

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

**September 19, 2023
9:02 a.m. – 12:57 p.m. EDT
Hubert H. Humphrey Building
200 Independence Avenue, SW
Washington, DC 20201**

Attendance

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

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

PTAC Members Not in Attendance

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

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

Lisa Shats, PTAC Designated Federal Officer
Steven Sheingold, PhD

****Via Webex Webinar***

List of Speakers and Handouts

1. Listening Session 2: Incentives for Increasing Rural Providers' Participation in Population-Based Models

Alana Knudson, PhD, EdM, Project Director, The Pennsylvania Rural Health Model (PARHM) Evaluation; Director, NORC Walsh Center for Rural Health; and Senior Fellow, NORC at the University of Chicago*

Tom X. Lee, MD, MBA, Chief Executive Officer, Galileo*

Randy L. Pilgrim, MD, FACEP, Enterprise Chief Medical Officer, SCP Health*

Handouts

- Listening Session 2 Presenters' Biographies
- Listening Session 2 Presentation Slides
- Listening Session 2 Facilitation Questions

2. Listening Session 3: Successful Interventions and Models for Encouraging Value-Based Transformation in Rural Areas

David C. Herman, MD, Chief Executive Officer, Essentia Health*

Ami B. Bhatt, MD, FACC, Chief Innovation Officer, American College of Cardiology, and Associate Professor, Harvard Medical School*

Thad Shunkwiler, LMFT, LPCC, Associate Professor, Department of Health Science and Director, Center for Rural Behavioral Health, College of Allied Health and Nursing, Minnesota State University, Mankato*

Susan E. Stone, DNSc, CNM, President, Frontier Nursing University*

Handouts

- Listening Session 3 Presenters' Biographies
- Listening Session 3 Presentation Slides
- Listening Session 3 Facilitation Questions

3. Public Commenters

Elizabeth Foster (Columbia Gorge Health Council)*

**Via Webex Webinar*

[NOTE: A transcript of all statements made by PTAC members and public commenters at this meeting is available on the ASPE PTAC website located at:

<https://aspe.hhs.gov/ptac-physician-focused-payment-model-technical-advisory-committee>].

The [ASPE PTAC website](#) also includes copies of the presentation slides and other handouts and a video recording of the September 19 PTAC public meeting.

Welcome and Co-Chair Update

Angelo Sinopoli, PTAC Co-Chair, welcomed the Committee and members of the public to day two of the September 2023 public meeting. He noted that Elizabeth (Liz) Fowler, Deputy Administrator of the Centers for Medicare & Medicaid Services (CMS) and Director of the Center for Medicare and Medicaid Innovation

(CMMI; the Innovation Center), spoke at day one of the public meeting about how PTAC's work is related to some of the Innovation Center's areas of focus. Co-Chair Sinopoli provided an overview of the second day of the public meeting, including two listening sessions, a public comment period, and a Committee discussion to shape PTAC's comments for a report to the Secretary of Health and Human Services (HHS) on encouraging rural participation in population-based total cost of care (TCOC) models. Co-Chair Sinopoli invited Committee members to introduce themselves and their experience with managing care transitions.

Listening Session 2: Incentives for Increasing Rural Providers' Participation in Population-Based Models

- Alana Knudson, PhD, EdM, Project Director, The Pennsylvania Rural Health Model (PARHM) Evaluation; Director, NORC Walsh Center for Rural Health; and Senior Fellow, NORC at the University of Chicago
- Tom X. Lee, MD, MBA, Chief Executive Officer, Galileo
- Randy L. Pilgrim, MD, FACEP, Enterprise Chief Medical Officer, SCP Health

Co-Chair Sinopoli moderated the listening session with three subject matter experts (SMEs) on incentives for increasing rural providers' participation in population-based models. Full [biographies](#) and [presentations](#) are available.

Alana Knudson presented on considerations for the design, implementation, and feasibility of population-based total cost of care (TCOC) models for rural providers.

- Rural areas supply much of the country's food, drinking water, energy production, and outdoor recreation. Rural areas are also home to one in five Americans, including a disproportionate number of veterans and active-duty service members. Dr. Knudson explained that addressing the health needs and challenges of rural communities is essential to ensure economic viability across the nation.
- Dr. Knudson discussed lessons learned from her experiences with rural participation in Alternative Payment Models (APMs).
 - The Centers for Medicare & Medicaid Services (CMS), the Center for Medicare and Medicaid Innovation (CMMI), and commercial payers should include rural health experts in value-based payment discussions.
 - Aligning rural providers can help these providers meet population thresholds, which have prevented rural provider participation in APMs in the past.
 - Consideration should be given to how a Rural Quality Reporting (RQR) program could be implemented and followed. RQRs are often optional for rural providers, but consistent clinical quality metrics are necessary for rural providers to monitor quality of care. In addition, rural providers serve a disproportionate number of people likely to need health care and operate under small to negative margins, making assumption of financial risk under APMs particularly risky for rural providers.
 - Rural communities are experiencing innovation fatigue. In particular, rural providers that adopted an innovation program that was later discontinued by CMS or CMMI may be less inclined to participate in innovation programs in the future.
- Dr. Knudson provided several recommendations for designing population-based TCOC models for rural providers, including engaging rural providers and community partners in the design of the model, determining success metrics before implementation, providing up-front funds to support implementation, minimizing new and additional staff and financial requirements, and providing

technical assistance. The full continuum of care, including long-term services and supports (LTSS), public health services, and community-based organizations (CBOs), must be considered during model design. Model implementation and performance expectations, such as metrics for data reporting, should be aligned across payment systems.

