PHYSICIAN-FOCUSED PAYMENT MODEL TECHNICAL ADVISORY COMMITTEE (PTAC)

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PUBLIC MEETING

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The Great Hall
The Hubert H. Humphrey Building
200 Independence Avenue, S.W.
Washington, D.C. 20201

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MONDAY, SEPTEMBER 18, 2023

PTAC MEMBERS PRESENT

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

PTAC MEMBERS NOT PRESENT

JOSHUA M. LIAO, MD, MSc

STAFF PRESENT

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

A-G-E-N-D-A

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1 P-R-O-C-E-E-D-I-N-G-S
2 9:32 a.m.
3 * CO-CHAIR HARDIN: Good morning, and
4 welcome to this meeting of the Physician-
5 Focused Payment Model Technical Advisory
6 Committee, known as PTAC. My name is Lauran
7 Hardin, and I am one of the Co-Chairs of PTAC
8 along with Angelo Sinopoli. Since 2020, PTAC
9 has been looking across its portfolio to
10 explore themes that have emerged from proposals
11 received from the public over the years. After
12 each theme, the Committee releases a public
13 report to the Secretary of HHS[1] with its
14 findings. In March we had our public meeting
15 on improving care delivery and integrating
16 specialty care in population-based models. We
17 plan to post the report to the Secretary on our
18 website in the next week. A listserv will go
19 out announcing the posting of that report.
20 We also plan to post the June report
21 to the Secretary on improving management of
22 care transitions in population-based models in
23 the next month.
24 Rural providers face challenges with
25 care delivery and approaches to address them,

1 Health and Human Services

1 particularly in relation to population-based
2 model participation, and this theme has come up
3 throughout the previous PTAC theme-based
4 discussions and in several submitted proposals.
5 We know that this topic is also of interest to
6 the Innovation Center at CMS.
7 And before our first presentation of the day,
8 we're very honored to have opening remarks from
9 Dr. Liz Fowler, the Deputy Administrator of CMS
10 and Director of the Center for Medicare and
11 Medicaid Innovation. Dr. Fowler previously
12 served as Executive Vice President of Programs
13 at the Commonwealth Fund and Vice President for
14 Global Health Policy at Johnson & Johnson. She
15 was Special Assistant to President Obama on
16 Healthcare and Economic Policy at the National
17 Economic Council. From 2008 to 2010, she also
18 served as Chief Health Counsel to the Senate
19 Finance Committee Chair where she played a
20 critical role in developing the Senate version
21 of the Affordable Care Act. Thank you so much
22 and welcome, Liz.
23 * **Elizabeth (Liz) Fowler, JD, PhD,**
24 **Deputy Administrator, Centers for**
25 **Medicare & Medicaid Services (CMS),**

1 **and Director, Center for Medicare and**
2 **Medicaid Innovation (CMMI) Remarks**
3 DR. FOWLER: Lauran, thanks. It's
4 so nice to be here. Dr. Sinopoli, nice to you
5 and all the rest of the PTAC members and also
6 note that we've got a number of CMS Innovation
7 Center folks who are eagerly listening in the
8 audience to the presentations today.
9 I just want to thank you for the
10 invitation to provide some opening comments
11 this morning, and it's great to be back for the
12 third quarterly meeting of 2023. The first two
13 quarterly meetings this year were very rich
14 discussions, and the Innovation Center has been
15 tracking closely a lot of these discussions,
16 the specialty care integration meeting in March
17 and then as you noted, the transitions of care
18 meeting in June.
19 Both of those meetings brought
20 together deep subject matter experts who
21 provided excellent thought-provoking
22 presentations. And I expect these discussions
23 on rural health to be more of the same.
24 We know people in rural communities
25 have a higher prevalence of chronic diseases

like diabetes and COPD[2], as well as higher rates of unintentional injury and disability compared to their urban counterparts. And we also know that access to care is a particular challenge in rural communities. These disparities and access challenges are linked to many different factors that speakers over the next two days will explore. For example, only 12 percent of physicians practice in rural communities, and more than half of health professional shortage areas in the U.S. are in rural areas.

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

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

2 Chronic obstructive pulmonary disease

1 decreased uptake in value-based care models in
2 rural areas.
3 Supporting access to care in rural
4 frontier and other geographically-isolated
5 communities is a priority for CMS. And we're
6 working across the Agency to think about and
7 how to address these challenges. Last year,
8 CMS finalized rules for Rural Emergency
9 Hospitals, a designation that would allow
10 Critical Access Hospitals and small rural
11 hospitals to convert to REH[3] status and receive
12 enhanced Medicare reimbursement. And starting
13 in January 2024, the Medicare Shared Savings
14 Program will provide advanced infrastructure
15 payments to new ACOs[4], and we hope that this
16 will provide a bridge for entities to join the
17 program, particularly in rural areas among
18 practices and providers.
19 Current and past models and
20 initiatives at the Innovation Center also
21 represent an extension of the CMS commitment to
22 support rural health. We continue to
23 administer two statutory demonstrations, the
24 Rural Community Hospital Demonstration and the

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3 Rural Emergency Hospital
4 Accountable Care Organizations

1 Frontier Community Health Integration Project,
2 FCHIP. We also lead the Pennsylvania Rural
3 Health Model or PARHM, which started in 2017
4 and will continue through 2024, which is
5 exploring the feasibility of care delivery
6 transformation in the context of hospital
7 global budgets. We have heard some hospitals
8 have commented that the global budget hasn't
9 funded all of their hospital transformation
10 activities, but the model has been a catalyst
11 to accelerate existing and build new community
12 partnerships.
13 And then two weeks ago, we announced
14 the States Advancing All-Payer Health Equity
15 Approaches and Development, or AHEAD model,
16 which focuses on state health systems and
17 transformation and also includes a hospital
18 global budget component. This model is open to
19 Rural Health Clinics and Critical Access
20 Hospitals.
21 Additionally, the new primary care
22 model we announced this summer has a strong
23 focus on underserved communities and particular
24 outreach and focus on community health centers,
25 and we hope that those providers and practices
26 and organizations who serve beneficiaries in

1 underserved areas, including rural areas, will
2 be coming into the model.
3 And as some in the audience may
4 know, in March 2023, we announced the
5 termination of the Community Health Access and
6 Rural Transformation, or CHART model, due to a
7 lack of hospital participation. CHART was
8 intended to innovate payments, increase access,
9 and improve the quality of care and health
10 outcomes in rural communities. While we were
11 disappointed at this outcome, we also
12 appreciate what we learned from our rural
13 partners about this model and why the outcome
14 wasn't what we wanted or expected.
15 As the CMS Innovation Center
16 continues to explore opportunities to expand
17 our work to address the challenges faced by
18 beneficiaries and providers in rural areas, we
19 look forward to hearing from all of the
20 speakers that PTAC has invited to this meeting.
21 In particular, I know we have a handful of them
22 who are participants in some of our models and
23 welcome them as well.
24 I'll close with a few general
25 questions that CMMI is hoping to learn over the
26 next couple of days. First, our teams are

1 challenged by the many definitions of rural.
2 How should it be defined for purposes of CMMI?
3 What kind of providers count as rural? And
4 which ones shouldn't count and why? And
5 second, what should we prioritize in a care
6 delivery model for rural populations? Third,
7 what are the changes to payment that are
8 interesting to rural providers, or what
9 flexibilities would they need to take on value-
10 based care arrangements? For rural providers
11 and practitioners that haven't been engaged in
12 value-based payment models, what are some of
13 the key factors holding them back? And
14 finally, given lower patient volumes in rural
15 health care settings, what does this mean for
16 measuring the quality of care? How can we
17 reliably measure the quality of care in rural
18 communities?
19 We are very grateful for the efforts
20 that went into developing the presentations
21 over the next couple of days and look forward
22 to learning more from all of you on how to
23 solve the disparities in health care
24 experienced in rural communities. We're eager
25 and excited that our partnership with PTAC will
26 help inform future innovations and actions in

1 rural health care.
2 So I'll stop there and turn it back
3 over to you, and thanks very much for the
4 chance to be here.
5 * **Welcome and Co-Chair Update -**
6 **Overview of Discussion on**
7 **Encouraging Rural Participation in**
8 **Population-Based Total Cost of Care**
9 **(TCOC) Models Day 1**
10 CO-CHAIR HARDIN: Thank you so much
11 for joining us, Liz. We really appreciate your
12 engagement and partnership and look forward to
13 working with you over the next couple of days.
14 For today's agenda, we will explore
15 a range of topics, including challenges facing
16 patients and providers in rural communities,
17 approaches for incorporating rural providers in
18 model design, provider perspectives on payment
19 issues related to rural providers, incentives
20 to increase rural providers' participation, and
21 successful interventions and models for
22 encouraging value-based transformation in rural
23 areas.
24 The background materials for this
25 public meeting, including an environmental
26 scan, are online. Over the next two days,

1 you'll hear from many esteemed experts. We've
2 worked very hard to include a variety of
3 perspectives throughout the two-day meeting,
4 including the viewpoints of previous PTAC
5 proposal submitters who addressed relevant
6 issues in their proposed models.
7 I also want to mention that tomorrow
8 afternoon will include a public comment period.
9 Public comments are limited to three minutes
10 each. If you would like to give an oral
11 presentation tomorrow, but have not registered
12 to do so, please email
13 ptacregistration@norc.org. Again, that's
14 ptacregistration@norc.org.
15 The discussions, materials, and
16 public comments from the September PTAC public
17 meetings will all feed into a report for the
18 Secretary of HHS on how to encourage rural
19 participation in public population-based
20 models.
21 The agenda for today and tomorrow
22 includes time for the Committee to discuss and
23 shape our comments for the upcoming report.
24 Before we adjourn tomorrow, we'll announce a
25 Request for Input, which is an opportunity for
26 stakeholders to provide written comments to the

1 Committee on improving care transitions.
2 Lastly, I'll note that, as always,
3 the Committee is ready to receive proposals on
4 possible innovative approaches and solutions
5 related to care delivery, payment, or other
6 policy issues from the public on a rolling
7 basis. We offer two proposal submission tracks
8 for submitters, allowing flexibility depending
9 on the level of detail of their payment
10 methodology. You can find information about
11 how to submit a proposal online.
12 * **PTAC Member Introductions**
13 At this time, I would like my fellow
14 PTAC members to please introduce themselves.
15 Please share your name and organization and if
16 you would like, feel free to describe any
17 experience you have with our topic.
18 First, we'll go around the table,
19 and then I'll ask our members joining remotely
20 to introduce themselves. I'll start.
21 I'm Lauran Hardin, a nurse and Chief
22 Integration Officer for HC2 Strategies. I
23 spent the better part of the last 20 years
24 designing care management models under all of
25 the ACO, BPCI[5] value-based payment initiatives

5 Bundled Payments for Care Improvement

1 and was a founding member of the National
2 Center for Complex Health and Social Needs that
3 partnered with states, communities, health
4 systems, designing models to meet the needs to
5 underserved populations and deeply working now
6 in California with the Medicaid 1115 waiver,
7 building connected communities of care deeply
8 in rural areas. Angelo.
9 CO-CHAIR SINOPOLI: Thank you,
10 Lauran. Angelo Sinopoli. I'm a pulmonary
11 critical care physician by training. Spent a
12 lot of my career in an organization called
13 Prisma Health, where I built and developed a
14 large clinically-integrated network there that
15 served about 1.2 million patients across two-
16 thirds of South Carolina. We had 5,000
17 providers in that network and obviously, in
18 South Carolina I've spent a lot of -- had a lot
19 of patients in rural, very rural areas, as well
20 as urban areas, and so I had a diverse
21 experience there taking care of those patients.
22 Most recently, I'm the Chief Network
23 Officer for UpStream, and looking forward to
24 the next few days. Jay.
25 DR. FELDSTEIN: Good morning,
26 everyone. My name is Jay Feldstein. I'm

1 originally trained as an emergency medicine
2 physician. I practiced emergency medicine for
3 10 years and then spent 15 years in the health
4 insurance world in government and commercial
5 programs. And in the last 10 years, I've been
6 the President of the Philadelphia College of
7 Osteopathic Medicine, turning out primary care
8 physicians in both urban and rural settings.
9 DR. WILER: Good morning. I'm
10 Jennifer Wiler. I'm the Chief Quality Officer
11 at UCHealth out of the Denver Metro area, one
12 of the largest health care systems in the Rocky
13 Mountain region. I'm also co-founder of the
14 Health Systems Care Innovation Center where we
15 partner with digital health companies to grow
16 and scale their solutions to improve patient
17 care. I'm a tenured professor at the
18 University of Colorado School of Medicine and
19 an emergency physician by training and co-
20 author of an Alternative Payment Model that was
21 considered by this Committee.
22 DR. WALTON: Good morning. My name
23 is Jim Walton. I'm a general internal medicine
24 physician. I started my career in Waxahachie,
25 Texas, in private practice and transitioned to
26 develop rural health centers in Ellis County

1 and then transitioned as a Medical Director of
2 Baylor Community Care for about two decades.
3 (Inaudible due to sound system
4 failure.)
5 DR. WALTON: Back to the
6 programming, I served as the Baylor Healthcare
7 Systems Chief Equity Officer and then
8 transitioned into the CEO of a large primary
9 care ACO in Dallas, Texas, serving both urban
10 and rural patients in Medicare and Medicaid and
11 commercial ACO contracts.
12 DR. KOSINSKI: I'm Dr. Larry
13 Kosinski. I am the founder and Chief Medical
14 Officer of SonarMD, a value-based company that
15 for the last 10 years has been my focus. We
16 bring risk-based, value-based solutions to
17 gastrointestinal specialists in the commercial
18 space.
19 Of note is the fact that SonarMD was
20 the first PTAC recommended physician-focused
21 payment model back in 2017. I look forward to
22 the next two days.
23 DR. LIN: Good morning. My name is
24 Walter Lin. I'm an internist and founder of
25 Generation Clinical Partners. We are a group
26 of providers based in the St. Louis-Southern

1 Illinois area that cares for the frail elderly
2 in senior living organizations such as nursing
3 homes and assisted living facilities.
4 DR. BOTSFORD: Good morning. I'm
5 Lindsay Botsford. I'm a family physician in
6 Houston, Texas, and a medical director with One
7 Medical. After 10 years in teaching residents
8 and medical students, I shifted to Iora Primary
9 Care, where we started caring for older adults
10 on Medicare in full-risk payment models, and
11 continued to serve as the medical director for
12 our practices in Texas.
13 DR. PULLURU: Good morning. My name
14 is Chinni Pulluru. I'm a family physician by
15 trade, most recently, Chief Clinical Executive
16 and Vice President of Clinical Operations for
17 Walmart Health, where I powered the expansion
18 of Walmart Health clinics, as well as the
19 integration of their national telehealth
20 platform and the transformation to value-based
21 care across the enterprise. Prior to that, I
22 served as Chief Clinical Executive for DuPage
23 Medical Group, now called Duly, and their
24 subsidiary medical services organization
25 leading the value-based care service expansion,
26 as well as physician engagement. Thank you.

DR. MILLS: Good morning. I'm Terry Lee Mills. I'm a family physician, and I'm Senior Vice President and Chief Medical Officer at CommunityCare, a regional health system-owned provider health payer in Oklahoma. We operate in the Medicare Advantage, commercial, and marketplace exchange space where for 30 years we've offered total cost of care, quality directed, capitated models in all three of those markets.

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

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

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

1 foundation for our discussion today.
2 We'll begin with the PCDT presenting
3 some of the findings from their analysis.
4 Additional background information materials are
5 available on the ASPE PTAC website.
6 PTAC members, you'll have an
7 opportunity to ask the PCDT any follow-up
8 questions afterwards. And now I'll turn it
9 over to Jay.
10 * **PCDT Presentation - Encouraging**
11 **Rural Participation in Population-**
12 **Based TCOC Models**
13 DR. FELDSTEIN: Thank you, Lauran.
14 I'd like to just thank staff of ASPE and NORC
15 for their hard work and support and my fellow
16 PCDT team members and the PTAC Committee for
17 their contribution and support.
18 Myself and Jim and Josh have a
19 special affinity and commitment to rural health
20 care, as all three of us have practiced and are
21 committed to rural health care. Jim practiced
22 rural health medicine in Texas. We actually
23 opened a medical school in rural South Georgia
24 with a population of 15,000 people. I know
25 Josh is committed, as well, to rural health
26 care in the state of Washington, so this is

1 really an exciting topic for all three of us
2 and for all members of the PTAC Committee.
3 So over the next two days, what
4 we're looking to do is to examine challenges.
5 The first one will be advancing the slides and
6 reading them at the same time; facing patients
7 and health care providers in rural communities;
8 identify care delivery models that are
9 effective in addressing patient needs,
10 improving outcomes, and encouraging value-based
11 transformation in rural areas; explore options
12 for encouraging participation of rural
13 providers and population-based total cost of
14 care models, and other Alternative Payment
15 Models; and to identify financial incentives
16 and mechanisms to increase participation of
17 rural providers in Alternative Payment Models.
18 Rural providers face unique
19 challenges and have been less likely to
20 participate in Accountable Care Organizations
21 and other population-based models. The Centers
22 for Medicare & Medicaid Services and the Center
23 for Medicare and Medicaid Innovation have
24 developed several models and programs designed
25 to encourage value-based transformation of
26 rural areas. PTAC has deliberated on the

extent to which 28 proposed physician-focused payment models met the Secretary's 10 regulatory criteria. Eleven of these proposals either included or targeted rural populations. And the goal for this meeting is to better understand these challenges and lessons learned from models and programs that have sought to address them.

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

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

PTAC is using the following working definitions for this presentation. The Office

1 of Management and Budget identifies
2 metropolitan areas as counties with 50,000 or
3 more people, and rural areas as counties with
4 fewer than 50,000 people. The U.S. Department
5 of Agriculture has nine Rural-Urban Continuum
6 Codes or RUC Codes that can be used to further
7 identify differences in rural counties based on
8 population size and proximity to metropolitan
9 areas.
10 PTAC is using the following working
11 definition of rural providers. Rural providers
12 are providers, including independent
13 practitioners and other types of providers that
14 are physically located in rural areas. PTAC is
15 aware that some rural areas also have access to
16 providers that are located in urban and
17 suburban communities. The key takeaway here is
18 how do we define them, how do we measure their
19 success, and how ultimately do we reimburse
20 them in payment models?
21 When we look at geographic
22 distribution by rural access by RUC Codes, you
23 can see that 15 percent of the U.S. population,
24 or close to 46 million lives, are people in
25 rural areas. Sixty-three percent of U.S.
26 counties are designated as rural areas. And

1 some counties include both rural and non-rural
2 areas. If you look at the scale, non-rural or
3 cities at 1 are representing by the rose-
4 colored geographic areas. And as we get to
5 dark blue, they become more rural with 9 being
6 the most rural areas in America.
7 Rural areas vary based on population
8 size and proximity to metropolitan areas. Half
9 of all rural counties have 2,500 to 19,999
10 residents, and a third have less than 2,500
11 residents. Half of all rural counties, 48
12 percent, are not adjacent to metropolitan
13 areas. The bottom line is rural areas are not
14 monolithic; therefore, effective delivery
15 models, financial incentives, and payment
16 methodologies may vary depending on the type of
17 rural area and the type of rural provider.
18 Rural areas with a shortage of providers may
19 experience different challenges compared to
20 rural areas with low patient volume or
21 insufficient competition among providers,
22 relative to having sustainable financing,
23 measuring performance, and being able to
24 participate in APMs[6].
25 There are regional differences among

6 Alternative Payment Models

1 rural providers as well according to population
2 and adjacency to metropolitan areas. Nearly
3 half of all rural counties in the West North
4 Central region have less than 2,500 residents,
5 and nearly two-thirds of all rural counties in
6 the West North Central region are not adjacent
7 to metropolitan areas.
8 I want to highlight on this slide
9 the Mid-Atlantic states, New Jersey, New York,
10 and Pennsylvania. The percentage that is
11 completely rural or less than 2,500, urban,
12 non-metro population are RUCC counties 8 and 9,
13 are less than 9 percent. Not adjacent to a
14 metropolitan area which are RUC Codes 5, 7, and
15 9 is 20 percent. Now compare that to the West
16 North Central. Forty-nine percent have areas
17 of less than 2,500 population bases, and 64
18 percent are not adjacent to a metropolitan
19 area. So there's tremendous variation across
20 the country.
21 There's also tremendous diversity
22 among rural providers. Rural providers differ
23 in the services that they offer and statutory
24 requirements. Some rural providers have
25 special payment rates and methodologies created
26 by statute. For example, Critical Access

1 Hospitals provide 24-hour emergency care
2 services, whereas Rural Health Clinics may be
3 limited to providing a specific type of primary
4 care. And rural health care centers and
5 Critical Access Hospitals are not paid by
6 service codes, so they are not accustomed to
7 coding and billing as the same way as other
8 providers, which makes measurement and
9 reimbursement sometimes difficult.
10 Additional differences between rural
11 and urban areas, compared to non-rural
12 counties, rural counties had lower income on
13 average, less than $9,000 per average per
14 capita in the U.S., and Americans living in
15 rural areas are more likely to live below the
16 poverty level. There are higher uninsured
17 populations. Rural areas have larger
18 proportions of adults under the age of 65
19 without insurance. It's an older population,
20 17.5 percent of the rural population is 65 and
21 over, compared to 13.8 percent in urban areas.
22 And most importantly, there is decreasing life
23 expectancy in rural counties. We'll explain in
24 more detail the life expectancy differences in
25 later slides.
26 Compared to non-rural counties,

1 rural counties had fewer primary care
2 providers, 37.9 versus 52.9 per 100,000 people;
3 fewer specialists, 46.5 specialists per
4 100,000, while urban areas have 146.4 per
5 100,000. And a theme that will come up during
6 the course of the presentation is reduced
7 broadband access. Less than 70 percent of
8 rural households have access to high-speed
9 internet compared to 85 percent of households
10 in large metropolitan areas. In fact, when we
11 were doing research for this theme-based
12 discussion, some potential subject matter
13 experts in rural areas could only be reached by
14 phone or fax because it had no internet access.
15 And there are lower Medicare
16 Advantage enrollment in rural areas compared to
17 metropolitan areas. That has basically
18 quadrupled since 2010, and now there are close
19 to a million Medicare Advantage beneficiaries
20 living in rural areas.
21 Just a graphic of the adjusted death
22 rates by the urban-rural classification in the
23 United States over the last 10 years, and you
24 can see that there's a discrepancy between
25 rural death rates and urban death rates. More
26 importantly, when you look at age-adjusted

1 death rates for the 10 leading causes of death
2 by urban-rural classifications, the greatest
3 discrepancies in death rates are in heart
4 disease, cancer, and chronic lower respiratory
5 diseases.
6 When we look at an overview of
7 issues affecting rural health care systems,
8 settings, providers, and patients, obviously,
9 there are going to be economic, social, and
10 environmental challenges, accessing federal
11 resources, poverty, lower health literacy, and
12 educational attainment. On the patient side,
13 there's higher rates of obesity, substance use,
14 and chronic disease, complications due to less
15 health insurance and access, higher rates of
16 unintentional injury, more older adults.
17 In the provider setting, there's
18 lower patient volume and provider revenues,
19 more publicly and uninsured patients, complex
20 patient populations, workforce shortages, and
21 an aging workforce and higher workload burnout,
22 as well as limited transportation options for
23 patients and insufficient ancillary health care
24 services. When we look at the intersection
25 between patient issues and provider issues,
26 lower income affects both. There's a mismatch

between infrastructure for broadband access, health information technology, provider mix, which is reflected in a lack of specialists, and a lack of community-based organizations and resources, and patient complexity.

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

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

Let's look at some of these in greater detail. Complex patient populations, rural areas tend to have higher rates of

1 behavioral health conditions, substance abuse,
2 and older adults, as well as higher disease
3 burden, compared to non-rural areas. A higher
4 rate of uninsured and publicly insured patients
5 under the age of 65 were 2.5 to 4 times more
6 likely than the urban peers to be uninsured.
7 And rural hospitals have a 20-percentage point
8 higher rate of Medicaid patients.
9 Lower patient volumes can affect
10 financial viability and reduce reliability and
11 validity or performance measurements results
12 and impact providers' ability to participate in
13 CMS-quality programs. Forty-seven percent of
14 rural hospitals have 25 or fewer staff beds,
15 and over 100 rural hospitals closed between
16 January of 2013 and 2020. Eleven rural
17 hospitals have closed in 2023, and over 600
18 rural hospitals are at risk of closure for this
19 year.
20 Rural PCPs[7] tend to make five percent
21 less than their urban counterparts. Now the
22 Consolidated Appropriations Act of 2021
23 established Rural Emergency Hospitals as a new
24 Medicare provider type to address the large
25 number of rural hospital closures during and

7 Primary care providers

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

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

Compared to non-rural areas, rural areas have fewer PCPs and specialists per 100,000. When we look at the specialists, 46

1 per 100,000, as compared to 146 in non-rural
2 areas, with a large discrepancy in
3 cardiovascular disease. There's only 1.1 per
4 100,000 in rural areas compared to 4.27 in non-
5 rural areas. Whether this fact is causative or
6 an association for the increased death rates
7 seen in rural areas for cardiovascular disease
8 remains to be seen; gastroenterology
9 specialists, .47 per 100,000 compared to 2.93;
10 and neurosurgery, .17 per 100,000 versus 1.3 in
11 non-rural areas.
12 So what are some of the
13 opportunities for addressing rural workforce
14 challenges? Well, due to the workforce
15 shortages in rural communities, there's
16 increased provider burnout and turnover.
17 There's increased difficulty with recruiting
18 and retaining providers, and there's limited
19 access to health care training and education in
20 rural areas for ancillary staff. Some of the
21 strategies for addressing rural workforce
22 challenges through the use of telehealth, ACOs
23 can provide resources to support telehealth.
24 They can help share financial risks and can be
25 cost effective and help rural providers adopt
26 higher-value telehealth applications, bonus

1 payments to rural health providers to develop
2 their telehealth infrastructure, incentives for
3 rural providers to increase the proportion of
4 telehealth visits and funds to provide rural
5 patients with access to necessary telehealth
6 technology, cell phones, facilities with
7 tablets, and again, increased broadband access.
8 In terms of giving rural providers,
9 they encounter challenges when implementing and
10 using health information technology and data
11 analytics. They have a lack of financial
12 resources. Again, 43 percent of rural health
13 centers reported costs for health information
14 technology improvements prevented their
15 participation in ACOs, and many providers lack
16 training on data analysis and decision support
17 systems, as well as having the support staff
18 help to use health data information. And
19 patients may not engage in health information
20 technology due to a lack of broadband access or
21 low digital literacy.
22 Some of the strategies for
23 addressing this infrastructure challenge are
24 funding for health information technology
25 infrastructure, providing technical assistance
26 and value-based incentives for health

1 information technology engagement.
2 Rural providers tend to participate
3 in APMs at a lower rate than their metropolitan
4 and non-rural counterparts, and physicians
5 participating in advanced APMs in rural areas
6 were most commonly in primary care specialties,
7 family practice, and internal medicine.
8 Again, the challenges affecting
9 rural providers to participate are financial
10 resources and risk management. They lack the
11 capital to finance the up-front cost of
12 transitioning to APMs. They're averse to
13 financial risk or lack reserves to cover
14 potential losses. And they treat too few
15 Medicare patients to justify investments in
16 APMs, and lower patient volumes result in less
17 predictable spending patterns, heightening the
18 financial risk. They're less able to control
19 the cost of care because patients are often
20 referred elsewhere for tertiary care. And
21 their lower patient volumes render less
22 predictable spending patterns.
23 They are unable to conduct data
24 analytics or financial modeling needed to
25 provide value-base care. The complexity and

1 cost of EHRs[8] or lack of high-speed internet
2 hinder EHR adoption. And the lack of EHR
3 interoperability and staff training, as well as
4 weakness of health information exchange between
5 providers inside and outside the community,
6 just are continued challenges for the adoption
7 of data and health information technology. And
8 again, staff resources and capabilities, they
9 lack staff members capable of managing the
10 transition to or participate in APMs. There's
11 a lack of capital to manage building a
12 population base, team-based approach for care
13 coordination and case management, and a general
14 overall lack of awareness of APMs.
15 Again, the design and availability
16 of models, there are limited APM options due to
17 models' participation restrictions, whether
18 geographic or provider type in volume, a lack
19 of nearby ACO or models appropriate for
20 providers in rural shortage or underserved
21 areas, economies of scale, and the potential
22 need for low-volume adjustments. They struggle
23 to adapt to changing model rules and
24 regulations.
25 The challenges faced by rural

8 Electronic health records

1 providers for total cost of care models are
2 attribution panel size, validity of outcome
3 data given limited information technology,
4 infrastructure and small populations, the
5 ability to take on risk, relevant performance
6 measures, and quality performance measurements.
7 For example, small panel sizes limit rural
8 providers' ability to calculate reliable and
9 valid performance measurement results.
10 Types of care that are most
11 difficult to provide in rural communities
12 include lack of post-discharge follow-up due to
13 workforce availability and transportation
14 issues; decreased access to mental health and
15 substance abuse disorder treatment; fewer
16 gastroenterologists, general surgeons,
17 radiation oncologists, and other specialists;
18 and limited access to ancillary service
19 providers from health care diagnostic testing
20 and dialysis.
21 Some of the approaches to address
22 the needs of rural communities include audio
23 and video visits, including telehealth, co-
24 location of health care services, leveraging
25 pharmacists as care providers, increasing
26 value-based payment models in rural hospitals,

