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

On September 19, 2023, the Physician Focused Payment Model Technical Advisory Committee (PTAC) requested input from the public on information that could describe current perspectives on rural participation in population based total cost of care (TCOC) models and physician focused payment models (PFPMs). PTAC has received five responses from the following stakeholders listed below:

1. Karen Leggett, DO
2. Jean Antonucci, MD
3. National Rural Health Association (NRHA)
4. American Association of Nurse Practitioners (AANP)
5. Rural Policy Research Institute Health Panel (RUPRI)

For additional information about PTAC's request, see PTAC's solicitation of public input.

From: Karen Leggett, DO <Karen.Leggett@archwellhealth.com>
Sent: Thursday, September 28, 2023 12:38 PM
To: PTAC (OS/ASPE) <PTAC@hhs.gov>
Subject: Request for input re: VBP models

To whom it may concern on the PTAC:

I am a geriatric physician who has practiced in a rural community from 2013-2014. Now I am practicing solely as a primary care physician for a company whose model is ONLY Value Based care.

In 2013 I agreed to take a position in rural northwest Maine based on having 15 minutes for sick visits, 30 minutes for each follow up patient and 1 hour for each new patient.

The clinic was associated with a critical care access hospital and a fee for service organization with government subsidies. As far as I knew they also accepted ALL patients regardless of ability to pay and also had some sort of sliding scale payment system for some patients who didn't have insurance or were able to pay something.

Anyway, they did give me the time promised and it went very smoothly. There was ample time to complete my work though it did take me (on my own time) about an hour or two extra per day to complete notes. Note that this is only because I spent ALL my time with patients during their visits and chose to do my work this way instead of charting during patient visits or spending lunch making call backs and documentation. I could have worked during lunch and documented during visits and gotten out earlier. This was my choice.

In any event, now I am practicing in a fully dedicated Value based system and have 1 hour for new patient visits, 40 minutes for complicated follow ups and 30 for regular follow ups and shorter time for a quick sick visit. So, all in all it's pretty much the same time between the two companies.

Value Based Care requires more focus on preventive screenings and following guidelines. That's all. If you REALLY examine the differences between what Fee for Service SHOULD be doing and what Value Based Care is - they aren't really that much different. You SHOULD be doing all the things in Fee for Service as you do in the VBC model. That's not the issue.

The PROBLEMS are far deeper than that. Doctors WANT to do the right thing for patients. But there are problems with **reimbursement and trust**. I will explain how we feel:

One of the problems is how at any moment Medicare can pull the rug out from under you. The second you agree to do something and start doing it... exactly as they have defined, they take something else away - or add something else - that makes things even more difficult to financially survive.

Let me give you an example. PAD (Peripheral Artery Disease) which is a very important condition that identifies FAR more than just PAD. Arteries are not just in the legs. They are everywhere - feeding every organ in your body including your heart and brain. And people don't just get isolated PAD. They get vascular disease in their heart vessels and vessels in their neck leading to their brain and in the brain itself. Screening for PAD and finding out that a person has PAD is a BIG deal. As a physician, I take PAD seriously because I know that I can identify PAD easily without an invasive or expensive study. In fact, we screen for it in our clinics. It helps us treat vascular disease EVERYWHERE. The diagnosis helps us manage potential heart attacks and strokes. The very things that cost Medicare a fortune.

PAD LAST year was a diagnosis that helped us in Primary care medicine with our risk adjustments in the VBC model. But THIS year it has been taken off of the list of diagnoses that risk adjust. What does that tell us?

And this example is just one of **many** HCC diagnoses that were taken off the 2024 list.

The second problem is that it takes MORE work to correctly code visits in a VB system. You may KNOW that the patient has Type 2 Diabetes with complications of PAD or peripheral neuropathy or macular degeneration or whatever - and code for all the diagnoses - BUT... if you do not pick the very right code - you will not code the visit properly to be adequately reimbursed under a VB system.

This causes physicians to be tied to "paperwork" instead of patient care.

There is one last problem as I see it. Primary Care physicians (I am board certified in Family Medicine and Geriatrics) work just as hard as any other specialty. Maybe harder. We require just as many support staff persons and buildings as any other doctor. Our overhead is NOT less than other specialists. But our salaries and opportunities are dwindling.

And... no one seems to care. Medicare is just making it harder and harder for Primary Care physicians to survive. Just look at the number of Primary Care residency positions that go unfilled each and every year. The number of physicians going into a primary care field like Family Medicine (and God knows even worse with Geriatrics) are continuing to decline year after year. No one wants to go into it. We are already at a major shortage of Primary Care physicians across the entire country. Not just rural areas! This is a SHAME and a very sad time

for patients and physicians alike.

And here's the key to that statement. It's not OUR fault! It's not the doctor's fault. It's not the company's fault - the companies that are trying to help like my company. It's the government's fault AND responsibility to FIX it.

But all we get is more and more threats (and ACTIONS) for continued lack of care, support and reimbursement.

With treatment by the very government agency that we are trying to help - what message does that send us? VB medicine is about keeping patients well and out of the hospital where the money gets absorbed. We do a good job at that - we have proven that VBC does exactly that. But what do we get in exchange?

More abuse.

We are left with distrust. Why does anyone want to change when we KNOW it's just a matter of time to be (once again) mistreated?

The problems do not lie with the doctor or the clinics. They are internal. Whoever is making the decisions to hurt Primary Care physicians and their employers are making very poor decisions.

Look after the Primary care physicians and their employers - THEN you will solve your problem of getting EVERYONE transitioned over to VBC. Take care of the companies who have already committed to VBC instead of giving them a message they are not important and supported - and you will solve the problem.

It's not rocket science. Do onto others as you would like to have done unto yourself. Reward those - ongoing reward - and you will receive YOUR reward in return.

Trust is critical. And doctors and clinics have learned they cannot trust whoever is making the decisions. It's a sad time for medicine in our country. I personally wanted to be a doctor since I was a little girl. I would not have stayed out of medicine under any circumstance. Even if payment was given in chickens and yard work. I have been practicing primary care medicine for 24 years. I am 64 years old. I plan to practice medicine as long as my body allows. I went to medical school after my child was in high school. I didn't go into medicine for the money. Thank goodness for that, because I would be very unhappy had that been my goal.

But you asked. And I'm telling you like it is. Plain and simple. Fix the problem with abuse to primary care physicians and you will get whatever you want. Treat us and the companies who

hire us with the respect and appreciation (money talks) so that Primary Care physicians can earn the money they deserve and the companies have the profit they deserve to hire and pay us to do exactly what we need to do - to keep patients healthy and out of the hospital - and you will get what you want.

You make that ONE change - and you will see the American Health Care system flourish. The truth is - the key is in the Primary Care physician's hands. Not the specialists. And THAT is why you want the rural clinics as well as ALL clinics to practice VBC. We SAVE the country money.

But... with the present mindset... I'm afraid our Health Care system is doomed.

Flourish or Fail. It's in the Primary Care Physicians' hands. And THAT is where the mistake lies. The people making the decisions don't believe that. Or if they do... they don't' care. You can't bite the hands that feed you. Eventually they are going to stop feeding. And truthfully, no one wants that. But our hands as physicians and companies who support VBC, are not the ones who can solve this problem.

Thank you.

