7,459
- Hillsboro: 7,417
- Marlin: 5,665
- McGregor: 5,522
- Groesbeck: 4,317
- Teague: 3,560
- Clifton: 3,442
- Hamilton: 3,095
- Fairfield: 2,868
- West: 2,807
- Mart: 2,092
- Whitney: 2,090
- Meridian: 1,491
- Hubbard: 1,423
- Rosebud: 1,372
- Holland: 1,280
- Valley Mills: 1,203
- Jewett: 1,167
- Riesel: 1,007
- Coolidge: 999
- Bremond: 932
- Chilton: 911
- Lott: 759
- Dawson: 803
- Frost: 621
- Oglesby: 484
- Kosse: 497
- Thornton: 526
- Penelope: 211
- Bynum: 199
- Aquilla: 109





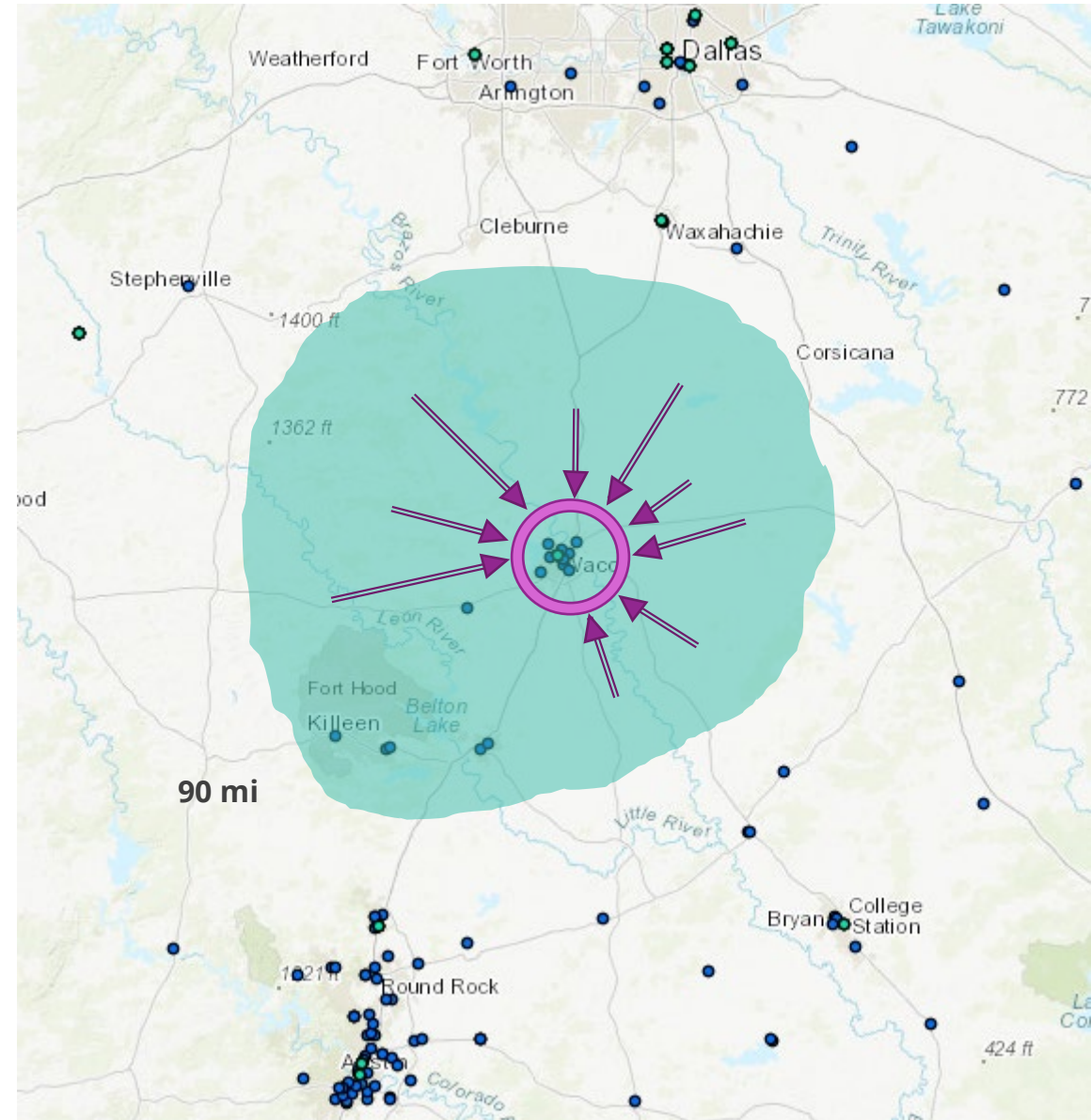
- FQHC with no funding from hospital district or Medicaid expansion
- 14 counties in an area larger than the state of Delaware
- 15 primary care sites - centrally
- Served 62,600 patients last year
- ½ of the population rural
- 73% below FPL
- Centripetal