- During model implementation, rural providers encounter variable, fixed, and standby costs. Variable costs are directly attributable to patient care, whereas fixed costs cover infrastructure required to support patient care regardless of patient volume. Standby costs are those necessary to deliver care at any time, such as emergency medical services (EMS).
- Dr. Knudson discussed recommendations to increase the feasibility of rural provider participation in population-based TCOC models, including linking financial risk to performance other than cost savings, applying financial risk only to aspects of performance controlled by model participants, not relying on fee-for-service (FFS) payments, and providing regulatory waivers to reduce innovation barriers. It is important not to place essential local services—including primary care, public health, and emergency medical services—at financial risk.

For additional details on Dr. Knudson’s presentation, see the [presentation slides](#) (pages 3-15), transcript, and [meeting recording](#) (8:00-22:00).

Tom Lee presented on encouraging rural participation in population-based TCOC models.

- Dr. Lee leads Galileo, a new care model designed to improve the quality and affordability of care, especially among rural and underserved communities. Galileo operates a digital-first model of care, with phone-based and digital consultative services, responding to labor and resource limitations in rural environments. The home is the first place of care for mobility-restricted and older patients who cannot travel to a doctor’s office. When needed, Galileo offers brick and mortar services as the second place of care.
- Dr. Lee discussed several infrastructure-related challenges in rural medicine, including connectivity, labor and time matching, skills matching, facility capabilities, and payment alignment.
 - One obstacle to treating patients cost efficiently in low-density markets is connectivity, with some regions having limited broadband and cellular access. Galileo uses landlines for home modalities, when needed.
 - The most challenging aspect of managing sustainable practices in rural environments is matching the appropriate supply of labor with demand. Technology, data, and connectivity solutions can help alleviate some labor challenges.
 - Another challenge is access to the necessary specialists in the appropriate markets and communities. Galileo leverages remote connectivity, remote skills, and team-based approaches to deliver expertise across a broad geographical range.
- Dr. Lee discussed five considerations to advance rural health and value-based care innovation: workforce, member density, home-first, technology enablement, and investment.
 - Overcoming clinician shortages requires cross-provider creativity and collaboration.
 - A sufficient population size is required to take on risk in low-density markets. Community partnerships are key to overcoming this challenge.
 - Home-first models require regulatory and reimbursement flexibility due to the care complexity and logistical needs associated with home-first care.
 - Permanent and adequate coverage of phone and asynchronous care is needed to ensure access in rural communities.

- Emerging models should cover up-front costs, such as those for data and technology, to support gradual transitions to risk bearing.

For additional details on Dr. Lee's presentation, see the [presentation slides](#) (pages 16-27), transcript, and [meeting recording](#) (22:08-29:35).

Randy Pilgrim presented on integrating health equity into value-based transformation.

- Rural communities often experience disproportionate health-related social needs (HRSNs) challenges. Addressing HRSNs is fundamental: Dr. Pilgrim used an analogy to the pyramid of Maslow's hierarchy, with HRSNs as the bottom layer, clinical care as the fundamental middle layer, and at the top, insurance, which empowers access to care.
- Achieving health equity requires equitable access, care delivery, and care transitions.
- Dr. Pilgrim discussed several value-based models that provide important learnings related to the integration of health equity into value-based transformation.
 - The Metro Community Provider Network (MPCN) Bridges to Care Model used on-site patient engagement during an emergency department (ED) visit for frequent ED patients, including patients with social determinants of health (SDOH), substance use, and behavioral health needs. The Bridges to Care Model led to significant reductions in ED visits and program savings.
 - Maryland's Global Budget Payment Reform system aligned hospital revenue with a global budget rather than patient volume or services delivered. Studies showed that this led to lower ED utilization, ED readmissions, and inpatient admissions, while mortality and ICU stays remained stable. However, disparities among ED readmissions were identified.
 - The *Acute Unscheduled Care Model (AUCM)*, a proposed physician-focused payment model (PFPM) that PTAC recommended to the Secretary of HHS for implementation, is a risk-bearing APM for emergency medicine that promotes safe discharges to home while reducing overall cost. AUCM includes telehealth waivers, home visits, and transitional care management for ED physicians. The proposed model has yet to be implemented, but some emergency physician partnerships with health plans use principles of the proposed AUCM model. These partnerships have been shown to reduce ED visits, improve patient experience, and reduce overall cost.
- Dr. Pilgrim explained that hospitals and EDs offer opportunities for providers to leverage existing structures and mechanisms, through more equitable access and care delivery, that achieve health equity objectives.
- Dr. Pilgrim highlighted existing laws, regulations, and processes that support integration of rural EDs into value-based models. The Emergency Medical Treatment and Labor Act (EMTALA) requirement, the prudent layperson standard, and public reporting requirements support equitable access to care. Equitable care delivery is encouraged through established standards of care, telemedicine oversight, and certification and regulation standards. Screening for SDOH, HRSN identification, care coordination, and aftercare provide a foundation for equitable transitions and continuity.
- To promote equitable access to care, models can incentivize providing care to a representative population of the community and increasing access for underserved populations. To promote equitable care delivery, payment can be adjusted based on the consistency of quality and operational measures across all patient groups. Incentives for equitable transitions and continuity