1 and coordination with community-based
2 organizations supporting nutrition and housing,
3 et cetera.
4 Strategies included in effective
5 models that drive valued-based care in rural
6 areas include promoting behavioral health care
7 services, supporting and encouraging care
8 coordination across providers, improving
9 specialty integration, and expanding care
10 networks or performing new entities.
11 Financial incentives to drive value-
12 based care transformation among rural providers
13 include providing startup funding for incentive
14 coordination of care, provide a fixed, up-front
15 payment regardless of patient volumes to
16 increase access to care and specialty care,
17 quality incentives to drive value-based care
18 transformation among rural providers, payment
19 tied to performance on quality measures, adjust
20 Medicare fee-for-service payments based on
21 performance against a set of quality measures
22 relative to their peers' performance because
23 performance impacts future payment adjustments.
24 Challenges affecting rural
25 providers' participation and performance
26 measurement: low case volumes place

1 limitations on the calculation of reliable and
2 valid performance measurement results. Several
3 CMS value-based programs exclude providers from
4 public reporting based on low care volumes;
5 staff shortages, as well as limited funds and
6 other resources; limited staff with experience
7 performing data extraction analysis, as well as
8 using measurement results to inform quality
9 improvement efforts. And rural patients tend
10 to be disproportionately impacted by health
11 conditions, making performance comparisons
12 between rural and non-rural settings difficult.
13 Measures should not be used to evaluate rural
14 providers' performance; for example, measures
15 of cost should be used with caution because
16 some rural providers do not have access to
17 lower cost treatment options or may encounter
18 higher supply chain costs compared to non-rural
19 providers.
20 Strategies to ensure that rural-
21 relevant measures appropriately measure the
22 performance of rural providers would be to
23 tailor performance measures to the type of
24 rural provider health care services offered,
25 modify measurement approaches for rural
26 providers, use risk adjustment to account for

1 differences in risk factors within and across
2 rural patient populations. You need to
3 consider how measuring the success of rural
4 providers might differ from measuring the
5 success of non-rural providers. One example
6 would be emergency department utilization
7 because EDs[9] are a critical source of after-hour
8 care in rural markets, so reducing ED
9 utilization may not adequately reflect value-
10 based care transformation in rural markets, and
11 again, potentially identifying other measures
12 related to retention of rural providers in APMs
13 and shared savings.
14 Examples of quality measures used in
15 prior APMs that target rural providers include
16 inpatient and ED visits for ambulatory care-
17 sensitive conditions, hospital readmissions,
18 ambulance transports, patient experience with
19 care, primary care and behavioral health
20 integration, influenza vaccination, screening
21 for depression, follow-up plan and rate of
22 adults with preventative care visits, care
23 coordination and care transitions, and
24 substance abuse -- use of pharmacotherapy for
25 opioid use disorder, use of opioids at high

9 Emergency departments

1 dosage in persons without cancer, and risk of
2 continued opioid use.
3 The National Quality Forum [NQF]
4 Measure Applications Partnership Rural Health
5 Work Group suggested that rural-relevant
6 measures should be NQF-endorsed, resistant to
7 case volumes, and address care transitions.
8 Now what are some of the lessons
9 that we've learned from CMMI models that
10 targeted or included rural participants?
11 Several CMMI models have either targeted or
12 included rural participants. The models used a
13 variety of payment mechanisms, including pre-
14 paid shared savings, per beneficiary per month
15 payments, global budgets, fee-for-service
16 payments, and population-based payments, bundle
17 payments, and performance-based payments.
18 Specific lessons learned include
19 establishing longer on-ramps for rural
20 practices interested in APM participation,
21 developing APMs that specifically target rural
22 settings, identifying suitable risk-adjusted
23 quality measures, providing risk protection
24 caps on risk exposure, extending bonus payments
25 for new advanced APM participants, and
26 decreasing qualifying participation thresholds

1 for rural providers operating under APMs.
2 Some selective lessons learned from
3 CMMI models relevant to opportunities for rural
4 provider participation include the Frontier
5 Community Health Integration Project, or FCHIP,
6 Demonstration where increased payments for Part
7 B ambulance transports and telehealth
8 origination services increased patient
9 satisfaction with telehealth. The Vermont All-
10 Payer ACO Model provided up-front funding and
11 limited downside risk. It was noted that
12 different attribution mechanisms may be needed
13 in rural communities to achieve scale. The
14 Pennsylvania Rural Health Model, which was a
15 creation of the Rural Health Redesign Center
16 Authority, helped foster relationships among
17 participants, payers, and partners, and
18 although global budgets provided stable cash
19 flow, participants and payers found it
20 challenging to monitor global budgets.
21 Preliminary Medicare per member per
22 month spending is below the national average
23 for rural hospitals, 80 percent of participants
24 improved avoidable utilization, and 83 percent
25 improved their hospital acquired condition
26 reduction scores. The Rural Community Health

1 Demonstration showed that rural community
2 hospitals may need support to update older
3 capital infrastructure, and the Next Generation
4 Accountable Care Organization model serving
5 rural areas used care management strategies
6 such as telephonic engagement and embedded care
7 management staff.
8 Additional learnings include the
9 Community Health Access and Rural
10 Transformation model or CHART, which attempted
11 to increase financial stability for rural
12 providers through new reimbursement processes
13 that provided up-front investment and
14 predictable capitated payments and removed
15 regulatory burden by providing waivers that
16 increase operational and regulatory
17 flexibility. Unfortunately, this model was
18 withdrawn this past year due to the feedback
19 from model stakeholders, as well as lack of
20 hospital participation.
21 The Medicare Care Choices Model was
22 actually for palliative care, which increased
23 funding for transportation, allowed outcomes
24 between rural and non-rural beneficiaries to be
25 equal for end-of-life care.
26 The Maryland All-Payer Model:

1 hospital leaders who are more rural or in
2 economically disadvantaged areas reported that
3 they would not be able to attract or retain
4 enough hospitalists and certain types of
5 specialists if they did not employ those
6 physicians.
7 And the Accountable Care
8 Organization Investment Model [AIM], which
9 included up-front payment of shared savings,
10 encouraged ACOs to form in areas with greater
11 health care needs and less access to
12 accountable care. And as of 2020, 14 of the 47
13 AIM participants remain in the Medicare Shared
14 Savings Program, and the ACOs remaining in the
15 program were larger and served less rural
16 markets.
17 So in summary, the experience with
18 rural providers' performance in APMs showed
19 that the ACO investment model decreased
20 spending, and maintained or improved quality of
21 care in rural and underserved areas.
22 Maryland's Total Patient Revenue model, which
23 was a global budget for rural hospitals, led to
24 reductions in outpatient utilization, but not
25 inpatient utilization. And earlier results of
26 the Pennsylvania Rural Healthcare Model stated

1 earlier, show that preliminary Medicare PMPM
2 spending is below the national average for
3 rural hospitals. In addition, 80 percent of
4 participants improved utilization, 83 percent
5 improved their hospital acquired condition
6 reduction score, and 100 percent maintained the
7 CMS admission rates.
8 The Medicare Shared Savings Program
9 inclusion of rural providers, this program has
10 been going on since 2012, is a voluntary
11 program that encourages groups of doctors,
12 hospitals, and other health care providers to
13 come together as an ACO to give coordinated,
14 high-quality care to the Medicare
15 beneficiaries. Participants must have at least
16 5,000 attributed Medicare fee-for-service
17 patients and agree to participate for at least
18 five years. FQHCs[10], RHCs[11], and CAHs[12], are
19 eligible to join in ACO and/or the MSSP, and
20 FQHCs, RHCs, and some CAHs are also eligible to
21 become their own ACO under an MSSP.
22 As of January 2023, 467 CAHs, or
23 approximately 35 percent of all CAHs, and
24 22,040 RHCs, approximately 51 percent of all

10 Federally Qualified Health Centers
11 Rural Health Clinics
12 Critical Access Hospitals

1 RHCs, were participating in an MSSP ACO.
2 Some of the lessons learned with the
3 Advanced Investment Payment, AIP, and a new
4 MMSP payment option is that rural ACOs
5 participating in MSSPs were less likely to
6 switch to a two-sided risk than urban ACOs, and
7 some of the ACOs remaining in the AIM serve
8 less rural areas.
9 CMS is offering a new payment
10 option, the Advanced Investment Payment, to
11 encourage ACOs to form in rural and underserved
12 areas. The AIP offers eligible ACOs an up-
13 front payment of $250,000 and two years of
14 quarterly payments to build the infrastructure
15 needed to succeed in MSSP and promote equity by
16 holistically addressing beneficiary needs,
17 including social needs. The AIP will be
18 recouped from the ACO’s shared savings. If
19 there are no shared savings, as long as the
20 eligible ACO continues to participate, monies
21 will not be recouped.
22 So what we've tried to do today with
23 our presentation is to set the table for the
24 next two days and to focus on the challenges
25 facing patients and rural providers in rural
26 communities, what the provider perspectives on

1 issues related to rural provider participation
2 in population-based models, the challenges with
3 measuring rural providers' performance in APMs,
4 some of the approaches from incorporating rural
5 providers into population-based total cost of
6 care model designs, incentives for increasing
7 rural providers' participation in population-
8 based models, and successful innovations and
9 learnings and models for encouraging value-
10 based transformation in rural areas.
11 We look forward to a great
12 discussion over the next two days and great
13 panels and great subject matter experts. Thank
14 you.
15 CO-CHAIR HARDIN: Thank you so much,
16 Jay. Jay, Jim, and Josh, excellent work. We
17 really appreciate all of this foundational
18 research and work on summarizing this really
19 important topic.
20 I'm going to turn it briefly to
21 Angelo for one question. Committee members, if
22 you can hold your questions until we have our
23 broad discussion later in the day. Angelo.
24 CO-CHAIR SINOPOLI: Yes, so I'll
25 echo what Lauran just said. Congratulations to
26 you and the other PCDT members. It's just an

1 amazing amount of work that had to go into this
2 and an amazing summary that's going to really
3 set the stage, not only for the next couple of
4 days, but I think for next year's work, so
5 really good, and congratulations on that.
6 I only had one clarification. So
7 early on in your slides, as you were describing
8 the rural environment, there was a specific use
9 of the word independent physician. And so I
10 wondered if there's any data or differentiation
11 between an independent physician or a physician
12 that may be employed by a local delivery system
13 or yet a distant regional health care delivery
14 system which provides them resources. Is there
15 any data that discriminates between those?
16 DR. FELDSTEIN: In terms of the
17 ratio of PCPs per 100,000?
18 CO-CHAIR SINOPOLI: Outcomes.
19 DR. FELDSTEIN: Not in terms of
20 outcomes. We haven't been able to find
21 anything yet.
22 CO-CHAIR SINOPOLI: Thank you.
23 CO-CHAIR HARDIN: I want to thank
24 you all again very much. We look forward to
25 diving into more discussion.
26 At this point, we're going to take a

1 break until 10:30 a.m. Eastern. Please join us
2 then. We have a great lineup of presenters
3 today. Our first panel discussion is on
4 challenges facing patients and providers in
5 rural communities. We'll see you at 10:30.
6 (Whereupon, the above-entitled
7 matter went off the record at 10:25 a.m. and
8 resumed at 10:33 a.m.)
9 * **Panel Discussion: Challenges Facing**
10 **Patients and Providers in Rural**
11 **Communities**
12 CO-CHAIR HARDIN: Welcome back.
13 We're excited to share with you our next
14 session with some esteemed panelists. We want
15 to thank Jay and the PCDT for starting us off
16 with a great summary and evaluation of the
17 foundational information that we're really
18 interested and focused on today.
19 And now I'm excited to welcome our
20 first panel. At this time I ask our panelists
21 to go ahead and turn on your video if you
22 haven't done so already. In this session we'll
23 have three esteemed experts to discuss
24 challenges facing patients and providers in
25 rural communities.
26 After each panelist offers a brief

1 overview of their work, I'll be asking them
2 questions. PTAC members, you'll also have an
3 opportunity to ask our guests follow-up
4 questions, so be capturing those as we go
5 through the presentations.
6 The full biographies of our
7 panelists can be found online, along with other
8 materials for today's meeting. I'll briefly
9 introduce each of our guests and their current
10 organizations and give them a few minutes each
11 to introduce themselves.
12 First, we have Ms. Janice Walters,
13 who is the Chief Operating Officer for Rural
14 Health Redesign Center. Janice, welcome.
15 MS. WALTERS: Thank you so much, and
16 thank you for this opportunity to be part of
17 this very important discussion today. I
18 certainly count it a privilege to be here and
19 offer insights into our work supporting rural
20 communities across the country, as well as
21 using my talents to be able to help and support
22 those communities.
23 So just a little bit about myself.
24 Obviously you can read my bio, and I have been
25 leading the Pennsylvania Rural Health Model
26 work specifically since 2018, which also

1 included the creation of the Rural Health
2 Redesign Center Authority, as well as the Rural
3 Health Redesign Center Organization.
4 The Authority allows us to do work
5 specific in Pennsylvania overseeing the
6 Pennsylvania Rural Health Model. And then the
7 organization is a not-for-profit, and we
8 oversee work being done in other states
9 specific to rural. So I'm giving my insights
10 in the topic at hand today that the challenges
11 faced by rural communities across the country.
12 You know, while our work really is
13 focused on supporting hospitals, we also
14 understand that in many rural communities,
15 those hospitals actually employ a predominance
16 of the physicians. And so ensuring that access
17 to care and rural hospitals remain open is
18 really fundamental to ensuring and preserving
19 the health care access, not only for important
20 hospital care, but primary care and specialty
21 care.
22 So some of the programs that we
23 oversee, it's obvious the Pennsylvania Rural
24 Health Model, which was highlighted in the
25 prior session. Heard a little bit about that
26 program, as well as its outcomes. Supporting

1 about 1.3 million Pennsylvanians with ensuring
2 access to care through keeping the rural
3 hospitals open.
4 Within that work, we're doing some
5 specific work around substance use disorder,
6 peer recovery expansion, and using peer
7 recovery. And we can talk a little bit more
8 about that as we go through some of the Q&A
9 session.
10 We also are overseeing the Rural
11 Emergency Hospital Technical Assistance Center.
12 So that's the new CMS designation that allows
13 hospitals, rural hospitals to become just
14 outpatient hospitals serving outpatient needs
15 of communities. Our organization is actually
16 overseeing the technical assistance to help
17 hospitals across the country as they identify
18 whether that is right for their communities or
19 not.
20 And then we also are doing some work
21 in the northern border region providing
22 technical assistance to hospitals really with
23 the goal of ensuring access to care remains in
24 these communities.
25 If we go on to the next slide. So
26 regarding disparities and some of the issues

1 that we see within the communities that we
2 serve, obviously there's common trends. So our
3 organization, currently this number changes
4 daily as we work with organizations really
5 across the country.
6 But we support about 2.6 million
7 rural residents. And so looking at that
8 demographic data across the country really does
9 identify some of the challenges that we have
10 specific to providing care in rural communities
11 and helping those communities specific to the
12 people that reside in them.
13 And so certainly our data shows
14 that, you know, populations at least where our
15 organization exists and is providing services
16 do have a lot of health disparities. They tend
17 to be older and sicker, which certainly we've
18 heard that before. But certainly we have that
19 data to show, and we can dig into this in a
20 little bit more detail throughout the Q&A
21 section.
22 But certainly we have higher
23 disability rates in the communities that we
24 serve, food insecurity. A lot of those social
25 lists, as well as higher deaths associated with
26 chronic disease, as well as deaths by despair.

1 And so some of the key takeaways
2 that -- I'll wrap up my opening comments here,
3 but some of the key takeaways that we certainly
4 see within our work supporting rural
5 communities is if you think about the work of
6 hospitals, as well as professionals, doctors,
7 and providers, these outcomes that we have on
8 the slide in front of you today are with some
9 health care services already in these
10 communities.
11 Can we imagine how much worse these
12 outcomes would be if we no longer have primary
13 care or specialty care in these rural
14 communities? And again preserving and
15 oftentimes keeping the hospital open is how we
16 preserve the professional providers in these
17 communities as well.
18 So also data as shown indicates that
19 many of the same social issues exist in urban
20 and rural communities, but rural solutions must
21 be vastly different due to the lack of
22 infrastructure that exists to solve the
23 problem, such as transportation, food
24 insecurity, et cetera.
25 And then certainly I'm a big
26 believer that there needs to be policy reform.

1 And it's needed to align incentives across the
2 rural health care continuum in order to create
3 reasonable and pragmatic solutions to these
4 problems.
5 So it really does need the whole
6 health care continuum from professional
7 services to hospital services and then post-
8 acute. And really I would say incentivizing
9 and paying for the type of care that we want to
10 see delivered in these rural communities.
11 So again, thank you. I count it a
12 privilege to be here today and really look
13 forward to the conversation. And I will turn
14 it back to the moderator, Lauran. Thank you.
15 CO-CHAIR HARDIN: Thank you so much,
16 Ms. Walters, really looking forward to diving
17 in with questions.
18 Next we have Dr. Meggan Grant-
19 Nierman, a family physician with First Street
20 Family Health and the Heart of the Rockies
21 Regional Medical Center.
22 Meggan, please go ahead.
23 DR. GRANT-NIERMAN: Hi there, thank
24 you very much. Thank you very much for
25 inviting me to the meeting. I don't
26 necessarily consider myself an esteemed

1 panelist, as somebody said earlier, but I am
2 really humbled to be asked to share my
3 experiences.
4 So I'm going to bring the
5 perspective of a rural family practice
6 physician in private practice who has been and
7 now will no longer be doing value-based care.
8 So I entered the profession with a strong
9 desire to join private practice and to do --
10 provide a full -- to provide full-spectrum
11 family medicine with surgical OB[13] in rural
12 Colorado.
13 And I was blessed to find a
14 professional home at First Street Family Health
15 at Salida. It's a private practice that had
16 been in business for 74 years, since 1949. And
17 I've worked there for 11 years.
18 When I joined in 2012, First Street
19 had just been selected as a pilot practice for
20 CPCI, the Comprehensive Primary Care
21 Initiative. And so my practice of medicine has
22 been informed by value-based care since the
23 beginning.
24 As many of you probably know, CPCI

13 Obstetrics

1 evolved to CPC+[14], which evolved to Primary Care
2 First. And our practice transformed quickly
3 and effectively, and we were pretty -- very
4 successful really in meeting all the quotas and
5 metrics and milestones through these programs.
6 However, as Primary Care First came
7 along, we looked really hard at that pro forma,
8 and under the very best of circumstances, we
9 knew we would lose money by being part of
10 Primary Care First.
11 We considered abandoning value-based
12 care at that point and becoming a rural health
13 clinic. But culturally and emotionally, we
14 were committed to the value of care that we
15 believed in and a lot of the hard-earned, hard-
16 fought methods we developed. And so we carried
17 on, hoped for the best.
18 At that point, the Aledade's
19 exquisite marketing for MSSP ACO enablement
20 organization found us, and so we signed up for
21 them in addition to Primary Care First, with
22 the idea that if we got a little prospective
23 money from Primary Care First, some money on
24 the back end from Aledade, we could make enough
25 money from the valuable work we were doing to

14 Comprehensive Primary Care Plus

1 hopefully make it through.
2 And that, now we fast forward one
3 short year, our practice of 75 years is closed.
4 Our building is sold to the hospital. And I'm
5 now employed by the hospital at Heart of the
6 Rockies Regional Medical Center, which is our
7 Critical Access Hospital and network for rural
8 health clinics, and whose leadership team is
9 aggressively opposed to participation in any
10 value-based payment model.
11 So this month has proven a very
12 pivotal professional moment for me. So lessons
13 that I would like to bring that I have taken
14 away from our experience in the last decade of
15 value-based care participation is, one, it is
16 good and valuable work, and patients are better
17 for the coordinated care and the proactive
18 management.
19 Capitalizing on team-based care and
20 highly functioning teams really improves the
21 joy of practice for a physician or provider and
22 improves outcomes.
23 And rural practices are poised to be
24 very successful in a lot of ways in providing
25 value-based care because of the familial nature
26 and the connectedness of rural communities.

1 There are a lot of things about being rural
2 that make doing this value-based care work
3 natural and easy, in my opinion certainly. So
4 yes, yes, yes.
5 And rural communities also struggle
6 to want to engage in, to be able to succeed.
7 We lack the available support workforce in a
8 wraparound to support services that are
9 necessary to be maximally effective.
10 And the increased payroll expense
11 necessary to staff the value-based work, if you
12 can find the employees to do it, outweighs the
13 financial return of participation in the value-
14 based programs.
15 The other -- the second challenge is
16 that our data chasm is very real thing. Rural
17 facilities overall in my experience have very
18 dysfunctional, inexpensive EMR[15] systems, both
19 hospital and clinic. So gathering and
20 reporting data is very difficult.
21 And also when you have a small
22 population, when you're reporting data metrics,
23 it takes one or two outliers to completely blow
24 up your stats and change your ability to get
25 paid. And so that's a statistical issue that

15 Electronic medical record

1 we run into.

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

9 I think it's my belief that AI[16] and
10 technology may be a huge game changer for this
11 in this space in the future in terms of good
12 data collection and meaningful data. But
13 that's yet to be proven I think.

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

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

16 Artificial intelligence

1 day. So if you have to employ a bunch of
2 people to do the value-based work and not get
3 paid for 18 months for who you just employed,
4 that kind of inconsistent funding stream makes
5 it difficult in rural communities to do that.
6 I have some pie-in-the-sky dreams
7 and suggestions of what might make rural
8 participation in value-based care a little more
9 appetizing. And one is a model for financial
10 support to help rural health care systems maybe
11 collectively afford access to higher-quality
12 EMRs and data dashboards that are timely and
13 accurate. And then collaborative
14 arrangements and funding sources that I think
15 the gal before me mentioned that help fund
16 across the whole community, organization, and
17 health care ecosystem in the whole county in
18 some places that braid funding from different
19 departments to help rural economic development
20 in education, so that the system itself can
21 support serving social determinants of health
22 and growing health within the community.
23 I mentioned earlier thinking hard
24 about downside risk and how that precludes
25 involvement from rural organizations. I think
26 it's important to remember multi-payer

1 alignment is important, not just Medicare-
2 Medicaid, but we need our private payers to
3 actively be part of the conversation and
4 financially be part of the conversation of
5 value-based care.
6 And also just to an earlier point,
7 resources to help support the part of the
8 medical neighborhood that includes like EMS[17],
9 long-term care, public health, social services,
10 et cetera.
11 That’s a lot, thank you very much.
12 CO-CHAIR HARDIN: Thank you so much,
13 Dr. Grant-Nierman. You are an esteemed expert,
14 and I know everyone is going to be really
15 interested in asking you more questions.
16 Lastly we have Dr. Jen Brull, a
17 family physician and Vice President of Clinical
18 Engagement for Aledade. Welcome, Jen, please
19 go ahead.
20 DR. BRULL: Thank you. I appreciate
21 the opportunity to speak with you all.
22 I am currently Vice President of
23 Clinical Engagement at Aledade, which is a
24 company that helps independent primary care
25 physicians form ACOs that are geographically

17 Emergency medical services

1 disparate and that take on risk in a
2 significant way.
3 Prior to that, my life involved
4 being a rural full-scope family medicine doc
5 for 22 years, in Plainville, Kansas. And I
6 participated in value care with that hat on
7 also. I certainly, my heart goes out to
8 Meggan, because I know how that feels to be in
9 a place and a space where you have limited
10 power to make change.
11 Aledade’s stats are on the slide. I
12 won’t spend much time talking about them
13 because what I really want to share with you is
14 on the next slide, please, Amy.
15 So as I think about both from my
16 perspective as someone who did rural primary
17 care in an Accountable Care Organization and
18 from someone who is in an organization trying
19 to solve for this, because many of our practice
20 partners are in rural areas, I’ve thought of
21 five things that I think if this group could do
22 and could solve for, we would make significant
23 progress. You’ll definitely hear echoes of
24 Janice and Meggan’s comments in what I have to
25 say.
26 The first one is to solve something

1 that we've coined the rural glitch. So rural
2 clinicians who participate in Accountable Care
3 Organizations are significantly disadvantaged
4 from their urban counterparts because they make
5 up a significant market share of the way that
6 regional benchmarks are set.
7 They're literally being compared
8 against themselves in many cases. So regional
9 benchmarking does not solve for them in the way
10 that it does for urban counterparts. Solving
11 for that glitch in the math is really important
12 as we think about being able to differentiate
13 the performance of rural positions and their
14 urban counterparts.
15 The second thing, I'll echo Meggan,
16 we need to invest in access. And by access I
17 don't mean that rural primary care physicians
18 don't understand what their patients need.
19 They do. Frequently, though, they lack the
20 community and specialty resources for the
21 patient populations they've identified, or
22 those resources are significantly underfunded.
23 I can't tell you how many times
24 someone has said -- told me about a resource to
25 help me find community resources like Aunt
26 Bertha and, you go online, you enter your zip

1 code, and it will give you resources in the
2 plenties that are three and four hours away
3 from the patients you are serving.
4 When you are working with social
5 drivers of health, it is almost impossible for
6 those same patients to achieve transportation
7 to the resources that are being promoted for
8 them.
9 Third, include CHCs[18] and Rural
10 Health Centers. I was excited to come in at
11 the end of your last conversation and hear
12 about AIP, which sounds like a move in this
13 direction. That is wonderful.
14 But CAH hospitals and Rural Health
15 Clinics have been left out traditionally of
16 some of these innovation models because they're
17 complex, and it's difficult to imagine how they
18 might integrate into the work that you are
19 doing.
20 When you instead flip it so that you
21 find a way to integrate them in all models, I
22 think that will be a tremendous benefit, and
23 you may see less resistance and hesitation to
24 being involved in accountable care.
25 Fourth, advanced pay. Again, AIP is

18 Community health centers

1 exciting here. Meggan mentioned resources are
2 a big deal. When you're trying to do value-
3 based care, you frequently need to expand your
4 staff to be able to do that. And you need
5 money to do that. And many times without a
6 significant cash on hand, it's really
7 challenging to envision how you can make that
8 happen and keep your doors open.
9 Being able to do it, we have these
10 pay models like AIM, and being able to make it
11 easy to access for rural providers will make a
12 huge difference.
13 And then finally, I love what you're
14 doing here today. And I think that continuing
15 to connect to rural subject matter experts is
16 going to be critical as you design systems that
17 might support them.
18 So many times I think policymakers
19 and administration officials have not well
20 understood the challenges and barriers that
21 rural clinicians face in their everyday life,
22 let alone their journey to become an
23 Accountable Care Organization or to deliver
24 value-based care.
25 And so when you seek out the
26 understanding before you write the legislation,

1 I think it's a great place to be. So thank you
2 very much for letting me be here today, and I
3 look forward to answering your questions.
4 CO-CHAIR HARDIN: Thank you so much,
5 Jen. I really want to compliment each of you.
6 Your presentations built on each other very
7 well and have set a wonderful foundation for
8 us.
9 Committee members, there's an
10 opportunity for you to ask questions. If you'd
11 like to pose a comment or question, please tip
12 your nametag up. In the meantime, I'll start
13 us off with a question.
14 I'm really interested in your
15 perspective on what the barriers are to
16 effective care coordination in rural areas.
17 And what strategies or innovations are you
18 seeing as actually improving care coordination?
19 I was intrigued by some of the
20 things you were saying about looking at
21 blending and braiding funding and looking at
22 this as a county-wide approach. So would love
23 to hear your thoughts about that.
24 And Janice, why don't you start us
25 off.
26 MS. WALTERS: Yes, thank you for the

1 question. So certainly some of the barriers,
2 as my esteemed colleagues and subject matter
3 experts have already stated, it really is the
4 lack of infrastructure and resources.
5 So I had to smile when Jen made
6 reference to Aunt Bertha. And you know, the
7 idea that there’s a plethora of resources out
8 there. And in rural communities, there really
9 aren’t.
10 So lack of -- you know, we call it
11 community benefit organizations or some of
12 these other infrastructures that really need to
13 be present in order to meet the needs of the
14 communities.
15 And so often even within our
16 program, certainly we -- our payment model
17 within the Pennsylvania Rural Health Model
18 really is asking our hospital leaders to change
19 how they typically viewed and really come to
20 start serving as the convener in that community
21 to bring the health care continuum together.
22 And so given their position within
23 most of these communities as either, you know,
24 one of the largest either employers or health
25 care organizations to say, you know, we’re not
26 asking you to solve the problem by yourself,

1 but help serve as the convener to pull
2 organizations together.
3 What we see is the infrastructure's
4 not there. And so you know, the barriers of
5 even, so funding, it all comes back to funding.
6 I'm a health care – health care's actually my
7 third industry. I started in manufacturing, I
8 was in communication, and now I'm in health
9 care. And I really believe, just going to back
10 to basic business principles, we get what we
11 pay for.
12 And so those investments just, the
13 funding has not been there. And so I truly do
14 believe too in rural. One of the challenges
15 that we face within CMMI directly is we know
16 that by statute, they have to produce savings
17 or improved quality for the same cost, but yet
18 there's not enough I would say funding in
19 health care alone.
20 So you do have to figure out how to
21 bring in these other revenue streams from our
22 community perspective. So you know, there's a
23 lot of despair at whether it's USDA[19] grant
24 funding or, you know, mental health, at least
25 in the state of Pennsylvania, mental health

19 U.S. Department of Agriculture

1 payment is a separate payment stream.
2 Then you've got health care, you've
3 got dental, we've got vision. Then you've got
4 funding for other community benefit
5 organizations. But how do we build a system
6 that everybody aligns for the improved health
7 of the community? And bring those funding
8 sources together.
9 So I don't know that I have anything
10 new to share beyond the barriers, because I
11 think we all recognize that the barriers that
12 exist, a lot of it does come down to funding.
13 But in terms of innovative
14 solutions, I can tell you within the work that
15 we're doing, we are seeing hospitals invest in
16 care management strategies that typically have
17 been done thinking of primary care.
18 But how do we bring, you know, that
19 care management for the people that are using
20 the emergency rooms as their primary care?
21 There needs to be able to -- somebody step in
22 and allow for that care coordination.
23 So you know, innovative strategies
24 that I have seen, a lot of our hospitals are
25 investing in care coordination strategies
26 versus discharge planning. Discharge planning

1 has really been the work of the hospitals up
2 until this point. Now they're truly investing
3 in care management, care coordination.
4 Using peer recovery specialists
5 within our emergency rooms. So again, trying
6 to intercept where the need is and identify,
7 okay, how do we invest in a different type of
8 infrastructure that's certainly our payment
9 model we believe allows for that? Because it's
10 no longer looking on volume, but it really is
11 looking on value.
12 And then you know, social
13 determinant of health screenings. I'm a big
14 proponent of data. And I completely echo the
15 sentiments of my colleagues: data is greatly
16 lacking within the rural infrastructure. But
17 really, you can't fix a problem if you don't
18 know the problem exists.
19 So simple things like doing social
20 determinant of health screenings for certain
21 populations that come into the emergency room
22 or into the hospital. They're taking very
23 pragmatic approaches to say what can we do
24 within the confines, what resources do we have
25 available.
26 And I would say starting with very -

1 - you know, use data to identify pragmatic
2 solutions that can be done without maybe a lot
3 of additional funding. However, additional
4 funding is needed if we truly want to move the
5 dial.
6 So that's how I would answer that
7 question.
8 CO-CHAIR HARDIN: Thank you so much,
9 Janice. Meggan, we'd love to hear from you.
10 DR. GRANT-NIERMAN: So yeah, I guess
11 when I was thinking through this question, my
12 mind went to the concept of a little bit with
13 care management, but also with transitions of
14 care. Is that somewhat we can talk about at
15 this juncture?
16 CO-CHAIR HARDIN: Definitely.
17 DR. GRANT-NIERMAN: So the idea of
18 TCM[20] to transitions of care management from a
19 primary care perspective, that's something that
20 our clinic worked to do pretty well. And I
21 think with support from some of the data
22 structures from -- data dashboards from Aledade
23 that we used, we were able to improve on that.
24 But in rural, I think sometimes
25 transitions of care can be easy in some ways.