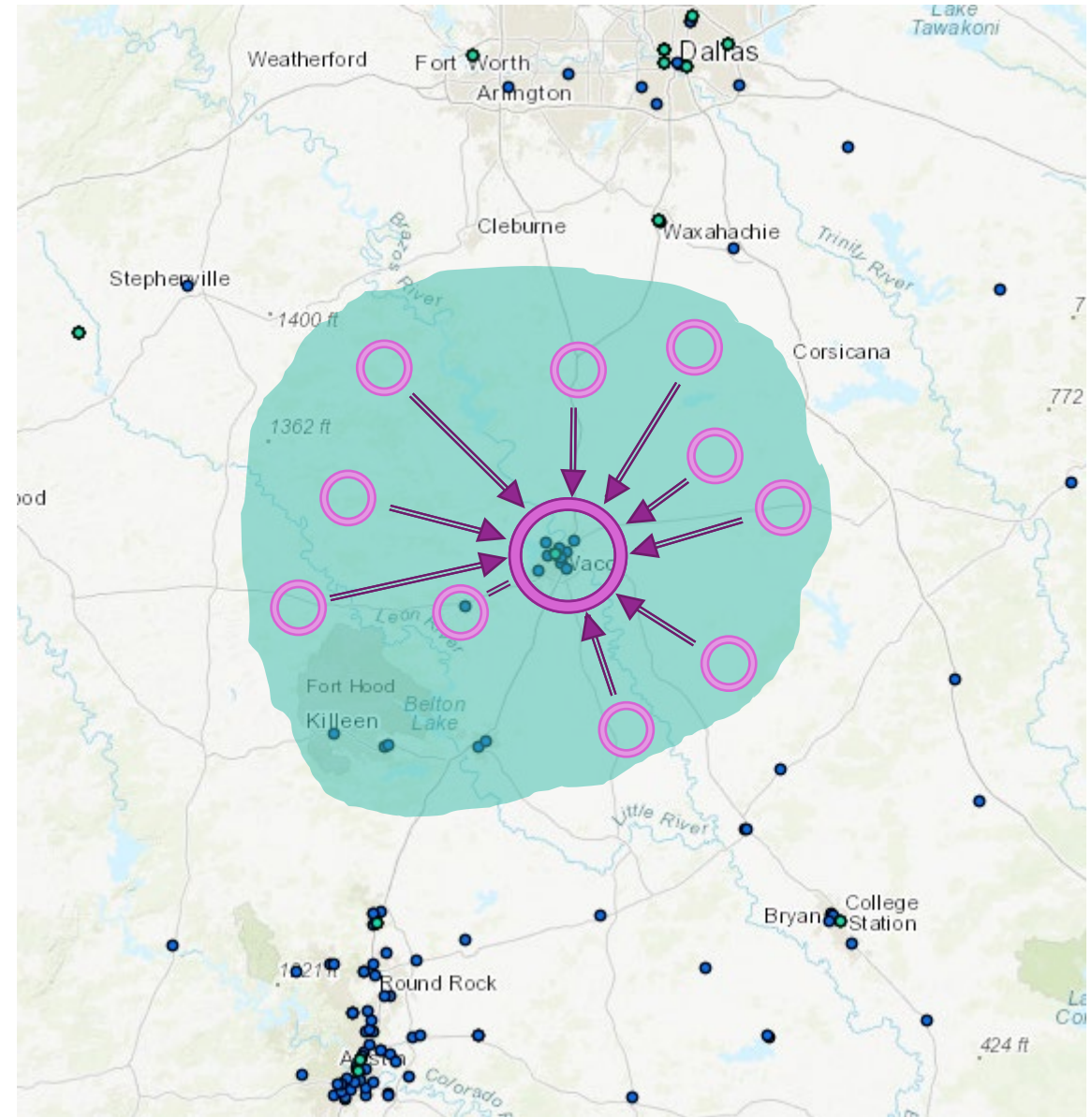


# The Waco Experience

- Lessons learned
  - ACO with Traditional MSSP
    - Hospital-centric
    - Low benchmark
  - Patients & patient care
- Encouraging rural participation
  - Longstanding funding shortages yields zero buffer for investment w/ risk
  - Need: front-end capacity building (grant funding & TA) to lower risk:benefit
  - Glide path toward TCOC
- Payment considerations / quality measurement & linkage to payment...



# What if?



# Hub & Spoke

Hub: FQHC-anchored ACO in PB-TCOC contract models, sufficiently funded and administered to manage a rural region's health

Spokes: rural communities within FQHC service area interested in participating: benefits of local health care investment + downstream economic gains from labor force, etc.

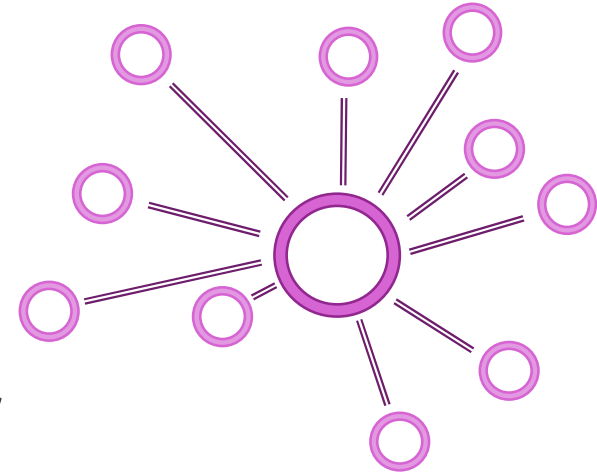


ACO participants: FQHC, rural hospitals, mental health authorities, specialists

Allied contributors: cities, counties, public health, nonprofits

# Why Primary Care Centric?

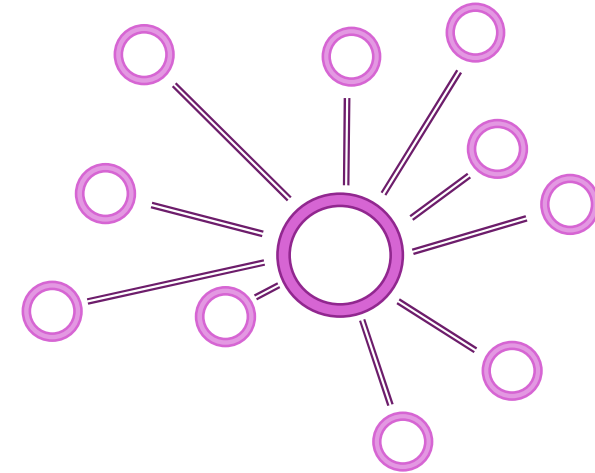
“Primary care is the only health care component where an **increased supply** is associated with **better population health** and more **equitable outcomes**.”