rely on process measures and transition indicators; however, alignment of primary care, specialists, and non-rural providers is often a challenge.

- Overcoming rural challenges requires a unified mission; an effective clinical, operational, and economic model; broad participation; and aligned resources.

For additional details on Dr. Pilgrim’s presentation, see the [presentation slides](#) (pages 28-44), transcript, and [meeting recording](#) (29:41-45:30).

Following the presentations, Committee members asked questions of the presenters. For more details on this discussion, see the transcript and [meeting recording](#) (45:30-1:38:46).

Dr. Lee discussed the context in which his new care model, Galileo, is implemented.

- Galileo is designed to fill gaps in regions without providers, as well as to collaborate with and provide infrastructure support to established providers in rural areas with provider shortages. Galileo helps facilitate handoffs between established providers and community-based organizations (CBOs). Galileo also delivers rural care digitally across all 50 states and provides home-based care in four states, particularly in rural communities.

Presenters discussed the effectiveness of digital interventions in rural environments.

- Dr. Pilgrim’s organization, SCP Health, established a 24/7 nurse call center to connect patients with primary care and other resources after an initial ED visit. SCP Health later added text messages to this post-discharge follow-up communication, and patient engagement increased from 60-70 percent with only phone calls to around 90 percent after adding text messaging. Currently, the organization is developing a web-based interactive site to provide diagnosis-specific recommendations to patients after discharge. In general, digital interventions can work in rural areas if the area has broadband capabilities and patients have access to cell phones.
- Telehealth use increased in rural areas during the COVID-19 Public Health Emergency (PHE), but telehealth has not been sustained at those levels, in part because the current cohort of older adults in rural communities prefer in-person care. The demand for telehealth may shift over time, as future cohorts of older adults have greater digital literacy. However, there are still waitlists to access behavioral health care via telehealth due to the shortage of behavioral health providers. It will be important to increase the health care workforce to maximize the opportunities associated with digital interventions.
- The ideal organization has capabilities to provide in-person care and a range of telehealth modalities. Galileo considers a variety of factors to connect the right patient to the right provider in the right location, allowing for more labor-efficient and cost-effective care. Although in-person visits may seem inefficient, Galileo always conducts the first visit in-person to build trust with patients and identify infrastructure limitations in the patient’s home.

Presenters discussed creative roles and disciplines that could be integrated into the rural health care system to alleviate workforce challenges.

- Patient navigation is often provided by nurses or advanced practice providers. However, individuals without a clinical license can typically deliver continuity of care services, such as making appointments, effectively. Policy makers should consider compensable actions that support continuity in transitions without requiring a clinical license to provide such services.

- Due to the lack of available skilled staff, organizations should consider hiring patient navigators from local communities. However, reimbursement structures will need to be updated to support this kind of framework.
- Community health workers (CHWs) are critical in rural and tribal communities, as they can establish trust and connect with patients. Unfortunately, despite their importance in advancing health equity, CHWs are not always reimbursable.

Presenters discussed infrastructure regulations that govern parts of care delivery, including telehealth-related requirements.

- Infrastructure regulations generally fall into two areas: 1) labor and workforce (that is, who can be reimbursed for what services); and 2) reimbursement flexibilities, particularly related to digital modalities.
- Regulations should support the use of telemedicine, without promoting misuse or abuse of clinical care. For example, the extension of telehealth capabilities through 2024 is generally beneficial. However, utilization guidelines are needed to ensure that clinical care objectives are met during telehealth delivery, to minimize or avoid provision of low-quality care.
- Regulations should support the use of telehealth for hospice care. During later stages of care, it is particularly important to keep patients in the home setting. In areas where providers are unable to visit the patient at home, telehealth visits are critical to support hospice patients and their families.

Presenters discussed whether ED and primary care providers (PCPs) should share responsibility for chronic disease outcomes and preventive care utilization, particularly in rural settings.

- The current reimbursement environment in emergency medicine is misaligned and does not support the reduction of health disparities or chronic disease. Primary care and appropriate specialty care should be better aligned with the ED. For example, EMTALA requirements could be relaxed, as sufficient longitudinal care can be provided without meeting rigorous EMTALA standards of assessment. Meeting EMTALA requirements uses substantial resources, which is particularly challenging for rural providers.
- Realigning the current reimbursement system is an important goal, but making such change will be difficult considering organizations' unique and complex infrastructures. Patients often visit the ED because they view it as the path of least resistance. One option is to redirect patients to more appropriate alternatives, such as phone-based or digital services, with financial alignment for those alternatives. In addition, communication between EDs and PCPs needs improvement.