20 Transitional care management

1 For example, if I admit my patient from the
2 clinic to myself in the hospital, I see them in
3 the hospital, and I discharge them back to
4 myself in the one hospital in town. That's kind
5 of easy.
6 But a lot of our patients get sent
7 out. They get flown out to Denver, they got
8 flown out to Colorado Springs. And so those
9 are the transitions that are a little bit more
10 tricky.
11 Back to data, the ADT[21] feeds that
12 can go into our HIEs, health information
13 exchanges, that can be helpful. But truthfully
14 a lot of small clinics, small practices, small
15 hospitals can afford to access or choose not to
16 afford to access the rural health HIEs
17 appropriately.
18 And so there is a struggle that we
19 found of really unless they're across the
20 street from us, and we admitted them to
21 ourselves, is really figuring out timely ADT
22 feeds and triggers to let us know when our
23 patients are being admitted or discharged from
24 various places.
25 Long-term care facilities don't

21 Admission, discharge, and transfer

1 often feed in ADT data in the same way. So as
2 a small clinic, it's hard to hire yet another
3 full-time equivalent to chase down who's being
4 admitted where, when, and how, and how do we
5 capture them to transition them back.
6 For the most part, when we do
7 succeed at doing that, the other struggle comes
8 into, as was alluded to earlier, just the lack
9 of the wraparound services necessary in the
10 rural community to receive them safely so that
11 they can stay home. Timely home health.
12 Sometimes pharmacy ability to get your meds
13 once you get home.
14 In the community where I grew up,
15 the pharmacies are an hour apart from each
16 other. So most people have a 30-40-minute
17 drive to a town with a pharmacy. So getting
18 meds when you get home in a rural community,
19 sometimes that falls through the cracks.
20 So the support services to catch
21 them when they land at home and help them
22 safely stay at home can be a big part of the
23 struggle.
24 I think that our community rural
25 Critical Access Hospital, they discharge
26 planners who do one token phone call, 48 hours

1 of discharge to be sure that the patient still
2 has a pulse, and then they say follow up with a
3 PCP and call it good. I think that's about as
4 much as we have from the hospital side for care
5 management in that way.
6 From the clinic side, we had nurse
7 care managers who would bulldog these patients,
8 hunt them, find them, call them, chase them
9 down to try to manage their care, which worked
10 well for us, but also as was mentioned earlier,
11 that's an expensive overhead that was
12 unsustainable to be able to provide that good
13 care.
14 So I don't know if that's a good --
15 if that answers the question well.
16 CO-CHAIR HARDIN: Thank you so much,
17 Meggan. And Jen, we'd love to hear from you on
18 this question.
19 DR. BRULL: I think I have the
20 benefit of sort of seeing across about 1,500
21 practices that we partner with at Aledade. And
22 I think we've seen three ways that people are
23 successful in care coordination, including
24 transitions of care.
25 The first way is, as Meggan
26 referenced, an embedded person in the clinic

1 whose role is care coordination. Whether
2 that's a nurse or a social worker, but someone
3 whose job description includes the list of
4 tasks of making sure that patients receive the
5 services in connections like they need when
6 they're available within the community.
7 That faces the challenges of the
8 practice needs to pay that person, and there
9 needs to be a sustainable source of revenue to
10 support that person's work.
11 The second way I think that we have
12 seen success is when practices partner with
13 their communities and are taking advantage of
14 community-based grants and resources that are
15 designed to communicate and coordinate
16 resources.
17 So for example, if you have a city
18 planning grant or a health-wise county grant
19 that are working, you can oftentimes partner to
20 make those resources more transparently
21 available and accessible to your patient
22 population.
23 That relies on the presence of grant
24 funds and visionary people within your
25 community that are doing this kind of work so
26 that you're not trying to do it yourself.

1 The third way I think that we've
2 seen success is through the use of telehealth
3 and teleservices. So not all services that
4 patients need at the time of discharge or in
5 any other care coordinating setting are
6 available in a telehealth platform. But when
7 they are, and the primary resources here are in
8 the mental health arena, so counseling services
9 or access to mental health providers.
10 This tends to work pretty well
11 because people don't have to leave their homes,
12 and fortunately, there are fewer barriers now
13 about people having devices that are accessible
14 to be able to do telehealth type supports. And
15 now funding supports that for the people
16 providing that care, which means that there is
17 a revenue stream for doing so.
18 So I'm not going to downplay at all
19 the barriers that Janice and Meggan presented,
20 I think they are very real. And I can tell you
21 that as a practicing clinician, I absolutely
22 saw those every day.
23 And I think there are some bright
24 spots and some ways that if we amplified those
25 bright spots, so funding in advance for people
26 in the clinic, grant streams for people in the

1 community, and continued payment for
2 telehealth. I think that those are places we
3 can amplify where there's some good things
4 happening and spread that.
5 CO-CHAIR HARDIN: Thank you so much,
6 Jen.
7 Jim, I'll turn it to you.
8 DR. WALTON: Yes, thank you. I
9 think Jen and then probably Janice, I was going
10 to try to see if you both would comment on
11 this. When we looked at the data, we see some
12 bright spots in the rural communities, and we
13 understand that rural health care isn't 100
14 percent broken. That is in some places in
15 rural America, it's working, and especially in
16 value-based care.
17 But on average, we see the results
18 to be suboptimal in that by and large, when you
19 compare rural versus non-rural areas, we see
20 that the rural areas aren't making the kind of
21 progress that we hoped for with regards to
22 value-based arrangements.
23 And I was curious about I guess a
24 couple questions that kind of crossed my mind,
25 and I think Jen, you just kind of touched on it
26 a little bit.

1 But maybe there could be a little
2 bit more exploration here, which is what are
3 the -- what do you think are the
4 differentiating factors that create bright
5 spots within rural America when the story
6 sounds so dire?
7 And on the Aledade question, or even
8 Janice, in your organization, do you do
9 assessments before you go into a community, and
10 what are you looking for that would help you
11 predict success between one rural community and
12 another as you choose to work with these
13 organizations in order to kind of create
14 forward progress?
15 DR. BRULL: Sounded like you were
16 pitching that to me first, so I'll take a stab
17 at it. And what I understood you to say is when
18 we see bright spots, why are they bright spots?
19 And what sort of evaluation do we do or could
20 we do to find those bright spots as we're
21 looking for successful places?
22 So I think the answer to the bright
23 spots question is that all the barriers that
24 Janice and Meggan and I have presented are
25 lower in those places, as a starting place. So
26 we all see places where there are enough

1 primary care physicians to serve the community.
2 That means there's a little bit of capacity to
3 take on this new work of value-based care.
4 We see places where there are great
5 collaborations between the hospital and the
6 community physicians, between the community and
7 the hospital that really mean that there's a
8 chemistry there and a supportive environment
9 that make it a fertile place for this to grow.
10 And some of that is not very
11 predictable in the data, but you might see the
12 data and be able to find that in the community
13 that's there. I think that's hard when you
14 think about it. So how do we predict that.
15 I can share with you Aledade
16 absolutely looks for places where -- and I
17 wouldn't say where we think people will be more
18 successful, but where we will need fewer or
19 more resources to support the work of value-
20 based care. And we don't exclude practices
21 because they're not high performers. We just
22 see them as opportunities for a larger delta.
23 And so yes, there is data you can
24 look at. There's lots of data from CMS that is
25 available to help you spot where things are
26 happening well, where practices are delivering

1 what looks like great value-based care. You
2 know, how many AWVs have they done, how many
3 transitions of care have they done? What does
4 their readmission rate look like?
5 All the things that I think we all
6 know to look at or point at a community that is
7 doing better, whether intentionally or through
8 good luck. And most of the time it's very
9 intentional.
10 Having said that, we love partnering
11 with any independent primary care practice, and
12 when we see places where people are maybe not
13 as far along on their value-based care journey,
14 maybe they haven't had the opportunity to be
15 involved or be in CPCI or any of these other
16 initiatives, although that's getting to be a
17 smaller group of people, we just see that as an
18 opportunity where people may need to enter the
19 world of ACOs in a non-risk-bearing status.
20 And they may need a year to get
21 those muscles built and be ready to move to
22 risk. Being in risk is certainly a better
23 proposition from our perspective because it
24 incentivizes and rewards the work of value-
25 based care much more strongly than not being in
26 risk. But some folks just aren't quite ready

1 for that, right as they start.
2 CO-CHAIR HARDIN: Would any of our
3 other panelists like to comment?
4 MS. WALTERS: Sure. So I'm happy to
5 jump in here and add a couple thoughts as well.
6 So I've had a little bit more time to process
7 the question than Jen did, but I think I can
8 attribute the success of what we've seen to a
9 couple of things.
10 So the first is leadership. And
11 does, you know, the local leadership in these
12 communities recognize the need for change? And
13 so I will say at least in the Pennsylvania, the
14 Pennsylvania Rural Health Model Program, it was
15 all voluntary. You know, the leaders that came
16 to the table certainly I would say were
17 visionary, and they recognized the need for
18 change.
19 So certainly, you know, as we talk
20 to a lot of hospitals, talk to over 30-plus, 40
21 hospitals, 18 of which came to the table, I
22 would say it was more innovative leadership
23 recognized that there needed to be a change and
24 wanted to be part of that change, wanted to be
25 part of the test.
26 There were a few that came out of

1 desperation that they knew this program was
2 probably the only way that their hospital might
3 stay open. But even so, recognized the current
4 paradigm fee-for-service was not going to yield
5 them, you know, longevity for their
6 organization, but really leadership.
7 And I would say the forward-thinking
8 nature of leadership wanted to be part of the
9 new mousetrap or the solution.
10 The other thing, it's a very
11 pragmatic, does the math work? So we want
12 folks to go into value-based, but if that
13 value-based arrangement doesn't produce a
14 better result than what the current paradigm
15 is, why would they change? So Meggan gave that
16 example where she really wanted to be part of
17 this, but the math didn't work.
18 And so in terms of assessments,
19 whether it was in the Pennsylvania program or
20 what we do within the Rural Emergency Hospital
21 space, we start with does the math work? We
22 certainly educate what is the new potential
23 opportunity. But then the next step is does it
24 produce a better result than what you're
25 currently having right now?
26 Is there the opportunity for

1 improvement, is there enough incentive in that
2 value-based work that actually leads to a more
3 sustainable path?
4 To go back to a comment that I think
5 it was Jen made about the Critical Access
6 Hospital, I think that's one of the issues that
7 we currently see, that Critical Access
8 Hospital, you know, cost-based reimbursement.
9 That piece of the pie for many
10 states is getting smaller and smaller because
11 we see Medicare Advantage, you know, that
12 there's an increase in Medicare Advantage,
13 which is actually decreasing the opportunity
14 under cost-based reimbursement for the Critical
15 Access Hospital.
16 And the other thing that I like to
17 say about critical, it was great, but it still
18 keeps folks at cost. Even for that piece of
19 the pie, the best they're going to do is
20 actually costs are now slightly less than costs
21 with sequestration.
22 So how does even in value-based, the
23 hospitals that chose to participate in our
24 program for that Medicare book of business,
25 it's still cost-based reimbursement. How do
26 you ever get to where it's -- you can, you

1 know, have a profit margin if you always come
2 back to cost.
3 So the incentives have to produce a
4 better result in order for a leader to actually
5 embrace, the math has to work. So a very
6 pragmatic approach. Does the new paradigm
7 offer something better than the current?
8 So again, leadership, we do a
9 financial assessment to say the math works.
10 And then I think there has to be a commitment
11 to transformation.
12 So at least within the Pennsylvania
13 program, in exchange for that global budget,
14 that predictable payment, we ask them to make a
15 commitment. What are you actually going to put
16 to writing that you will commit to transform?
17 So it's one thing to say we're
18 moving to value-based, it's another thing to
19 actually be held accountable for that
20 commitment. And so thinking about the
21 hospitals and even in the Rural Emergency
22 Hospital space, you know, who's coming to the
23 table.
24 Obviously the math has to work in
25 order for them to even consider the new
26 designation. In the Pennsylvania program, it

1 was does the math work, do we have leadership
2 that's committed to making the transformation?
3 And I do believe that's what's
4 yielded the results that were shared in the
5 prior session where most of our -- you know, it
6 is favorable. The Medicare member per month
7 spent is still less than the national average,
8 and we have seen avoidable utilization
9 decrease. The right care being provided in the
10 right setting. And our quality indicators are,
11 you know, are being maintained.
12 So that's how I would answer that
13 question. Thank you.
14 CO-CHAIR HARDIN: Thank you so much.
15 Lee, I'll turn it to you next.
16 DR. MILLS: Thank you, Lauran.
17 Well, Meggan, my heart certainly
18 goes to you. I'm so sorry you're having to go
19 through this. But thanks for your commitment
20 and getting up each morning and serving your
21 community the best you and your partners can.
22 I'm fascinated by your all's
23 experience, you and Jen particularly, of going
24 from walking the walk on a value-based payment
25 journey with your patients from a practice
26 perspective, now larger to a system perspective

1 and trying to implement that from small to
2 large.
3 And so from a perspective of this
4 wrinkle you brought out about it’s hard to get
5 facilities who are often the employers, if not
6 the physicians directly, the assets you need to
7 connect the dots in a community, all those
8 employees. This wrinkle you brought out that
9 it’s hard to get leaders of cost-plus
10 reimbursed facilities to see that there’s any
11 squeeze for them, if you will, there’s no
12 juice.
13 So from an alternate payment
14 mechanism perspective, I would love to hear
15 your all’s advice. What would you recommend
16 that we can pass onto the Secretary that has
17 worked in changing the trajectory? If you had
18 the federal policy magic wand, how would you
19 pay in rural communities differently to change
20 the trajectory of these health systems?
21 MS. WALTERS: Well, I’m willing go
22 first. So I truly do believe that we get what
23 we pay for. And I think the Pennsylvania
24 program is testament to that. That we are
25 paying our hospitals a global budget. The
26 intent was predictable.

1 You know, as was brought out in the
2 prior session, that has proved to be
3 challenging. But that all comes back to the
4 current methodology. And I do believe there's
5 opportunity to refine methodology.
6 But if we truly want to engage
7 facilities on this journey, we have to align
8 the incentive that actually allows them to do
9 that, especially in rural communities.
10 So having been a former rural
11 Critical Access Hospital, you know, finance
12 leader for the organization, as much as I
13 wanted to like not have people presenting in
14 the emergency room because they didn't need to
15 be there, the reality is, is that rural
16 provider needs every billable service in order
17 to stay open.
18 They can't afford to naturally do
19 what's in the best interest of the community
20 when you need billable services just to keep
21 your door open. So if we truly want to engage
22 rural hospitals on this journey, we need to
23 align the incentive that actually allows them
24 to do that.
25 So one of my participant CEOs, when
26 he came to the program and signed on, he said I

1 feel this program for the first time actually
2 brought me to the table as a partner in this
3 journey, versus being treated as a cost center
4 with everybody trying to keep their patients
5 out of the hospital.
6 I'm now at the table as part of the
7 partnership, and no longer -- if I actually
8 keep people out of my hospital because they
9 don't need the care, and they're getting good
10 quality of care, and they're generally
11 healthier, I don't have to worry about payment
12 for that. I'm suddenly incentivized to help
13 reduce avoidable utilization.
14 And so it's allowed them -- and then
15 you give them the data that they need to
16 identify who's coming into their hospitals that
17 don't need to be there, suddenly there's the
18 incentive for them to hire the care manager, to
19 keep the patient out of the hospital. Because
20 they no longer have to fear their revenue
21 stream is going to be hurt because of it.
22 Now, you know, there are controls in
23 our program that we don't just want them going
24 someplace else. So we do have to monitor that
25 a little bit, that the patients are truly
26 getting the care they need, not being turned

1 away. And they're not going someplace else,
2 but they actually are being healthier.
3 So to me it's aligning the incentive
4 of how do we actually want these rural
5 hospitals to operate, recognizing we have to
6 keep the asset in the community. Because on
7 the flip side of that, if we don't do
8 something, we're not going to have rural
9 hospitals left.
10 And again, that's going to have a
11 domino effect, because oftentimes they're
12 employing the primary care, the specialty care.
13 So we want to make sure access to care remains
14 in the community, and I fully believe you do
15 that by fundamentally changing how rural
16 hospitals are paid.
17 I'm obviously a proponent of global
18 budgets, because even ACO frameworks are built
19 on volume. Most ACO frameworks, there's a
20 volume consent -- incentive. So if I have the
21 magic wand for something to come out of CMS, it
22 would be allow global budgeting more broadly to
23 rural hospitals across the country.
24 Because it really does allow them to
25 do what's in the best interest of their
26 community without having to worry about keeping

1 their doors open because there’s predictability
2 of payment. And then for Critical Access
3 Hospitals, there has to be some way to actually
4 get paid for value. Because the Critical
5 Access Hospital as it stands today still comes
6 back to cost.
7 So even if they do reduce avoidable
8 utilization for that Medicare fee-for-service
9 book of business, they run their cost report,
10 they get paid cost. It’s got to be a cost plus
11 a value type of incentive.
12 DR. BRULL: I’ll add. So having
13 worked in a rural community with a Critical
14 Access Hospital, and when we joined an
15 Accountable Care Organization in 2015 for a
16 2016 start year, the board, who are wonderful
17 people and are collaborative, were scared to
18 death that we were going to close their
19 hospital because of joining an Accountable Care
20 Organization and reducing the need for patients
21 to be in their hospital.
22 And that felt very scary for them.
23 Which, even though we are in a small community
24 and all friends, it made them feel very
25 defensive. The way that we got to an
26 immediately better place was to align not on

1 payment but on values, which is you are here,
2 and we are here because we want our community
3 to be healthier.
4 The work of accountable care and
5 value-based care is designed to make our
6 community healthier. And as soon as we got to
7 an aligned incentive, then we could have
8 conversations about how to make sure that it
9 did not result in a financial downfall for the
10 hospital.
11 And the way that we framed this in
12 our community is there's no doubt through
13 numerous studies that what patients need more
14 of is great primary and preventive care.
15 Hospitals can be part of primary and preventive
16 care.
17 And instead of focusing on revenue
18 from heads in beds, if instead we focus on
19 revenue that is on primary and preventive care,
20 helping our community be healthier with things
21 like fall prevention programs and preventive
22 imaging and preventive services and urgent
23 walk-in care instead of ER[22] care, if we can
24 flip the book of business for the hospital to
25 that side-- and we love for them to be in that

22 Emergency room

1 side, it's not a competition, it's a
2 collaboration. Then they could see how they
3 can both deal with their cost-based
4 reimbursement and be part of the solution for a
5 healthier community.
6 I'm going to plus one, though, to
7 Janice's comments that we need to think more
8 about how rural hospitals, particularly
9 Critical Access Hospitals, can be part of cost-
10 plus value. Because that's still a sticking
11 point.
12 CO-CHAIR HARDIN: Meggan, did you
13 want to add comment as well?
14 DR. GRANT-NIERMAN: I guess just
15 simply to agree with the idea of having
16 cohesive incentives across the medical
17 ecosystem.
18 And in our experience just day-to-
19 day, we would work very hard to keep a patient
20 from having to go through the emergency room
21 and get them over to the hospital for maybe an
22 infusion in the infusion center to avoid an ER
23 visit. And the nurse at the hospital would
24 say, uh, you should just go to the ER. And
25 then do everything we just did.
26 And it's because of those misaligned

1 incentives. And so kind of global as the
2 incidence across the medical neighborhood is
3 certainly important.
4 And then payment structures that
5 look at braiding funding from other federal
6 organizations outside of HHS and insurance so
7 that we can invest in the whole community. I'm
8 not for sure of the details, I'm not fully
9 educated on this.
10 But I believe some of the ACO
11 programs have a requirement where a certain
12 percentage of shared savings needs to be -- is
13 required to be reinvested into the community
14 for the health of the community. Is that
15 correct to people's understanding?
16 And so if there was a requirement
17 from the money that is saved to the payers,
18 that a certain amount of that can then be
19 reinvested to community structures and
20 supports, such as EMS, long-term care, public
21 health services, so that the community can
22 better strive to succeed in the health of the
23 community. I think that can be pretty helpful.
24 CO-CHAIR HARDIN: Thank you so much,
25 Meggan.
26 Angelo, I'll turn it to you.

1 CO-CHAIR SINOPOLI: Yes, so again,
2 thank you all for participating in this today.
3 Obviously rural health care is a big issue
4 nationally, and it's a big issue for PTAC and
5 CMMI. And hopefully we can come out of this in
6 the next few days and over the next few months
7 with some specific recommendations and programs
8 to address rural health care.
9 I think one of the very basic
10 questions that we've been wrestling with is
11 what is the definition of a rural community and
12 rural health?
13 And as we've looked at the data, it
14 doesn't come across as clear that there's one
15 single definition, that there's a spectrum of
16 rural environments, from those that have a
17 little bit more resources to those that have
18 very little and they're across the more -- a
19 different kind of geography.
20 So I'm curious to hear from each one
21 of you how you think about rural as a
22 definition of a rural environment and how you
23 would help us define that. And if you agree
24 that there's a spectrum of rural environments
25 and how you would help define those. So maybe
26 if we could start out with Meggan on that.

1 DR. GRANT-NIERMAN: Yeah, I’ve
2 recently learned to better understand that
3 there is a huge variation in how people
4 interpret rural. My interpretation of rural is
5 somewhat similar to maybe what Dr. Brull
6 experienced in Plainview, is what others might
7 consider actually frontier as opposed to rural
8 hospitals that are 40 minutes away from another
9 rural hospital.
10 So absolutely there’s a huge
11 discrepancy of physicians and patients who live
12 two hours from the closest cardiologist and
13 three or four hours to closest labor and
14 delivery, which would probably be considered
15 more frontier. But that’s the reality of where
16 I grew up and never thought otherwise.
17 That’s definitely legitimately rural
18 and frontier. And then we have small Critical
19 Access Hospitals in parts of the country, in
20 the Southeast, for example, that are wailing
21 and gnashing teeth because 40 miles away a
22 hospital closed, and God forbid we drive 45
23 miles to the next health care. To me that’s a
24 luxury, that’s lovely, to drive only 45 miles.
25 So absolutely frontier and rural are
26 two different things. I think that would be an

1 interesting opportunity when we look at risk-
2 stratifying health populations for value-based,
3 population-based dollars, is maybe a zip code
4 and distance from health care services-related
5 risk score that automatically helps stratify
6 those differences.
7 Because rural that is 50 minutes
8 away from Boston is not the same rural as
9 Plainview, Kansas. It's just not. And so the
10 resources, the finances, and the logistics are
11 just not the same.
12 CO-CHAIR SINOPOLI: Thank you. Jen.
13 DR. BRULL: Yeah, when you asked the
14 question, the phrase that came to mind is like
15 you know one when you see one. And that
16 doesn't help you at all.
17 I think Meggan's comments resonate
18 with me in terms of there is a spectrum. And I
19 think it's important to recognize the spectrum,
20 because people who are an hour from Boston are
21 still an hour from Boston, they're not in
22 Boston. And their challenges are different
23 than those who live in Boston suburbs and those
24 who live in Salida, Colorado, or Plainview,
25 Kansas.
26 And so I think recognizing the

1 spectrum is something I would advise. I will
2 double down on Meggan's comments that I think
3 there are some key drivers that you could
4 evaluate.
5 And some of that is distance in
6 miles and some of that is distance in time.
7 Because 45 minutes in Kansas is -- I mean 45
8 miles in Kansas is 45 minutes. Forty-five
9 miles in Colorado might be a couple of hours if
10 you've got some mountain passes to go through.
11 And so one of the things I would do
12 is recommend that you identify things like
13 where is the closest emergency services? Where
14 is the closest key specialty services, not
15 necessarily every specialty, but some of the
16 most important ones to primary care-sensitive
17 conditions?
18 Where is the closest obstetric
19 services? We have a lot of obstetric deserts
20 in the United States. And then how far are
21 those in miles and time to patients?
22 And I think that that, more than
23 population, is going to tell you who needs to
24 be considered and classified various strata of
25 rural health care services.
26 CO-CHAIR SINOPOLI: Great, thank

1 you. And now Janice?
2 MS. WALTERS: Yeah, I don't know
3 that I have a lot new to offer, other than to
4 echo Jen's sentiment that it has to be about
5 time as well. Because when you're dealing with
6 mountainous terrain, mileage does not show that
7 as it relates to going over mountains in the
8 state of Pennsylvania. And to the point of
9 mileage, a map only tells a portion of the
10 story.
11 So certainly that has proven to be a
12 challenge in our current program. We use a
13 state-based definition of rural. And so within
14 the Pennsylvania, within the state of
15 Pennsylvania, we had a definition of any county
16 that had less than 284 people per square mile
17 was deemed rural.
18 And I know when you're talking
19 frontier, that's a huge amount of population.
20 You know, we've certainly heard that. But that
21 did create some issues in terms of qualifying
22 for the program. We had hospitals in the state
23 that were deemed rural from a state perspective
24 but not from a federal perspective.
25 And so certainly definition is
26 something that would need to be solidified.