(NASEM, 2021)

# Why Primary Care Centric?

- Whole-person
- Sustained relationships
- Critical role of communities
- Equitable access & cultural humility
- Person-centered
- Interprofessional teams
- Diversity of settings and modalities used to deliver services

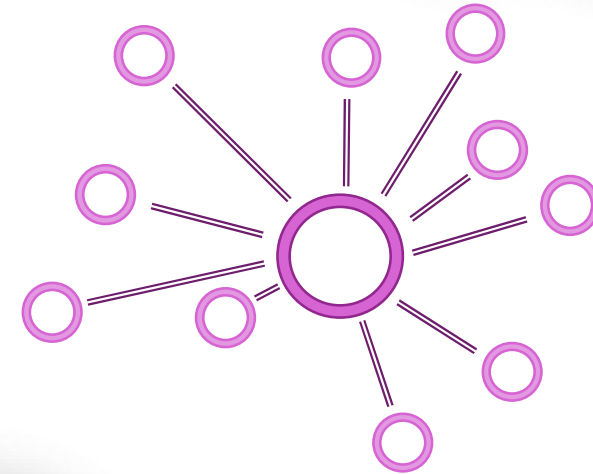


(NASEM, 2021)



# Why Primary Care Centric?

- Tailored to culture and needs, e.g., in Texas:
  - Agriculture & ranching
  - Values & tendencies
  - Distance of travel & related needs
  - Age, income, education
  - Rural tensions around race, gender, sexuality
- Comprehensiveness: one-stop shop
- Built on trust



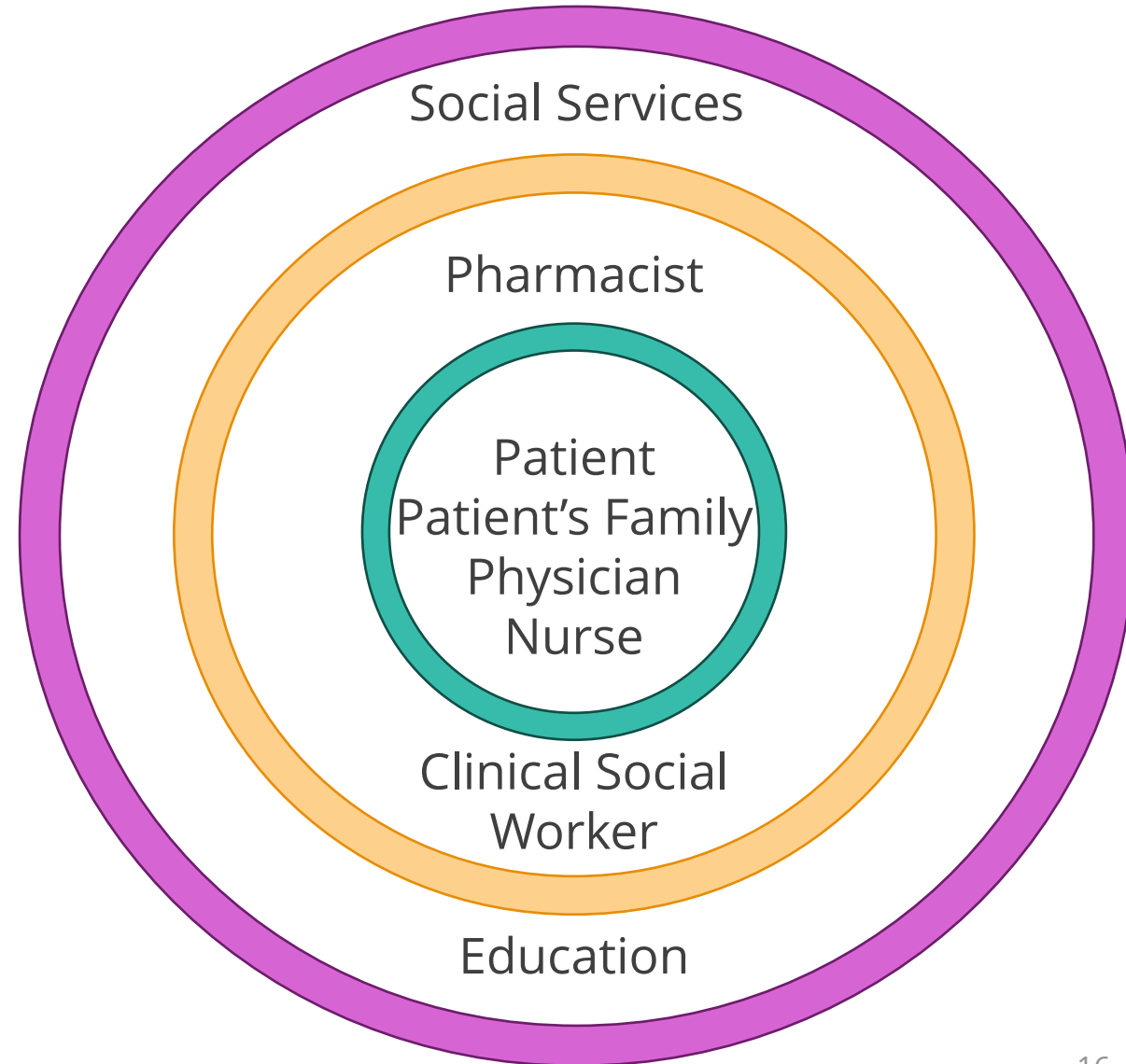
# Why Primary Care Centric?

## Interprofessional PC Team

Core Team

Extended  
Health Care Team

Extended  
Community Care Team



# Why FQHC Anchored?

- Population based: required needs assessment for service area — health status, access, services needed, SDOH, satisfaction, sociocultural factors
- Tailored to meet vulnerable community's needs
- Roots & values in equity
- Enabling services required (e.g., transportation, translation)
- Won't turn anyone away for inability to pay
- Patient majority boards
- Collaborative
- Accustomed to quality reporting (UDS)
- A few built-in advantages: FTCA, 340b, Medicaid PPS