Sincerely,

Karen Leggett DO

Request for Input on Rural Participation in Value-Based Care Models – October 20. The Physician-Focused Payment Model Technical Advisory Committee (PTAC), an independent federal advisory committee, seeks public input to inform their report to the Secretary with recommendations to encourage rural participation in value-based payment (VBP) models. They request information on what definitions of rural are most relevant for VBP, what are the needs of rural providers, what are the barriers to rural participation in VBP models, and what non-medical interventions do rural populations need. Send questions or comments to PTAC@HHS.gov.

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10/16/23

Thanks for letting folks respond. I was a panel participant in your recent meeting, but I feel so strongly about this issue that I am writing to reinforce some of what I said, and to add to what I said.

One of the PTAC members asked how you could have Value Based Care without financial risk. I tried to be polite. In fact, I wanted to jump up and down and scream that it's not a question we should even be asking. This is truly bizarre in capital letters I scream at you- physicians should not be asked to take insurance risk. This is wildly inappropriate, and some kind of dangerous Kool-Aid everyone has drunk.

Physicians have more than enough on their hands. We certainly cannot be responsible for the financial dysfunction of the current healthcare system. We have to beg to be paid and take plenty of risk, thank you, every time we walk into a room -for missing diagnoses or wrong diagnoses or in fact, because patients don't pay us, on and on. Physicians are taking financial risk due to the wash of the "somebody loses if somebody wins" in the MIPS program - how much more?

If you want to recruit physicians to rural areas, your best bet is to recruit medical students from those areas and to get medical students to take rotations in those areas; however, what you also need is for those physicians to have lots of professional connections -- to live in a small town with no other professionals, where the nearest medical society or hospital meeting is a 45 minute drive away in bad weather on difficult roads, becomes isolating. We already know physicians have a high rate of depression and suicide risk. Physicians in rural areas, need to have dentists and veterinarians in the town, also ophthalmologists. I found this out when I worked in Alaska - these are the things that you need and one way to do all this is have specialists visit the towns so that the psychiatrist comes one week the dentist, another. And so on.

Physicians in primary care need to be paid simply, we don't need any more models tested on us or more codes. Remember when everybody thought the chronic care code was just wonderful? Then we realized patient had to have TWO conditions and it had to be in a calendar month.

I'd like to tell you two stories. The chronic care code was something I used frequently, it was only about $40 but at least I got paid for managing say, someone's diabetes. I always submitted at the end of the month. I did it during early March once, and at the very end of March the patient was admitted and that's when CMS saw the bill. They refused my $40 payment, can you imagine the humiliation of that, I kept getting told -and I appealed it – but the people you appeal

to are some contractors in Florida who only repeat the same thing which is “the patient is not eligible for the service because she’s in the hospital.” She was not in the hospital when I provided the service -- pay attention to this kind of humiliation from CMS to doctors!

And finally, I saw a patient last week who is struggling mightily to stay clean - he’s one of my drug addict patients. He’s a very likable guy. He works a little bit but housing is a big issue and he is sharing a place with an alcoholic/drug abusing relative. The patient bought a new mattress and the relative brought someone home from the bar and had sex on the mattress and before you say ICK, as we were discussing how to move his life forward and what else we might do, a knock came on the exam room door, and a hand came in with a black bag. We partner with the Good Shepherd food bank, so the nurse was handing him the bag of food. They’re entitled to get one a week; that was my signal to reach for the brown paper bag, which I usually bring a few of to the office for vegetables that are extra from my garden. I asked him would he take these for me as a favor? I had carrots, onions, green beans, and potatoes. And he said oh my oh my this is wonderful I could make soup. I would really love to do that. I can go buy some chicken stock.

My question to you about this story is what metric would fit for what I did for him - how are you going to measure that he has no transportation so I haven’t been able to get his labs done so in fact, I’d be dinged for not getting a lipid profile done, but you tell me what metric measures this kind of care??

Value based care is a bunch of hogwash. Metrics should you should be very simple. The institute of medicine suggested some a few years ago; they should include simple things like does the patient carry a medication list?

Primary care needs to be capitated very simply and very fairly and I told you exactly how to do it.in my PTAC proposal. Please call upon me for any further help I can give you; some of us out here on the ground know exactly what needs to be done, and we have a little to no voice. Help us stay in the field.

J Antonucci MD

National Rural Health Association

Physician-Focused Payment Model Technical Advisory Committee
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U.S. Department of Health and Human Services
200 Independence Ave, S.W.
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Re: Encouraging Rural Participation in Population-Based Total Cost of Care Models Request for Information (RFI)

Dear Co-Chairs Hardin and Sinopoli and Members of the Committee,

The National Rural Health Association (NRHA) thanks the Physician-Focused Payment Model Technical Advisory Committee (PTAC) for the opportunity to weigh in on rural participation in total cost of care (TCOC) models. We appreciate the attention given to rural providers and the unique barriers and challenges that impact participation.

NRHA is a non-profit membership organization with more than 21,000 members nationwide that provides leadership on rural health issues. Our membership includes nearly every component of rural America's health care, including rural community hospitals, critical access hospitals, doctors, nurses, and patients. We work to improve rural America's health needs through government advocacy, communications, education, and research.

1. What definitions of "rural" areas are the most relevant for identifying the needs of rural patients, providers, and health care systems within the context of population-based total cost of care (PB-TCOC) models?

As PTAC notes, there are several federal definitions of rural, each used for different policy and programmatic purposes. There are four federal government agencies whose definitions of what is rural are in widest use: the U.S. Census Bureau, the Office of Management and Budget (OMB), the US Department of Agriculture (USDA) Economic Research Service (ERS), and the Federal Office of Rural Health Policy. Rural communities are diverse, and each has their own unique needs and challenges in health care, thus it is imperative to use an inclusive definition without over-including suburban or metro areas. While some definitions of rural are very broad, either overcounting the number of people in rural areas (i.e., Census Bureau) or undercounting them (OMB), several government agencies have created detailed and nuanced definitions of rural to inform rural-specific research, policies, and programs.

The Office of Management and Budget (OMB) defines a metro area as a core urban area with a population of 50,000 or more, and non-metro therefore is an area with less than 50,000. This definition uses county-level data which can misconstrue true rural areas because some counties may be geographically large with one urban center, resulting in that county being considered metro despite its overall low population density. Overall, this definition is inclusive and is most typically used in statutes and regulations to measure the rurality or urbanicity for hospital payment.[1] Additionally, many national health data sets use counties as core geographic units.

The USDA definition uses Rural-Urban Commuting area (RUCA) codes which provide a sub-county alternative to the OMB definition that takes functional relationships, population, and population

[1] 42 U.S.C. 1395w(d)(2)(D).

density into account. The taxonomy allows for better targeting and is adjustable to fit unique needs. The Federal Office of Rural Health Policy (FORHP) builds upon the OMB definition by using the non-metro definition and Rural-Urban Commuting Area (RUCA) codes to recategorize areas in metro counties as rural areas. It considers census tracts inside metro counties with the codes 4-10 as rural. Both the FORHP and OMB definitions are effective in identifying rural areas, while the FORHP definition specifically can distinguish among different kinds of rural areas and may be best for identifying rural needs.

Another important lens to consider is the definition of rural providers to be included in alternative payment models (APMs). Rural providers should be identified in two ways. First, rural safety net designations identify providers that are specific to providing care in rural areas. Rural designations include Rural Health Clinics (RHCs), Critical Access Hospital (CAHs), Rural Emergency Hospitals (REHs), Sole Community Hospitals (SCHs), Low-Volume Hospitals (LVHs), and Medicare Dependent Hospitals (MDHs). Second, PPS and FFS providers that are located in rural areas, but do not have a particular designation, should be captured as rural. These providers may not benefit from advantageous safety net payment structures but nonetheless face the same operational challenges as those that do.