1 And I would also encourage to get other
2 stakeholders at the table to ask this question,
3 especially if you’re looking for all-payer
4 types of programs.
5 Because it’s one thing to come up
6 with a definition for a Medicare program, but
7 if we’re asking, you know, all payers to come
8 to the table, they certainly are more apt to
9 want to pay a global budget to one type of
10 rural hospital versus another type of rural
11 hospital that in their mind might be more
12 urban. But because of the county, the
13 demographic of the county, the hospital is
14 deemed eligible.
15 So I do think there’d be broader
16 stakeholders that we would get -- should get
17 their voice into that question, especially if
18 we are asking for all-payer types of programs.
19 CO-CHAIR SINOPOLI: Great, thank you
20 all, appreciate it.
21 CO-CHAIR HARDIN: Chinni, I’ll turn
22 it to you.
23 DR. PULLURU: Good morning,
24 everyone. And thank you, Meggan, particularly,
25 for your passion and all of the sort of
26 commitment that you’ve displayed. I know

1 having been in multiple VBC[23] transformation
2 roles, this is really hard. And you've spent a
3 lifetime doing the right thing for your
4 patients, and so thank you to all of you
5 panelists.
6 The question I have and would love
7 to hear from Jen and all of the panelists is
8 when you think about measurement and data
9 pooling for risk, I know one of the struggles
10 is really on how rural populations,
11 particularly RUCC 9 populations, have such few
12 eligible participants that it really, you know,
13 one or two outliers can throw the data off.
14 So I would love to hear your
15 thoughts and recommendations around how you
16 would envision data pooling around medical
17 service areas and counties.
18 DR. BRULL: Thank you. I'll bet
19 there are other folks who can speak to this
20 more eloquently than me, but I'll tell you two
21 thoughts that come to mind.
22 The first is in MSSP and in other
23 innovation spaces in general, rural folks are
24 aggregated, and I think that's very wise
25 because yes, if Jen Brull with her 200 Medicare

23 Value-based care

1 patients has an outlier in cost, it's going to
2 sink the whole boat. But if Jen Brull is a
3 member of an ACO that has 10,000 Medicare
4 patients, the one that I have that is an
5 outlier won't sink the ACO's boat.
6 So globally I think thinking about
7 larger denominators is a good thing for rural
8 folks. And anything you can do to make it
9 easier to aggregate lives across geographically
10 disparate populations is wonderful, which I
11 think we're in that space.
12 When I think about specific metrics
13 and measures and things like blood pressure
14 control and A1C control and some quality
15 metrics that we're working on, certainly you'd
16 like to be able to provide people with feedback
17 of their performance. And the more direct
18 feedback and transparent feedback you can give,
19 the easier it is to improve performance, both
20 in the quality and in a cost-based environment.
21 So I think that there's a balance in
22 that space between providing performance data
23 and using that data in an individual sense to
24 determine performance. And there's a
25 difference between someone who has 200 patients
26 and 100 percent, you know, 100 of them are out

1 of line for performance versus one of them is
2 out of line for performance. And I think you
3 can treat that data differently.
4 I think the other thing that
5 happens, helps is something that Meggan said
6 earlier, which is if you can align across all
7 payers, then you grow your patient population
8 and your denominator from a couple of hundred
9 Medicare patients to a couple of thousand all-
10 payer patients.
11 And that makes a huge difference
12 when you're looking at outliers. Because
13 you've just grown your denominator, but it's
14 the same person providing care to all of those
15 people.
16 DR. GRANT-NIERMAN: I would like to
17 agree with Jen for sure. We're not -- I hope
18 this doesn't come off as like the Aledade
19 celebration presentation, but we worked with
20 Aledade just for one year, and their dashboard
21 is awesome for providing meaningful feedback
22 and to aggregate a bunch of data.
23 So working with that organization
24 was really helpful for us as a small practice.
25 And then having enable the organization create,
26 at least start with the contracts of more

1 multi-payer alignment so that we're doing the
2 hard -- putting all the work in for the
3 Medicare dollars, and all the private payers
4 are just benefitting and just getting richer
5 from our hard work.
6 But actually having them recognize
7 and value the value-based work too was super
8 helpful, so I definitely want to agree with
9 that.
10 When you were talking about data
11 pooling as in aggregate pooling, O-O-L, or
12 pulling as in pulling data? I heard that two
13 different ways at the initial question.
14 DR. PULLURU: I was thinking about
15 aggregate pooling.
16 DR. GRANT-NIERMAN: Got it, okay.
17 And I'll let the next person talk at that point
18 then.
19 MS. WALTERS: Yeah, the only thing I
20 would add to what has already been stated is
21 really the identification of rural-relevant
22 measures.
23 So I do know that's one of the
24 things that within our Pennsylvania program,
25 you know, some of the metrics that were
26 originally identified to measure outcomes. You

know, we realized that they were necessarily rural-relevant.

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

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

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

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

And so if you standardized that

1 where everybody is pulling in the same
2 direction, it’s already been said before,
3 alignment, getting everybody to agree on what
4 the outcome is that we’re looking for and how
5 we’re going to be measured against that and get
6 that alignment at the beginning.
7 It makes the whole value-based
8 journey a lot less arduous for everyone
9 involved if we all agree on what the most
10 important outcomes are that we’re trying to
11 measure at the beginning.
12 DR. PULLURU: Thank you.
13 CO-CHAIR SINOPOLI: Larry.
14 DR. KOSINSKI: Well, first of all, I
15 want to commend Jay and the PCDT for compiling
16 such a fantastic set of SMEs[24] for this session.
17 There certainly is tremendous experience in the
18 three of you.
19 All three of you present a very
20 significant statement around the problem with
21 access. And that access not only has to do
22 with distance and time, it also has to do with
23 do you have available personnel to provide the
24 services?
25 And we can’t possibly put together

24 Subject matter experts

1 value-based structures if half of your patients
2 are leaking out to out-of-network specialty
3 sites that are 50 miles plus away.
4 So my question, and I don't think
5 we've -- I heard you address this, how do we
6 fully leverage the primary care base that we
7 have there? Jay eloquently presented the fact
8 that the disparity between the PCPs in rural
9 versus the PCPs in non-rural, although it is
10 less, is significantly less disparate than that
11 for the specialist.
12 I'm a gastroenterologist, so I keyed
13 in on his GI number, and there's six times as
14 many gastroenterologists in the non-rural area
15 as there are in the rural area. Which begs the
16 question of training and broadening the
17 expertise of the primary care.
18 My colleagues in GI will probably
19 not want me to say this, but we need to be
20 training PCPs to do colonoscopies more. And we
21 need to train dentists to do more than just
22 crowns. They need to do some endo and some
23 oral surgery.
24 So we can't build value-based care
25 unless we have the pieces there to perform the
26 care. So what are the three of you seeing done

1 to expand the PCP abilities and raise them to a
2 higher level of their performance than we'd see
3 in a more urban environment?
4 MS. WALTERS: So I'm happy to go
5 first on this one. I can tell you we fully and
6 firmly believe that in order to address the
7 needs in the rural communities where we're
8 present is we need to develop additional types
9 of primary care extenders.
10 So we certainly know that
11 transportation is a huge issue in rural
12 communities. So how do we develop other types
13 of resources in the communities that can, I'm
14 going to say stretch the primary care that's
15 already there through concepts such as mobile
16 integrated health?
17 So are there ways that through
18 protocols, and we can develop other folks to
19 support that care team and using, for example,
20 some mobile integrated health strategies,
21 working with technical schools in these rural
22 communities. Can we develop additional, I'm
23 going to say hands and feet of the primary care
24 provider that would be working in partnership
25 with them to expand that knowledge in the rural
26 community?

1 So one of the things we're exploring
2 is the use of mobile integrated health
3 solutions, broader peer medicine type programs.
4 How do we build out a better clinical team?
5 Because none of -- you know, the primary care
6 shortage. The ability to recruit a primary
7 care doctor to rural America, that challenge is
8 not going to go away in the near term.
9 But we also know one of the things I
10 believe, again having lived rural my whole life
11 and having watched the demise of my community
12 is, you know, how do we bring some economic
13 alternative career paths, et cetera, to start
14 addressing the economic issues in a lot of
15 these communities?
16 And is there a way to develop
17 alternative types of providers of, you know,
18 whether it's the community health worker,
19 paramedics, EMTs[25]? How do you develop other
20 types of care and allow them to practice at the
21 full extent of their license to bring
22 additional primary care to the community and
23 make sure from a payment policy perspective
24 that payment is there to allow for these other
25 types of providers to be paid and address the

25 Emergency medical technicians

1 need that way?
2 So that's how I would say we're
3 viewing this within the Pennsylvania program
4 and some other, you know, within the REH spaces
5 there's the opportunity to develop other types
6 of care. Providers to extend and partner with
7 the primary care that already exists in that
8 community to meet the needs.
9 DR. GRANT-NIERMAN: I can comment
10 just a little as well. So I did my residency
11 training at Via Christi, which is one the
12 handful of programs in the country that do
13 train their residents to do full spectrum
14 family medicine procedures with the intention
15 that they go to rural Kansas, rural Colorado,
16 Africa, you know, and do mission work.
17 And so there are a few training
18 programs that train family practice docs to
19 have the higher scope of practice.
20 And in my experience of watching the
21 classes of residents that go through, everybody
22 grabs the bull by the horns. We're going to
23 learn all the things and do all the things for
24 everybody everywhere. Nobody lasts that long
25 doing that because saying we should have the
26 family docs do the scopes, which back in the

1 day they did, many people have.

2 And eventually that's been burnt out

3 because you can't do everything well in an

4 environment where in a court of law you are not

5 going to be able to defend yourself against a

6 GI doc.

7 Do you know what I mean? Like the

8 medical-legal neighborhood of that, having them

9 do all the things, is really great, and it's

10 also very risky. And it's not very sustainable

11 with quality of life.

12 So I definitely agree that allowing

13 physicians who can be trained to do a higher

14 scope of practice is a great goal. There are

15 residency programs that do that, but those

16 residency programs have a hard time fighting to

17 maintain that training from the specialists at

18 that level to be willing to train FPs[26] to do

19 it. So there's a struggle.

20 And then when they get out there,

21 they realize that it's not compatible with life

22 to do the scopes, the deliveries, the C-

23 sections, the ER, the hospitalization, all the

24 clinic, all the social determinants of health,

25 solve the housing crisis. Don't forget to

26 Family physicians

1 check on them at home because EMS can't pick
2 them up. You may need to go and pick up their
3 prescriptions because we don't have pharmacy.
4 So in the same breath that we say we
5 need to support primary care, all of the
6 solutions all come down to we should ask
7 primary care, teach primary care to do that.
8 Let's add that to what they're doing.
9 So we're kind of squishing from both
10 directions, and in the middle saying oh, by the
11 way, we're going to financially squeeze you and
12 put you at risk too, by the way. So I'm
13 hearing a lot of interesting forces and
14 potential solutions that as a primary care doc
15 feel like a squeeze, a pull, and a push in
16 every direction.
17 So I agree that extending and
18 getting support networks within the community,
19 if that was possible to take off some of the
20 burden of doing things that physicians don't
21 necessarily need to be doing. Being very
22 mindful of not adding more administrative
23 burden to participate in value-based care.
24 Computer clicking boxes for the sake of
25 clicking boxes. Treating a payer and a
26 computer and a dashboard instead of a patient.

1 That's things that we're adding to
2 physicians as well in rural communities, and
3 then we're wondering why they aren't sticking
4 around. We have to be really mindful to pay
5 attention to all the things we're going to add
6 and ask of the already shrinking workforce.
7 Because what we're seeing is primary
8 care docs are saying I'm done with medicine, or
9 I'm done with the payers. I'm going to direct
10 primary care. I'm removing all of this. I'm
11 getting back to my patient, thank you, goodbye.
12 So I agree that family medicine docs
13 can deliver babies and do C-sections. I do
14 that currently. They can do scopes.
15 But to say that all the things can
16 be done by the PCP when there aren't enough of
17 them is a hard -- that will take decades of
18 culture change, medical-legal malpractice
19 change, financial change, reimbursement change
20 before that's I think going to be a reality
21 again.
22 I'm hopeful. I don't mean to sound
23 negative Nancy, because I really am hopeful,
24 and I love doing full-spectrum care, and I
25 don't ever want to stop delivering babies and
26 working in the hospital. I'm not going to stop

1 doing that.
2 But across the community, residents
3 aren’t trained to that. Residency programs are
4 disincentivized to train residents to do that.
5 And the medical community is actually not
6 welcoming to that kind of full-spectrum
7 provision of care from family medicine in most
8 parts of the country.
9 DR. BRULL: I want to amplify just a
10 little bit of what Meggan said, which is I
11 absolutely think family physicians are capable
12 of providing expanded services, with the caveat
13 if there are enough of us. Which means that
14 you get more lifting up than pressing down.
15 And there is a shortage of primary
16 care specialists in rural communities, just
17 like there's a shortage of gastroenterology
18 specialists in rural communities. And so I
19 don’t think the solution is shifting the work
20 of various preventive services, colonoscopies
21 being the example we’re talking about, but
22 there are just hundreds of them, to the primary
23 care specialist.
24 I think it’s more about ensuring
25 that there are a sufficient quantity of primary
26 care specialists to serve the population of the

1 United States, urban and rural. We just feel
2 the gap harder in the rural areas because there
3 aren't as many of the other specialties to take
4 care of the other parts of the patients in
5 those areas.
6 And to me that comes down to
7 reimbursement, which I think you all are
8 working to solve. I think value-based care is
9 the space for primary care to benefit from.
10 We are the folks who are looking at
11 people's total and comprehensive cost of care.
12 We are involved with every organ system, with
13 every transition, with every part of people's
14 lives when they are needing a health care
15 system.
16 And so I think the more that we are
17 able to make a path forward to do advanced
18 payments, do predictable payments in value-
19 based care, we will make primary care
20 specialties more desirable as a specialty to
21 pursue for students who are graduating from med
22 school, we'll increase the population of
23 primary care specialists throughout the United
24 States, which will in turn increase the
25 population of primary care specialists in rural
26 areas.

1 In addition, there are some really
2 nice incentive programs. And many places,
3 Kansas is one of those states where you can go
4 to med school for free if you're willing to
5 give four years of your time back to a rural
6 area.
7 And if we had enough of that going
8 on, even if we have a different population of
9 physicians coming and going in rural areas.
10 The problem is once somebody leaves, there's
11 not usually somebody in line to take their
12 place like there is in an urban area.
13 And so we just, we need to increase
14 those programs that pay primary care well and
15 that make it attractive for them to spend some
16 time in a rural area, just like they might
17 spend some time in Denver or Kansas City.
18 Thanks.
19 CO-CHAIR HARDIN: Thank you all so
20 much. We have about five more minutes left.
21 Jay, I'll turn it next to you.
22 DR. FELDSTEIN: Thanks. Janice, you
23 touched on my question briefly. You know, one
24 of the -- we're not talking about dentistry and
25 dental care today, but mobile dental care has
26 used to fill the gaps, because there's a

1 tremendous, you know, there's no access for
2 dental care in rural America, let's just call
3 it what it is.
4 And they've used mobile services to
5 fill the gap. So I'm curious for each of you,
6 what's your experience been with mobile
7 services to fill some of the gaps we're talking
8 about in health care delivery for rural
9 America?
10 MS. WALTERS: Yes, so I'm happy to
11 take lead on that. So not in this current
12 role, but when I was the financial leader for a
13 Critical Access Hospital in the state of
14 Pennsylvania, we actually did introduce mobile
15 clinics within our Rural Health Clinics.
16 And so that's how we began
17 addressing the need of lack of dentistry within
18 our service area, was to do mobile clinics and
19 bringing them into the Rural Health Clinics.
20 Generally, as I administrate, you
21 know, the programs that the Rural Health
22 Redesign Center has been privileged enough to
23 manage, we really do believe there's a huge
24 opportunity to do mobile integrated health
25 solutions. Anything from social determinant of
26 health screenings, you know, taking -- as

1 physician extenders can go into the home and
2 begin doing some of this.
3 Even things like prenatal. We have
4 a colleague that we work with who has
5 experience doing even prenatal work and doing
6 some of that through mobile integrated health.
7 Certainly we're not going to be delivering
8 babies.
9 But what are the opportunities that
10 if we develop the right workforce? Because
11 that also, that addresses some of the
12 transportation barriers.
13 So we do have examples of where this
14 type of program is working and certainly
15 looking to replicate that. But understanding
16 that policy changes will probably be needed.
17 Again, reimbursement at the federal level to
18 make sure that their reimbursement.
19 So for example, one of CMMI's
20 programs was the ET3[27], which, you know, it was
21 a reimbursement, alternative reimbursement
22 model that would allow EMS systems to get paid
23 through responding. Unfortunately in a lot of
24 these rural communities, traditional Medicare
25 is getting smaller and smaller.

27 Emergency Triage, Treat, and Transport

1 But we really need policies that do
2 allow for EMS to be reimbursed, not only when
3 they transport somebody to the hospital, but
4 when they go out and do this type of in-home,
5 making sure the reimbursement is there.
6 You know, the use of community
7 health workers, at least in the state of
8 Pennsylvania, all of that has been grant-funded
9 to date. And so allowing the policy, both at
10 the state and federal level, to make sure that
11 there's payment for these services is also
12 going to be a big piece. And then also the
13 workforce development.
14 So we think it's a very viable
15 strategy. But it's again getting education,
16 you know, your technical schools as well as
17 your workforce, you know, labor and industry to
18 the table. As well as policy then to make sure
19 that there's payment for these types of
20 services when they are delivered in the rural
21 community.
22 CO-CHAIR HARDIN: Jen and Meggan,
23 did you want to comment briefly?
24 DR. BRULL: I'll just give -- I'm
25 solidly nodding my head to Janice's comments.
26 DR. GRANT-NIERMAN: I don't have

1 much experience with mobile delivery systems to
2 have a -- have much to say.
3 CO-CHAIR HARDIN: Jim, I think we
4 can fit in your question then, if you make it
5 brief. So we have about three more minutes.
6 DR. WALTON: Yeah, my question is
7 really such a big question. It's about can the
8 market solve this problem, which is -- it
9 sounds to be like that the all-payer model,
10 particularly as an example, might be a
11 destination that we might want to look toward
12 as a solution to help make progress.
13 Can the marketplace be motivated to
14 do this, in your experience?
15 DR. BRULL: I'll give my one-liner.
16 Not until the marketplace has the same
17 incentives that we do. Not until saving money
18 makes you more money than putting a head in a
19 bed or getting a dollar for making a widget.
20 Like, we have to change the alignment of the
21 marketplace before they're going to help us
22 solve this problem.
23 MS. WALTERS: And I would echo that.
24 That would be we get what we pay for, and until
25 we change, fundamentally change the incentives.
26 So I do think we need to compete on something

1 beyond volume. And so I do think the
2 marketplace can, if we change what we’re
3 competing for, which is high-quality, improved
4 care, value-based.
5 So my answer would be yes, if we get
6 the right incentives and compete on something
7 different.
8 DR. GRANT-NIERMAN: I would agree I
9 guess with what the other two gals have said,
10 but I’m also -- just want to spit out the
11 curious nature of what the market is showing us
12 right now. Which is the overwhelming
13 investment from private equity, venture
14 capitalists, the vertical and horizontal
15 integration that is going absolutely haywire
16 and bonkers, because there is billions of
17 dollars being made by people who are not
18 providing health care, taking away care from
19 the patients who we claim we care about
20 serving.
21 And so I think the market is
22 speaking loudly and doing a lot of crazy and
23 wild things. In America, it’s probably a
24 little bit more urban than rural at the moment
25 where a lot of the money is.
26 But I think it’ll be curious to see

1 what the market does when Walmart now is the
2 provider of health care in rural Florida and
3 Arkansas, I think that's where they're already
4 starting. Or Intermountain Healthcare takes
5 care of all of the health care in this part of
6 the country. Like, there are big market forces
7 at play really quickly, really scary.
8 So I think that it'll be really fun
9 to watch the train wreck.
10 CO-CHAIR HARDIN: I want to thank
11 each of you so much for this very, very
12 valuable discussion. It's been really
13 interesting, and I know we could asking you
14 questions for another hour at least.
15 But you've helped us cover a lot of
16 ground during this session, and you're welcome
17 to stay and listen to the rest of the meeting
18 as much as you can.
19 At this time we have a break until
20 1:00 p.m. Eastern. Please join us then. We
21 have great lineup of additional guests, and our
22 first -- in addition to this first listening
23 session of the day.
24 So we'll see you back here at 1:00
25 p.m. Eastern. Thank you.
26 (Whereupon, the above-entitled

1 matter went off the record at 11:58 a.m. and
2 resumed at 1:00 p.m.)
3 *** Listening Session 1: Approaches for**
4 **Incorporating Rural Providers in**
5 **Population-Based TCOC Model Design**
6 CO-CHAIR SINOPOLI: Welcome back.
7 Angelo Sinopoli, one of the co-chairs of PTAC.
8 I'm pleased to welcome three experts who have
9 experience with how payment features can
10 encourage some of the innovations we've been
11 discussing earlier today.
12 You can find their full biographies
13 posted on the ASPE PTAC website along with
14 their overview slides. I'll briefly introduce
15 our guests and give them a few minutes each to
16 share an overview of their key takeaways.
17 First we have Ms. Aisha Pittman, a
18 senior vice president of government affairs
19 with the National Association of ACOs, NAACOS.
20 Aisha, welcome.
21 MS. PITTMAN: Good afternoon,
22 everyone. Thank you so much for having me. If
23 you go to the next slide, just a little bit
24 about NAACOS. We are an association that
25 represents more than 400 ACOs, an MSSP,

1 Medicare Share Savings Program, the ACO REACH[28]
2 model, and then other CMMI models. And our
3 members are also engaged in risk value
4 arrangements with other payers.
5 We really appreciate PTAC's interest
6 in examining the barriers to rural provider
7 participation in total cost of care models. I
8 think, if we are to ever reach CMS's goal of
9 having 100 percent of traditional Medicare
10 beneficiaries, in a clinical relationship
11 responsible for total cost of care and quality,
12 we really need to think about how we bring more
13 participation to rural providers, including
14 Federally Qualified Health Centers, Rural
15 Health Centers, and Critical Access Hospitals.
16 So if we go to the next slide to get
17 into some of our recommendations, we're really
18 thinking about this from the perspective of how
19 can we bring more rural providers into the
20 existing ACO models which are strong total cost
21 of care models.
22 Ultimately we really have to
23 recognize that rural providers are
24 fundamentally different in how we pay them, the
25 populations they serve, and the unique

28 Realizing Equity, Access, and Community Health

1 challenges. The one size fits all approach has
2 not worked, and we need to adapt existing total
3 cost of care models or create new models
4 targeted towards rural providers.
5 I think efforts to bring rural
6 providers into total cost of care must account
7 for access. And so we have to really build
8 everything from maintaining or increasing
9 access to care. And potentially that also
10 means having a lower focus on reducing costs.
11 Because ultimately some of the lower
12 cost care settings might not be available. If
13 we think about the lack of specialty care,
14 urgent care, and post-acute care. That's a
15 unique challenge that you might not have in
16 other areas.
17 So for example, in the absence of an
18 inpatient rehab facility, the care may need to
19 be delivered in a Critical Access Hospital.
20 That represents a lack of an opportunity for a
21 rural community to lower costs that might be
22 available in other cities.
23 So from here I want to go through,
24 if we're using the ACO as a chassis for
25 increasing rural provider participation, what
26 are some of the opportunities to improve the

1 current models for rural providers?
2 So on to the next slide, wanting to
3 first think about attribution, so ultimately
4 ACOs are built on this primary care
5 relationship. If we think about some of the
6 providers in rural settings, this creates
7 several limitations.
8 So one being that many rural
9 practices do not include a physician and
10 therefore don't drive attribution. We hear
11 from our members with significant penetration
12 in ACOs, but they lose a lot of attribution
13 just because they have several NP[29]-only TINs[30].
14 And the current construct for attribution in
15 ACOs is all based around a primary care visit.
16 So needing to think about that a
17 little bit differently, if we look at, for
18 example, Federally Qualified Health Centers, a
19 significant portion of their -- they have a lot
20 of patient churn and so therefore can't
21 maintain attribution from year to year.
22 Additionally the billing at the
23 facility level makes it difficult to understand
24 when are attributing beneficiaries to your ACO

29 Nurse practitioner
30 Tax identification number

1 and through which providers?
2 Some potential solutions in this
3 area are to create rural-specific attribution
4 approaches. So does that mean one of the
5 things would be attribution steps for certain
6 rural providers so you could have, say, an
7 advanced practitioner provider attribution just
8 for rural communities, looking at multi-year
9 approaches of alignment in attribution to
10 account for the churn that the rural providers
11 tend to see?
12 If a patient's only having a visit
13 occasionally, then they might not attribute to
14 the ACO from year to year. So how can we
15 expand that and look at more years?
16 And then just additional data is one
17 thing that we strongly heard from our members,
18 being able to better understand how and why
19 providers are aligning to the ACO.
20 If we go to the next slide, I wanted
21 to talk about benchmarks and the challenges
22 that exist there. So FQHCs, RHCs, and Critical
23 Access Hospitals all operate under unique
24 billing and reimbursement conditions which
25 present challenges to the participation in
26 total cost of care models.

1 We think about FQHCs and RHCs. They
2 are limited to being reimbursed for one service
3 per day. So this creates a scenario where the
4 FQHCs can deliver multiple services per visit,
5 but they're only getting paid for one service.
6 This has led to a climate where
7 clinicians are often picking and choosing what
8 services they provide patients. And then
9 sometimes the patients have to come back for
10 additional services.
11 This just creates a challenge in
12 when you want to think about how you redesign
13 care delivery because of the restrictions of
14 the existing payment system.
15 I think another example for FQHCs
16 and RHCs is they are prohibited from providing
17 the annual wellness visit and any chronic care
18 management in one day. They tend to provide
19 these things both in one day, but it doesn't
20 get captured in billing. And so it becomes
21 difficult to really assess what type of care
22 that they are providing.
23 We think about a Critical Access
24 Hospital. They're paid under a cost-based
25 reimbursement system. So 90 percent of their
26 costs for fixed and opportunities for spending

1 reductions are limited.

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

10 Another challenge with regard to
11 benchmarks is around the risk adjustment
12 approaches. So in the existing payment systems
13 for these settings risk adjustment is --
14 there's no incentive to focus on risk
15 adjustment.

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

24 It's just under-emphasized because
25 of the historical approach for reimbursement in
26 those settings. And so you have to think about

1 are there ways to adjust risk adjustment for
2 these populations that historically don't have
3 significant coding documentation.
4 Some potential solutions in this
5 area, you know, when we're thinking about total
6 cost of care, this is where we might need
7 additional models. So thinking about global
8 budgets or prospective population-based
9 payments, those are options that are really
10 attractive to rural providers.
11 I think, when CMMI was considering
12 the CHART model that was going to be a rural-
13 based population model, there was some interest
14 in that. I think timing prevented, and
15 mandatory Medicaid participation prevented that
16 from moving forward.
17 I know with the recently announced
18 AHEAD model that would be a global budget
19 focus. That is something that can address some
20 of those overarching payment challenges in
21 rural settings.
22 Some other things to think about are
23 lowering the discounts of minimum savings rates
24 for rural providers in risk-bearing models,
25 just recognizing that you might not be
26 accounting for the historical costs in the

1 current benchmarking approach. And so their
2 ability to create additional savings is
3 limited.
4 In terms of the risk challenges I
5 mentioned, adapting risk adjustment policies so
6 you do not disadvantage sicker populations,
7 this could be things like accounting for the
8 lack of historical coding. So you could
9 increase the risk caps for rural populations or
10 beneficiaries without historical access to
11 care.
12 And also as, I think is a hope, is
13 to bring in more social risk factors over time
14 to improve the risk coding methodology.
15 There also have to be some
16 considerations for specific costs that are
17 unique to rural communities. You know, I heard
18 an example from one of our members that they
19 had two needs for air ambulance in a year. And
20 because of that significant cost, it was going
21 to cause them to exceed their benchmarks for
22 that particular performance year.
23 That is something that is much
24 harder to account for. And so we need more
25 outlier approaches so that we're not penalizing
26 the ACOs for these minor changes of care.

1 And then I think additionally is
2 thinking about alternative measures of success
3 to financial benchmarks. So is it that,
4 instead of saving cost constantly, maybe it is
5 that you're reducing your trend over time.
6 And then if I go to my final point
7 around flexibility within the models on the
8 next slide, I think one of the things we
9 overarchingly hear is that providers need
10 additional technical -- rural providers need
11 additional technical support to participate in
12 models.
13 Things that our members have raised
14 is that the waivers tend to be a one size fit
15 all approach as well, so thinking about waivers
16 in models and that are specific to rural
17 providers.
18 So for example, for the FQHCs in
19 rural health communities, waiving the one
20 visit/one site requirement, making it easier to
21 provide Hospital at Home, removing some of
22 their face-to-face billing requirements for
23 certain services, like the annual wellness
24 visits and then, I think, providing more
25 avenues for rural providers to understand the
26 impact of the total cost of care policies on

1 those providers.
2 I just described three settings, the
3 FQHCs, Rural Health Centers, and Critical
4 Access Hospitals, where they are, to date,
5 participating in ACOs. But when they’re asked
6 to seek support of how their payment system
7 interacts with the ACO, it’s really hard to get
8 answers, so having much more of a focus of how,
9 and more detailed information from CMS for how
10 those providers can meaningfully participate in
11 any value-based care model.
12 And that sums up my comments. Thank
13 you so much for your time.
14 CO-CHAIR SINOPOLI: Great
15 presentation, thank you, Aisha. Jackson?
16 DR. GRIGGS: Hello. I’m really
17 honored to visit with you today and really
18 appreciate the opportunity. I’m particularly
19 honored to be included in the discussion with
20 Aisha and Mark Holmes. These guys are truly
21 subject matter experts. I’m just boots on the
22 ground in central Texas. So I’m going to speak
23 fairly generally.
24 But I want to start, next slide,
25 with Texas. Texas holds the distinction of
26 having the largest rural population in the U.S.