# How?

Health Care

Public Health

Local nonprofits

Cities & Counties

State agencies

HRSA

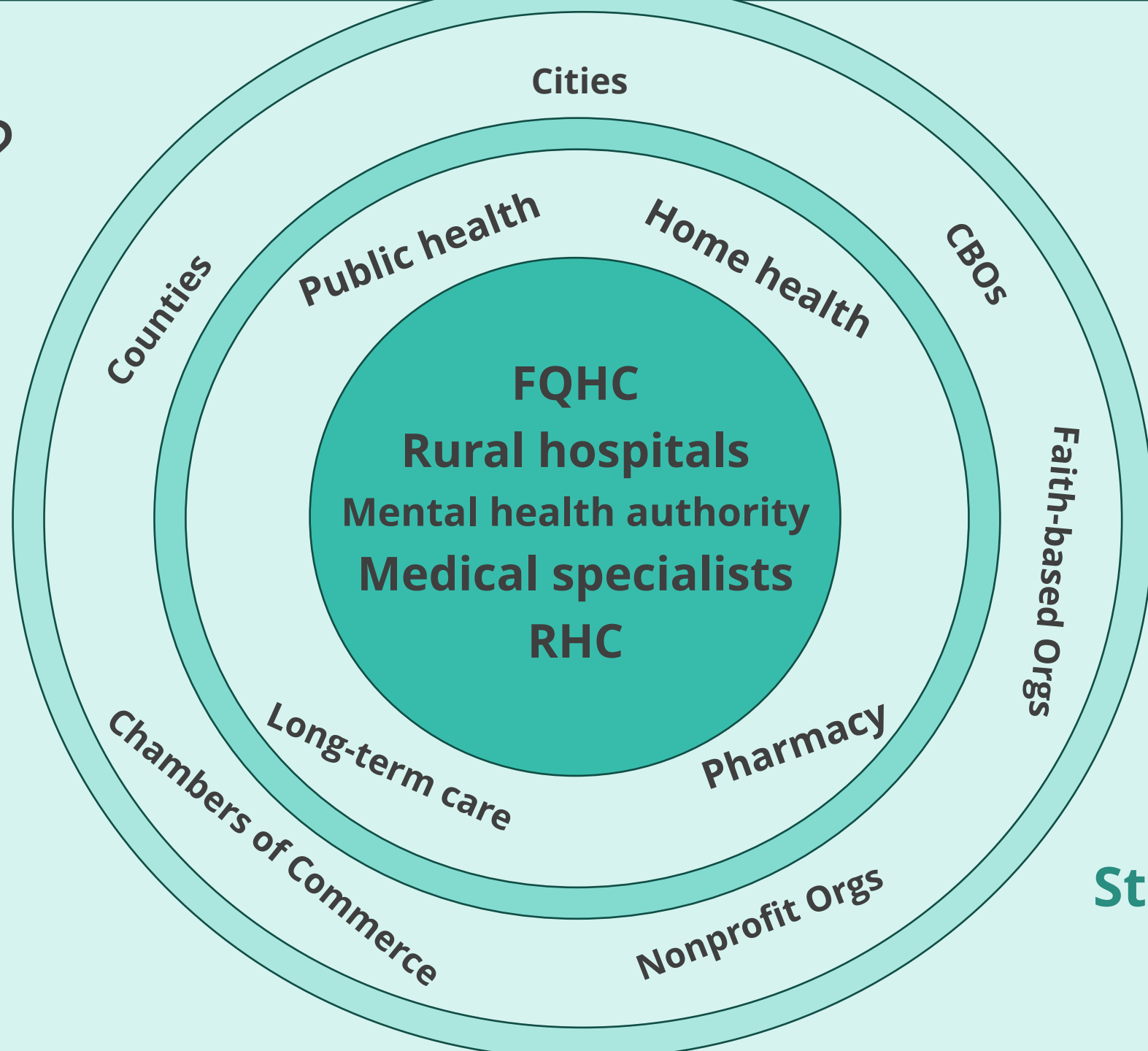
CMS



How?