Presenters discussed how their organizations are proactively reaching out to populations in need of primary care.

- Galileo incorporates proactive services that simultaneously meet patient engagement, preventive care, chronic care, and quality of care goals. It is difficult to find time to provide proactive care while working in busy primary care practices. Technology and data can help identify where there are gaps in proactive care, but a scalable labor force is needed to engage patients and close those gaps. Additionally, members of the primary care team operating in different environments need to be aligned with similar objectives.
- Historically, EDs have not conducted outreach to the community. All visits are unscheduled and patient-driven, which limits ED participation in value-based models. In comparison, primary care uses a roster-based mechanism, with PCPs held accountable for a list of patients. Most of SCP Health's opportunity to provide proactive care occurs during outreach after an initial ED visit.

Outreach includes connecting patients with primary care and has been effective. However, patients who do not visit an ED may still receive proactive care, particularly in rural areas.

- The Pennsylvania Rural Health Model funds hospitals that work with communities, but under the model, primary care has remained foundational to outreach and advancing population health outcomes. Models and payment systems must be aligned so that hospitals, primary care, and EDs work together toward the same goals. For example, misalignment occurs when hospitals have different value structures or incentives than PCPs. Maryland's Total Cost of Care Model uses an all-payer rate, which is foundational to the success of the model. The all-payer rate aligns incentives and payment across hospitals, EDs, primary care, behavioral health, and the rest of the care continuum.

Presenters discussed potential solutions to challenges with attribution in low-density rural areas.

- The Rural Emergency Hospital (REH) designation, which began in January 2023, provides up-front funding for rural hospitals. Value-based models, even those with global budgeting, use volume as a basis for payment. New payment structures could provide base payments for rural hospitals and providers, along with incentives and accountability to address population health metrics. In addition, rural EDs are a safety net for those with mental health disorders who cannot access treatment. A grant program or up-front payments for rural hospitals that address population health needs, such as behavioral health, would better suit low-volume facilities.
- In low-density markets, it may be helpful to have a regional organization to help share responsibilities and provide centralized services across many primary care groups and local hospitals. For example, the Rio Patient Health Records System facilitates patient aggregation and shared responsibility across different community service providers, helping smaller health care organizations overcome scale-related issues.
- A provider should have attribution in some form if they deliver any clinical service to a patient. However, providers need clarity between attribution with respect to a clinical event and attribution regarding the population for which a provider is responsible. The intricacies of attribution across multiple providers and systems are challenging, for example, in distributing attribution among primary care and acute care providers. The Committee should consider how to design an attribution scheme that combines acute and longitudinal care.

Presenters discussed how county or regional hubs of providers can share responsibilities to help alleviate challenges with standby costs.

- Texas has a clinically integrated network with 23 hospitals. Beyond hospitals and clinics, some long-term care providers are beginning collaboration to combat staffing and resource limitations at a regional level.
- Hospital-based acute care, including for standby capacity and responsiveness, is expensive. There are opportunities to leverage standby services from existing hospitals and EDs to reach more community members and achieve equity objectives. However, there are downsides of using inherently expensive standby services to achieve other health objectives.
- The nuances of different rural communities mean that frameworks for regional provider hubs should not be overly prescriptive and should allow for shaping and customizing by individual communities.
- Regional provider hubs require structure, including funding and dedicated effort from staff to schedule convenings.

Dr. Lee discussed Galileo's reimbursement model and target population.

- Galileo aims to discreetly identify the factors that go into a patient encounter and uses what it calls knowledge- or translational-based care where expertise reflecting multiple specialties is conveyed digitally to providers, to improve decision-making during patient care. Galileo aims to reduce the amount of time providers spend collecting information, resulting in more efficient use of provider time and a lower unit price. Lower unit prices allow providers to effectively operate within most FFS and risk-based environments. Providers also have more time available to tend to high-complexity patients who are more labor-intensive.

Presenters discussed factors that make certain rural providers uniquely successful in APMs.

- Rural providers that are successful in APMs are innovative, draw on their strengths, and are willing to take risk. For example, Maryland Health Care Commission’s Chestertown practice was about to close. However, Chestertown identified a strength in its community: a high proportion of older adults committed to ensuring health care access in their community. Chestertown providers worked together with community members to implement a new model for the practice.
- Rural providers that have success in APMs often have a progressive mindset, and they have buy-in and alignment among the community and clinicians. Rural providers that do not succeed in APMs often lack the capital to invest in technology infrastructure. Additionally, it is important to have reasonable backstops in risk-bearing arrangements, or providers will not want to invest.
- Successful rural providers have leaders who are rooted in the community and are more operationally and financially experienced than the average PCP. Most PCPs struggle with the rigid structures of APMs, which do not allow for innovation. In addition, struggling providers need more financial assistance than current reimbursements.