1 with over 70 percent of its counties housing
2 fewer than 50,000 residents.
3 Rural Texas is economically vital
4 though. It produces an impressive 50, sorry 21
5 billion in annual goods. But the region's
6 beset by challenges, high rates of poverty,
7 educational shortfalls, food insecurity, which
8 intensify health challenges.
9 Next slide. So here in Texas we've
10 re-purposed a maritime term to fit our cattle
11 industry. A bum steer in Texas signifies a
12 deal that doesn't deliver as expected. So
13 rural health systems see the move to
14 value-based care in that light.
15 So value-based care translates to
16 underfunded initiatives that pile on
17 responsibilities without truly addressing the
18 unique challenges of rural Texas health care.
19 Next slide. So to illustrate my
20 main argument, I'm going to use Abraham
21 Maslow's familiar hierarchy of needs that was
22 first described in 1943. This hierarchy, you
23 know, starting from basic physiological needs
24 ascends to self-actualization. But you've got
25 to satisfy each level before progressing on.
26 So next, clinical systems operate in

1 a similar fashion. The end goal is a health
2 care system that offers equitable health care
3 to all segments of the population. But
4 reaching that summit of health equity first
5 demands foundational infrastructure followed by
6 financial stability.
7 Because how can rural health systems
8 envision delivery reform to achieve health
9 equity when they're just trying to pay their
10 nurses a fair wage, and bankruptcy is
11 constantly nipping at their heels?
12 With financial security, then
13 integration within the broader health and
14 social ecosystems can be achieved. And once
15 integrated, then we can arrive at true quality
16 in aggregate. But of course, in aggregate
17 doesn't mean that health equity, a situation
18 which everyone in society has the opportunity
19 to thrive, has been achieved.
20 Health equity is a national moral
21 imperative. But for medicine in particular,
22 health equity is intrinsic to our core bioethic
23 of justice. So it's critical that we invest
24 sufficiently to get there. So how do we create
25 systems in underfunded communities to achieve
26 health equity?

1 Next, so my aim in this model is to
2 present a conceptual framework, obviously not
3 to offer precise financial calculations. What’s
4 crucial is recognizing the need for
5 foundational investments before assuming
6 capacity of higher-level performance.
7 Next. In a nutshell, I'm suggesting
8 that foundational investment’s necessary before
9 there can be expectations of high performance.
10 And such investments should be rooted in proven
11 methods, and tailored to specific rural
12 demographics, all while safeguarding our
13 already overburdened health care professionals
14 from the burnout risks associated with clinical
15 practice and systems change.
16 Next. More about us, our FQHC
17 resides in the heart of Central Texas through -
18 - so our service area is McLennan County and
19 the city of Temple, but the patients from 14
20 counties seek our services.
21 Next. This depicts that region
22 there.
23 Now, next, in the same region
24 several Rural Health Clinics and Critical
25 Access Hospitals are managing to stay
26 operational on a shoestring.

1 Next. But if we zoom into that same
2 area, we find numerous small communities, each
3 housing less than 2,000 residents, spread
4 across an area that exceeds the size of the
5 state of Delaware.
6 Next. A staggering 73 percent of
7 our FQHC patients live below the federal
8 poverty level with a third lacking any form of
9 insurance. And of course, in Texas, Medicaid
10 has not been expanded, and FQHCs have also
11 missed out on the state's 1115 waiver benefits.
12 And this creates dire challenges.
13 And in light of these constraints,
14 patients drive long distances in a centripetal
15 pattern to see us. Patients carrying a
16 disproportionate burden of chronic illness,
17 mental health conditions, substance use
18 disorder, and health-related social needs
19 associated with their rural circumstances.
20 Next. Could value-based care help
21 with this? Well, what we've learned from our
22 initial experiences in a hospital-centric ACO,
23 with a traditional MSSP, well, it would suggest
24 no. It can't.
25 A hospital-focused approach misses
26 numerous opportunities for quality, equity, and

1 cost reduction. Benchmarking based on an
2 already underfunded region is
3 counterproductive. And superficial changes are
4 seductive distractions when scarce funding has
5 made your imagination for significant delivery
6 reform rather cachectic.
7 So to boost participations, three
8 things are needed: a front-end investment in
9 infrastructure to allow rural health care
10 sufficient buffer to take risks associated with
11 delivery or reform, a glide path to total cost
12 of care, and meaningful measures that are
13 properly incentivized.
14 Next. So this then brings me to a
15 nascent idea. I was asked to consider what it
16 might look like to create an APM leveraging the
17 assets of an FQHC. So I'll try to describe
18 that here. Remember how I mentioned a minute
19 ago that our patient flow is centripetal?
20 Well, what if we made the model centrifugal?
21 What if we met the patients where they were in
22 a tailored, community-focused model?
23 Next. There are 1,400 community
24 health centers in the United States, each with
25 a designated service area. In rural settings,
26 expanding these areas often isn't viable due to

1 lack of economies of scale.
2 But in a value-based hub and spoke
3 model anchored in a community health center,
4 that could pose potential solutions. It would
5 allow health centers to widen their service
6 footprint by forming strategic partnerships,
7 aligning with HRSA[31]'s vision and CMS
8 objectives.
9 Potential ACO partners would include
10 kind of obvious players, FQHCs, rural
11 hospitals, local mental health agencies, while
12 local allied contributors would consist of
13 various interested community parties.
14 Next. The rationale for a primary
15 care centered approach is straightforward. Why
16 a primary care centered? It's the most direct
17 route to achieving population health and health
18 equity.
19 Next. Moreover, the primary care
20 approach is intrinsically holistic. It's
21 relationship-based, community-focused,
22 tailored, and integrated using
23 interprofessional teams where the patient is at
24 the center.
25 Next. And that tailored approach

31 Health Resources and Services Administration

1 creates trust, which is a really big deal in
2 Texas.
3 Next. And rural regions grappling
4 with health care professional shortages, an
5 interprofessional primary care team isn't just
6 ideal, it's indispensable. A team approach
7 ensures quality outcomes while preventing
8 burnout of the precious few physicians
9 available.
10 Next. Now why ground a total cost
11 of care model in the FQHC framework? Well, for
12 starters, FQHCs already embody principles of
13 justice, and frugality, collaboration, and
14 accountability. They also bring tangible
15 benefits like the Medicaid PPS[32] rate, the FTCA[33]
16 coverage, and the 340 B program.
17 Next. So if these are all of our
18 constituent pieces, let's conclude by
19 discussing how to piece together a locally
20 tailored FQHC anchored hub and spoke model
21 collaboration.
22 Next. Division structure as
23 concentric circles, with the ACO at its core,
24 supported by the aforementioned allied

32 Prospective Payment System
33 Federal Tort Claims Act

1 contributors in the immediate periphery, and
2 more
3 distally supported by state and national
4 agencies playing imperative roles in financing,
5 you might even also consider USDA or other
6 non-traditional health care funders for SDOH[34]
7 investments.
8 Next. Since there's little to no
9 risk tolerance within rural health care, and I
10 mean even in the investment of existing staff
11 time and resources, much less downside
12 contractual risks, there needs to be a clear,
13 simple glide path to progression.
14 Next. Heeding NASEM[35]'s insights
15 both structural and programmatic resources
16 should be considered and these should be goal-
17 aligned.
18 Next. Prioritizing structural
19 resources means bolstering existing rural
20 systems so that they can confidently embrace
21 population-based total cost of care frameworks.
22 Next. And Congress' role includes
23 sufficiently funding HRSA to support rural
24 health care. And subsequently HRSA, via your

34 Social determinants of health
35 National Academies of Sciences, Engineering, and Medicine

1 primary health care and the federal Office of
2 Rural Health Policy, should allocate
3 unprecedented new funds for rural initiatives.
4 CMS through CMMI should pave the way
5 for FQHCs to spearhead discussions on a
6 tailored MSSP model for rural communities. And
7 concurrently, CMS should incentivize non-
8 expansion states to prioritize FQHCs and total
9 cost of care strategies through 1115 waivers.
10 And then finally, my last slide,
11 next, is -- oh, sorry, one back, is
12 programmatically -- we'll get this right here.
13 There you go, perfect. That's very good.
14 So programmatically, if an MSSP is
15 designed for a rural population, it should be
16 simple. And it should revolve around primary
17 care. It should utilize existing resources for
18 Critical Access Hospitals, FQHCs, and local
19 mental health authorities. And it should
20 emphasize initial investment and rural health
21 infrastructure. Thanks so much.
22 CO-CHAIR SINOPOLI: Thank you. That
23 was a great presentation also, Jackson. Just
24 to reassure you, we do value the input from
25 front-line providers that are out there doing
26 the work.

1 And lastly, we have Mark.
2 DR. HOLMES: Great. Thank you for
3 inviting me here today. I look forward to
4 sharing my thoughts. So I was charged with
5 discussing, focusing on attribution.
6 Next slide. And so I'm going to put
7 the highlights up front. My key takeaways here
8 are that, starting off first, most attribution
9 schemes have a design assuming -- it says PPS,
10 it really should have said fee-for-service data
11 flow.
12 Although recent modifications have
13 been more flexible, and based on that, a second
14 point, I don't think there's a lot of evidence
15 -- I should put it this way, I don't think
16 attribution, per se, is a major factor
17 inhibiting rural provider enrollment.
18 There's certainly some thoughts.
19 And I think what Ms. Pittman outlined in
20 particular, I think, are a couple issues to be
21 considered. But I think if we had this
22 discussion five years ago, it would be a pretty
23 different point I would make on this. But I
24 think some of the recent changes have addressed
25 that. And we'll get into that a little more in
26 a minute.

1 The third point is that the cost of
2 non-PPS payment schemes that are attributed to
3 providers may often be higher, which makes cost
4 savings more challenging for those with
5 beneficiaries seeing rural providers.
6 And I want to stress that last part
7 there. I'm saying beneficiaries seeing rural
8 providers which is different from rural
9 providers. And Ms. Pittman outlined a number
10 of these CAH, cost-based Medicare upper payment
11 limit as it relates to Rural Health Clinics.
12 But I think, as we talk about this
13 in particular, the notion of different payment
14 structures for some types of rural providers
15 mean that it can be really challenging to fit
16 that in a fee-for-service type setting that we
17 normally think of value-based payment models
18 being built on.
19 And then finally, other challenges
20 in rural context, such as the ability to manage
21 financial risk in infrastructure, and the
22 infrastructure to manage utilization, may be
23 more important than attribution per se.
24 It's always interesting to go last
25 on a panel, because I've been -- certainly
26 circumstances where the first person raises

1 points, and I'm, like, oh, I'm going to say
2 something totally different. But I think 80
3 percent of what Dr. Griggs and Ms. Pittman have
4 covered are aligned with my message as well.
5 So that's a great sign.
6 I can go through the next slide
7 relatively quickly since this is a recap that
8 we've sort of covered. We saw the data on the
9 far left which is sort of the Notre Dame colors
10 that GAO[36] likes to use. It's contrasting rural
11 and urban participation on the left along with
12 a number of challenges that inhibit
13 participation in ACOs. And we'll talk about
14 some of these. And some of them have certainly
15 already come up so far today.
16 Next slide. So just a quick review
17 for attribution and that payment models
18 generally depend on the attribution of
19 beneficiaries or members, depending on whether
20 we're thinking of private or public systems, to
21 one provider.
22 And I'm using provider in a very
23 general sense here. It might be grouped around
24 a TIN, it might be a system, it might be a
25 clinic, it might be an individual health

36 Government Accountability Office

1 professional. But for the purposes of this,
2 it’s not really critical.
3 A typical rule is that the
4 beneficiaries assigned to the provider with a
5 plurality of E&M visits or payments for the
6 year with some sort of tiebreaker there.
7 So generally it’s what, you know,
8 who did the patient, did the member, did the
9 beneficiary see, and where did they get the
10 preponderance of their care, and how do we
11 measure that?
12 But the key design requirement built
13 in that is that provider payments, and really
14 more accurately data, but a primary source of a
15 lot of our data comes from payments, is that it
16 has to align with a PPS or, again,
17 fee-for-service system.
18 So, if you're not submitting payment
19 reimbursement that’s in that system, you’re
20 losing that ability to align them. And Ms.
21 Pittman really explained that much better than
22 I can in the context of some of the elements
23 that she raised. Particularly, Federally
24 Qualified Health Centers is a great example.
25 So if the reimbursement data do not
26 support this type of model, then those

1 providers cannot be included. And so a common
2 approach in the past has been to say, well, we
3 don't know what to do with them, so we're going
4 to leave them out, which is a pretty typical
5 rural story.
6 And there's an example there, the
7 Oncology Care Model exempted Rural Health
8 Clinics, Federally Qualified Health Centers,
9 Critical Access Hospitals in Maryland as well,
10 and just saying we don't know what to do, so
11 they're not going to be eligible to
12 participate.
13 And so there's a lot of interest, of
14 course, in saying okay, this isn't sustainable
15 if we want to have the value-based payment,
16 Alternative Payment Models on as broad a
17 provider-base as possible. So we need to come
18 up with new approaches.
19 Next slide. So MSSP is built on it,
20 so taxpayer identification number, or TIN. I
21 deal mostly with hospitals, and so think in
22 CCNs[37]. And this is how we think about
23 providers.
24 But providers that have a large
25 presence in rural areas, such as Rural Health

37 CMS Certification Numbers

1 Clinics, Critical Access Hospitals,
2 particularly Method 2 where what we would
3 normally think of as Part B service is billed
4 through the hospital. And Federally Qualified
5 Health Centers bill through CCNs not TINs. And
6 so a logic that's built on TINs is stuck from
7 the beginning and has no place to go.
8 And so there were fixes to this. As
9 an example, the 21st Century Cures Act, along
10 with others, have added these to qualified
11 providers by saying all right, well, we can't
12 see exactly what the care is that you got from
13 RHC and FQHC. So we're going to assume that
14 they're all primary care services. And so
15 therefore any visits to an RHC or FQHC we're
16 going to deem as a primary care service and
17 qualify that for attribution.
18 That's probably, well, the extent of
19 my expertise, such as it is, probably says it's
20 not clear that's unreasonable, but was the fix
21 in order to include those providers into an
22 attribution method.
23 Now it bundles those at the CCN
24 level. So if you have multiple Rural Health
25 Clinics under one CCN, as you might if a
26 provider-based RHC, for example, under one

1 hospital, then that would be bundled under one.
2 Again, we can have discussion about whether
3 that's appropriate.
4 Another similarity of that would be
5 Vermont's approach for Medicaid, as we covered
6 earlier, where they addressed the fact that,
7 for example, with Medicaid churn, looking at
8 attribution based on last year wasn't going to
9 work as well.
10 What happens if I have a beneficiary
11 who has never gotten primary care services?
12 That's going to be a challenge. And so they're
13 attributed based on population base.
14 I don't really have another place to
15 put this, but I'm going to raise it here as
16 well in that -- can you go back a slide, sorry,
17 Amy -- is that we also need to think about
18 bypass and selection.
19 And so what I mean by that is
20 certainly in the hospital literature there are
21 multiple studies that have shown, as a rural
22 resident, I have two options. I can get my
23 health care locally, or I can go and get it
24 from a larger facility, typically in a non-
25 urban setting.
26 And we know that lower-income

1 Medicare beneficiaries are more likely to get
2 their health care locally, whether that's
3 transportation needs, or transportation
4 limitations, or other challenges that make it
5 harder to go those farther distances.
6 So what that means is that at the
7 hospital level you have a lower-income Medicare
8 base than you do based on the population. And
9 if those same principles hold in a primary care
10 setting, it would be the same sort of story
11 here, that if I don't have a car, I don't have
12 choice where to go. And so there may be a
13 disproportionate level of lower-income at the
14 local level.
15 Okay. Now, Amy, you can move
16 forward. So Ms. Pittman raised this point as
17 well in her challenges, that coding is
18 substantially different in rural and urban
19 settings. Hierarchical condition categories,
20 which we use for risk adjustment, generally the
21 scores are lower for those who see rural
22 providers. Again, I'm choosing my words
23 carefully there.
24 This may be an accurate measure of
25 risk, but it also may be that rural providers
26 do not code as completely as urban providers,

1 generally. And Aisha got into that fairly
2 well.
3 The call-out on the right-hand panel
4 there is from a study that RUPRI[38] out of, well,
5 a rural health value consortium of RUPRI and
6 Stratus Health out of Iowa put together where
7 they did sort of an in-depth analysis of one
8 particular rural ACO. And they also outlined
9 challenges with coding.
10 And, you know, if you go to one of
11 these, well, larger facilities have more
12 ability to really train their coders to
13 understand coding, the ramifications of long-
14 term coding. But if you're someone whose
15 billing doesn't depend on that, you're just not
16 going to be as complete with that.
17 Next slide. Other considerations,
18 and really all of these fit under the larger
19 bucket of it all comes back to volume, and my
20 sort of approach to most of rural health is
21 that volume is king.
22 And we can read these in depth here,
23 but basically most of these come back to the
24 idea that with fewer lives, members,
25 beneficiaries, patients, whatever you want to

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1 call those benes, you're often going to have
2 lower liquidity.
3 You're spreading your fixed costs,
4 which includes not just direct costs for
5 technology and infrastructure. But also harder
6 to understand costs such as expertise, and the
7 time to invest, and understanding what these
8 models look like, are spread over fewer people.
9 And mention again that broadening
10 the base across multiple payers may be helpful.
11 And we heard that earlier as well from Janice.
12 Last slide, dealing with referrals
13 and costs, and I mentioned this earlier as
14 well, in that when you're looking at -- and
15 there was an allusion to it earlier, that for
16 many types of services, care is going to be
17 higher, if not much higher cost in rural areas.
18 And so what that means is that, for
19 not just rural providers but also urban
20 providers, who are looking at, I would use the
21 word steering patients, and whether, let's
22 suppose I'm a rural bene, I get my care in an
23 urban hospital. My post-acute, I have the
24 option to stay 50 miles away from my family or
25 go to the rural place which might be 20 percent
26 higher cost.

1 You know, from a total cost of care
2 standpoint, the provider providing that care in
3 the bundle is going to be incentivized to keep
4 it in their urban low cost setting. We have a
5 study to look at that. This particular
6 citation is from GAO.
7 So, I'm at my 11 minutes. Sorry for
8 being over. And thank you for your time today.
9 CO-CHAIR SINOPOLI: Great
10 presentation, Mark. Three really good
11 presentations just loaded with information.
12 So we're going to move to some
13 questions now. And PTAC members, if you have
14 questions, if you'll flip your name cards over,
15 I'm going to start out with a couple of
16 questions, and then look to the PTAC members to
17 chime in. They've been asking a lot of great
18 questions earlier today.
19 So earlier today Liz Fowler was
20 here, and she actually gave us some ideas of
21 things that she was curious about. And I like
22 the idea that one of you mentioned about
23 building a foundation before we build the
24 skyscraper.
25 And so I'm interested to hear from
26 you all very specifically, what few things

1 would you prioritize as we change our models in
2 regards to looking at rural health care? What
3 would you prioritize, and why would you
4 prioritize those?
5 And so maybe if I can start out with
6 Jackson on that one.
7 DR. GRIGGS: Well, you know, I'm
8 going to quickly defer to my colleagues on what
9 the levers are. But, you know, just in the
10 NASEM implementing paper the argument was made
11 that we just need more of the percentage of the
12 overall spend on health care to go to primary
13 care.
14 And I think that is particularly
15 important in rural settings. I think that how
16 that happens, how we get more dollars to flow
17 into rural primary care, you know, well, I
18 think that it's going to be dependent on
19 whether we're talking about rural and far West
20 Texas or rural Massachusetts.
21 I mean, there's going to be
22 different levels of readiness to move towards
23 something that's risk-bearing and could acquire
24 more of the shared savings, for example.
25 So I think that how those dollars
26 flow is probably more of a question for someone

1 with a little more familiarity with what the
2 different levels are.
3 CO-CHAIR SINOPOLI: Great, thank
4 you. Aisha?
5 MS. PITTMAN: Yes, I'll say two
6 things. I think one is more up-front
7 investments for rural providers. I think we
8 all documented just the technical challenges.
9 And we've seen that come into place in MSSP,
10 but I think we need to think about it globally
11 across any potential model.
12 And the second thing would be just
13 ensuring that any total cost of care model has
14 the right adequate budget. So I mentioned
15 things about accounting for differences that we
16 see in risk, differences in that the patient
17 populations.
18 There's a lot of debate currently
19 around how much is regionally versus nationally
20 weighted if you're defining a benchmark. So I
21 think if you set it more regionally, it can
22 address some of the challenges that we see with
23 benchmarks and their impact on rural providers.
24 CO-CHAIR SINOPOLI: Great, thank
25 you. And Mark?
26 DR. HOLMES: Yes, in addition to

1 those points, I think I'm going to expand on
2 Aisha's last point in particular in thinking
3 about the benchmarks. There's price
4 standardization as a common approach for
5 looking at this. So, for example, for post-
6 acute care in rural, providers may be more
7 expensive than in urban settings.
8 To the extent that those are
9 included in the benchmarks, and recognized that
10 we as a society have made a decision, and
11 recognized that
12 financial sustainability may be more
13 challenging in rural areas, and have designed
14 some payment methods that recognize that, and
15 yet that offers often a barrier for meeting
16 benchmarks that are not aware of those rural
17 provisions.
18 COCHAIR SINOPOLI: Thank you. Jim?
19 DR. WALTON: Thank you. Great
20 presentations, I appreciate all the input. I
21 think the Committee benefitted a lot from what
22 you guys have shared with us.
23 I wanted to pick up on a theme that
24 I've been thinking a little bit about, and
25 wanted to ask you guys what you think about it,

1 which is, Mark, you brought up the HCC[39] risk
2 scoring. And we've heard about this earlier
3 today, that there's reasons why rural providers
4 may not focus on that as a strategy as much as
5 urban providers in value-based care.
6 My question just kind of circulates
7 around this idea that what about the social
8 risk, what about Area Deprivation Index as a
9 proxy for social risk, and that an interplay,
10 if you will, with the ADI of a community with
11 diagnostic coding risk to identify communities,
12 or differentiate different communities within
13 the rural definition, that may have more
14 combined risk, both diagnostic and social.
15 And the follow-on question to that
16 would be which federal departments would you
17 recommend HHS collaborate with to stack funding
18 streams for the motivated rural areas to
19 address their vision for improved health and
20 health equity?
21 DR. HOLMES: I'll tackle that first,
22 I guess, and I think others can weigh in. So
23 I'll do the second part first, simply because I
24 remember that question better, other federal
25 agencies. I think USDA has a number of

39 Hierarchal condition category

1 economic development approaches, and
2 particularly from a loan standpoint.
3 And I'm very sympathetic to Ms.
4 Pittman's point about the up-front costs. I'd
5 love to see that as a grant or recognized
6 within the program. But loans may also be
7 another mechanism.
8 USDA tends to focus on larger
9 facilities such as hospitals and the like. But
10 that may be an important avenue. CDC[40] has an
11 Office of Rural Health that they're standing up
12 now. They're looking for, it's my
13 understanding it's a long-term sustainable
14 funding.
15 And I think, when you think about
16 public health, and social needs, that's a great
17 partner right there at the CDC to really
18 leverage the exciting work that they've been
19 pushing into this as of late. Those would be
20 the two that I would start with, the federal
21 agency standpoint.
22 The first question, see, I knew I
23 would forget, can you remind me, Jim? Sorry.
24 DR. WALTON: Yes. The idea of
25 leveraging the Area Deprivation Index --

40 Centers for Disease Control and Prevention

1 DR. HOLMES: Yes, thank you.
2 DR. WALTON: -- as a proxy for
3 social risk and somehow combining it with the
4 HCC scores to get a better, maybe more clear
5 view of the risk of a population within
6 different rural areas.
7 DR. HOLMES. Yes, I think that's a
8 very compelling case. The thing that always
9 makes me pause with these models is you have to
10 be really careful to not have a two-track
11 system. And by that I mean say, oh, if we get
12 40 percent for low income, that's just as good
13 as getting 60 percent for high income. And it
14 makes it seem like we're lowering the benchmark
15 and is sort of antithetic to health equity.
16 So finding a model that recognizes
17 there may be additional challenges with social
18 needs, if you don't have transportation, it's
19 harder to get you your follow-up care, but not
20 setting a benchmark lower for populations with
21 more needs, just coming up with a model that
22 balances those two competing interests.
23 MS. PITTMAN: I'll just elaborate on
24 that. And I think ADI is a sort of tool that
25 we have that we could use in leverage today.
26 But ideally, you would want to, like, use

1 patient reported social risk factors to
2 incorporate over time. And I know there's
3 efforts by the agency to encourage better
4 collection of that.
5 On the ADI, just some lessons we've
6 learned from its use in REACH is it needs to be
7 regionally adjusted. If you're just using
8 national ADI, you are going to, in any
9 benchmarking approach, disadvantage urban
10 communities that also have other challenging
11 needs.
12 And then beyond that, I think the
13 challenge that we see in REACH is that ADI is
14 used to adjust the benchmark up or down. So
15 those with -- I forget whether -- some have a
16 lower benchmark and others have a higher
17 benchmark.
18 I think there's a recognition that
19 for vulnerable communities, it's just
20 additional money needs to go in. And you
21 should be lowering the benchmark of other
22 providers to give it to different ones. So it
23 needs to be -- the budget neutral approach
24 that's used in ACO REACH is not something that
25 would be sustainable more broadly.
26 CO-CHAIR SINOPOLI: Any others want

1 to comment on that before we move on?
2 DR. GRIGGS: I think this is
3 probably apparent to everyone, but in terms of
4 coding, you know, we've got big urban systems,
5 you know, hospital systems that are billions in
6 budget who have a whole workforce that's
7 dedicated to optimizing coding. And then
8 you've got, you know, Rural Health Clinics and
9 FQHCs that just don't have any infrastructure
10 to maximize coding.
11 So it's sort of the -- I think it's,
12 so I don't know literature well enough to be
13 able to articulate where the evidence is at
14 sort of the national level, but based on
15 personal experience, you know, we're just not
16 able to spend our resources without seeing a
17 clear ROI[41] there.
18 And I think that's the key. It's
19 that this is sort of the argument to simplify,
20 simplify. It's when we're engaging rural
21 health communities that have dilapidated
22 infrastructure, you know, there has to be a
23 very clear, if you do A, you will get B. And
24 here's the timeline for the investment before
25 you'll see a return on that investment.