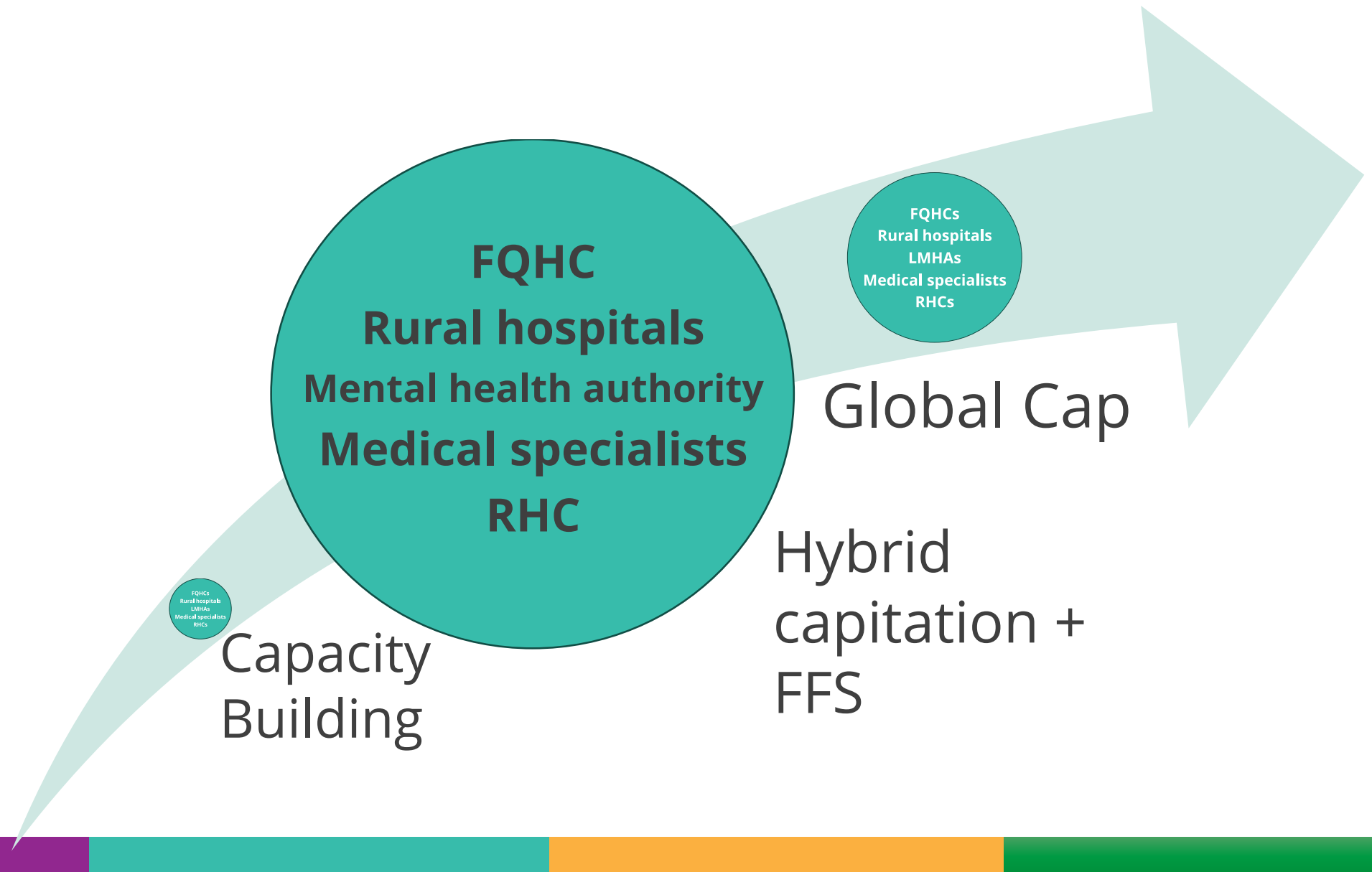
HRSA

CMS



State Agencies

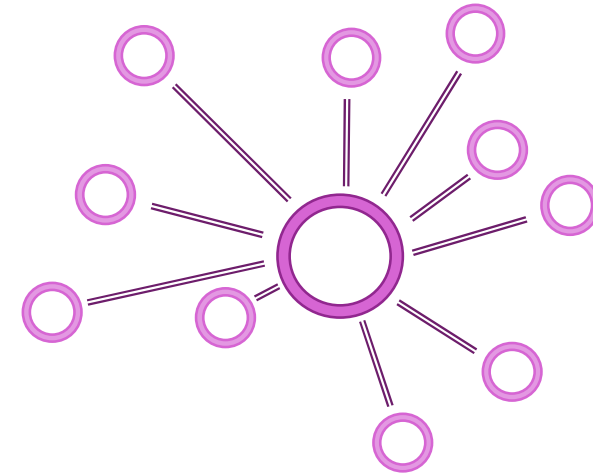
# How?



# How?

“Vision statements, research evidence, leadership, and well-intentioned policy will not change the structure and performance of a system if they are not supported by adequate, goal-aligned resources.” – NASEM, 2021

- Structural
- Programmatic



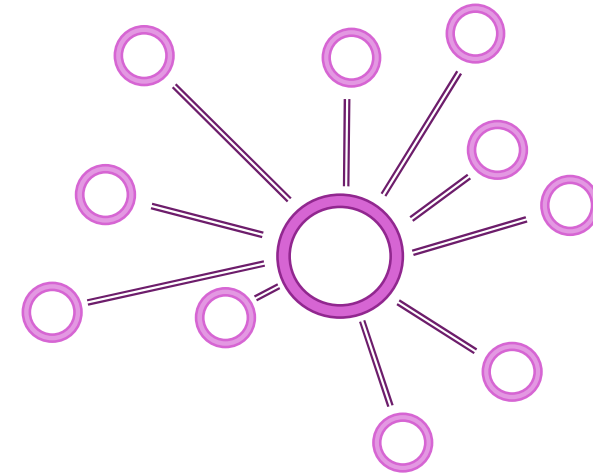
# How?

Structural

## HRSA

- Primary care is grossly underfunded
- Any initiative to support FQHCs as an anchor for a PB-TCOC rural model will necessitate multi-agency support