Listening Session 3: Successful Interventions and Models for Encouraging Value-Based Transformation in Rural Areas

- David C. Herman, MD, Chief Executive Officer, Essentia Health
- Ami B. Bhatt, MD, FACC, Chief Innovation Officer, American College of Cardiology, and Associate Professor, Harvard Medical School
- Thad Shunkwiler, LMFT, LPCC, Associate Professor, Department of Health Science and Director, Center for Rural Behavioral Health, College of Allied Health and Nursing, Minnesota State University, Mankato
- Susan E. Stone, DNSc, CNM, President, Frontier Nursing University

Co-Chair Lauran Hardin moderated the listening session with four SMEs on successful interventions and models to facilitate value-based transformation in rural areas. Full [biographies](#) and [presentations](#) are available.

David Herman presented on unique challenges and lessons learned for providing value-based care in rural communities.

- Essentia made an organizational commitment to focus on quality of care and patient outcomes, rather than focusing on the volume of care, with an emphasis on coordination and integration of care.
- Within its service area, Essentia identifies its patients and their care needs, including chronic illness management and care management, to support appropriate utilization and lower health care spending. Essentia identifies patients’ HRSNs and serves as a bridge organization to provide

partnerships among the government, private payers, and community organizations, as stewards of funds in and for the community.

- Essentia invests strategically in community projects and engages in community coalitions to implement and evaluate strategies to improve community health.
- Dr. Herman discussed how Essentia’s approach relies on analytics, action, and accountability to create care delivery models that can be standardized and yet customized to meet unique patient and community needs.
 - Analytics provide information to conduct risk stratification and apportion resources, close care gaps, and manage referrals.
 - Action involves alternative care delivery models—such as virtual care, remote monitoring, and home EMS services—to improve care transitions and to ensure that patients do not fall through care gaps, that social needs are addressed, and that chronic illnesses are well-managed.
 - Accountability is achieved through established goals, performance oversight coaching, transparent quality data that providers can use to track their progress, and ongoing quality improvement.
- The starting point is to address the needs of Essentia’s communities, addressing immediate non-medical needs of a patient. The organizational part is to develop partnerships to address such needs beyond the medical setting. Collaboration with community members and local stakeholders is important to identify needs and then close the gaps.
- Essentia Health addresses community needs through screening primary care patients, with appropriate follow-up from community care associates who make referrals to resources and partnerships.
- Nearly 40 percent of Essentia Health’s revenue flows through value-based programs, with about 80 percent of value-based contracts including upside and downside risk.
- Dr. Herman emphasized that, in order to succeed in value-based care, organizations must make a concerted commitment and build infrastructure to determine patient and community needs, then close gaps in patient care. Essentia Health is capacity limited and for this reason will have different organizational strategies than other organizations in very rural areas that may be limited in terms of demand.

For additional details on Dr. Herman’s presentation, see the [presentation slides](#) (pages 46-75), transcript, and [meeting recording](#) (0:40-14:50).

Ami Bhatt presented on successful interventions and models for encouraging value-based transformation in rural areas.

- Dr. Bhatt noted that trends for cardiovascular care in rural hospitals show lower procedure rates, including decreased rates of cardiac catheterization, coronary artery bypass grafting, systemic thrombosis, and intervascular therapy. Mortality is higher in rural hospitals for heart attack, heart failure, ischemic stroke, and acute heart failure.
- When considering value-based models that include cardiovascular care, it is necessary to differentiate chronic from acute care. To make progress in the initial stages of such value-based models and to improve outcomes in Critical Access Hospitals (CAHs), the root cause of disease must be addressed by moving into the community and catching diseases earlier.
 - For acute care, one necessary step is to strengthen the telehealth and transfer network for acute care between rural and non-rural hospitals. Tele-stroke care has been very successful in improving the ability to treat stroke patients.

- For chronic care, it is important to provide more care and address the rural workforce shortage. Interventions need to be provided close to home for rural populations, as quality improvement efforts based out of office locations are not as successful as home-based telecare.
- Dr. Bhatt emphasized the need to build rural cardiovascular care infrastructure.
 - The American College of Cardiology’s (ACC’s) rural-oriented design team is focused on expanding the use of allied practitioners, nurse practitioners, physician assistants, pharmacists, and community health workers to improve the ability to provide more customized care in rural areas. Considering the payment model for an expanded team is important.
 - Efforts to expand value-based care and payment through disease-based closed loop programs, such as those focused on atrial fibrillation, heart failure, and hypertension, will help educate the community, offer earlier diagnosis, implement care in communities, and provide patients with higher-level care when necessary.
 - Rural care delivery systems need a unique blend of community-based care, telemedicine, and larger practices to offer flexibility for different practices to adapt as they determine what is necessary for each patient population. Through a collaboration with Dispatch Health, the ACC is learning how to expand access to home-based care while achieving cost savings for communities and patients with less access to testing, considering the metrics and the balance between cost and quality.
 - High-impact, lower-complexity digital health interventions are necessary to build infrastructure for growth.
- Dr. Bhatt discussed potential advantages for cardiovascular care in rural populations.
 - Patient volume in rural areas is lower in general, yet cardiovascular risk factors and disease are prevalent, so there is an important opportunity to study cardiovascular disease and primary care together.
 - Remote monitoring services are effective in cardiology and serve as a force multiplier to overcome the finite human and financial resources in rural areas.
 - Compensation can be linked to non-cost saving metrics through the algorithms developed for guideline-directed medical therapies established for most cardiovascular diseases.
 - It is necessary to incentivize team-based care and innovative local community health roles.
- She noted that rural health clearly fits the digital health paradigm or pyramid, with the base comprising chronic management for the bulk of cardiovascular disease, through partnerships with primary care that are patient-centric and that reduce low-value specialist care. The middle layer of the pyramid represents patients identified with progressing illness, to be managed either at home by PCPs or at a specialty practice, and at the apex, those patients who require intervention and specialty care at a CAH or another setting.
- The ACC is focused on engaging patients through patient and caregiver education, flexibility to provide both in-person and virtual visits, self-monitoring, matching rural needs with specific interventions, and digital monitoring registries.