2. What are the characteristics and health care needs of rural Medicare beneficiaries (demographics, chronic conditions, practice patterns, other factors)?

In general, rural populations are older, sicker, and poorer than their urban counterparts. This manifests as higher rates of chronic conditions,[2] obesity, health behaviors like smoking, alongside lower socioeconomic status, educational attainment, and health literacy. These factors all impact lower rural life expectancies and contribute to overall worse health outcomes, as compared to their urban and suburban counterparts.[3] As a result, rural beneficiaries would benefit from innovations in health care delivery like care coordination across the continuum, connection to community-based organizations (CBOs), preventive care services, chronic care management, among others. Yet rural beneficiaries live in a paradox where they need these services arguably more than some urban beneficiaries but do not have access to them due to decades of underinvestment in rural health care.

The primary social determinant of health (SDOH) that is unique to rural beneficiaries is transportation. Rural areas generally do not have public transportation and thus older or poorer beneficiaries that do not have cars or cannot drive are at a great disadvantage when seeking care. Even beneficiaries that are able to drive themselves or otherwise arrange for transportation have to travel on average twice as far as the typical urban resident to get medical care. Longer travel times are a well-documented disincentive to seeking care. In the event of a medical emergency, longer travel times to a hospital or emergency department or lack of robust EMS infrastructure can be a life-threatening situation.

Closely related to transportation is access to health care services. Over 160 rural hospitals have closed or lost inpatient services since 2010, including 25 in 2023. Of those, 14 hospitals have converted to REH since the model was launched in January, meaning that those communities have lost local access

[2] NATIONAL ADVISORY COMMITTEE ON RURAL HEALTH AND HUMAN SERVICES, *Social Determinants of Health*, January 2017, https://www.hrsa.gov/sites/default/files/hrsa/advisory-committees/rural/2017-social-determinants.pdf.
[3] Joel Achenbach, et al., *An Epidemic of Chronic Illness is Killing Us Too Soon*, THE WASHINGTON POST (Oct. 3, 2023), https://www.washingtonpost.com/health/interactive/2023/american-life-expectancy-dropping/?itid=hp-top-table-main_p001_f001.

to inpatient care, resulting in the need for transport for acute care needs. Further, workforce is a perennial challenge that impacts patients' access to care. Rural areas have about 10 physicians per 10,000 residents whereas urban areas have 31, showing the stark maldistribution of practitioners in rural vs. urban settings.[4] Specialty and subspecialty care are even less likely to be available. For older adults and Medicare beneficiaries specifically, there is a lack of rural home- and community-based services making these groups more reliant on informal caregivers or nursing homes. This reliance is threatened given that more than 500 nursing homes in the rural areas had either closed or merged between 2008 and 2018.[5]

Other SDOH are not wholly unique to rural beneficiaries but are exacerbated given geographic isolation or spread. Uninsurance rates are higher in rural areas (13%) than in metropolitan areas (10%), with people in rural areas also being more likely to have Medicaid coverage or subsidized Marketplace plans.[6] Rural populations have higher poverty rates than urban,[7] so when services not affordable or covered, rural beneficiaries may forgo care. Rural areas often have inadequate community infrastructure, more exposure to environmental risks like poor air or water quality, and less safe and healthy housing. Many of these disparities are related to the fact that more than half of rural counties are classified as persistent poverty counties.[8] Rural areas offer less healthy and affordable food options and about 12% of rural residents experiencing food insecurity.[9] Additionally, 16% of rural households participate in SNAP.[10]

4. What major programs, payment mechanisms, and other policies have sought to assist rural health care providers in serving rural communities and patients?

Rural hospitals and providers face many challenges including low patient volumes with high-fixed costs, heavy reliance on Medicare and Medicaid, workforce shortages, aging infrastructure, and a complex, high acuity patient population. Several rural safety net payment designations offer payment structures to help address challenges associated with operating in rural areas.

As previously mentioned, rural hospital payment designations include CAH, DSH, SCH, LVH, MDH, and REH. While there is a patchwork of designations, mostly for hospitals, each plays an important role in sustaining rural hospitals and consequently access to care –

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[4] RURAL HEALTH INFORMATION HUB, *Rural Healthcare Workforce*, (Feb. 2023), https://www.ruralhealthinfo.org/topics/health-care-workforce.

[5] Hari Sharma, et al., *Trends in Nursing Home Closures in Nonmetropolitan and Metropolitan Counties in the United States, 2008-2018*, RUPRI CENTER FOR RURAL HEALTH POLICY ANALYSIS, UNIVERSITY OF IOWA COLLEGE OF PUBLIC HEALTH (Feb. 2021), 2 https://rupri.public-health.uiowa.edu/publications/policybriefs/2021/Rural%20NH%20Closure.pdf.

[6] Timothy McBride, et al., *An Insurance Profile of Rural America: Chartbook*, RUPRI CENTER FOR RURAL HEALTH POLICY ANALYSIS, UNIVERSITY OF IOWA COLLEGE OF PUBLIC HEALTH (Oct. 2022), 4, https://rupri.public-health.uiowa.edu/publications/other/Rural%20Insurance%20Chartbook.pdf.

[7] America's Health Rankings, United Health Foundation, *Health Disparities Report 2021* (2021), 24, https://assets.americashealthrankings.org/app/uploads/2021_ahr_health-disparities-comprehensive-report_final.pdf#page=24.

[8] National Advisory Committee, *supra* note 1, at 3.

[9] Diane Whitmore Schanzenbach, *SNAP Supports Rural Families*, American Enterprise Institute (Apr. 2022), 1, https://www.aei.org/wp-content/uploads/2022/03/SNAP-Supports-Rural-Families.pdf?x91208.

[10] FOOD RESEARCH AND ACTION CENTER, *Rural Hunger in America: Supplemental Nutrition Assistance Program* (2018), 2, https://frac.org/wp-content/uploads/rural-hunger-in-america-snap-get-the-facts.pdf.

- CAHs were created to help pause a wave of rural hospital closures by increasing payments to rural hospitals at risk for financial distress and address the higher costs associated with providing care in a small community.
- DSH hospitals receive reimbursement to offset uncompensated care costs based upon their patient percentage which takes into account Medicare and Medicaid patient days. Rural areas see more residents that rely on Medicare and Medicaid for coverage, and less employer-sponsored coverage, thus many rural hospitals qualify for DSH payments.
- SCHs must be located at least 35 miles from other like hospitals or be located in a rural area and meet certain conditions related to market share and accessibility. SCHs often provide essential services that would otherwise be unavailable, such as trauma care and mental health services.
- LVHs receive payment adjustments to offset extremely low patient volumes compared to other hospitals. LVHs are typically smaller, government-owned, more geographically isolated, and have lower total and operating margins than other rural hospitals.[11]
- MDHs are rural hospitals with 100 beds or less and at least 60% of their inpatient days attributable to Medicare Part A. They receive additional payments if their costs are higher than what they would otherwise receive under the Inpatient Prospective Payment System (IPPS).
- The new REH provider type launched in January 2023. This designation is one option for struggling rural hospitals to remain open by ceasing inpatient services and receiving a special payment rate that is equal to the Outpatient Prospective Payment System rate plus 5% and additional monthly facility payments totaling $3.2 million for 2023. As mentioned above, 14 hospitals have converted this year so far.