41 Return on investment

1 Because everybody is just peddling
2 as fast as they can already without the
3 capacity to see why we would add more staff in
4 order to improve coding, unless there’s some
5 clear return on that.
6 CO-CHAIR SINOPOLI: All right, thank
7 you.
8 So given what we’ve heard from you
9 all and we’ve heard this morning, what
10 considerations should be made when we are
11 thinking about measuring quality in rural
12 providers? And what performance measures would
13 you consider most appropriate for rural
14 providers, and how can rural providers'
15 performance most appropriately be linked to
16 payment?
17 And we’ll start out with Jackson.
18 DR. GRIGGS: Well, I think that we
19 need to move all of our quality-based metrics
20 towards patient-centered metrics. And I think
21 that that poses its own challenge sort of
22 across urban, suburban, rural environments.
23 But I think specific to rural
24 environments, you know, the accessibility,
25 responsiveness to individual needs from the
26 time an individual needs an appointment to when

1 they can achieve that appointment, what is the
2 length of time there?
3 Again, I think from a patient-
4 centered standpoint, the effectiveness of
5 communication with an emphasis on clarity and
6 empathy, capacity of a therapeutic plan to
7 incorporate the patients' unique values,
8 obviously preventative screenings, timely
9 interventions, hospital readmissions, I think
10 all of those things could be potential metrics,
11 integration of primary care, behavioral health,
12 oral health, into social services, into care,
13 and the degree of integration.
14 I mean, I think that that we've got
15 to include measures of disparities in outcomes.
16 How close are we getting to health equity by
17 looking at disaggregated data, by
18 subpopulations, particularly race
19 subpopulations?
20 Those are some thoughts on how do we
21 move towards more patient-centered measurements
22 particularly in rural settings.
23 CO-CHAIR SINOPOLI: Great, thank
24 you. Aisha, can you address that?
25 MS. PITTMAN: Yes, I would just
26 concur with everything that Jackson just said

1 in terms of how do we assess providers in a
2 particular model? I think more globally, if
3 we're assessing if a model or an approach is
4 working, we would also want to look at measures
5 of access, so not necessarily assessing access
6 at the provider level, but does the model help
7 retain access in communities that are at a
8 threat of losing access to care?
9 CO-CHAIR SINOPOLI: Great. And
10 Mark?
11 DR. HOLMES: I think both Aisha and
12 Jackson have covered it very well. I have
13 nothing to add.
14 CO-CHAIR SINOPOLI: Perfect, thank
15 you all. Any other questions from PTAC members?
16 If not, so I'll pose the question,
17 how do we get past the small number of benes
18 issue, which is obviously a common issue in
19 small practices in the rural areas.
20 And I'll start with Mark on that
21 one.
22 DR. HOLMES: So the approaches that
23 we've just discussed, I think, get us a long
24 way there, so something that's patient-
25 reported, for example.
26 From a hospital setting, for

1 example, one of the few quality measures that
2 is consistently available at a hospital level
3 is HCAHPS[42] satisfaction, so looking at patient
4 reported satisfaction, anything that's based on
5 broad-based was probably going to get us
6 farther along than something like control for
7 people with diabetes, which is going to limit
8 your percentage of eligibles pretty quickly or
9 the denominator.
10 This has been a standard challenge,
11 a long-standing challenge. And I think there's
12 a reason it remains out there, in that the
13 solutions aren't super palatable. And it's all
14 going to entail compromise.
15 Statisticians will tell you, oh,
16 here's an opportunity for a Bayesian model,
17 with shrinkage, but it's really hard to tell a
18 provider, yes, you got 15 out of 15 right, but
19 we're going to call that 87 percent, because
20 that's closer to the mean.
21 And so we really have to deal from
22 an accountability and transparency standpoint,
23 something that people can understand when
24 you're talking about putting dollars at risk or

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1 any sort of financial incentives as well.
2 So I think there's another reason
3 why measures of access, satisfaction,
4 integration, that were just previously
5 outlined, are far more compelling than some of
6 the more traditional quality or cost which is
7 going to be highly variable if you get one area
8 ambulance, one broken femur. All of a sudden
9 your total cost is out the window.
10 CO-CHAIR SINOPOLI: Yes. And I
11 think part of my asking that question was to
12 also address the actuarial risk with such low
13 numbers which you did. So appreciate that.
14 And so I'll move to Aisha for the
15 same question.
16 MS. PITTMAN: I mean, I think in
17 terms of the actuarial risk, we have approaches
18 that work if we look at, like, an ACO model
19 that allows providers to remain independent but
20 share actuarial risk across a larger group of
21 providers.
22 And then I think what happens in
23 there is they're using quality metrics that are
24 different than what you assess at a population
25 level. They get to more individual metrics in
26 terms of how they shift or reward individual

1 provider level care.
2 I think the small N is always going
3 to be a challenge to getting to individual
4 provider level care. And if we look at things
5 like access to more population health metrics,
6 you need to access those from a larger group of
7 aligned providers, which is essentially what
8 the ACO model does.
9 CO-CHAIR SINOPOLI: Jackson?
10 DR. GRIGGS: Yes. I just think it's
11 really difficult when we're talking about
12 FQHCs, and Rural Health Clinics, and
13 particularly traditional Medicare. I mean
14 those numbers are just really, really small for
15 those populations.
16 So if you have larger FQHCs, I mean,
17 again, just working through this in my head,
18 thinking about that kind of hub and spoke
19 model, if you have larger FQHCs that can have
20 multiple sites in smaller communities, again,
21 you get to potentially numbers that work.
22 You know, obviously, like Aisha
23 said,
24 the ACO tries to account for that, but that ACO
25 ends up having, again, for a Medicare
26 population, ends up having to rely heavily on a

1 lot of front-end work, building the
2 relationships, maintaining the relationships.
3 The HIT, which we haven't gotten to
4 in rural environments, is just terrible. I
5 mean, there’s just no sophisticated health
6 information technology workforce or systems
7 base in rural environments to gather the data.
8 So I think all that says there’s got
9 to be front-end investment like we started with
10 in order to get the collaborations built, the
11 HIT developed, and even the technical
12 assistance in developing a properly fit ACO
13 when there are so many MSSP options to sort of
14 select from.
15 So all that’s got to be kind of
16 baked into any initiative to get rural health
17 up to play.
18 CO-CHAIR SINOPOLI: Okay. I like
19 that. And so going back to my actual first
20 question, if we put more money into primary
21 care, and we’re paying for up-front costs, what
22 do you all consider the most important thing
23 that you want to make sure that money goes to?
24 Obviously putting more money into
25 primary care, not necessarily go into their
26 biweekly paycheck, but what are they using that

1 money to invest in? What do you think are the
2 top three priorities that we need to make sure
3 they're focused on with that money?
4 Again, start out with Jackson again.
5 DR. GRIGGS: So the vision for the
6 interprofessional primary care team has not
7 been realized in large part because there's not
8 funding for health professions outside of
9 traditional medical providers.
10 So if I had community health
11 workers, if I had social workers who were on my
12 team, if I had nutritionists who could join me
13 and help, life coaches, I mean, there's a whole
14 array, promotoras, doulas. There are proven
15 strategies that we just can't pay for right
16 now.
17 So I think that staffing the
18 interprofessional primary care team is one of
19 those top three. Then I think data reporting
20 infrastructure, and so health information
21 technology would be a key second.
22 And then just back to my, kind of,
23 Maslow's hierarchy, there are so many
24 infrastructural things, you know, we're one of
25 the larger FQHCs, we have 62,000 patients, and
26 we just can't retain nurses, because we can't

1 pay market rates, you know?
2 I mean, we're competing with big
3 hospital systems that have had big mergers of
4 huge economies of scale. And we're competing
5 for the same stuff. So there's a lot of just
6 basic infrastructural things that with more
7 dollars flowing into primary care we could
8 address just to stabilize our basic operations.
9 MS. PITTMAN: Yes, I would, this is
10 Aisha, concur exactly with what Jackson said.
11 And then also one thing additional is just
12 increased investment in primary care.
13 And then particularly if you're
14 doing that as a population-based perspective
15 payment, you can get rid of some of the
16 constraints of being limited to providing
17 services that are simply in the CPT[43] book and
18 addressing a broader set of services. And I
19 think this is the way that we're going to be
20 able to address social needs a little bit
21 better as well.
22 DR. HOLMES: Yeah, I like that. And
23 so I've written down Jackson's
24 interprofessional care teams, I think, being
25 critical. But as we heard earlier, if there's

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1 no social organizations that can address those
2 needs within 50 miles, you're kind of stuck.
3 So I call this partnership
4 cultivation. I'm not sure exactly what that
5 means, but helping, working with the community
6 to help address those needs and make sure those
7 resources are there. Identifying someone who's
8 food insecure is helpful, but less so if you
9 can't say, well, here's where to go next.
10 CO-CHAIR SINOPOLI: Good, thank you.
11 So can any of you identify rural models out
12 there that have been demonstrated to work well?
13 And can you cite those and give us some insight
14 into those?
15 DR. HOLMES: I think the evidence is
16 we have tends to be those that are more
17 integrated, so system-based looking. I'm going
18 to try not to identify any specifics, but those
19 that are really cross-services, systems that
20 include inpatient, outpatient, post-acute,
21 something that looks closer to a global budget
22 type setting where you don't have the
23 incentives that have been identified over the
24 last five hours, I guess, four and a half hours
25 at this point.
26 Because the fact of the matter is

1 that, for many rural services, it is hard to
2 compete financially because of that volume.
3 And so if we can find a model that recognizes
4 we, as 340 million Americans, have decided that
5 we're willing to help support those rural
6 places, because we think health care is a
7 right, and as I'm driving down I-80 in the
8 Midwest, I hope that there's a hospital there
9 in case I have accident.
10 Now again, that's antithetic to most
11 of what we're talking about here, so all that
12 is to say, the original question was, oh, where
13 does it work best? And those are places where
14 you have multiple providers usually, you know,
15 acting as one. That often is something that
16 could be as formal as one dominant system.
17 CO-CHAIR SINOPOLI: All right, thank
18 you. Aisha?
19 MS. PITTMAN: Yes. I think,
20 elaborating, I agree with that point about
21 seeing where you can implement global budgets,
22 that's something that we've heard from our
23 members. While, you know, they could say that
24 the ACO model works for rural providers, I
25 think I brought to the table a lot of the
26 things where we would want to see it shifted.

1 Those shifts in an ACO model work,
2 but I think also there’s a desire to think
3 about global budgets and the advantage of
4 global budgets being that they’re all-payer,
5 and that the model's not just limited to just
6 Medicare fee-for-service, but it’s across the
7 board.
8 And I think one of the things where
9 we’ve seen it's been successful in that
10 approach for rural providers is in the Maryland
11 model in stabilizing payment to rural
12 providers.
13 CO-CHAIR SINOPOLI: All right.
14 Jackson?
15 DR. GRIGGS: I don't have examples
16 like Aisha and Mark, but there was a paper that
17 the Federal Office of Rural Health Policy put
18 out that was titled a Guide to Rural Health
19 Collaboration. 2019 is the date on that.
20 And they gave some practices that
21 were working in terms of collaborating between
22 rural agencies, one of which I just illustrated
23 in the appendix of my slides. It happened to
24 be with a Critical Access Hospital and FQHC,
25 that demonstrated some improvements in cash on
26 hand and net margins for both entities once

1 they began to collaborate.
2 CO-CHAIR SINOPOLI: Perfect, thank
3 you. Chinni, do you have a question?
4 DR. PULLURU: Thank you to our
5 panel. This question is, to start out with, for
6 Mark and obviously also the rest of the panel.
7 I want to hear your thoughts as well.
8 When we talk about, you know, what
9 I'm hearing through this discussion is
10 basically that in a systems-based sort of
11 perspective payment or population-based,
12 interprofessional primary care teams should be
13 incentivized. And access, Aisha had mentioned
14 access as well for a possible quality metric.
15 When you take the three of those
16 together, one of the things that's been floated
17 is a solution in providing access care and good
18 care to rural-based populations is telehealth.
19 So I'd love to hear your thoughts on how
20 telehealth, whether it be removing barriers and
21 restrictions, or it could be an attribution
22 model if embedded into sort of a total cost of
23 care.
24 DR. HOLMES: That's a great
25 question. Thank you for that.
26 So for years we've been saying the

1 promise of telehealth, and it wasn’t until
2 March 2020 that we really started seeing it get
3 utilized. Of course what we saw is that urban
4 -- I’m being careful, I think it’s urban
5 beneficiaries ended up using telehealth more
6 than rural which, I think, kind of surprised
7 some people but is really consistent with what
8 we talked about with broadband barriers and
9 the like, for example.
10 So one thing, and this is an
11 opinion, I’ve not found any studies, and I
12 continue to look for this, I think when we talk
13 about telehealth, we have to be really explicit
14 about who's benefitting. And by that I mean as
15 a resident beneficiary.
16 You know, I love telehealth. When
17 my son broke his toe on the beach, I was able
18 to hold the phone over it and get a consult
19 within 20 minutes when nothing around me was
20 open.
21 That was great for me. But as
22 telehealth becomes more accessible, I’m not
23 sure what that means for care that used to go
24 locally to the rural. So if, for example, in
25 that case, my trade-off was go to the ED, the
26 urgent care that's just down the road, instead

1 I connected with someone, I don’t know where
2 this telehealth unit was based, that was care
3 that was now being delivered at an urban
4 setting.
5 So if we’re talking about rural
6 providers, I think we still don’t know yet what
7 the ramifications of that are. I think we're
8 just starting to see the data come in. If we’re
9 talking about rural beneficiaries and rural
10 patients, I think it seems pretty clear that
11 telehealth is a net plus.
12 And I want to also separate, let’s
13 call it, what, rural specialty, so things like
14 telepsych, or sorry, telespecialty, so
15 telespecialty, so telepsych, I think, is a very
16 different ball game. If there’s nothing with -
17 - if I cannot find a mental health professional
18 within an hour of me, but I can connect to
19 something locally, yes, that’s great. And I
20 can get access to it.
21 But I think it’s a, what, triple
22 edged sword. I’m an economist, so I always say
23 on this hand and on the other hand. But there
24 might actually be three hands in this case,
25 just being mindful of what it is that -- the
26 multiple ramifications of telehealth and how it

1 impacts different populations, I think, need to
2 be thought out carefully.
3 DR. PULLURU: Jackson?
4 DR. GRIGGS: Yes. I think it's a
5 question of if you build it, will they come?
6 And while I whole heartedly agree
7 with Mark that there’s a broadband issue in
8 rural populations that would have to be
9 addressed, then there is, in addition to what's
10 the best fit for telehealth in terms of
11 clinical practice, this issue of trust. You
12 know, what’s shocked me during the pandemic was
13 how evidenced medical interventions became
14 polarized along the political spectrum and how
15 the trust in the traditional institution of
16 medicine eroded very, very quickly.
17 I think that when we’re thinking
18 about rural populations, we have to apprise the
19 culture of the different ruralities. Again, I
20 mentioned before, you know, West Texas versus
21 Massachusetts rural might be very, very
22 different.
23 I know that telehealth, as a one
24 size fits all, I don’t think if you build it,
25 they will come. I know in our community, we’ve
26 had, well, we’ve had telehealth up since -- I

1 think it was April in 2020. We've just seen
2 very sluggish uptake.
3 And people were very quick to return
4 to their primary care clinician but have been,
5 despite all of our promotion and marketing to
6 try to make it as easy as possible,
7 particularly the aging population just has not
8 had a large uptake in -- so, there's some
9 medical skepticism.
10 There's some erosion of trust in the
11 industry of medicine. But I certainly trust
12 this doctor who I know. They're my family
13 doctor. Of course, I trust Dr., you know,
14 Smith. But seeing a stranger on a screen,
15 there's just layers of kind of cultural
16 barriers, I think, for a lot of rural
17 populations.
18 DR. PULLURU: Aisha?
19 MS. PITTMAN: The only one quick
20 point I'll add to Mark's point of we didn't
21 really see telehealth use until 2020, and I
22 think while there have been telehealth waivers
23 available in any sort of model test, it has not
24 been expansive of -- permitted during the
25 public health emergency.
26 So I think it just -- in thinking

1 about how different communities will utilize
2 telehealth, we also have to think about how
3 it’s restricted and where we want to waive the
4 current fee for service requirements and really
5 open up telehealth in the context of value
6 models.
7 Those concerns about fraud and abuse
8 are really mitigated when you’re responsible
9 for a population and are going to ensure -- and
10 for cost and equality you’re going to ensure
11 that they’re going to have in-person visits
12 when necessary and utilize telehealth as
13 available.
14 And we just haven’t had that in the
15 models to date. So I think we can take lessons
16 learned from the pandemic, and apply that in
17 any sort of value arrangement.
18 DR. HOLMES: Yes. I’d just add on
19 that that sometimes telehealth can help with
20 things that you couldn’t get otherwise.
21 There’s a narrative I heard, which we always
22 have to be careful with that, but someone
23 talking about a telehealth with one of their
24 patients. And they were bundled up in a jacket
25 and a blanket.
26 And they’re like, what’s going on?

1 Like, well, my heat was cut off two days ago.
2 Oh, you might not have picked that
3 up in office visits. So, the ability to
4 sometimes get a different perspective on
5 circumstances that may be affecting health care
6 is maybe enhanced in a telehealth setting.
7 DR. PULLURU: Thank you.
8 CO-CHAIR SINOPOLI: Yes, thank you.
9 Lauran?
10 CO-CHAIR HARDIN: I'm going to ask a
11 tiny question, but I think it's interesting,
12 and it's repeatedly come up, related to rural.
13 So I think a lot about transportation. So,
14 we've talked about hubs, we've talked about
15 telehealth. But I'm curious what each of you
16 are seeing or if you have seen innovation in
17 really solving for transportation.
18 I work with many rural counties in
19 design, more for Medicaid populations, but I've
20 seen some interesting things there emerge. And
21 then I personally, when I'm not traveling, live
22 on a farm in Appalachia.
23 And there is an underground railroad
24 for getting people to health care that occurs
25 in the mountains where people know who to call.
26 And that's how you get fast enough to an

1 emergency room that can treat you, or to pain
2 management, or other things. So it just has
3 made me reflect interestingly.
4 So the question is have you seen
5 innovation in solving for transportation? And
6 what has that looked like outside of the
7 telehealth?
8 DR. GRIGGS: I'll be real quick. We
9 just started using Uber Health, the ride
10 sharing program. And I think that that may
11 offer us, you know, some potential ways in
12 which to bring some of our remote rural
13 populations in to see us.
14 However, we're eating that cost
15 right now. I mean, if we were moved towards
16 population-based total cost of care, global
17 cap, you know, obviously that would be part of
18 the spend. But right now it's something we're
19 just eating.
20 DR. HOLMES: I love Lauran's story.
21 To me this is -- we want to think about rural
22 with an asset-based lens, and there aren't many
23 assets that we can leverage. And one of those
24 is the social capital. Social connectedness is
25 often much higher in rural communities. And
26 you've given a perfect example for that.

1 Whether it's built around, you know,
2 the school, or the house of worship, or
3 whatever, I think that's a great opportunity.
4 But of course, you're leveraging a volunteerism
5 base which is more difficult to take the scale.
6 So I think that's important to address. The
7 micro-transit that Jackson had mentioned I've
8 written down as well.
9 And then a third would be community
10 paramedicine where if I have an EMS truck
11 that's "not doing anything," basically, at a
12 time, then I can use that for house calls and
13 can address a lot of this interprofessional
14 care as well.
15 So I think that's not technically
16 addressing your transportation, Lauran, in the
17 sense that it's not getting the patient out.
18 But in many ways it may be better. Because
19 once again, I get up there, and I can see sort
20 of what's going on in this setting.
21 CO-CHAIR SINOPOLI: So, I have one
22 last question, kind of reflecting back on the
23 comment Aisha made. So I'm just curious, and I
24 think we've talked about it over the course of
25 the day with all of the support that we've
26 talked about giving rural primary care

1 practices, but just thinking through.
2 So what would encourage a well-
3 performing urban ACO to want to incorporate a
4 rural practice, knowing that their
5 infrastructure costs are going to be higher,
6 and their outcomes are going to be lower? How
7 would you see that being structured so that
8 they would be incorporated into a larger ACO or
9 a larger pool of patients?
10 So I'll start out with Aisha on
11 that.
12 MS. PITTMAN: I think it gets to the
13 type of community service that we already see
14 urban and rural combined depending on, you
15 know, particularly some of the larger health
16 system ACOs, so just how they saw a broader net
17 of patients.
18 And I think if we address some of
19 the things like attribution and the benchmarks,
20 they'll be more encouraged to bring those
21 providers into the model.
22 I think there's also something to be
23 said for rural communities banding together to
24 manage risk across them. So it doesn't
25 necessarily have to be connected back to an
26 urban community. We see that as well, that

1 multiple rural communities come together to
2 form ACOs.
3 CO-CHAIR SINOPOLI: Any other
4 comments on that question?
5 DR. HOLMES: Sometimes hospitals
6 will do this to get access to high-value
7 services. I'm not sure that's a strategy we
8 want to encourage, but the idea being if I, as
9 an urban, I think, a large urban system can
10 work with a rural ACO that's high performing,
11 and I can figure out a way to get some of those
12 high-value services, cardiology, orthopedics,
13 for example, to come to my system, that could
14 be an incentive.
15 But that's an economist talking.
16 I'm not sure that's really the kind of thing
17 that we want to leverage. But that might be
18 one driver.
19 CO-CHAIR SINOPOLI: Got it.
20 Jackson, any comment about that?
21 DR. GRIGGS: No, thanks.
22 CO-CHAIR SINOPOLI: So, before we
23 close, any issues that we've not covered today
24 or any insights that you all want to share with
25 us at the end of this?
26 DR. HOLMES: I think the only thing

1 I would mention is the definition of rural
2 community came up both from Dr. Fowler, as well
3 as you, Angelo. I think you mentioned this in
4 the previous session.
5 And I think there are multiple
6 places to draw the line for what is rural. I'd
7 say one thing that did not come up was a FAR[44]
8 code, which is a -- I forget what it stands
9 for, but it's basically, as you might expect,
10 how far is this zip code from a large city kind
11 of thing. And that might be an alternative way
12 to think about some of this. Because that
13 really gets at access.
14 But no matter where you draw the
15 line, there's going to be one of these rural
16 communities that's going to look least rural.
17 And so I do a lot with rural definitions. A
18 lot of people I talk to say I drive by a cow on
19 my way to work. That must mean I'm in a rural
20 community. I'm like, no --
21 (Laughter.)
22 DR. HOLMES: -- you know. We need
23 to think about it more than that. But it's
24 going to vary depending on the setting. And so
25 if I'm getting my radiation oncology treatment,

44 Frontier and Remote Area

1 what probably matters more than anything is how
2 far I'm driving every day for five weeks in a
3 row for that.
4 If I'm, you know, getting an
5 infusion, and probably it's going to be, do I
6 have a sufficient number of people in my
7 community to support an oncologist? So it's
8 going to depend on the particular service which
9 always means that there's no great answer.
10 CO-CHAIR SINOPOLI: Perfect. Any
11 other comments?
12 DR. GRIGGS: Just the fact that, in
13 order to be able to measure performance of
14 rural communities when it gets better to just
15 judge how we're going to fund, you know, this
16 kind of programmatic intervention versus that
17 one, we've got to get the definitions down.
18 And so I agree, I'm glad you mentioned that,
19 Mark.
20 CO-CHAIR SINOPOLI: Perfect. Good.
21 So, thank you all. This has been another great
22 session. It was very informative. It's going
23 to help us create a great document to send to
24 the Secretary.
25 And so I think that we're going to
26 break at this point, and you all are welcome to

1 stay and listen to as much of the next meeting
2 as you would like. We'd certainly love to have
3 you stay on and listen. But right now, we'll
4 go ahead and take a break until 2:40.
5 All right. Thank you.
6 (Whereupon, the above-entitled
7 matter went off the record at 2:19 p.m. and
8 resumed at 2:40 p.m.)
9 * **Roundtable Panel Discussion:**
10 **Provider Perspectives on Payment**
11 **Issues Related to Rural Providers in**
12 **Population-Based Models**
13 CO-CHAIR SINOPOLI: Welcome back.
14 When planning this meeting, PTAC
15 wanted to prioritize hearing from those with
16 frontline experience managing care transitions
17 within value-based care.
18 To that end, we invited four experts
19 from across the country for this next panel.
20 You can find their full biographies
21 posted on the ASPE PTAC website along with
22 their slides.
23 At this time, I ask our panelists to
24 go ahead and turn on your video if you haven't
25 already.
26 After all four have introduced

1 themselves, our Committee members will have
2 plenty of time to ask questions.
3 First, we'll hear from Dr. Adrian
4 Billings who is the Chief Medical Officer and
5 Associate Professor of Family and Community
6 Medicine at Texas Tech University School of
7 Medicine.
8 Please go ahead, Adrian.
9 DR. BILLINGS: Thank you very much
10 for the introduction. Buenas tardes.
11 My name is Adrian Billings, and I
12 have been a rural family and community
13 physician for my entire 17-year career,
14 primarily, first, in private practice in the
15 same community in rural southwestern part of
16 far west Texas.
17 And merged my private practice with
18 a Federally Qualified Health Center as a way to
19 try and expand my impact and improve services
20 beyond primary care and try and debut
21 behavioral health services, pharmacy, as well
22 as dental health services.
23 And so, I've been the Chief Medical
24 Officer of this Federally Qualified Health
25 Center for the past dozen-plus years in a very
26 medically under-resourced area of the Texas-

1 Mexico border with a high HPSA[45] score of 19 and
2 high Maternity Care Target Area score of 21.
3 And have been very, very much
4 involved in hospital medicine as well,
5 practicing out of a Critical Access Hospital,
6 admitting my own patients for medical reasons,
7 as well as for obstetrical reasons and have
8 delivered babies in these settings.
9 We've also debuted a rural family
10 medicine residency with Texas Tech.
11 And academically, I'm serving as
12 their Associate Academic Dean of Rural and
13 Community Engagement also as a way to try and
14 leverage more resources out to our rural
15 communities within our health science center
16 service area.
17 Next, please?
18 So, that's the perspective that I
19 bring.
20 And I won't go into detail on this
21 first bullet point. I was able to attend a
22 little bit this morning Dr. Feldstein's
23 excellent introduction to the rural health care
24 disparities that you all have already heard.
25 But, you know, I just want to

45 Health Professional Shortage Area

1 highlight that I recognize, as a medical
2 student rotating in rural communities, as a
3 resident when I went back to the rural
4 community where I ultimately ended up serving
5 my career at, I knew that there was a paucity
6 of services from a medical standpoint, no
7 social workers, you know, very few specialist
8 physicians, lack of care management.
9 What I under recognized was the lack
10 of business and financial wherewithal as well
11 and those resources.
12 And so, I haven't heard anything
13 with regards to that. And I just do want to
14 point out that, in addition to all of the
15 health care disparities and the under-resourced
16 disciplines that are a paucity in our rural
17 areas, I just want to also encourage that we
18 think of it from a business standpoint and a
19 financial standpoint.
20 How can we best support those people
21 who really hold the financial purse strings?
22 And I think when we're thinking
23 about value-based care, that will be a
24 discipline that is going to be so important to
25 enable those of us who are clinicians to
26 continue to provide the care that we do.

1 And I think I always practiced with
2 the humility that I did not have nor did my
3 community nor did my health care organization
4 have all the knowledge nor all the resources
5 that we needed to care for our patients, that
6 our patients deserved.
7 And so, it was really only through
8 collaboration with primarily academic health
9 centers that we were able to expand our
10 services within the Federally Qualified Health
11 Center and debut the rural residency program in
12 partnership with a Critical Access Hospital
13 and the Federally Qualified Health Center.
14 And now that I'm wearing an academic
15 hat, and that's my role is to try and leverage
16 resources out to these rural communities.
17 I have the understanding now that
18 really, these publicly supported academic
19 health centers really should have the
20 responsibility and the social accountability of
21 wanting to take care of the neighborhoods and
22 the areas around these academic health centers.
23 And in my bias as a rural physician,
24 I really feel that it's these rural communities
25 that need the most help, certainly.
26 So, I think my other point would be,

1 any financial incentives that could be given to
2 academic health centers to encourage leveraging
3 of their resources out to these rural
4 communities is important.
5 And on the other hand, on the flip
6 side of the coin, also, anything that could be
7 encouraged from a payment model to encourage
8 these rural health care organizations to
9 collaborate as well would, I think, go a long
10 way in standing up more services and more
11 access to care in these rural communities.
12 Next, please?
13 And so, really, it's, you know,
14 these financial incentives for sending and
15 accepting students and trainees that,
16 hopefully, plant roots and, ultimately, stay.
17 And I can tell you that, as a rural
18 physician, I, at least, you know, need to learn
19 more about value-based care. And I think that
20 also extends to the entire health care
21 discipline within rural communities.
22 So, any partnership with larger,
23 urban organizations that can hold our hand and
24 walk us through the value-based care and
25 getting us on board would be very, very
26 helpful.

1 So, thank you so much for this
2 opportunity.
3 CO-CHAIR SINOPOLI: Great, thank
4 you.
5 So, next, we have Dr. Howard Haft, a
6 consultant and former Senior Medical Advisor of
7 the Maryland Primary Care Program.
8 Welcome, and go ahead, please,
9 Howard.
10 DR. HAFT: Thank you very much. It's
11 an honor and a privilege to be here today.
12 And I am, as you said, a primary
13 care internist going on 50 years of experience
14 now. At least 30 of those years have been
15 delivering primary care in rural settings.
16 I also served as a state health
17 officer, state health official.
18 And during my watch, I served as the
19 initial Executive Director and helped form the
20 Maryland Primary Care Model as part of the
21 negotiation we did over many years with
22 wonderful colleagues at CMMI.
23 That model is one that continues
24 even after I left state service and under great
25 continued leadership.
26 And it really encompassed almost

1 two-thirds or two-thirds of all eligible
2 primary care practices in Maryland.
3 The model included practices in 17
4 rural counties. Maryland is one of those
5 hybrid states that is both rural, urban, and
6 suburban. But a majority of counties in the
7 state are considered rural.
8 And, you know, I am now, I think,
9 understanding that, after almost a 50-year
10 career, I'm coming back to find the real joy in
11 serving people in rural communities. And I'm
12 looking forward to, after all this journeying,
13 finding where I started again and only really
14 recognizing it for the first time.
15 Let's have the next slide, please.
16 So, I want to just first get a
17 little bit of artwork in. This is Norman
18 Rockwell, a painting that he did as part of his
19 series in Americana that appeared in the
20 Saturday Evening Post over many years in the
21 '40s and early '50s.
22 But this is a picture that Norman
23 painted, actually, of himself and his family
24 being cared for by Dr. George Russell.
25 I think it really goes back to the
26 roots of, why are we doing this now?

1 I think this was a picture that
2 Norman painted, not for the cover, but kind of
3 a piece that he really wanted to talk about
4 what Dr. Russell meant to his community.
5 Because it's a rural community in
6 Arlington, Vermont, that he said, when Dr.
7 Russell came there, really changed everything
8 in the community.
9 Dr. Russell cared for the physical
10 needs of the community, but also identified
11 social needs and environmental needs, provided
12 transportation when people needed to get to go
13 to specialists, did vaccinations, started
14 public health nursing, really said, I have a
15 fiduciary responsibility to this community that
16 I serve.
17 And in turn, the community supported
18 Dr. Russell.
19 So, this is really the roots of
20 health care and primary care. And really, the
21 foundation, I think, in which all health care
22 should be delivered, on the strong foundation
23 where there's a clear fiduciary responsibility
24 of the primary care provider, the internist,
25 the family physician, to care for those people
26 that they serve.