For additional details on Dr. Bhatt’s presentation, see the [presentation slides](#) (pages 77-85), transcript, and [meeting recording](#) (14:56-30:43).

Thad Shunkwiler presented on challenges, opportunities, and the path forward for behavioral health in rural areas.

- There is a disparity between the number of individuals requiring behavioral health care and available providers—an issue that is magnified in rural areas. The treatment gap is not

geographically equitable, as most rural areas of the country are Health Professional Shortage Areas for mental health.

- The behavioral health professional shortage is only becoming worse, with rising demand coupled with fewer behavioral health providers due to retirement, insufficient new providers in the pipeline, and provider burnout.
- Mr. Shunkwiler shared some barriers and potential solutions to recruiting the behavioral health workforce in rural areas.
 - Financial barriers and student loan debt can be addressed through enhanced scholarship and grant programs at the front end to incentivize more people to join the profession.
 - Recruiting from within rural communities is key to retaining providers, to grow the academic pipeline organically rather than relying on transplant providers.
 - A lack of approved clinical supervisors highlights the need to increase the training capacity of rural institutions and to develop more supervisors.
- Mr. Shunkwiler discussed barriers and potential solutions to retaining the behavioral health workforce in rural areas.
 - Low reimbursement rates emphasize the need to enforce payment parity and develop APMs for mental health.
 - High provider burnout necessitates shifting responsibility away from the individual onto the system to solve the issue holistically.
- Mr. Shunkwiler noted that data should inform the conversation regarding future policies.
 - Policy should expand mental health workforce capacity for both licensed providers and paraprofessionals.
 - APMs that improve access and deliver better care should be expanded.
 - Upstream interventions to prevent individuals from seeking care in EDs should be prioritized.
 - The best treatment is prevention. To decrease demand, models should focus on building resilience and incentivizing preventive practices.

For additional details on Mr. Shunkwiler’s presentation, see the [presentation slides](#) (pages 87-96), transcript, and [meeting recording](#) (30:48-43:10).

Susan Stone presented on SDOH and their effects on rural health, promising APMs, and measures needed to evaluate rural quality of care.

- Rural individuals are more likely to experience social factors that have negative impacts on health. The factors include poverty, lack of literacy, poor environmental health and water quality, and decreased access to safe and affordable transportation, safe homes, healthy and affordable food, and health care services.
- In rural areas, people are older, poorer, less likely to have a high school education, more likely to report four or more chronic conditions and use the ED and often lack a PCP.
- Dr. Stone discussed strategies to address SDOH, including policy and laws, data and surveillance, data evaluation, evidence building, partnerships and collaboration across organizations, community engagement, and expansion of infrastructure and capacity. Efforts should pay attention to equity and work to combat biases in the health care system.
- There are different kinds of rural areas, and not all rural areas face the same challenges. Community assessments are important to identify the major issues when designing programs for rural communities.

- Dr. Stone summarized some current efforts to address social needs, including comprehensive asthma home assessments and education, Federally Qualified Health Centers (FQHCs) with legal assistance, web-based systems to identify and refer patients to community resources, telehealth services, and community health workers.
- Dr. Stone shared promising models that improve outcomes for rural patients, including:
 - Technology systems that allow providers to screen for social needs and identify resources in communities
 - Accountable Care Organizations (ACOs) participating in Pathways to Success in the Medicare Shared Savings Program (MSSP) that show comparable or better outcomes with decreased costs compared with traditional FFS
 - Partnerships with doulas to offer information and support to pregnant women
 - Recruitment of nurse-midwives to provide first-line comprehensive maternity care that addresses SDOH
 - Advocating for distance learning to allow nurses who live in rural and underserved areas to remain in their communities during their graduate education, encouraging the growth of culturally and community concordant providers
- A few promising models have been implemented and sustained, including the hub-and-spoke model where larger hospitals partner with smaller hospitals that are at risk of closure and similar models in which hospitals develop clinics in high-need areas or partner with existing clinics. These models have shown success in bringing primary care closer to populations in need while leveraging the larger hospital for more serious medical needs.
- An APM can support patient-centered, multidisciplinary care in rural areas, because it allows providers to build a team and to address the SDOH of patients without time pressures incentivized by FFS reimbursement. A thoughtfully-implemented APM can facilitate team-based care, innovations in care delivery, and collaboration with advanced practice registered nurses (APRNs), physician assistants (PAs), and other allied health professionals.
- Patients in rural areas have higher morbidity, so it is important to operationalize and add social risk factor adjustments to traditional risk assessments that focus on medical complexity. Measurement should compare clinician performance and patient outcomes attributable to differences in quality of care.
- The heterogeneity of rural areas has particular implications for health care performance measurement. Measures must be flexible to account for variations in geography, population density, and availability of health care services so that providers are not penalized.