RHCs are one critical component of the rural health safety net. Over 5,200 RHCs across 45 states provide vital access to primary care services to rural residents.[12] RHCs serve 37.7 million patients per year which is more than 11% of the entire population and over 60% of the 60.8 million Americans that live in rural areas.[13] RHCs are reimbursed at their all-inclusive rate (AIR), which was recently changed by the Consolidated Appropriations Act of 2021 and subsequent legislation. While the change brought a much-needed payment update for free-standing RHCs reimbursement, it has significant implications and unintended consequences on the provider-based RHC program in small rural hospitals.

Several CMS demonstrations and CMS Innovation Center (CMMI) models have attempted to assist rural providers in participating in value-based care (VBC). The Community Health Access and Rural Transformation (CHART) Model was a rural-specific model that CMMI ended early in September 2023 due to lack of hospital participation and feedback from stakeholders. The model aimed to implement health care delivery system redesign through innovative financial arrangements, operational flexibilities and regulatory flexibilities to address rural health disparities. Unfortunately, the failure of this model is indicative of the challenges with a larger effort to include rural in VBC. Ideally, rural would be integrated into broader VBC model frameworks with a rural specific track.

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[11] Rebecca G. Whitaker, G. Mark Holmes, and George H. Pink, *The Impact of the Low Volume Hospital (LVH) Program on the Viability of Small, Rural Hospitals*, NC RURAL HEALTH RESEARCH PROGRAM, CECIL G. SHEPS CENTER FOR HEALTH SERVICES RESEARCH, UNIVERSITY OF NORTH CAROLINA AT CHAPEL HILL (Oct. 2016), 1, https://www.shepscenter.unc.edu//wp-content/uploads/dlm_uploads/2016/10/Impact-of-LVH.pdf.

[12] NATIONAL ASSOCIATION OF RURAL HEALTH CLINICS, 60% of Rural Americans Served by Rural Health Clinics (Apr. 7, 2023), https://www.narhc.org/News/29910/Sixty-Percent-of-Rural-Americans-Served-by-Rural-Health-Clinics.

[13] *Id.*

5. What are the major barriers that affect rural providers' participation in APMs?

Fee-for-service (FFS) reimbursement does not align with the reality of operating rural hospitals and providers, mainly due to high unit costs spread over low patient volumes. VBC models or APMs have the potential to solve for rural low-volume challenges that come along with FFS payment while also improving quality. However, these models, particularly those created by CMMI have struggled to properly include rural providers. Many barriers to entry into APMs are structural.

Many VBC or APM designs are built with the average, urban or suburban, provider in mind. This one-size-fits-all approach is problematic because it does not consider the unique challenges that set rural providers and patients apart from other populations. Conditions described below, including cost savings requirements, assumption of down-side risk, and minimum attributable lives can all create barriers for rural providers. Further, unique payment methodologies for rural providers frequently lead to avoidance of inclusion (as in an accountable care organization [ACO] model) or complete exclusion from participation (as in the case of RHCs in the new Making Care Primary model).

The objective of APMs and innovative models is to achieve cost savings, while increasing access and quality. The CMMI statutory requirement for demonstrated cost savings is a disadvantage to rural providers who frequently operate on slim to negative margins. It is virtually impossible for many rural providers to meet the Congressional charge of achieving cost savings in short timeframes. Rural areas face generations of systemic underfunding, tying back to issues of health equity, combined with the dearth of social service infrastructure. This will likely mean that initial costs may increase, if not remain at the same level, given increases in access to better care for a population that has been long deprived. However, over time the costs will decline which generates savings if reasonable timelines are established. Therefore, extended timeframes to allow for care transformation are critical to achieve desired outcomes.

Concerns around cost of participation for rural providers in APMs and VBC models is twofold. First, many rural providers are not able to assume risk where required for certain shared savings or ACO models. Hospitals may have a higher tolerance for risk than other providers because of their ability to potentially cut costs in other areas. Other providers like RHCs are even less risk tolerant because they are often small, physician-run clinics. Simply put, rural providers don't have the capital to afford downside risk, nor the capacity to analyze what the exposure would be. Research indicates that rural providers may have a higher risk tolerance if the following considerations are taken: inclusions of rural relevant measures and stop-loss or outlier protections, as well as opportunities to receive technical assistance, education, and to learn from peers.

Outside of assuming down-side risk, a second issue is the cost of participating in a model and meeting the requirements. Rural hospitals are generally poorly capitalized and underfunded, so there is no flexibility or resources to draw upon when the hospital has a down year or needs upfront money for investing in an APM. Again, RHCs and other clinics are in an even worse position to do so. Rural providers need significant financial incentives to participate in APMs and overcome cost prohibitive requirements. For example, rural providers are less likely to have adequate health information technology (HIT) needed to participate or do not have the resources to comply with data and reporting requirements. Upfront incentives are necessary to get rural providers involved in APMs.

Another common barrier that uniquely affects rural providers is the required number of attributable lives or beneficiaries. For most models, like ACOs, the ACO must have a minimum number of covered lives. This is a structural barrier to participation due to the nature of rural areas being more sparsely

populated. In some states, like Washington, rural hospitals have come together to develop a network to meet the minimum number of covered lives and participate in ACO REACH, yet this is still not completely inclusive of rural providers. RHCs and rural FQHCs frequently do not have the same administrative sophistication as hospitals to understand the complexities of joining an ACO or a statewide arrangement.

Given the unique circumstances facing rural providers and beneficiaries, flexibility should be built in to adjust models based on new information as the transition progresses. Rural hospitals need to have a better understanding of waivers available to them as participants in an APM. ACO Investment Model (AIM) participants were able to apply for waivers to Medicare rules and regulations that impeded their ability to coordinate care on behalf of the beneficiaries they served. Further, transition to programs that continue successful parts of the model or allow a smooth transition to model substitution is critical in order to maintain continuity of care transformation. Many rural providers participating in the Comprehensive Primary Care+ model were disillusioned when the model ended without a path for continuation, thus pulling back from future engagement in VBC efforts.

Relatedly, future models focused on Medicare beneficiaries must be responsive to the growth of Medicare Advantage (MA). This year the number of beneficiaries enrolled in MA surpassed Traditional Medicare nationally.[14] This trend is reflected in rural areas as well. The growth rate in MA enrollment has been higher in nonmetropolitan counties compared to metropolitan counties.[15] For CMMI and Medicare demonstration programs, only Traditional Medicare beneficiaries are counted as attributable beneficiaries or covered lives. As more beneficiaries switch to or enroll in MA plans this will continue to impact not only provider entry into some APMs due to minimum thresholds but also beneficiaries' ability to benefit from enhanced services offered through participation in an APM. Since MA beneficiaries are outside of most accountable care arrangements, the trend in MA growth will begin to make APMs less effective models.

8. How do rural-specific issues affect care coordination, specialty integration, and care transition management?

Rural communities tend to have less resources than urban areas for a multitude of reasons including a smaller population and historic underinvestment. Consequently, care coordination, specialty integration, and care transition management can be difficult to implement. When there are less resources in the community, such as CBOs to address SDOH or home- and community-based services for aging populations, coordinating care across the continuum is not possible. Referrals, whether to a specialist, a CBO to help with a patient's SDOH, or post-acute care discharge can be challenging for rural providers when access to all three areas is limited.