1 You know, I say this and then, I
2 think that the NASEM report in implementing
3 high-quality primary care in 2021 really
4 described how it could be done now in the
5 current context with health information
6 technology and hybrid payments that are both
7 fee-for-service and population-based, and
8 addressing equity, and said all the right
9 things about that.
10 I was just really not disappointed
11 and shocked, but I think went back to reality
12 when I heard earlier today one of the
13 presentations, one of the presenters, it was
14 Meggan Grant-Nierman talk about how this system
15 has really failed her in rural health, how they
16 embraced a lot of the things that were
17 happening, but there was just insufficient
18 funding.
19 And I think that's at the heart of
20 the problem that we have, is that we have
21 insufficient funding.
22 We know that rural healthcare
23 providers are called upon to do more, you know,
24 with their patients, all the things that you've
25 heard all through the day today.
26 Their patients are sicker. They're

1 older. They have transportation issues.
2 There's, you know, the lack of connectivity.
3 And still, we don't recognize we
4 don't pay primary care enough to begin with.
5 We know that they're 4 to 5 percent of the
6 total spend.
7 But this is even more of an acute
8 problem and a serious problem in the rural
9 settings where it actually costs more to
10 provide that care, and they're actually getting
11 paid less, the GPCIs[46] are less, the ability to
12 engage in these programs is less.
13 And then, as I think one of the
14 other presenters said earlier on, we're doing
15 this, but at the same time, we're saying, we'll
16 give you a little bit more money, but we want
17 to put you at financial risk for that money.
18 Now, that's so, so painful. And one
19 of the things that I heard during my time in
20 the Maryland Primary Care Program loud and
21 clear from all providers, but particularly from
22 the rural providers, we don't have enough now
23 to build infrastructure.
24 If you give us a little bit of money
25 and you put us at risk for that, what happens

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1 if we don't score as well as we can? And then,
2 you're taking away our infrastructure again?
3 So, one of the take home messages
4 from us is that, for me, is that we have to
5 start by recognizing and paying our primary
6 care providers more.
7 How we deliver that to them, I
8 think, is a matter of the art of regulation and
9 policy and manipulation of the payment systems
10 within ACOs or otherwise and clearly, with some
11 value-based payer -- value-based payment
12 systems.
13 And let's be careful about putting
14 small individual rural providers at risk, but
15 primary care providers, probably in general, at
16 financial risk.
17 Financial risk really, you know,
18 implies, you know, and I'll end here for this
19 slide, really implies actuarial risk, as you
20 heard before. And that requires large numbers.
21 It requires sophistication in taking that risk.
22 And that's not what providers have
23 to begin with, and it's not what they signed up
24 to do to begin with.
25 Let's go on to the next slide.
26 So, a couple of key takeaways: rural

1 providers really benefit from the flexibility
2 offered by the non-visit-based population-based
3 payments such as Care Management Fees.
4 In the Maryland Primary Care
5 Program, I think they, largely, the providers,
6 and particularly the rural providers said, we
7 can really do a lot with the Care Management
8 Fees that are provided that are really risk
9 free, Care Management Fees.
10 We can implement a lot of things in
11 care management and building out this team-
12 based care that's been described as really
13 important, and we know it's really important.
14 But it's probably still not enough.
15 It still falls short of being able to build a
16 full boat of what we are asking people to do in
17 terms of addressing equity and the social needs
18 of patients and behavioral health integration
19 and all of the other things that primary care
20 could do if it was funded well enough.
21 Quality benchmarks were talked about
22 earlier also. And I think they really don't
23 need to be so much adjusted because that can
24 cause a, you know, if you lower a benchmark,
25 actually may cause less equity rather than
26 closing -- bringing greater equity.

1 But I think we can recognize that we
2 can pay for achievement or improvement, as well
3 as achievement.
4 Improving towards a benchmark, if
5 you make sufficient adjustments, should be as
6 valuable as achieving the benchmark,
7 particularly in rural settings.
8 One of the things that I -- that was
9 a take home message to me also, and this is, I
10 think, going to be really important going
11 forward, is Medicare Advantage begins to really
12 usurp traditional Medicare.
13 So, many states, it's 50, 55
14 percent, others even higher.
15 It really cuts down the number of
16 beneficiaries who could be funded through the,
17 at least the Medicare or CMMI APM models.
18 And if there's a narrow restriction
19 that the funding that goes to them, which is
20 going to be smaller and smaller, can only be
21 used for that small group of patients, it
22 really hamstrings the providers in saying, with
23 this small amount of money, there's probably
24 little that I can do for these patients.
25 But perhaps there's something that
26 we can do if we spread this out over all of our

1 patients for a single initiative.
2 But it's been very tightly
3 benchmarked to just to be used for one
4 particular patient -- one particular group of
5 patients.
6 Now, hopefully, we'll see in the
7 future all-payer models that will make those
8 kind of issues go away.
9 But right now, the limited payments
10 that come with some of the APM models really,
11 particularly when they're pigeonholed to one
12 particular patient type, makes it really
13 difficult to institute at the practice level of
14 a real program.
15 So, I think I'll just stop there and
16 be happy to address issues during the question-
17 and-answer period.
18 CO-CHAIR SINOPOLI: Great, thank
19 you, that was actually very helpful.
20 So, next, we have Dr. Jean
21 Antonucci, a family physician with Northern
22 Light Health and previous submitter to PTAC.
23 Welcome, Jean, and please begin.
24 DR. ANTONUCCI: Hi, I've had lots of
25 technical troubles being a rural provider, can
26 you hear me?

1 CO-CHAIR SINOPOLI: We can.
2 DR. ANTONUCCI: Oh, that's
3 delightful, okay.
4 So, I'm sort of staring at you so I
5 don't misinterpret that and thank you for
6 calling me an expert, that was very sweet.
7 I am a rural primary care provider
8 out in Maine. I've been here for 33 years.
9 And so, I think I'm here for two
10 reasons, to try and be useful to you. One is
11 that I do have extensive experience being a
12 solo primary care provider and working with
13 small providers all over the country a little
14 bit.
15 I've worked in many settings, but
16 the best was my own practice.
17 I think that a few things, one is,
18 small practices are somewhat in this country
19 like Vitamin C. There's a myth that they are
20 cottage industries and disconnected and can't
21 afford EMRs.
22 And yet, the data from folks like
23 Casalino says that we do very good care.
24 I had an EMR before lots of people.
25 And so, I want to tell you that some
26 of the programs and payments and program things

1 I was in, I saw every patient the day they
2 called and on time for many years.
3 And I did PCMH[47] and was Level III.
4 And I was in a few programs. We had an ACO,
5 and it started out fairly sweetly and then,
6 basically stopped.
7 There was politics, and the hospital
8 fired the guy who was bringing us together
9 trying to do some good work. And I never heard
10 from him again.
11 One day, I Googled him, and they
12 said, oh, but we meet every month. Well, no
13 one was telling me anything about it.
14 I mean, it was just a failure from
15 my end, except once a year when they wanted my
16 data.
17 I was in a program called a health
18 homes project run through the state Medicaid.
19 And there were lots and lots of strings
20 attached. And I really wanted to be in that
21 project because they had a community, a care
22 team, which I wanted for my patients.
23 And then, it turned out it didn't
24 make any difference. And there was a little
25 extra money, but lots of us, I think, left that

47 Patient-Centered Medical Home

1 project because of the hoops we had to jump
2 through.
3 I did do NCQA[48], as I said, PCMH.
4 And I can tell you also, you know, I've been
5 listening most of the morning to what I've been
6 listening to all morning.
7 And I think there's a very big
8 disconnect. There's a lot of good thoughts
9 about what to do for rural providers and pay us
10 and such, but it is a lot of other regulations
11 and rules we're up against.
12 And so, Meaningful Use is a good
13 example because I had a great EMR that did
14 things my big fancy EMR where I'm employed
15 cannot do now.
16 For instance, it had a plain old
17 tickler reminder system. That's one reason I
18 got it. And now, I have to keep that on paper
19 to make sure a test was done, that I got
20 results, that I told the patient the results.
21 To me, that is a hallmark collection
22 of primary care. And so, I can't do that.
23 And when I did Meaningful Use, I had
24 to get a different EMR because mine didn't meet
25 Meaningful Use, although it was great.

48 National Committee on Quality Assurance

1 And then, the Government sent my
2 $11,000 to someplace I hadn't worked for years.
3 And so, it's not just payments we're
4 up against.
5 I have also been paying through a
6 program that's a little similar to the proposal
7 that I submitted. And that's the second reason
8 I am here.
9 I heard you could submit proposals,
10 so I did. You know, I'm not slick or polished,
11 I'm kind of direct and sometimes blunt because
12 I've been out here doing this work for a long
13 time.
14 But I submitted a proposal and came
15 to PTAC. And the feedback I got from my three-
16 person committee was, this was so innovative we
17 weren't quite sure what to do with it.
18 And I would urge anyone who hasn't
19 read it to read it, because some of the prior
20 speakers today were talking about how do we
21 measure risk? And how do we incorporate social
22 determinants of health?
23 And I did all that because I used
24 somewhat innovative methods.
25 And I -- my method for payment was
26 capitation based on risk. And I did get one

1 small payer.
2 If we can do the next slide, please?
3 I forgot all about my slides. Next slide, Amy?
4 I did get one payer to pay me that
5 way. And because you had to a run a low
6 overhead practice, I did very well on that.
7 I know that it would take a lot for
8 some practices to learn capitation.
9 So, I do think out of the box about
10 a lot of things just because of what I've
11 lived.
12 And I thank you, Dr. Haft. I don't
13 think that primary care practices except little
14 ones, especially little ones, should be doing
15 risk.
16 The risk we take is when Mom calls
17 us at 3:00 in the morning, and their little one
18 has a fever of 103. That's the risk I take
19 every day.
20 I should not be taking insurance
21 risks. I should be paid fairly. And I think
22 the states should be having primary care czars
23 as the NASEM report suggested.
24 And to join us all together, the
25 hospitals are a real problem for small
26 practices. That's why I open up and close my

1 practice.

2 I think I might have interrupted my

3 own self, which I do a lot.

4 I would say two things. I think

5 value-based care, I'm sorry, I think it's the

6 latest Kool-Aid. And I think it's trying to

7 fit a round peg into a square hole.

8 It was Uwe Reinhardt at Princeton

9 who said, it's the prices. I can't control

10 prices, I can't even control a lot of prices

11 you think might be under my care by going to

12 one hospital I send my patients to for their

13 MRI.

14 I seem to have lost my examples.

15 I have patients that are trying to

16 get on the portal last week so they didn't have

17 to deal with the terrible phone system.

18 And I look at their phone, and I say

19 to them, I can get you on the portal, you have

20 a smartphone. And they would say, no, I don't.

21 They don't even know they have a smartphone.

22 So, a lot of technology barriers out here.

23 So, in conclusion, I have to tell

24 you, I now work for a big system. I only work

25 part-time. And what I do now is MAT[49], Suboxone.

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49 Medication-assisted treatment

1 I take care of recovering drug addicts. I take
2 care of an incredibly difficult population.
3 It's a lot of fun when I get there.
4 Every one of them has been abused.
5 They have terrible places to live, and
6 screening for housing trouble doesn't do me any
7 good. I was taught as a resident, you don't
8 screen for something you can't do anything
9 about.
10 We give them food. They -- even if
11 I have a place for them to go, I send them to
12 the dental school for dental care, it's two and
13 a half hours away. And even if they have a
14 car, they tell me they won't drive there,
15 that's too scary.
16 So, I'm trying to paint a picture
17 for you about a lot of things we're up against
18 out here. It's not just payments, although I'm
19 a big believer in capitation for primary care.
20 And I use some tools through How's
21 Your Health and the What Matters Index.
22 And I'll just conclude with that
23 before Amy yells at me for talking too long.
24 I have to tell you, Amy and Heidi
25 have been wonderful to me today. The barriers
26 to get audio and visual at the same time today

1 have been very difficult out here.
2 And so, the thing I would close with
3 is a tool I use, and it's what I see. And I
4 think probably every working physician sees
5 this, even if they don't know they see this.
6 What our patients lack is
7 confidence. They have no ability to solve
8 problems. This is a huge problem when taking
9 care of them.
10 And so, none of these measurements
11 that we have or metrics really matter a lot to
12 some of my patients. The What Matters Index
13 [inaudible].
14 And then, I would only throw in, I
15 think a metric, it should matter, and what you
16 should measure is whether the patients carry a
17 medication list. I used to give them all
18 medication lists.
19 So, I'd say a lot of different
20 things. I do have a lot of experience and
21 hoping I can be helpful to you today. Thank
22 you.
23 CO-CHAIR SINOPOLI: Thank you, Jean,
24 that was great. Appreciate all that insight
25 and experience.
26 So next, we'll go to Dr. Karen

1 Murphy who's Executive Vice President and Chief
2 Innovation Officer, as well as the Founding
3 Director of the Steele Institute for Health
4 Innovation at Geisinger.
5 Karen, please go ahead.
6 DR. MURPHY: Thank you, it's a
7 pleasure to be here today to address the group
8 and also such esteemed panelists. So, I'm
9 thrilled and can't wait to hear the discussion.
10 So, just a little bit of background
11 so you know where my comments are grounded.
12 I started my career out as a
13 registered nurse. I worked in an ICU for 10
14 years, and I always say, I'm not that smart. I
15 never would have been able to do the things
16 that I did if I didn't work in that ICU and
17 understand the importance of not only medical
18 care, but also taking care of patients and
19 their families.
20 So, when I'm -- I've worked in a
21 hospital in northeastern Pennsylvania. My last
22 position there, I was CEO.
23 Then went on to CMMI, had the
24 wonderful pleasure of working with Howard's
25 teams in Maryland with the Maryland model and
26 also with the state innovation models.

1 And prior to coming to Geisinger, I
2 was Secretary of Health for the Pennsylvania
3 Department of Health where I worked with the
4 team there and CMMI on developing the
5 Pennsylvania Rural Health Model.
6 For those of you that are aware of
7 Geisinger, Geisinger -- not aware of the
8 details of Geisinger, so we take care of
9 patients, we manage care, and we also research,
10 educate, and innovate.
11 And I would remark that most of our
12 clinical assets at Geisinger are in rural
13 communities. So, I have the honor to continue
14 that work when I came to Geisinger.
15 Next slide, please?
16 So, as was stated before, I know
17 that you've covered deeply, and as our
18 panelists have talked about, the rural health
19 care in crisis and why. So, I'll let that go
20 because I'm sure by now we have the background
21 enough.
22 We've also talked about Alternative
23 Payment Models.
24 But I really want to take a minute
25 to talk about the future and a couple of things
26 that we have said here before, and I've been

1 thinking about rural health now for almost 10
2 years from a policy perspective.
3 And I think the most important thing
4 that Howard and Adrian and Jean have alluded to
5 is the social accountability.
6 If we really want to address the
7 needs in rural communities, we have to get
8 serious about it, and we have to do it in a way
9 that invests in rural communities.
10 We are going nowhere without
11 investment.
12 And from a federal government and a
13 state government perspective, the role of
14 government is to protect the vulnerable. And
15 rural communities represent the vulnerable
16 populations in our country.
17 So, I'm a firm believer, I think we
18 can do it, I just think we have to do it in a
19 much more holistic way than perhaps I was even
20 thinking about, I'd be the first to say, in
21 2015 when we start the discussion on the
22 Pennsylvania Rural Health Model.
23 What I mean by a holistic approach
24 is everything that Jean just talked about it,
25 not only the medical care, but the social
26 determinants of health.

1 And medical care, not only the
2 medical care, it's not acceptable for
3 individuals in rural communities to travel two
4 and a half hours for health care that could be
5 delivered adequately and appropriately in the
6 rural community.
7 And whether that's through
8 leveraging digital technology or whether that's
9 through partnerships with larger centers.
10 You know, to take a day off from
11 work to go to the doctor is just not
12 acceptable.
13 So, when I talk about a holistic
14 model, what I'm talking about is I would
15 propose if I was designing a model today, I
16 would propose a holistic model looking at the
17 community that we're serving.
18 So, there are, you know, really,
19 there's about four or five prototypes that
20 every rural community would fit in. Some are
21 more challenged than others.
22 But looking at a holistic community,
23 I think, is so critically important because,
24 rural communities are really -- health care is
25 the physicians are really intertwined very much
26 with the rural hospitals.

1 So, I think we really have to take
2 those two together, not isolate, look at this
3 payment model and look at the rural hospital
4 model. I think we have to look at it together.
5 I think the second point that has
6 been made, I do not believe until we get a
7 sustainable -- a financially sustainable model
8 developed for rural communities that we can ask
9 rural providers to take risks.
10 The numbers are too small. The
11 stakes are too high. And we don't have the
12 model right. So, why would you design, you
13 know, a payment model that has risk in it? I
14 did it, so I take full responsibility.
15 But having learned and thinking
16 about moving forward, I think we have to select
17 the model that -- the models or model that can
18 be sustainable, implement those for a period of
19 a long runway because you're not going to get
20 anybody to agree to transform substantially if
21 there's not a long runway.
22 And really work at improving that
23 while we meet the behavioral health needs, the
24 social needs, and the medical care.
25 So, I could go on forever, but I'll
26 stop there.

1 CO-CHAIR SINOPOLI: Great, thank
2 you.
3 So, again, I'll remind the PTAC
4 members to flip their cards over if they have
5 questions.
6 And I have a couple of questions
7 here, but we'll look to PTAC to ask further
8 questions.
9 So, we'll focus on a few things that
10 have already been discussed a lot today, but
11 just interested in this group's perspectives
12 also.
13 And so, when you're really getting
14 down to specifics in terms of what a payment
15 model would look like in the rural environment
16 that would incentivize those things I just
17 heard all four of you talk about.
18 And realizing that rural providers
19 can't take capitation. They can't take global
20 risks, those kinds of things, is what I'm
21 hearing.
22 What would that structure look like?
23 And what would the payment model look like?
24 And if you're infusing more money
25 into the rural provider environment, again,
26 help us prioritize, what would that money go

1 for? What are the most important three things
2 to begin with to drive changes and outcomes in
3 the rural environment? And what would those
4 things be? And I'll start with Adrian first.
5 DR. BILLINGS: Yes, thank you for
6 that question.
7 And I'll try and be brief, but rural
8 providers need to be paid more. It has been
9 shown that we do more with less because of
10 payment.
11 And we need to be incentivized for
12 innovations of collaborations. Because for
13 small practices or small communities, we need
14 to be incentivized for bringing in social
15 workers, students.
16 Bringing in behavioral health care
17 work for integration of behavioral health
18 within primary care.
19 We need to be incentivized to
20 establish rural residencies.
21 On the other hand, academic health
22 centers also need to be incentivized to have
23 more of a rural impact and a rural footprint.
24 We have too few rural academic
25 health centers out in our rural communities of
26 need. We need to open more rural academic

1 health centers that are multi-disciplinary in
2 nature.
3 It's not just the physician that's
4 needed, it's the rural labor and delivery
5 nurse. It's the rural social worker. It's the
6 MA[50]. It's everything from the associates
7 degree level to the terminal degree level that
8 is severely lacking in rural health care
9 workforce, and some of that is economics.
10 And if value-based health care is
11 going to financially penalize our rural
12 providers because we're taking care of sicker
13 patients with less access to care, they're
14 showing up later in our offices because we just
15 don't have the capacity to take them.
16 On the U.S.-Mexico border, we're
17 taking care of a large amount of immigrant
18 population, for the first time, we're seeing
19 them.
20 And if we're going to be penalized
21 for that because we're just willing to take
22 care of them, and we want to take care of that
23 population, we have to figure out.
24 Rural is not urban and, I agree very
25 much that more investment is needed in rural

50 Medical assistant

1 health care, including, you know, more
2 knowledge.
3 It's not just money, but it's really
4 more resources and more knowledge and more
5 enabling our calling and our mission to provide
6 increased access to multi-disciplinary health
7 care.
8 Thank you.
9 CO-CHAIR SINOPOLI: Great. All
10 right, Jean?
11 DR. ANTONUCCI: Yes, thank you.
12 So, I'm going to tell you exactly
13 how to pay us and maybe it needs some tweaking.
14 But because I submitted a proposal, I'm going
15 to tell you what's in it.
16 You take six months and assess the
17 risk of cases by burden of disease. I used a
18 tool called How's Your Health. And we were to
19 be paid by capitation. Capitation has to be
20 both adequate and you have to limit -- the
21 patient population. You can't just take lots
22 of money and sit down with your feet up, of
23 course.
24 But the way, I got what I proposed
25 was the very low risk patients, to pay
26 physicians a dollar a day, two dollars a day

1 for medium-risk patients, and three dollars a
2 day for high-risk patients, 365 days a year.
3 That amount of money even at one
4 dollar a day, which is what I did, with one
5 payer for all my patients worked well for me
6 because I was good with low overhead.
7 But if you do the math for the
8 number of patients, 1,500 in a panel and many
9 of them are high-risk or medium-risk, that
10 brings a lot of income into a practice.
11 And the physician gets to decide
12 what to do with that money. Almost all of us
13 would hire someone to call the people who were
14 in the ER or just saw a consultant. I used to
15 do that, but I ran out of time.
16 That's the real definition of care
17 coordination, to act on it.
18 Hey, you know, Lauran, do you know
19 why you went to the cardiologist? Do you know
20 what he said? Did he give you any new
21 medicines? Is it the same as what you have?
22 Do you know what happens next?
23 And I used to do that until I ran
24 out of time and money.
25 And why did you go to the ER? You
26 didn't know you could call me? That kind of

1 stuff. And there could be bonuses. I wrote it
2 all in my proposal.
3 I understand that simple isn't easy.
4 I'm not [inaudible] an expert on a lot of
5 things. But I have lived by this and I will
6 put it out there as a very valid experiment to
7 try, a dollar a day, two dollars a day, and
8 three dollars a day.
9 Not my original idea, I stole it
10 from someone. I encourage us to think about
11 something like this.
12 CO-CHAIR SINOPOLI: Perfect.
13 And what I'm hearing from both of
14 you so far is that those monies would be
15 redirected toward care coordination, team-based
16 care, those kinds of support systems is what
17 I'm hearing.
18 So --
19 DR. ANTONUCCI: So, I think that you
20 should give some to the physicians. Though I
21 have to say, the people who design projects
22 don't always realize it's my patient.
23 And if you have to live by it, think
24 about what are the hoops you have to run
25 through?
26 I just would say that we have to put

1 Cheerios on our tables, and we came out of
2 school with massive loans. And so, we should
3 get a little of it.
4 But I think we all recognize we just
5 really wish we had services to give patients.
6 Thank you.
7 CO-CHAIR SINOPOLI: Got it. All
8 right, Howard?
9 DR. HAFT: Probably, it's the
10 important money question that you're asking. I
11 think it starts with saying, what do you want
12 to get from rural health providers?
13 Particularly primary care providers.
14 If you, as the consumer, I'm not
15 talking about the payers now, what is it the
16 consumer wants?
17 And I think the consumer wants
18 someone that will be there to take care of them
19 24/7 and provide the comprehensive services,
20 the things that Barbara Starfield described in
21 the Four Cs. And I think that's enduring.
22 Well, what's the question, what does
23 it cost to provide this team-based care that
24 includes behavioral health integration, that
25 attends to the social needs of patients, and
26 care management and all those other things in a

1 way that is substantial and sustainable?
2 And you know, I'm not going to put a
3 dollar amount on that, but other people have
4 said, you know, I saw this one time in a micro-
5 simulation study, and it was a little north of
6 $62 per person per month to provide the social
7 needs, supports that are necessary.
8 Parents and others have the PCMH
9 kind of, you know, team-based care, $60, $65.
10 So, all those numbers together well,
11 well, much higher than anything that we've seen
12 now in the marketplace, but also reflects the
13 fact that, you know, primary care providers are
14 getting three or four or five percent maybe of
15 the total health care spend out of this $3
16 trillion dollars that we have. There's a lot of
17 head room there.
18 I know that 21 states have already
19 said, we're going to do something about that.
20 We're just going to study what primary care is
21 getting paid. It's a percentage of the total
22 spend.
23 And at least six or seven states
24 have said, we're going to set a target of 10,
25 12 percent, and we're going to get there.
26 So, two or three times what they're

1 getting now.
2 But your question specifically is,
3 okay, we've got to put more money in the
4 system, how do we give it to them?
5 And the answer to that is, you can't
6 give it piecemeal. You can't say, okay,
7 Medicare, you're going to do a good job, and
8 you're going to give them $80 per beneficiary
9 per month, whatever that number is. But none
10 of the other payers do. That doesn't get you
11 there.
12 Or Medicaid, you're going to go up
13 by 10 percent. That doesn't get you there. It
14 has to be a multi-payer. It has to, ideally,
15 be an all-payer delivery of care.
16 Then, how you do it once you get all
17 the payers together, but you can't do it
18 piecemeal, it doesn't make sense, and it
19 doesn't get you there.
20 And after you get all the payers
21 together, you figure out what it costs to
22 deliver this service, this care that you need,
23 and I would include Jean's comment about, you
24 have to pay primary care more or nobody's going
25 to want to do it.
26 And if you don't pay them more,

1 nobody does it, you're also dead in the water.
2 Right?
3 So, you have to include that. You
4 have to pay the providers more if they're at
5 the bottom. They don't need to be at the top
6 of the pay scale, but it wouldn't be bad. But
7 they need to be somewhere near the middle of
8 the pay scale anyway. So, you need to factor
9 that in also.
10 And then, deliver it. I mean, you
11 know, the NASEM report did a nice job. They
12 looked at the data and said, you know, you give
13 some infrastructure payments, things that you
14 can't really count for in fee-for-service,
15 although I would say, now that the, you know,
16 the PFS[51] is going to announce it, the fee
17 schedule could include payments for population-
18 based care.
19 So, that is a possibility. I think
20 that's been recommended in some of the letters
21 on the PFS. We'll see how that pays out.
22 There could be a lot of tinkering
23 with the -- that could be done currently with
24 the CPT codes right now, that there's 8,000 of
25 them. They could be trimmed down considerably

51 Physician Fee Schedule

1 and separate out the E & M[52] codes from the
2 procedural codes, and perhaps it would put more
3 money in the E&M codes that have already been,
4 you know, undervalued for, you know, for the
5 last 40 years.
6 You know, maybe, you know, have some
7 more technical expert panel that might add
8 some, you know, some additional information as
9 you're doing now on top of what the RUPRI does,
10 with less self-interest just to bolster the fee
11 schedule. That's one way that we can improve
12 that.
13 But then, in terms of value-based
14 care, once you get the fee schedule right, you
15 know, having a hybrid payment of some
16 infrastructure capitated risk adjusted, social
17 vulnerability adjusted together with strong
18 fee-for-service payments that are appropriate
19 at an appropriate level.
20 I think it's a beautiful way to
21 enhance the system. But you've got to get the
22 money right and then you figure out how to
23 deliver it.
24 How do you - trying to deliver it
25 when you don't have the money right, doesn't

52 Evaluation and management

1 get you anywhere.
2 CO-CHAIR SINOPOLI: Great, right,
3 thank you. And Karen?
4 DR. MURPHY: So, I agree with
5 everything that has been said before.
6 I guess I would start with, I do
7 believe capitation, global budgets work for
8 rural communities. I think the issue is they
9 just can't have risk.
10 So, you could do a global budget and
11 readjust that global budget as you move forward
12 in a holistic way. I think we just have to
13 take risk out of the equation.
14 I also agree with my colleagues to
15 say that there has to be investment in primary
16 care because the reality is, the rural
17 communities have a very difficult time
18 recruiting specialists because of numbers.
19 So, I mean, there's just not enough
20 numbers sometimes to support rural physicians.
21 And I think the other piece is that
22 the infrastructure now for acute care has
23 gotten so sophisticated that I think it's very
24 hard to have an ICU without a pulmonologist
25 being on call. You know, that kind of critical
26 infrastructure.

1 So, I think the primary care
2 doctors, without a doubt, have to be paid,
3 again, social accountability. What we're
4 talking about is part of the government that we
5 just have to figure that out, it has to be
6 different for rural.
7 I think the other piece is
8 investment. You know, I've visited rural
9 hospitals that had three floors of empty beds,
10 but they were set up as an acute care facility.
11 And the reason why sometimes the
12 charges are higher is because they're just
13 trying to sustain themselves.
14 And again, we're sustaining a bad
15 model that is no longer relevant to rural
16 communities. But they don't have cash on --
17 you know, they don't have 365 days of cash on
18 their books to be able to take out and do major
19 infrastructure supports.
20 And I think if we are going to look
21 at a model that is primary care-centric and
22 recognize that we're not going to have a lot of
23 specialists, then we have to provide as many
24 support services for those primary care
25 physicians through an appropriately designed
26 rural hospital or health center, whatever it

1 may be, because they can't do it alone.
2 And then, lastly, I know that Howard
3 has talked about this, but I do think there has
4 to be not only incentives, but it must be, that
5 if you have rural communities, you're a large
6 academic medical center in large urban areas,
7 if you have in your market, if you have a rural
8 area, then you must figure out a way to deliver
9 care there, particularly specialist care.
10 So, get the vans with the
11 mammograms. Get the, you know, be able to do
12 procedures in -- you don't have to do that
13 every day, but let's take a look at how we can
14 do, not only telehealth, but actual physical
15 care within the community, specialty care. Not
16 every day, like I said, but on a basis where we
17 serve the needs of the community.
18 And I think that is -- I think to --
19 if we had those three investments that looked
20 at the needs of the community and designed the
21 system accordingly, I think we'd be a lot
22 further along than we are now.
23 CO-CHAIR SINOPOLI: Great, great.
24 Great insight, appreciate that. Jim?
25 DR. WALTON: Thank you all for being
26 with us today.