## CMS





# How?

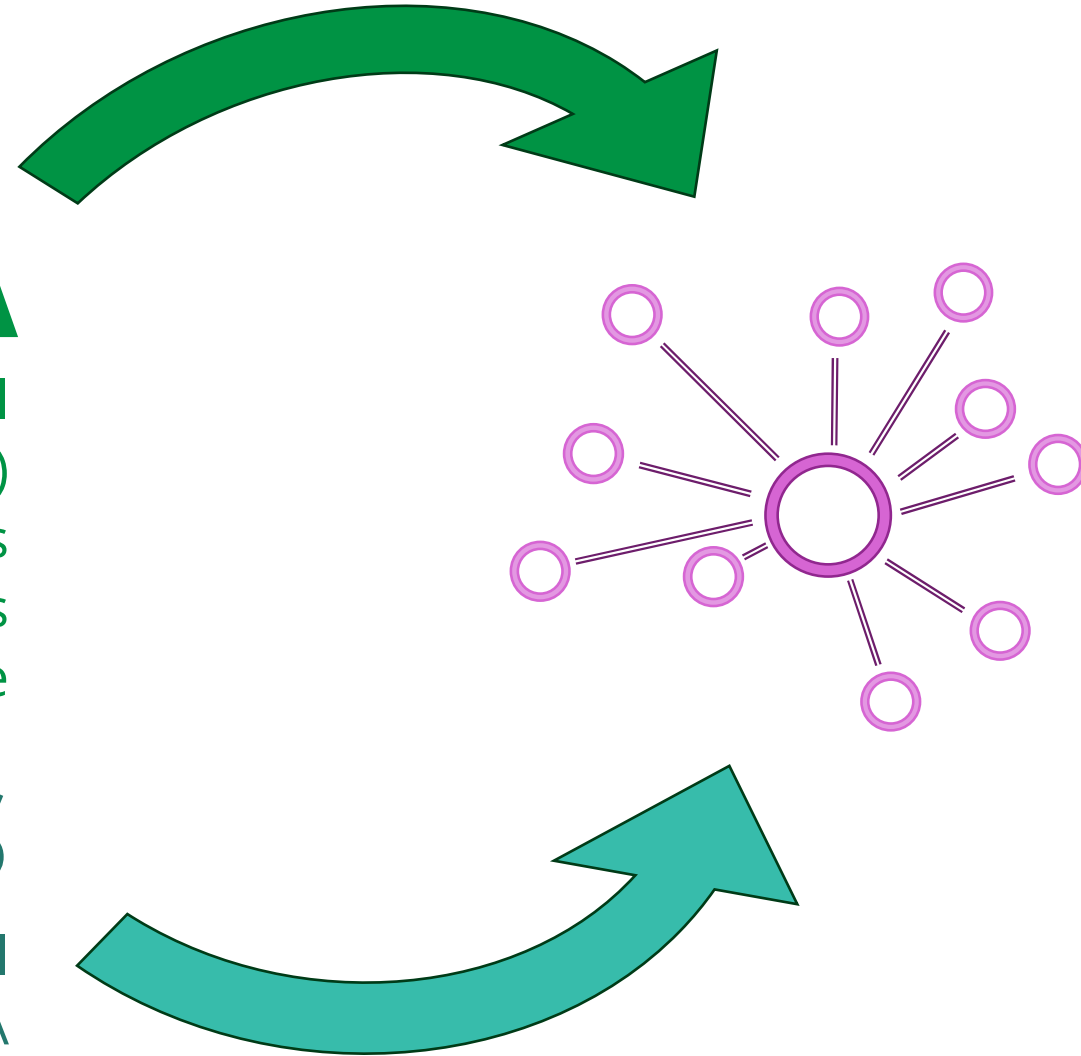
## Structural

### HRSA

- Rural pilot grants for both capital
- Health Center Grant (PHSA §330)
  - Incentives
  - Waivers
- Workforce

### CMS

- Tailored MSSP model
- Up-front grants for operations & TA
  - 1115 Waiver dollars



# How?

## Programmatic



## Principles of MSSP for Rural Health

1. *"Simplicity, simplicity, simplicity! I say, let your affairs be as two or three, and not a hundred or a thousand."* – Thoreau, Walden
2. Primary-care centered
3. Rural-oriented design
4. Leverage existing advantages (e.g., FQHC values & assets)
5. Upfront infrastructure investment

# Problems: Suggestions

- Modest success with CMS VBC: Use a strengths-based approach and lean into successes — physician-run, primary-care centered (not hospital or subspecialty centered)
- Anemic population health outcomes: fund domains that are proven to improve population health (primary care, FQHC, SDOH, etc.)
- Neutral to adverse health disparities: Focus support on safety net funding (in order to recover from chronic scarcity) before expecting downside risk; build-in equity measures

# Problems: Suggestions (cont.)

- Clinician burnout: measurements must be meaningful and patient-centered w/o adding burden; time with sick patients vital; building therapeutic relationships heals moral injury
- Wrong pocket problem: small short-term cost savings will not lessen big long-term costs
- Inefficiencies: use regulatory control to align payers; simplify administration
- Low-uptake in high-risk vulnerable populations: reward safety nets for their hard work; face validity offering clear gains for cachectic systems is imperative

# List of Appendices

A: Ideas for Rural Health MSSP

B: Ideas for Patient-Centered Measurement in Rural Health MSSP

C: Case example of successful FQHC / CAH Collaboration

D: Progressive investment in SDOH

E: Citations

# APPENDIX A

## Ideas for Rural Health MSSP

- Establish long-term savings schema and methods  
short term savings  $\neq$  long-term prevention & savings
- Simplify administration (e.g., align conflicting models & payers, clear expectations)
- Size of savings must take into account chronic underfunding: upfront grants, then rural portion of share might look much larger than similar model for urban
- Quality gates should be slowly progressive, considering limited staff & resources
- Population based, regionally-adjusted fixed cost coverage to account for:
  - Systems in 10 states without Medicaid expansion
  - Lower volumes at rural hospitals that require stable / available infrastructure

# APPENDIX A

## Ideas for Rural Health MSSP (cont.)

- Eliminate cost sharing (shifting cost to patients) for all high-value preventive services and for chronic disease management, and unquestionably for individuals < 200% FPL
- Instead of using historical benchmarks for rebasing (which punishes efficient systems) create new, innovative goal models that reflect rural health economics and regional rural (i.e., excluding metro) realities.
- Benchmarks should not be based on the thin, underfunded systems in existence; they should factor in unique challenges of rural hospitals and rural populations

# APPENDIX B

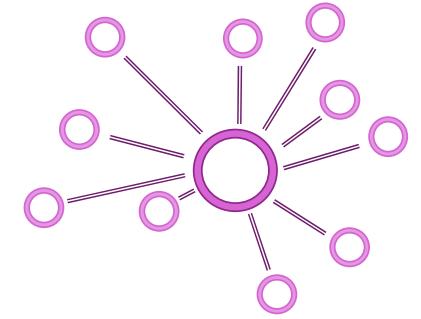
## Ideas for **Patient-Centered Measurement** in RH-MSSP

- Effectiveness of communication, with an emphasis on clarity and empathy
- Timeframe for follow up
- Accessibility and responsiveness to individual needs
- Capacity to incorporate patient's unique values
- Preventative screenings, timely interventions, and hospital admission reduction
- Adherence to evidence-based care guidelines
- Evaluate the integration of medical, behavioral health, dental, and social services
- Efforts to reduce disparities within rural populations
- Continuous improvement efforts



# APPENDIX C

## Case Example: Successful Rural VBC Collaboration



North Dakota FQHC / CAH collaboration

	Before Collaboration (2011)	After Collaboration (2017)
<b><i>Critical Access Hospital</i></b>		
Cash-on-Hand	64 days	84 days
Net Margins	0.8%	4.2%
<b><i>Federally Qualified Health Center</i></b>		
Cash-on-Hand	8 days	203 days
Net Margins	-11%	10.9%