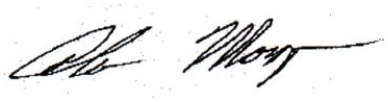
NRHA again thanks PTAC for its focus on rural participation in APMs. We look forward to the Committee's work on this issue and encourage PTAC to use NRHA as a resource in this work. Please

[14] Nancy Ochieng, et al., *Medicare Advantage in 2023: Enrollment Update and Trends*, KAISER FAMILY FOUNDATION (Aug. 9, 2023), https://www.kff.org/medicare/issue-brief/medicare-advantage-in-2023-enrollment-update-and-key-trends/.

[15] Edmer Lazaro, Fred Ullrich, and Keith Mueller, *Medicare Advantage Enrollment Update 2022,* RUPRI CENTER FOR RURAL HEALTH POLICY ANALYSIS, UNIVERSITY OF IOWA COLLEGE OF PUBLIC HEALTH (Jan. 2023), 1, https://rupri.public-health.uiowa.edu/publications/policybriefs/2023/Medicare%20Advantage%20Enrollment%20Update%202022.pdf.

contact NRHA's Regulatory Affairs Manager, Alexa McKinley (amckinley@ruralhealth.us), with any questions or for further information.

Sincerely,



Alan Morgan
Chief Executive Officer
National Rural Health Association

October 18, 2023

Physician-Focused Payment Model Technical Advisory Committee

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

To Whom it May Concern,

The American Association of Nurse Practitioners (AANP), representing more than 355,000 nurse practitioners (NPs) in the United States, appreciates the opportunity to comment on this request for information (RFI). We thank the Physician-Focused Payment Model Technical Advisory Committee (PTAC) for its' focus on improving participation in population-based total cost of care models in rural communities. It is critical that these models fully integrate and recognize nurse practitioners who are providing vital services in these communities and will continue to have a key role in improving value-based care participation. We look forward to working with PTAC to develop sustainable models that will improve access to accountable care relationships in rural areas.

As you know, NPs are advanced practice registered nurses (APRNs) who are prepared at the masters or doctoral level to provide primary, acute, chronic and specialty care to patients of all ages and backgrounds. Daily practice includes assessment; ordering, performing, supervising and interpreting diagnostic and laboratory tests; making diagnoses; initiating and managing treatment including prescribing medication and non-pharmacologic treatments; coordinating care; counseling; and educating patients and their families and communities. NPs hold prescriptive authority in all 50 states and the District of Columbia (D.C.) and perform more than one billion patient visits annually. Currently, twenty-seven states, the District of Columbia and two U.S. territories have adopted full practice authority (FPA), granting patients full and direct access to nurse practitioners.[1]

NPs practice in nearly every geographic region and health care setting including hospitals, clinics, Veterans Health Administration and Indian Health Services facilities, emergency rooms, urgent care sites, private physician or NP practices (both managed and owned by NPs), skilled nursing facilities (SNFs) and nursing facilities (NFs), schools, colleges and universities, retail clinics, public health departments, nurse managed clinics, homeless clinics, and provide the most home-based care to Medicare beneficiaries.

Nurse practitioners provide a substantial portion of the high-quality[2], cost-effective[3] care that our communities require. As of 2021, there were over 193,000 NPs billing for Medicare services, making NPs the largest and fastest growing Medicare designated provider specialty.[4] Approximately 42% of Medicare patients receive billable services from a nurse practitioner[5], and approximately 80% of NPs are seeing Medicare and Medicaid patients.[6] According to the Medicare Payment Advisory Commission (MedPAC), APRNs and PAs comprise approximately one-third of our primary care workforce, and up to half in rural areas.[7]

[1] https://www.aanp.org/advocacy/state/state-practice-environment.
[2] https://www.aanp.org/images/documents/publications/qualityofpractice.pdf.
[3] https://www.aanp.org/images/documents/publications/costeffectiveness.pdf.
[4] data.cms.gov MDCR Providers 6 Calendar Years 2017-2021.
[5] *Ibid*.
[6] NP Fact Sheet (aanp.org)
[7] https://www.medpac.gov/wp-content/uploads/2022/06/Jun22_MedPAC_Report_to_Congress_SEC.pdf (see Chapter 2).

NPs are a significant part of the health care workforce in rural areas and areas of lower socioeconomic and health status. As such, they understand the barriers to care that face vulnerable populations daily.[8],[9],[10] They are also "significantly more likely than primary care physicians to care for vulnerable populations. Nonwhites, women, American Indians, the poor and uninsured, people on Medicaid, those living in rural areas, Americans who qualify for Medicare because of a disability, and dual-eligibles are all more likely to receive primary care from NPs than from physicians."[11] According to HRSA, in 2022 there were over 12,000 FTE NPs in community health centers, who performed over 25 million in-person clinic visits, and almost 4 million virtual visits, more than any other individual clinician group.[12] NPs also represent the largest discipline within the National Health Service Corps (NHSC) with approximately 5,400 clinicians, and NPs "fill a critical need for primary care where shortages exist throughout the country."[13] According to the Government Accountability Office (GAO), in FY 2020 NPs were the most common type of NHSC clinician to receive funding to work at an NHSC site.[14]

MedPAC's 2022 beneficiary survey found that "[a]mong both Medicare beneficiaries and privately insured people, higher shares of rural and low-income respondents reported receiving most or all of their care from an NP or PA", which was one of the few substantive differences they found between rural and urban beneficiaries.[15] MedPAC also found that, among all clinician types, NPs on average had the highest share of allowed charges associated with low-income subsidy (LIS) beneficiaries, which includes Medicaid beneficiaries. "In 2019, 41 percent of the allowed charges billed by NPs who practiced in primary care were for LIS beneficiaries, as were 36 percent for NPs who practiced in specialty care compared with 28 percent for primary care physicians and PAs and 25 percent for specialty care physicians and PAs."[16] A 2019 study of Medicaid participation of buprenorphine waivered providers in Virginia found that buprenorphine waivered NPs were more likely to treat Medicaid patients compared to physicians and the probability of an NP treating a large number of Medicaid patients was higher among NPs relative to physicians.[17] A recent study published in *Health Affairs* also found that from 2011-2019 the number of psychiatric-mental health NPs (PMHNPs) treating Medicare beneficiaries grew by 162%, compared to a 6% drop in psychiatrists during that same period.[18] The study also found that the proportion of all mental health prescriber visits provided by PMHNPs to Medicare beneficiaries increased from 12.5% to 29.8% during that same period, exceeding 50% in rural, full practice authority regions.[19]

A GAO report on rural hospital closures also found that "from 2012 to 2017, the availability of all physicians declined more among counties with [rural hospital] closures (16.2 percent) compared to counties without closures (1.3 percent)" whereas "[c]ounties with rural hospital closures experienced a greater increase in the availability of advanced practice registered nurses (61.3 percent), compared to

[8] Davis, M. A., Anthopolos, R., Tootoo, J., Titler, M., Bynum, J. P. W., & Shipman, S. A. (2018). Supply of Healthcare Providers in Relation to County Socioeconomic and Health Status. Journal of General Internal Medicine, 4–6. https://doi.org/10.1007/s11606-017-4287-4.

[9] Xue, Y., Smith, J. A., & Spetz, J. (2019). Primary Care Nurse Practitioners and Physicians in Low-Income and Rural Areas, 2010-2016. Journal of the American Medical Association, 321(1), 102–105.