For additional details on Dr. Stone’s presentation, see the [presentation slides](#) (pages 99-112), transcript, and [meeting recording](#) (43:15-1:01:45).

Following the presentations, Committee members asked questions of the presenters. For more details on this discussion, see the transcript and [meeting recording](#) (1:01:50-1:29:55).

Dr. Herman discussed how Essentia’s revenue from value-based contracts is used to incentivize providers and in particular specialists.

- The capacity constraint within its rural health care system means that specialists are not providing unnecessary care even though they are compensated based on productivity. Additionally, Essentia shifted from providing incentives for quality to designing standards of work to make sure that quality care is delivered, leading to stronger performance and quality measures.

Presenters discussed how to address the imbalance between cardiovascular disease outcomes in rural and urban populations, reflecting both chronic disease and acute events, particularly given the low resources in rural hospitals.

- Some mortality ratios for cardiovascular disease will be higher in rural hospitals while building capacity within systems to recognize patients at risk, for example, through techniques such as virtual task practice.
- Identifying rising risk patients, such as those with diabetes and hypertension, and providing patient and family education can help improve outcomes and spread awareness across the community, as well as education for rural PCPs on guideline-directed medical therapy.
- Prevention is of critical importance with cardiovascular disease, with health care systems designed around prevention and recognition. Rural health systems cannot accept that there will be a lower standard of care and need to be designed and staffed to require a high standard of work.

Presenters discussed recommendations for financing and facilitating hub-and-spoke structures for community collaboration.

- Humility is the first requirement for any health care provider or health care system. Health care organizations in rural communities need to have conversations with and learn from partners in order to have a positive impact on the health of the community.
- Partnerships between CAHs and larger regional health care organizations can provide the additional funding and other resources, such as technology and leadership, to keep hospitals operating within communities.
- University systems and training institutions must be included in conversations about the health care workforce to ensure that there is a pipeline of willing and capable providers for community organizations. Additionally, incorporating funding and resources from non-traditional sources can help increase community investment and maintain provider pipelines.
- Disease management requires clearly defining the continuum of shared accountability for each diagnosis, in terms of the person providing the care. This continuum, once created, as a defined, reproducible infrastructure of care, would be achieved through buy-in from patients, caregivers, and clinical caregivers.

Dr. Herman discussed the proportion of Essentia's value-based revenue that comes from public and commercial payers.

- Essentia has developed some successful joint-accountability value-based programs with commercial providers, although the vast majority of revenue is from public programs. It is important to build relationships with payers and change the perspective to be more collaborative with value-based care.

Dr. Bhatt discussed remote monitoring opportunities beyond rhythm disturbances for targeted cardiac conditions.

- Remote blood pressure monitoring and cholesterol monitoring are two main areas of interest. Additional targeted investments and partnerships with specific monitoring companies will help fit remote monitoring into existing or reasonable new provider workflows and encourage the collaborative development of new technologies for atrial fibrillation, heart failure, hypertension, and low-density lipoprotein (LDL) cholesterol screening.

Presenters discussed messaging to encourage the progression to value-based care.

- Culture change is critical in the movement toward value-based care. By designing an organization around behaviors that align with value-based care, and measuring and reinforcing the right behaviors, organizational culture shifts to support value-based care.
- A focus on quality measures and accreditation based on quality measures ensures the provision of high-quality care regardless of payment type, with the hope that the culture will change to focus on value-based care rather than FFS.

Presenters discussed the glide path to risk to encourage rural providers' participation in APMs.

- It is important to question whether additional risk is necessary to change behavior. Some organizations are happy to take on upside and downside risk because they have the relevant infrastructure to support achievement in value-based quality measures, but other providers, particularly smaller providers, may not have the patient volume to maintain stable achievement on quality measures. It is important to use a toolkit of mechanisms to build standards that can be uniquely applied across the different types of rural health care providers to incentivize the right behaviors.
- The glide path needs to be measured. Quality measures need to be assessed within practices to build transparent outcomes and move toward value-based care. It is challenging for small practices to build such analytics; a solution could be a shared analytic toolkit.
- Cardiovascular risk scores can be included in patient electronic health records (EHRs) and adjusted and re-calculated based on changes to blood pressure and LDL. Scores can be leveraged by dietitians, nutritionists, and pharmacists, among others, as patient education, and teaching tools across the continuum of care. More clinicians need to know how to use these tools, and their use needs to be measured to understand their impact.
- Translating quality measures into actual lives saved helps encourage organizational alignment and emphasizes the tangible impacts of quality improvement.