- US Dept of HHS, "A Guide for Rural Health Care Collaboration," 2019

# APPENDIX D

## Progressive Investment in SDOH

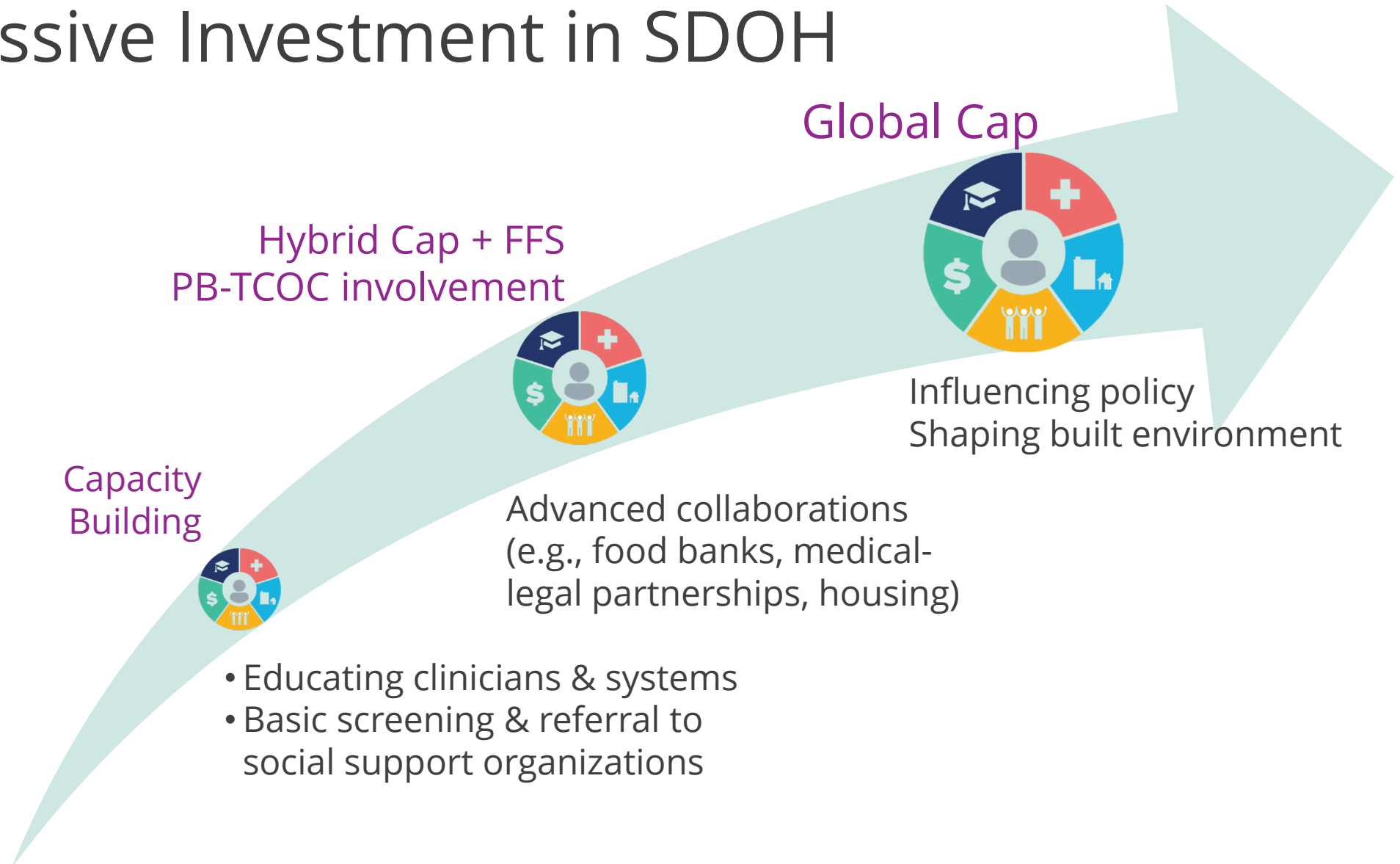


Epidemiologic studies show socioeconomic and behavioral factors outweigh health care or genetics (Artiga and Hinton, 2018; Braveman and Gottlieb, 2014; McGinnis et al., 2002).

- Safe housing, transportation, neighborhoods
- Racism, discrimination, violence
- Education, job opportunities, income
- Access to nutritious foods
- Physical activity opportunities
- Language and literacy skills

# APPENDIX D

## Progressive Investment in SDOH



# APPENDIX E

## Citations

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**Mark Holmes, PhD**

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

# Attribution in Rural Areas

Mark Holmes, PhD

Director

NC Rural Health Research Center, Sheps Center, UNC

18 September 2023

# Key Takeaways

1. Most attribution schemes (to which provider each beneficiary is attributed) have been designed assuming PPS data flow, although modifications are more flexible
2. My read: Not much evidence attribution *per se* is a factor inhibiting rural provider enrollment
3. The costs 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* ( $\neq$  rural providers)

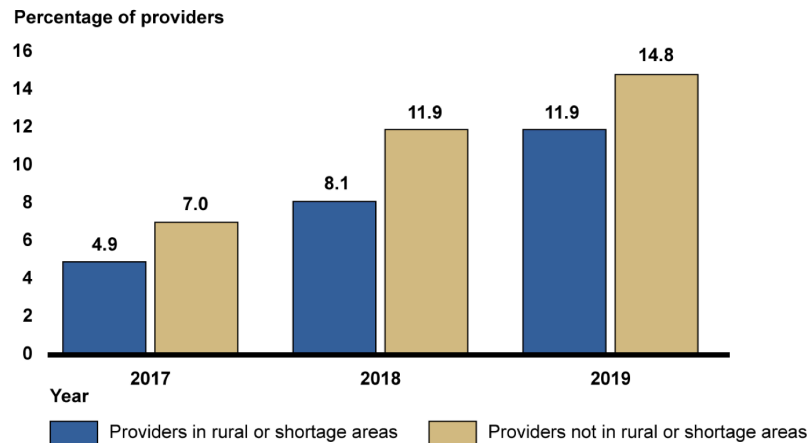
Classic examples: CAH/cost-based, Medicaid Upper Payment Limit (UPL)

4. Other challenges in rural contexts, such as ability to manage financial risk and infrastructure to manage utilization, may be more important



# GAO: rural providers less likely to participate in Advanced APMs. But why?

**Percentage of Medicare Providers in Rural or Shortage Areas and Providers Not Located in These Areas Who Participated in Advanced APMs, 2017 – 2019**