[10] Andrilla, C. H. A., Patterson, D. G., Moore, T. E., Coulthard, C., & Larson, E. H. (2018). Projected Contributions of Nurse Practitioners and Physicians Assistants to Buprenorphine Treatment Services for Opioid Use Disorder in Rural Areas. Medical Care Research and Review, Epub ahead. https://doi.org/10.1177/1077558718793070

[11] https://www.aei.org/research-products/report/nurse-practitioners-a-solution-to-americas-primary-care-crisis/

[12] https://data.hrsa.gov/tools/data-reporting/program-data/national/table?tableName=5&year=2022.

[13] https://public3.pagefreezer.com/browse/HHS.gov/30-12-2021T15:27/https:/www.hhs.gov/about/news/2021/11/22/hhs-announces-record-health-care-workforce-awards-in-rural-underserved-communities.html.

[14] https://www.gao.gov/assets/gao-21-323.pdf.

[15] https://www.medpac.gov/wp-content/uploads/2023/03/Mar23_MedPAC_Report_To_Congress_SEC.pdf, at page 116.

[16] *Ibid.* at page 135.

[17] Saunders, Heather, et.al (2022). Medicaid Participation Among Practitioners Authorized to Prescribe Buprenorphine. *Journal of Substance Abuse Treatment*, Epub. https://pubmed.ncbi.nlm.nih.gov/34148758/.

[18] Cai, Arno, et.al (2022). Trends in Mental Health Care Delivery by Psychiatrists and Nurses Practitioners in Medicare, 2011-2019. *Health Affairs*, 41(9), 1222-1230. https://www.healthaffairs.org/doi/full/10.1377/hlthaff.2022.00289

[19] *Ibid.*

counties without closures (56.3 percent)."[20] The data above highlights the significant and positive impact NPs have on access to care in rural and underserved communities. Below are our specific recommendations in response to feedback requested in this RFI. **AANP is committed to working with PTAC as it develops recommendations on improving value-based care participation in rural and underserved communities and respectfully requests that PTAC ensure that NPs are recognized for the work that they are doing in these communities and included throughout any model recommendations.**

What major programs, payment mechanisms, and other policies have sought to assist rural health care providers in serving rural communities and patients?

Remove Federal Barriers to Care on Nurse Practitioners

Health care workforce shortages are prevalent across the country, and it is important that we maximize the efficiency of our current health care workforce by enabling clinicians to practice to the full extent of their education and clinical training. Removing federal barriers that prevent NPs from practicing to the full extent of their education and clinical training has garnered widespread bipartisan support. In addition to bipartisan support in Congress, reports issued by the American Enterprise Institute,[21] the Brookings Institution,[22] the Federal Trade Commission,[23] the World Health Organization[24] and the U.S. Department of Health and Human Services under multiple administrations[25,26,27] have all highlighted the positive impact of removing barriers on NPs and their patients. Value-based care models are an important opportunity to remove outdated practice barriers that result in delays in care, duplicative services, and which do not promote efficient, high-quality health care.

This recommendation is consistent with the National Academy of Medicine (NAM) *Future of Nursing Report 2020-2030: Charting a Path to Achieve Health Equity* which recommended that "all relevant state, federal and private organizations enable nurses to practice to the full extent of their education and training by removing practice barriers that prevent them from more fully addressing social needs and social determinants of health and improve health care access, quality, and value."[28] Removing barriers to practice on NPs has been demonstrated to increase access to necessary health care in rural and underserved communities. For example, after the passage of the *Comprehensive Addiction and Recovery Act of 2016* (CARA), studies found that NPs increased access to medication-assisted treatment in rural and underserved communities. One study found that NPs and PAs were the first waivered providers in hundreds of rural counties, representing millions of individuals.[29] The Medicaid and CHIP Payment and Access Commission also found that the number of NPs prescribing buprenorphine for the treatment of opioid use disorder (OUD), and the number of patients with OUD treated with buprenorphine by NPs increased substantially in the first year they were authorized to obtain their Drug Addiction and Treatment Act waiver, particularly in rural areas and for Medicaid beneficiaries.[30]

An example of a model that has encouraged participation and streamlined care delivery by removing barriers to practice is the ACO REACH Model. Within ACO REACH, the Innovation Center offered a

[20] https://www.gao.gov/assets/gao-21-93.pdf.
[21] https://www.aei.org/wp-content/uploads/2018/09/Nurse-practitioners.pdf.
[22] https://www.brookings.edu/wp-content/uploads/2018/06/AM_Web_20190122.pdf.
[23] https://www.aanp.org/advocacy/advocacy-resource/ftc-advocacy.
[24] https://apps.who.int/iris/bitstream/handle/10665/331673/9789240003293-eng.pdf
[25] https://www.hhs.gov/sites/default/files/Reforming-Americas-Healthcare-System-Through-Choice-and-Competition.pdf
[26] https://aspe.hhs.gov/pdf-report/impact-state-scope-practice-laws-and-other-factors-practice-and-supply-primary-care-nurse-practitioners.
[27] https://www.cms.gov/About-CMS/Agency-Information/OMH/Downloads/Rural-Strategy-2018.pdf.
[28] https://www.nap.edu/resource/25982/FON%20One%20Pagers%20Lifting%20Barriers.pdf
[29] https://www.healthaffairs.org/doi/abs/10.1377/hlthaff.2019.00859.
[30] https://www.macpac.gov/publication/analysis-of-buprenorphine-prescribing-patterns-among-advanced-practitioners-in-medicaid/.

Nurse Practitioner Services benefit enhancement, which is designed to "allow ACOs to increase flexibility in care delivery, improving care coordination for their aligned beneficiary populations."[31] The NP services benefit enhancement removes many of the traditional barriers to NP care within the Medicare program, including authorizing NPs to order diabetic shoes, establish, review, and sign a written care plan for cardiac and pulmonary rehabilitation, certify a beneficiary's need for hospice care, establish, review, sign, and date a home infusion therapy plan of care, and refer for medical nutrition therapy. The Innovation Center notes that this Benefit Enhancement will "capitalize on established relationships between a beneficiary and a NP to reduce impediments to better coordinate care for beneficiaries and bridge potential gaps in coverage to provide more equitable access to health care."[32] CMS described the benefit enhancement as one of five policies introduced in ACO REACH to promote health equity and itis "expected to reduce disparities in health such that those with the greatest needs and least resources receive the care they need."[33] **AANP strongly recommends that the NP Services Benefit Enhancement and other similar benefit enhancements be made available throughout all new and existing payment models.**

What are the major barriers that affect rural providers' participation in APMs?