Public Comment Period

Co-Chair Hardin opened the floor for public comments. The following individual made comments:

- Elizabeth Foster (Columbia Gorge Health Council)

Committee Discussion

Co-Chair Hardin opened the floor to Committee members to reflect on the day's presentations and discussions. The Committee members discussed the following topics. For additional details, please see the transcript and [meeting recording](#) (1:34:05-2:04:38).

- Hospitals and primary care practices need to be aligned for the rural health care system to continue to function. Currently, a lot of hospital staffing is outsourced to private enterprises.
- Payment models should be aligned across all payers because the Medicare or Medicaid population alone is not enough to support rural providers.
- Improving the rural health care system will require local and state and federal investments.
- Essentia's connections to its community have allowed it to improve performance metrics and build systems to deliver outcomes reliably.
- Data transparency is necessary for success in value-based payment models.
- It will be important to balance standardization and a degree of uniqueness or flexibility for future APMs to be effective in rural areas.
- It is important to consider how the time expectations of primary care and other providers are handled in reimbursement.

- The data and infrastructure to risk stratify on the front end are particularly important for rural areas.
- Payers should make team-based wraparound payments for CHWs and allied health professionals in a way to maintain budget neutrality.
- Cost savings are a secondary consideration when the financial viability and existence of rural hospitals and other providers are the primary concern.
- Models such as hub-and-spoke or Accountable Health Communities (AHC) should leverage resources and not expect rural hospitals to transform without extra support.
- Stable funding for rural hospitals to take different actions could help alleviate the reliance on patient volume for financial sustainability.
- State involvement to align quality measures would help reduce administrative burden for rural providers.
- Flexibility for home-based or alternative sites of care, and flexibility in telehealth, are particularly important for rural communities. Policies should be more concerned with health outcomes rather than how or where providers deliver those outcomes.
- Non-clinical staff and actions that improve value or HRSNs should be adequately reimbursed.
- There are essentially two health care systems in the United States—one for urban settings and one for rural settings—and each faces different challenges.
- Payment model redesign should feature team-based delivery models tailored to rural health.
- Staff and resource shortages could be addressed through telehealth and non-licensed health care workers, which could leverage more intensive primary care to decrease the need for specialty care. More efficient use of non-health or primary care resources could increase specialist capacity.
- Financing must be prioritized if the goal is value-based care.
- Providers are experiencing fatigue or burnout from ongoing changes at the margins, rather than having a clear timeline for significant change.
- The ideal care delivery model would feature high-touch, proactive, team-based care.
- There are likely unintended, unmeasured health disparities in rural America because of value-based care.
- Federal government agencies and programs that relate to health and health care could be arrayed and coordinated to help rural providers reduce inequality.
- There is a bipartisan, cross-governmental opportunity to address the economic, infrastructure, and human capital challenges facing rural communities.
- The concept of moving from volume to value is not applicable to the rural community construct regarding value-based care delivery and payment models.
- Aggregation of patients for attribution or risk methodology is the wrong approach.
- Risk-based models may not be necessary to change behavior. Rural providers already practice in an at-risk environment, considering that their patients are, on average, less healthy compared with urban areas.
- Financial viability is critical to foster a sustainable workforce and a network that support patients and providers.
- Keeping patients in their communities should be a priority, while escalating the level of care as needed.
- Because much of the costs of care delivery to rural communities is fixed, policies should focus on using existing resources more efficiently and effectively. Current payment structures are preventing health care systems from leveraging the resources that already exist in rural communities.
- Public-private partnerships are critical to seeking and implementing funding.
- A community-based ACO program could foster unique partnerships.

- CHWs are critical infrastructure.
- There is a lack of capital investment, community resources and partnerships, and data infrastructure.
- The issues with quality measurement that are seen in urban areas are magnified in rural areas.
- A less fragmented, well-functioning health care system would eliminate the need to have a rural ACO. An integrated system would connect urban and academic medical centers and their resources to rural hospitals, PCPs, and specialists. It is important to consider how such a model would be operationalized and integrated across diverse geographies in the United States.
- State-level resources should be integrated with other health care system resources.

Closing Remarks

Co-Chair Hardin announced that a Request for Input on the topic of encouraging rural participation in population-based TCOC models will be posted [online](#). Co-Chair Hardin adjourned the meeting.

The public meeting adjourned at 12:57 p.m. EDT.

Approved and certified by:

//Lisa Shats//

12/4/2023

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

Date

//Lauran Hardin//

12/4/2023

Lauran Hardin, MSN, FAAN, Co-Chair
Physician-Focused Payment Model Technical
Advisory Committee

Date

//Angelo Sinopoli//

12/4/2023

Angelo Sinopoli, MD, Co-Chair
Physician-Focused Payment Model Technical
Advisory Committee

Date