Source: GAO analysis of Centers for Medicare & Medicaid Services (CMS) data. | GAO-22-104618

**Table 2: Examples of Challenges Faced by Providers in Rural, Shortage, or Underserved Areas in Transitioning to Alternative Payment Models (APM), Including Advanced APMs**

Category of challenge	Challenge to participating in APMs
<b>Financial resources and risk management</b>	Providers lack the capital to finance upfront costs of transitioning to APMs
	Providers are averse to financial risk or lack reserves to cover potential losses
	Providers treat too few Medicare patients to justify investments in APM participation, and lower patient volumes result in less predictable spending patterns, heightening financial risk
	Providers are less able to control cost of care because they often must refer patients elsewhere for tertiary care
<b>Data and health information technology</b>	Providers are unable to conduct data analytics or financial modeling needed to provide value-based care
	Complexity and cost of electronic health records (EHRs), or lack of high-speed internet, hinder EHR adoption
<b>Staff resources and capabilities</b>	Practices lack the staff members capable of managing the transition to or participation in APMs
	Providers lack awareness about APMs
<b>Design and availability of models</b>	Providers have limited APM options due to models' geographic or participant restrictions, a lack of nearby accountable care organizations, or a lack of models appropriate for providers in rural, shortage, or underserved areas
	Providers struggle to adapt to changing model rules and regulations

Source: GAO analysis of Centers for Medicare & Medicaid Services and stakeholder interviews, and literature. | GAO-22-104618

# Review: Attribution

- Payment models generally depend on the attribution of beneficiaries (or members) to one provider\*
- Typical rule: beneficiary assigned to the provider with the plurality of E&M visits (or payments) for the year, with tiebreakers if necessary
- **Key design requirement: provider payments (well, data) “align” with the PPS system**
- If the reimbursement data do not support PPS(-ish) based attribution, then those providers cannot be included
- Common approach is to make certain providers ineligible for participation (e.g. OCM – RHC, FQHC, CAH, Maryland)

\* Provider is defined in a general sense here – often a TIN, might be a system, or clinic, or individual professional.

# TIN vs. CCN

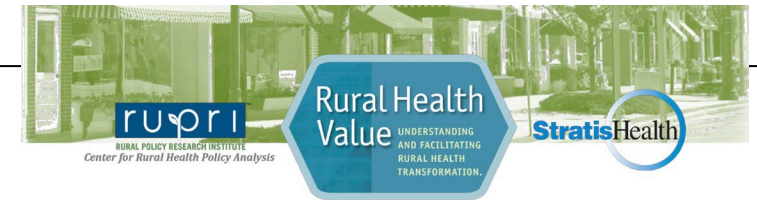
(Taxpayer Identification Number vs. CMS Certification Number)

- MSSP is built on a TIN infrastructure.
- Providers that have a larger presence in rural areas: Rural Health Clinics (RHC), Critical Access Hospital (CAH) Method II (where the “Part B service” is billed through the hospital), and Federally Qualified Health Centers (FQHC) bill through CCNs, not TINs
- → TIN logic does not work
- Fix: 21<sup>st</sup> Century Cures (et al) added these to qualified providers
  - Assume all RHC and FQHC are primary care services that qualify the visit for attribution
  - Bundles at the CCN level – even if multiple RHCs under one CCN

# Coding practices

Hierarchical Condition Category (HCC) scores are lower for those seeing rural providers. This may be an accurate measure of risk. But it also may be that rural providers do not code as completely as urban providers.

When SERPA-ACO was first established, providers and administrators did not understand the importance of accurate patient risk-scoring and risk-adjustment. This has become an important aspect of operations both in terms of billing and coding but also establishing patient care goals. To support coding accuracy SERPA-ACO: conducts coding education for providers; holds regular coder meetings; conducts regular chart audits through an external auditor; collaborates with providers to be sure they are documenting accurately; encourages providers to use scribes; and shares coding impact information with staff.



**Rural Innovation Profile**  
*A Rural Accountable Care Organization's Journey*

Cochran, G.L. and Horn, S.D. (2015), Potential Effect of Coding Differences on Comparisons of Rural and Urban Outcomes. J Am Geriatr Soc, 63: 2210-2212. <https://doi.org/10.1111/jgs.13692>

Malone T et al. Association of CMS-HCC Risk Scores with Health Care Utilization among Rural and Urban Medicare Beneficiaries. NC RHRP, 2020.

Rahman M, White EM, Mills C, Thomas KS, Jutkowitz E. Rural-urban differences in diagnostic incidence and prevalence of Alzheimer's disease and related dementias. Alzheimers Dement. 2021 Jul;17(7):1213-1230. doi: 10.1002/alz.12285. Epub 2021 Mar 4. PMID: 33663019; PMCID: PMC8277695.

# Other considerations

- Liquidity: rural providers are often less financially liquid and face greater challenges in financially managing risk
- Technology and infrastructure: rural providers may have fewer resources to improve health via case management
- Rural costs: higher costs in low volume rural settings, coupled with rural-specific payment models (e.g. CAH, swing beds), means that many services in rural settings have higher Medicare expenditures; standardized costs addresses some of these issues, but not all
- Low volume: broadening the base (e.g. Pennsylvania) would help

# Referrals / costs

**Referrals limit control over cost of care.** Providers in rural, shortage, or underserved areas can face difficulty controlling the cost of care, which can affect their ability to meet an APM's financial benchmarks, because they often must refer patients elsewhere for tertiary care, according to some of the stakeholders and CMS officials.<sup>37</sup> APMs are intended to create continuity and accountability for patients' care over care episodes and time, according to CMS officials. Providers in rural, shortage, or underserved areas may not be part of a health system that includes specialists and sometimes must refer patients to another practice to receive specialized care, which can result in costs beyond their control, according to some stakeholders. It is easier for providers in large, urban health systems to control costs because they can offer more comprehensive treatment in one location, some stakeholders said. Additionally, ACOs may exclude rural providers from joining if their costs are too high, one stakeholder told us.