Patient Attribution

As PTAC considers supporting new value-based care models, it is important that these models have maximum flexibility to utilize participating clinicians in the manner best suited to meet their patients' needs. Research has shown the positive impact of increased involvement of NPs in ACOs. As noted in the Innovation Center's strategic direction, CMS has established a goal of having 100 percent of Medicare fee-for-service (FFS) beneficiaries and the vast majority of Medicaid beneficiaries in an accountable care relationship by 2030.[34] Nurse practitioners play an increasingly critical role in this transition. A recent GAO report, entitled *"Medicare: Information on the Transition to Alternative Payment Models by Providers in Rural, Health Professional Shortage, or Underserved Areas"* notes that after physicians, the next most common type of providers participating in Advanced APMs, regardless of location, are advanced practice providers, including nurse practitioners.[35] The July 2023 data book on *Health Care Spending and the Medicare Program* released by the Medicare Payment Advisory Commission (MedPAC) states that 30% of beneficiaries in MSSP ACOs were attributed to "nonphysician practitioners."[36] Additionally, the report notes that among clinicians who qualified for an A–APM (advanced alternative payment model) bonus in 2022, 39 percent were "nonphysician practitioners" such as nurse practitioners or physician assistants.[37]

A recent study, entitled *"The Impact of Nurse Practitioner Care and Accountable Care Organization Assignment on Skilled Nursing Services and Hospital Readmissions"*, also highlighted the high-quality of care provided by NPs in ACOs. The study found that "greater participation by the NPs in care delivery in SNFs was associated with a reduced risk of patient readmission to hospitals. ACOs attributed beneficiaries were more likely to obtain the benefits of greater nurse practitioner involvement in their care."[38] The article states that "[p]atients receiving E&M care from nurse practitioners in SNFs were less likely to experience hospital readmission than beneficiaries with no E&M care delivered by nurse

[31] ACO Realizing Equity, Access, and Community Health (REACH) Model Request for Application (cms.gov)
[32] Ibid
[33] ACO REACH | CMS Innovation Center
[34] Strategic Direction | CMS Innovation Center
[35] GAO-22-104618, MEDICARE: Information on the Transition to Alternative Payment Models by Providers in Rural, Health Professional Shortage, or Underserved Areas (Page 19)
[36] July2023_MedPAC_DataBook_SEC.pdf
[37] Ibid.
[38] Meddings, J. Gibbons, JB, Reale, BK, et.al, The impact of nurse practitioner care and accountable care organization assignment on skilled nursing services and hospital readmissions. Med Care. 2023; 61:341-348

practitioners"[39] and concludes that "increasing nurse practitioner care delivery in SNFs could help to improve outcomes for older adults receiving post-acute care."[40]

While most Innovation Center models recognize the importance of NPs to value-based care programs and fully include them in the attribution methodology, the Medicare Shared Savings Program (MSSP) continues to have a limitation that prevents NPs' patients from being fully attributed to the program. According to CMS' own analysis, this has limited the participation of low-income patients and patients in rural and underserved communities in the MSSP. In conversations AANP has had with ACOs— particularly those who care for complex patient populations, serve rural and underserved communities, and deliver home-based care— they relayed that not fully including NPs in the current MSSP assignment methodology hinders their ability to participate in the program due to the difficulty in having all their patients obtain a physician visit. This disparity highlights the importance of ensuring that NPs are fully included in the attribution process for new and existing care models in order to achieve the goal of increasing access to value-based care in rural communities. **It is imperative that as PTAC makes recommendations to increase access to value-based care in rural communities, a component of these recommendations is to develop models that fully include NPs and integrate their patients into the attribution methodologies.**

The MSSP barrier referenced above is that the claims-based beneficiary assignment pathway still requires a patient to receive at least one primary care service from a primary care physician each year for the patient to be assigned to an ACO. While this restriction does not prevent NPs from joining MSSP ACOs, it prevents their patients from being assigned to an MSSP ACO through claims-based assignment and any benefits that result from such participation, unless the NPs send their patients to receive a primary care service from a primary care physician. This results in either unnecessary utilization of services or reduced participation in the MSSP, both of which are contrary to the intent of the MSSP.

In its *Fiscal Year 2021 Budget in Brief*, the U.S. Department of Health and Human Services estimated that basing MSSP ACO assignment on a broader set of primary care providers, including nurse practitioners, would better reflect our current primary care workforce and lead to $80 million in savings for the Medicare program over ten years.[41] In the Calendar Year 2024 Medicare PFS proposed rule, CMS has proposed to update the beneficiary assignment methodology to better account for patients seen by NPs, which according to CMS would support access to the MSSP for underserved beneficiaries, including those who are disabled, low-income subsidy (LIS), and who reside in areas with higher area deprivation index (ADI) scores.[42] As CMS has recognized, these patients have been historically underrepresented in the MSSP. Patients in these categories often benefit the most by entering an accountable care relationship, and it is a matter of equity that they be able to do so. Including NPs in the attribution methodology across all models is an important step to ensuring that patients in rural and underserved areas have access to the benefits associated with value-based care programs.

Reimbursement Challenges

As noted in the NAM *The Future of Nursing* report, "Payment reform can help improve population health, address social needs and [social determinants of health], reduce health disparities, supporting the provision of effective, efficient, equitable, and accessible care for all across the care continuum instead of incentivizing the volume of care or low value procedures and practices."[43] Value-based programs are essential to reforming historical payment inequities for NPs, such as being reimbursed at 85% of the

[39] *Ibid.*
[40] *Ibid.*
[41] https://www.hhs.gov/sites/default/files/fy-2021-budget-in-brief.pdf (page 84).
[42] 88 FR 52443.
[43] The Future of Nursing 2020-2030 | National Academies P.148

Medicare Physician Fee Schedule (PFS), with many State Medicaid programs and private insurers also reimbursing NPs at a reduced rate.

Evidence has shown that increasing reimbursement for NPs (along with removing State barriers to practice) can improve access to care. A 2016 study of Medicaid programs found that, "NPs had 13% higher odds of working in primary care in states with full scope of practice; those odds increased to 20% if the state also reimbursed NPs at 100% of the physician Medicaid fee-for-service rate. Furthermore, in states with 100% Medicaid reimbursement, practices with NPs had 23% higher odds of accepting Medicaid than practices without NPs. Removing scope of practice restrictions and increasing Medicaid reimbursement may increase NP participation in primary care and practice Medicaid acceptance."[44] Addressing historic payment inequities, as well as barriers to practice, is an effective way to increase the ability of NPs to meet the health care needs of rural and underserved communities and incentivize participation in value-based care models.

These payment disparities are also often even more acute in rural areas because currently, under Section 1833(m) of the Social Security Act, Medicare pays a 10% bonus to physicians who provide medical services in primary medical care Health Professional Shortage Areas (HPSAs), and psychiatrists receive a 10% bonus for services provided in mental health HPSAs.[45] However, nurse practitioners (and other clinicians) providing the same services in the same communities are not eligible for these bonuses. Since NPs are reimbursed at only 85% of the Medicare PFS, this means that they can face up to 25% payment disparities in underserved communities relative to their physician colleagues.

As PTAC evaluates payment methodologies in new and existing models, it is important that value-based models equitably reimburse providers regardless of their licensure based on the quality and level of care that is provided. Advancing health care equity for patients must also include equity for health care providers. **We strongly encourage PTAC to recommend that the payment aspects of value-based care models, whether those be linked to fee-for-service, quality bonuses prospective population-based payments, shared savings, or other, not be differentiated based on a clinician's licensure.** Addressing these payment disparities, and reimbursing clinicians equitably for the services that they provide, will enable NPs to continue to deliver the high-quality care patients deserve, particularly in rural and underserved communities.

AANP also supports models including prospective population-based primary care payments. In March, AANP in conjunction with the Primary Care Collaborative and 25 other organizations sent a letter to CMS advocating for this approach within the MSSP.[46] **We reiterate our support for this prospective payment option within applicable models and look forward to working with PTAC to continue to support the participation and success of primary care practices within advanced payment models.**

[44] H. Barnes, C.B. Maier, et al., "Effects of Regulation and Payment Policies on Nurse Practitioners' Clinical Practices," 74(4): 431-451, May 13, 2016. https://www.ncbi.nlm.nih.gov/pmc/articles/PMC5114168/

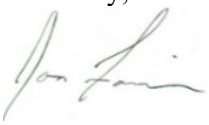
[45] https://www.cms.gov/medicare/payment/fee-for-service-providers/physician-bonuses-health-professional-shortage-areas-hpsas.

[46] https://thepcc.org/sites/default/files/news_files/PCC%20NAACOS%20Sign%20On%20Letter%203.22.23%20FINAL_0.pdf.

Conclusion

AANP thanks the PTAC for its consideration of these comments and looks forward to working with PTAC to ensure patients in rural and underserved communities have access to high-quality health care from their provider of choice in value-based care models. Should you have comments or questions, please direct them to MaryAnne Sapio, V.P. Federal Government Affairs, msapio@aanp.org, 703-740-2529.

Sincerely,



Jon Fanning, MS, CAE, CNED
Chief Executive Officer
American Association of Nurse Practitioners

RURAL POLICY RESEARCH INSTITUTE
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Keith J. Mueller, PhD, Chair
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October 23, 2023

Physician-Focused Payment Model Technical Advisory Committee
Office of the Assistant Secretary for Planning and Evaluation
Encouraging Rural Participation in Population-Based Total Cost of Care Models Request for Information
By electronic submission at: PTAC@HHS.gov

Dear Members of the Committee,

The Rural Policy Research Institute Health Panel (RUPRI) was established in 1993 to provide science-based, objective policy analysis to federal lawmakers. The panel is pleased to offer comments and resources in response to the PTAC Request for Information (RFI) regarding rural participation in population-based total cost of care models. The following RUPRI sources are grouped by the RFI's questions to the public.

1) What definitions of "rural" areas are the most relevant for identifying the needs of rural patients, providers, and health care systems within the context of population-based total cost of care (PB-TCOC) models?
   We encourage the Committee to consider rural definitions consistent with others used in federal programs. We refer the committee to our recommendations for defining rural, in pages 11 – 12 of this document:
   - Considerations for Defining Rural Places in Health Policies and Programs

2) What are the characteristics and health care needs of rural Medicare beneficiaries (demographics, chronic conditions, practice patterns, other factors)?
   The RUPRI Health Panel offers suggestions for addressing population in rural places:
   - Advancing Population Health in Rural Places: Key Lessons and Policy Opportunities

3) What are the characteristics and care delivery needs of rural providers (e.g., practice size, specialty, care delivery and coordination infrastructure, etc.)?
   We call attention to the Health Panel's emphasis on primary care as a foundation of a High Performing Rural Health System. We have offered policy considerations to bolster primary care in rural places, page 14 of this document:
   - Primary Care: The Foundation for a High Performance Rural Health Care System

4) What major programs, payment mechanisms, and other policies have sought to assist rural health care providers in serving rural communities and patients?

We encourage the Committee to consider lessons learned from the Frontier Extended Stay Clinic demonstration, the Frontier Community Health Integration Program, and the Advanced Investment Model in the Medicare Shared Savings Program, now being integrated into the program as an option for new entrants. The RUPRI Health Panel published a summary of progress made in various programmatic efforts initiated as a result of the Patient Protection and Affordable Care Act:

- Taking Stock: Policy Opportunities for Advancing Rural Health

The Panel, with Dr. MacKinney as the lead author, has also set forth a proposal to modify hospital payment in the Medicare Flex Program:

- Modernizing payment to critical access hospitals: A Proposal for the next iteration of the Flex Program.

5) What are the major barriers that affect rural providers' participation in APMs?
   a. *Criteria affecting rural participation*: Attributable population size is especially challenging when restricted to a specific program such as Medicaid (Accountable Health Communities) or Medicare (Accountable Care Organizations). Rather than a predetermined minimum population, applications to new programs could be required to show how they will assess success, including the number of enrollees they expect and how that number is sufficient to judge success.
   b. *Address rural providers' lack of external support:* No comment.
   c. *Focus on specific type of rural provider:* The Panel believes that rather than identifying a particular provider type, programs should be sure they do not explicitly or implicitly exclude any provider type (Making Care Primary explicitly excludes Rural Health Clinics).
   d. *Issues affecting participation of FQHCs and RHCs in population-based models*: A principal reason these providers may not participate in new models is that the payment design would result in a loss of revenue as compared with their current payments, particularly Medicare and Medicaid payment.
   e. *Additional barriers*: No comment.

6) What care delivery interventions are the most effective in encouraging value-based care (VBC) transformation in rural areas?
   The Panel has published recommendations for designing value-based payment reform, based on our analysis and (third document) based on discussion with those leading successful rural models:

   - Policy Brief: Medicare Value-Based Payment Reform
   - Medicare Value-based Payment Reform: Priorities for Transforming Rural Health Systems
   - Toward a High Performing Rural Health Care System: Key Issues and Recommendations from Rural Health Care System Innovators

   We also recommend publications from the Rural Health Value project (three Health Panel members are in the leadership team):

   - Rural Health Value Summit: Driving Value Through Community-Based Partnerships
   - Rural Health System Value-Based Care Innovator Roundtable: Strategies and Insights

7) How do rural-specific issues affect social determinants of health (SDOH), health-related social needs (HRSNs), equity, and behavioral health (e.g., mental health and substance abuse disorders)?
The RUPRI Health Panel has addressed issues related to SDOH and behavioral health in rural places and for rural populations in a conceptual framing (High-Performing Rural Health System) and specific to behavioral health needs in the following documents:
    - High-Performing Rural Health System
    - Meeting the Behavioral Health Needs of Farm Families in Times of Economic Distress
    - Behavioral Health in Rural America: Challenges and Opportunities

8) How do rural-specific issues affect care coordination, specialty integration, and care transition management?
The RUPRI Health Panel published an analysis of care coordination n rural places, including policy recommendations, in 2015:
    - Care Coordination in Rural Communities: Supporting the High Performance Rural Health System

9) What kinds of resources have been effective in assisting in the development of health infrastructure to support VBC among rural providers?
The RUPRI Health Panel supports implementing telehealth initiatives that support existing health system infrastructure in rural communities. Responding to the Committee's question about telehealth expansion potentially worsening disparities in some settings, telehealth that supplants local primary care in rural communities may well worsen disparities. If insurance plans, including Medicare Advantage, are able to meet network adequacy standards by bringing telehealth to the community to serve their enrollees, leaving the local system to meet the needs of others, local providers may not be financially sustainable, eventually leading to loss of local care. The Committee should find these papers helpful:
    - The Role of Telehealth in Achieving a High Performing Rural Health System: Priorities in a Post-Pandemic System
    - The Evolving Landscape of National Telehealth Policies during a Public Health Emergency: Responsiveness to Rural Needs

10) What kinds of resources have been effective in assisting in the development of the rural health workforce, including ancillary providers?
The Health Panel's work on primary care helps address this question (as well as the earlier question 3):
    - Primary Care: The Foundation for a High-Performance Rural Health Care System

11) What are examples of promising APMs and model design components that include or target participation by rural providers?
The Health Panel published a paper tracing the history of new Medicare payment policies for rural hospitals, ending with a summary of current value-based payment demonstrations:

- The evolution of Hospital Designations and Payment in the U.S.: Implications for Rural Hospitals

Publications referenced earlier, from the Rural Health Value project, identify design components particularly important to rural providers:

- Rural Health Value Summit: Driving Value Through Community-Based Partnerships
- Rural Health System Value-Based Care Innovator Roundtable: Strategies and Insights

Sincerely,

Keith J. Mueller, Ph.D.
Gerhard Hartman Professor of Health Management and Policy
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