1 I've sat most of the day, and the
2 testimony of the SMEs has kind of been one of
3 those sobering moments where you realize that
4 things are -- could be bad. Right? I mean,
5 that's what I'm hearing.
6 And I reflect back on a time that
7 was similar where the United States did two
8 things in the same decade that they did very
9 well.
10 They were addressing threats, one
11 was a domestic threat in the '60s, which were
12 around the coverage of Medicaid and Medicare,
13 the creation of those two sentinel things
14 occurred in the '60s.
15 At the same time, the United States
16 built a space program because of an
17 international -- a perceived international
18 threat.
19 And so, we've illustrated, I think
20 as a nation, that the ability to walk and chew
21 gum at the same time or the ability to perceive
22 threat and to kind of work to mitigate that.
23 One of the -- I have two questions
24 for the panelists.
25 The first one was, and it's around
26 this notion of threat which is, what are the

1 potential unintended consequences that you see
2 of the -- if there's a persistence of the
3 value-based direction we are on now when we
4 compare rural to non-rural markets?
5 And are there any significant,
6 serious enough -- are any of them serious
7 enough to drive new policy approaches, from
8 your opinion, from your point of view?
9 And then, I'll wait for your answer
10 then I'll ask the second question.
11 DR. BILLINGS: This is Adrian
12 Billings.
13 I think, you know, anything that
14 further disincentivizes rural health care
15 payment runs the risk of more rural hospital
16 closures, more rural clinic closures, and less
17 access to care.
18 And our patients -- our rural
19 patients foregoing care in an urban specialized
20 environment because of the lack of access to
21 having paid time off or having daycare for
22 their child when they're sick to go access
23 care.
24 Or the unfortunate issue where one
25 of my patients -- two of my patients driving
26 back together were killed after seeing a

1 specialist in a head-on rural, two-lane
2 undivided highway.
3 So, it's really lost lives, more
4 morbidity, more mortality, that worsening delta
5 between life, mortality, and just comfort level
6 between our rural and urban population.
7 So, again, I think rural, just more
8 investment is needed, more access is needed.
9 And we just -- we want to provide
10 evidence-based care. We want our rural zip
11 codes to not be a risk factor for our patients'
12 lives and the health of our patients' lives.
13 But in order to make that a reality,
14 as you said, we need to make rural health care
15 a moonshot opportunity by both our state and
16 federal governments and our insured, both our
17 Medicaid insurers and our commercial insurers,
18 they have an investment and a role to play as
19 do our academic health centers.
20 Thank you.
21 DR. MURPHY: And, Jim, the only
22 thing that I would add is, it is a threat. It
23 is a real threat for the United States in terms
24 of survivability of health care in rural
25 communities. So, it is a threat.
26 And I would go back to the emphasis

1 that I made on no risk. That doesn't mean that
2 it wouldn't be value-based.
3 So, you could do value-based care
4 without risk. And we did it -- we've done it
5 forever in Medicare that they require certain
6 levels of quality and monitor outcomes.
7 So, it's not that we would just push
8 the investment to the rural communities without
9 accountability. They would -- physicians and
10 hospitals would be accountable for making sure
11 that the care that we've invested in is really
12 delivered in a high-value way to our patients.
13 DR. HAFT: I'll just add to the
14 urgency here for, you know, policy response.
15 And that I think that, you know, the
16 rural health care providers, particularly the
17 primary care, rural health care providers are
18 the canary in the coal mine.
19 So, I think -- and then, I think
20 they are seriously threatened right now. And
21 we'll lose -- we stand to lose substantially,
22 that safety net of providers and hospital
23 systems from afar can't take up the slack for
24 that.
25 You know, I think that in that --
26 when that falls, it's just a matter of time for

1 further loss of the moving in closer to the
2 urban and the academic centers.
3 But you don't -- we don't want a
4 system built -- you know, I'm part of an
5 academic medical center myself, so I'm not
6 going to bash them in any way, shape, or form.
7 But I know that the hospitals and
8 the academic medical centers cannot be the
9 center part of our health care delivery system.
10 It's not a foundation. It's the
11 dessert. We need the main course, and the main
12 course is primary care. That's the foundation
13 that we need to build on.
14 And if we don't invest in the
15 foundation, then you know what happens to
16 buildings when they have crumbling foundations.
17 So, I think there is some real
18 urgency.
19 There are no -- there's not been any
20 reduction in HPSAs and MUAs[53] in the last 20
21 years.
22 DR. WALTON: Jean?
23 DR. ANTONUCCI: Yes, I think the
24 question is, if we continue down this road with
25 value-based payments, what will happen in rural

53 Medically Underserved Areas

1 primary care, is that the question?
2 DR. WALTON: Yes.
3 DR. ANTONUCCI: Okay.
4 And the others have said it well. I
5 can't hear Dr. Haft well, but fortunately, I've
6 already read his article with Dr. Berenson
7 recently. And we're all on the same page.
8 Primary care providers are not so
9 much burnt out as they have been burnt.
10 They're sick of being called providers, and
11 nobody will even change and say physicians.
12 And so, yes, you're just going to
13 lose more and more.
14 We're held together in primary care
15 right now by the DOs and some nurse
16 practitioners.
17 Fewer and fewer MD graduates will go
18 into primary care, and there are more of them.
19 So, I think, yes, we have to think
20 outside that box. Most -- I'm a blunt talker -
21 - most of us see this as just one more fad
22 going by, one more piece of waste to shovel.
23 And that's why we need teams.
24 So, we need payments, but it's not
25 just payments, it's not just money. We need
26 tools that work and time to do our work. We

1 don't have tools to do our work, and we have
2 rules and regulations that interfere.
3 So, if you want to save primary
4 care, there’s a big picture to look at.
5 DR. WALTON: I guess sometimes I
6 think about this, that if we take a step back
7 and look at history, there were certain forces
8 that galvanized enough people at one point in
9 time to say, hey, maybe we should have a policy
10 that is a moonshot, whether that was the
11 creation of Medicaid or Medicare or building a
12 rocket that would go to the moon and come back.
13 And so, I was thinking about, well,
14 what would be serious enough, you know, what
15 information could we surface here that would be
16 actually serious enough to warrant someone to
17 think about something bigger than tinkering
18 around the edges?
19 And so, the way I -- my brain works,
20 I think I would pose it this way.
21 And the second question really is,
22 in the absence of new policy approaches, what
23 might the risk be, from your perspective,
24 panelists, with current marketplace aggregation
25 strategies of primary care services in rural
26 markets?

1 Where do you see that leading us?
2 Because that's really what is
3 filling in the blanks, oftentimes, in the
4 absence of a solution that would pay primary
5 care physicians more.
6 And as a primary care doctor -- as a
7 primary care physician, I've heard this
8 conversation for a few decades that the
9 solution to our problem is to pay primary care
10 physicians more. But that hasn't happened.
11 So, there hasn't been enough
12 compelling evidence to create a vision or a
13 concern or a perceived threat to change it.
14 And so, maybe the marketplace's
15 response that is by aggregating primary care
16 resources in rural communities might have
17 unintended consequences that we -- that you can
18 see that we, as a Committee, need to elevate to
19 the Secretary of Health and Human Services and
20 the Executive Branch of the government.
21 I'm just curious if maybe you've
22 thought about that and what you would -- what
23 you might think -- how you would respond to
24 that question?
25 DR. BILLINGS: I think beyond just
26 the social justice merit of investment in rural

1 health care, our nation, and even our world's
2 food, fiber, and fuel is produced in rural
3 America.
4 And so, this is a threat to our
5 overall economy.
6 You know, why is this of interest to
7 an urban resident? Someone who's going to
8 spend their entire life of working in an urban
9 area, it's because when you choose to vacation
10 as so many did during the heights of the
11 pandemic and come out to rural America.
12 And you get in that motor vehicle
13 accident or you have a myocardial infarction or
14 you have a stroke or you have a three-month-old
15 with a fever in the middle of the night, you
16 want, in a rural area, you want to be able to
17 go to a facility in a rural community and
18 receive evidence-based care whenever it's
19 needed, and oftentimes, life-saving care.
20 So, I think, you know, the -- it's
21 really vital for our nation and our world's
22 economy to sustain rural health care because of
23 the food, fiber, and fuel that is produced in
24 the rural areas of our country.
25 DR. ANTONUCCI: I think that it is
26 unlikely anything will happen. And the same

1 things are being written, as you said, for
2 decades.
3 I, and during COVID, things were
4 pretty interesting with how people talked to
5 us.
6 I think if you want to change
7 things, first of all, you stop saying things
8 like, how do we maximize coding and HCC codes
9 to make our patients look sicker to get paid
10 more?
11 But I think the only thing that
12 might shake up the country and make -- because
13 I hear you saying, how do we get a moonshot?
14 How do we, you know, get Rosie the Riveter back
15 to work? And you know, all these kind of
16 national things.
17 This is not a country that has ever
18 wanted primary care. We have a culture that is
19 in a certain way.
20 And I think if primary care went
21 away, people might miss it after a while.
22 I've often felt we should strike,
23 but I don't think the country's very interested
24 in primary care.
25 And so, if there were great
26 leadership somewhere to help us, that would be

1 nice. But this is not a country that wants
2 primary care, doesn't see the value of it and
3 change of culture takes a long time.
4 DR. HAFT: So, I think your question
5 that you asked is really at the heart of how do
6 we bring about broad-based change?
7 And I think as a domestic policy
8 issue, we have to say the country is sick, and
9 it's getting sicker.
10 We're living shorter now after five
11 decades or six decades of increasing our life
12 span, we're seeing a shorter life span over the
13 last three years, not just due to COVID.
14 And it's more acute, and again, the
15 canary in the coal mine is the rural areas
16 where people are sicker yet. Their life
17 expectancies are lower yet.
18 And the policy question is, is this
19 what we want for our $3 trillion investment?
20 Do we want to continue to invest so that we
21 can get sicker and sicker and die younger and
22 younger and have shorter lives?
23 And the answer has got to be no.
24 And then, it's got to lead us to, well, let's
25 do something. Where's the moonshot here? What
26 do we do about it?

1 Where is the Lyndon Johnson to say -
2 - to take, you know, the, you know, a divided
3 Congress and say, let's do something about this
4 because we all win with making the health of
5 this nation better.
6 It's something I think everybody can
7 get behind, and everybody wants to be healthier
8 and live longer.
9 So, I don't think any constituents,
10 red or blue, are going to say no, I don't do --
11 I don't want that. I want to die younger, and
12 I want to be sicker.
13 So, it is -- I think it has been the
14 hallmark of something that could be done in a
15 bipartisan way.
16 You know, cancer moonshot is a good
17 -- great idea, one group of diseases. But
18 that's not the whole thing, that's doing a
19 disease or a condition at a time.
20 We need to really rebuild the
21 system. And honestly, we don't have a health
22 care delivery system in this country.
23 Most economically developed
24 countries in the world have a health care
25 delivery system. We have a fragmentation of
26 wonderful, different organizations that can do

1 glorious things, but don't work together with
2 any kind of theme that supports kind of the
3 health of the nation.
4 So, I'll get off of that soapbox and
5 pass it on to someone else.
6 DR. MURPHY: I think I was going to
7 say the same -- I'm optimistic. And the reason
8 I'm optimistic is because of all the issues
9 that we said is the gravity of the situation.
10 It is we've got to do something as a
11 country like everybody said.
12 But I think the advantage here, I
13 would emphasize Howard's point, there's not a
14 lot getting done in a bipartisan way. This is
15 a bipartisan issue.
16 Every -- most state and federal
17 government representatives, congressmen,
18 senators, they all have -- most of them have at
19 least a part of their district or their
20 geography that they cover in rural communities.
21 So, it's not a red victory or a blue
22 victory, it's a victory.
23 And I think that is there -- I
24 think, to your point, Jim, of what would I say
25 to, you know, Secretary Becerra is, this is
26 something that you could really -- this is

1 something that we could do through regulation,
2 legislation, and really move the federal
3 approach and also the same approach with the
4 states.
5 So, I think we can't emphasize
6 enough that we shouldn't let the opportunity go
7 by thinking that, well, you just can't get, you
8 know, you just can't get anything done.
9 I think that -- I think rural
10 communities and rural health primary care
11 physicians are critically important right now.
12 And I know -- I'm sure that the federal
13 government and state governments feel the same
14 way.
15 DR. HAFT: If I could add one other
16 thing to this conversation.
17 I understand that the Assistant
18 Secretary of Health has produced an action plan
19 for HHS. And I think it's still in the process
20 of going through the approvals.
21 But that would be a delightful way
22 to move forward and move that to advance all of
23 these issues with having a cohesive action plan
24 for the entire agency.
25 Just as another thought.
26 CO-CHAIR SINOPOLI: Great, thank

1 you, that was a great, great discussion.
2 So, Larry, it looks like you have
3 your card up?
4 DR. KOSINSKI: I've been enjoying
5 listening to all of you and have jotted down
6 some statements that have stuck with me from
7 all of you.
8 And you know, Karen's statement that
9 we're going nowhere without investment.
10 The four of you have made it very,
11 very clear that we have to put our money where
12 our mouth is, and we have to pay for this if we
13 want it.
14 CMS is not paying enough for value.
15 I think Howard said that.
16 And I'm really struck with Jean's
17 one dollar per day, because that is so far less
18 than any concierge practice is getting today.
19 God bless you, that's -- that keeps
20 my optimism going.
21 But I had two questions, and I think
22 one was for Adrian and one was for Howard.
23 I think Adrian answered mine
24 already. I was intrigued by his statement
25 about the academic medical centers should
26 leverage their strengths to help the rural

1 community.

2 If you want to say something more on

3 that, that's fine.

4 But where I really want to go with

5 my question here is with Howard, because you

6 really struck something with me when you

7 brought up MA[54].

8 This is a fear that, and again,

9 we're falling into probably political waters

10 here, one side of Congress would like

11 everything to be under MA, and Medicare to be

12 totally privatized.

13 And the other side would like to

14 assure that all beneficiaries are receiving

15 what they should be receiving.

16 And we're at a push and pull here

17 now, and we can see where the trend is going.

18 So, Howard, I'd like you to expound

19 a little bit on your statement.

20 You mentioned the word foundation.

21 And I always think about that condo building in

22 Florida that fell and killed 90 people.

23 And there were inspectors that were

24 inspecting it. And there was a board that was

25 supposed to be responsible for it.

54 Medicare Advantage

1 But the skeletal infrastructure fell
2 apart, and it was the people who lived in the
3 building who were hurt.
4 And my fear with MA is that, unless
5 we have foundation and infrastructure --
6 foundation and structure -- inside these
7 entities, the beneficiaries are the ones that
8 are going to ultimately lose, and I think they
9 already are.
10 But I'd like to hear you expound on
11 your statement.
12 DR. HAFT: Yes, I will.
13 I think, you know, that there
14 certainly was value in some of the MA plans.
15 And you know, and the studies that
16 have been done show that it's questionable
17 quality. You know, they've taken very large
18 amounts of profit over the course of the recent
19 years.
20 There's been issues, you know, with,
21 you know, selective recruitments and other
22 things.
23 But that's not the issue to my mind.
24 I think those things can be fixed.
25 CMS can put regulations and
26 guardrails in to fix that.

1 The question is really, do we want
2 to have 300, 400 MA plans, each with a
3 different payment scheme, each paying primary
4 care and other providers in a different way as
5 part of our overall strategy going forward?
6 It may look good to privatize from
7 the top down, but we're, you know, what we're
8 doing is, it would give, you know, the nation's
9 largest or second largest entitlement, we're
10 commercializing it and taking it out of any
11 kind of public control.
12 And so, that's an issue. But the
13 bigger issue is, when I look at, you know, from
14 a practice level, which I'm happy to say I'm
15 back in, you know, I've been practicing again
16 now and enjoying taking care of people in a
17 rural setting, just a delight.
18 But I look at the comparison to
19 participate. The practice that I'm with
20 participates in a state plan, the Maryland
21 Primary Care Program.
22 And it has very defined payments,
23 and it has even equity payments, there's hard
24 payment that we ginned up over the last few
25 years for people who are in high ADI areas, who
26 have high HCC scores.

1 But what happens when those
2 beneficiaries choose to go to Medicare
3 Advantage, one or another of the Medicare
4 Advantage plans that have come into the region,
5 the practice loses all of that benefit.
6 They lose the capitation. They lose
7 the equity payments. And they get whatever
8 they can negotiate with the Medicare Advantage
9 Plan which is either, you know, a point above
10 or a point below whatever fee-for-service is.
11 Very few -- and I've looked at this
12 in some detail and written about it, very few
13 of the MA plans actually are adhering to what
14 the NASEM report would say in terms of, let's
15 provide hybrid payments and, you know, mixed
16 fee-for-service and capitation.
17 They're doing basically what
18 insurers did, you know, years ago. We're going
19 to negotiate, get the best rates we can for us
20 for our profit because they're for-profit
21 entities.
22 To me, that's an issue. And harkens
23 back to this other issue. First, it fragments
24 the number of payers that a primary care has to
25 deal with.
26 It reduces their ability to get real

1 capitation that can support a whole program.
2 But it also, then, puts more of the
3 money out of kind of this fiduciary
4 responsibilities need to my patient and puts
5 more into, now, I've got some, you know,
6 somebody else, a fiscal intermediary who has --
7 their fiduciary responsibility is to their
8 Board and their CEO.
9 And I don't think that's where the
10 fiduciary responsibility in health should be.
11 So, I have a -- and I think, again,
12 there could be good MA plans. I don't think
13 making the whole Medicare, you know,
14 traditional Medicare turning it, as it looks
15 like the trajectory is now, to all Medicare
16 Advantage is going to benefit primary care in
17 any way, shape, or form.
18 Sorry about that.
19 DR. KOSINSKI: No, you answered it
20 well.
21 Adrian, did you want to add anything
22 to yours, or did you cover that earlier?
23 DR. BILLINGS: I will cede my time.
24 Thank you.
25 CO-CHAIR SINOPOLI: Any other
26 Committee or any other participants want to

1 make a comment about that?
2 No? All right, then, Walter?
3 DR. LIN: I want to just add my
4 thanks for our subject matter experts being
5 with us today. It's just a really rich,
6 informative discussion, sometimes provocative.
7 So, thank you for that.
8 You know, I think a clear and
9 resounding theme throughout not just this
10 session, but the prior ones today has been need
11 to pay rural providers more.
12 They take care of sicker patients.
13 They do more with less. The patients have less
14 access. We need to pay rural providers more.
15 And I think we've heard that loud
16 and clear. And I'm not sure that any of us
17 would necessarily disagree with that.
18 But there have been several
19 questions from Committee members around how to
20 distribute that payment and how best to use
21 that payment, assuming that we can get it.
22 I have actually two questions, if
23 the Chair and Chairwoman would so indulge me.
24 One, you know, I'm actually
25 intrigued by this statement, we should allow
26 rural providers to participate in value-based

1 care without risk.
2 That just seems like a very
3 oxymoronic, if you will, concept to me.
4 How can we allow providers to
5 participate in value-based care without risk?
6 That's my first question.
7 DR. MURPHY: So, maybe I was the
8 loudest on no risk.
9 I think the reality here is all the
10 problems that we've stated, there is no way
11 that rural communities with physicians or
12 hospitals are going to survive without a change
13 of payment structure.
14 So, again, I think I go back to the
15 social accountability in terms of we have to
16 make investments in these communities in
17 primary care and the support systems that
18 surround them.
19 Why I say you can do value-based
20 care without risk, and we do it all the time
21 now, I mean, we do it, you know, in value-based
22 arrangements that have upside risk. Right?
23 So, you can -- if you lower the
24 total cost of care, you can benefit. But if
25 you lose, you don't have to pay.
26 So, I think by now, since 2010, when

1 we've been doing and designing all of the
2 value-based models is that there is a way to
3 create value. Right?
4 Value doesn't have to -- value does
5 not have to answer risk. It has to answer a
6 value question.
7 So, to me, it certainly can be
8 designed to create value.
9 I think the second piece is risk
10 just doesn't work because it's not that we're
11 overspending in rural communities, we're
12 misappropriating what we are spending.
13 So, it's just not a system designed
14 for sustainability.
15 So, for payers to say they have to
16 reduce their costs in rural communities, no,
17 because we're still not meeting the needs of
18 the communities.
19 We have to decide what the needs of
20 the community are and pay appropriately for the
21 way we've all discussed, with enhancements to
22 primary care and investments into the
23 community's health infrastructure.
24 So, I have no doubt that we can
25 create value-based systems without risk.
26 And you know, we've tried to do the

1 risk deal in rural communities, it doesn't
2 work. The numbers are too small. The
3 financial picture in rural communities of both
4 primary care physicians, whatever specialties
5 are left, and rural hospitals are all dire.
6 They don't -- they cannot take risk
7 in the current system.
8 DR. BILLINGS: And I think, just a
9 point of clarification that I want to make with
10 regards to paying rural providers more.
11 I think, you know, what we mean is,
12 we all want the tools of our trade that our
13 urban providers have, our urban patients have
14 the privilege of having access to.
15 Every rural clinician wants the
16 tools of the trade to take care of the patients
17 so there's not a discrepancy in care received
18 in a rural facility versus that in an urban
19 facility.
20 So, when -- I think you're hearing
21 us say that rural providers need to be paid
22 more. What we mean is, we want that investment
23 to give us the tools of the trade that our
24 patients deserve and our rural clinicians
25 deserve to have to be able to offer that to
26 improve rural public health.

1 DR. LIN: I appreciate that. I
2 appreciate those responses, and I do agree that
3 probably a lot can be achieved through shared
4 savings.
5 I guess, in my mind, I think about
6 risk as a mechanism by which we can achieve
7 certain desired outcomes through the increased
8 payments and kind of direct funding toward that
9 goal as opposed to maybe some less desirable
10 outcomes.
11 But I kind of see what you guys are
12 saying now.
13 My second question, kind of on a
14 related note is, you know, I think there's been
15 a strong sentiment within the panel of paying
16 primary care providers more.
17 And you know, as a primary care
18 provider, I'm in agreement.
19 But I do want to touch upon this
20 point because I think there is a shortage of
21 primary care providers, not just in rural
22 areas, but kind of across the nation. It's
23 just really hard to find them and probably even
24 harder to get them to move out to some rural
25 areas.
26 And so, I guess paying them more

1 might be one solution.

2 Some of our other panelists have
3 discussed maybe paying for non-physician
4 providers as an idea.

5 So, for example, paying for nurses
6 or social workers. I think someone mentioned a
7 doula earlier in the other session, and patient
8 care ambassadors.

9 Why not have kind of, instead of
10 increasing the payments for PCPs, increase
11 payments for non-physician, non-NP, non-
12 advanced practice providers to encourage their
13 services to take away responsibilities from the
14 PCP's plate that don't need their level of
15 training so that the PCPs can actually practice
16 at their full level, full scope?

17 DR. HAFT: Dr. Lin, I think you're
18 exactly right. I think that's where the
19 intention is in the NASEM report and others.
20 It's not to pay providers to care for people,
21 it's to pay for teams to provide health for
22 communities.

23 And, you know, pay for -- this
24 notion of paying more is not just, we're going
25 to put more, as somebody said, more money in
26 the, you know, in a biweekly paycheck of

1 primary care providers.
2 It's really about, as you kept
3 hearing here, giving the necessary resources to
4 get the job done, to do the work that's asked
5 to be done, which includes caring for social
6 needs and behavioral health integration, care
7 management, and having the HIT tools to do
8 that.
9 So, that's where the -- it is all
10 about teams and being able to make that
11 investment, but not -- I don't think it's
12 individually to now we're going to start paying
13 nurses more and hope they'll go to a rural area
14 or pay a social worker more and hope they don't
15 go to a rural area.
16 I think it's about building those
17 teams that all work together as one and have
18 this kind of this global capitation or risk
19 adjusted payment per beneficiary per month or
20 patient per month or per year, however you want
21 to carve that.
22 But it's enough that infrastructure
23 pays for the whole team or whatever the team is
24 that you want.
25 You know, you may say, we don't need
26 social workers, we just need community health

1 workers.
2 Whatever that is that, you know,
3 that you're asking providers to deliver, you
4 need to pay enough to actually deliver that,
5 and includes all of those other people, MAs and
6 front office staff, and billing people and all
7 those other things that go into the bundle.
8 But it's not just -- it is clearly
9 not just what you're going to pay the provider.
10 DR. ANTONUCCI: Dr. Lin, I think
11 that Dr. Haft is partly right, but somebody
12 else has to manage that team now, don't they?
13 Who's going to send out those people?
14 And it takes me back to this value-
15 based issue about risk. Risk should not be
16 money, the risk is care and how we measure
17 care.
18 And I think -- I guess I'm answering
19 3,000 questions ago, but no physician out here
20 really thinks that any of these metrics really
21 can be measured accurately and matter to most
22 of our patients.
23 And so, I really have to speak
24 about, we don't just need more payment, we need
25 restructuring of payment.
26 And also, we could use a few doulas

1 or social workers or community health care
2 workers, but they have to have the physicians
3 to run the team.
4 And I don't think we have to have
5 teams. So, I think it's kind of a peripheral
6 question, with all due respect.
7 I think we have to look really long
8 and hard about redesigning how we get medical
9 care to patients and, yes, might include some
10 of those other things.
11 I think we spent a lot of time in
12 Alaska, and I saw community health workers who
13 had six weeks' worth of training. But the
14 doctor went to the waiting room every morning
15 and called every one of them.
16 And so, you can't have one without
17 the other. And that, the value, the risk is
18 poor care. The risk isn't around money.
19 That's how I see it.
20 DR. LIN: I'm sorry, Dr. Antonucci,
21 did you say, just so I make sure I heard you
22 right, did you say you don't think we need to
23 have teams?
24 DR. ANTONUCCI: Okay, now, I didn't
25 hear you. Did I say we don't need to have --
26 DR. LIN: Teams? Did you say that

1 or did I mishear? Do we need to have teams or
2 not?
3 DR. ANTONUCCI: Yes, I think we're
4 having -- payments? We need to pay physicians
5 more, but I think we keep saying that sentence.
6 And I don't think that's the right sentence to
7 say.
8 We need to pay them differently, and
9 they do need to get paid more.
10 But I think as long as we keep
11 saying, we need to pay primary care more, we're
12 not going to get anywhere because we've been
13 saying that for a long time.
14 And it does get political because
15 some of it's a zero sum game with CMS and
16 RVUs[55]. Right?
17 And so, the radiation oncologists
18 have to be paid less if we get more. And it
19 becomes messy.
20 So, sure, we need to make more, but
21 we need to make money differently also.
22 A tiny example is, where the doctors
23 have to submit an incredibly complicated
24 timecard for every 15 minutes' worth of work we
25 do.

55 Relative value units

1 Coding for billing costs my small
2 practice $10,000 a year.
3 You wouldn't have to give me any
4 more money if you could do it in the coding for
5 billing game. I'm not submitting any counter
6 form.
7 And you have -- if you're paying me,
8 you have every right to expect I provide value.
9 But why do I have to do it the way we do it now
10 and that wouldn't cost any more money if you've
11 got all those timecards for every 15 minutes'
12 worth of work?
13 DR. MURPHY: I think of one point
14 that I'd add about teams that makes them
15 critically important is that we have to do the
16 math.
17 And the math in the country on
18 physicians, primary care physicians and nurses
19 and advanced practitioners to cover the needs
20 of the country, the math doesn't work to say,
21 well, we're going to have one, we're not going
22 to have the other.
23 We need to -- I believe that we need
24 team-based care. And I think that we can do a
25 lot more with team-based care than we maybe did
26 in the past.

1 But I think that the shortage of
2 primary care physicians, the shortage of all
3 those other professionals that I talked about,
4 the math doesn't work unless we stretch to
5 include team-based care because we just can't
6 deliver care like -- I would say like when we
7 had supply, adequate supply across the country.
8 DR. LIN: Thank you.
9 CO-CHAIR SINOPOLI: Chinni, you have
10 a question?
11 DR. PULLURU: Yes, just listening to
12 all of you, you know, I think about physician
13 training and family medicine particularly
14 training and looking at the vast majority of
15 training organizations are still family
16 medicine residencies and other primary care
17 residencies are still in urban areas.
18 And so, any thoughts to how we could
19 better sort of incentivize more physicians and
20 other types of providers to come to rural areas
21 to practice, you know, people besides training?
22 You know, there's obviously loan
23 repayment and other things, too.
24 But would love to get, you know, you
25 guys are in the trenches, I would love to get
26 your thoughts on that.

1 DR. BILLINGS: Thank you for that
2 question.
3 In the medical literature, in the
4 medical student and resident physician
5 literature, Shipman, et al, who used to be at
6 AAMC[56], put out the 2019 Health Affairs
7 manuscript that showed declining matriculation
8 of rural students into medical school.
9 The two biggest factors for a
10 physician that prognosticates a future,
11 predicts a future of rural practice is, first,
12 being from a rural community or having a
13 significant life experience in a rural
14 community.
15 The second biggest factor is having
16 some rural exposure during medical school
17 and/or during residency.
18 And so, that gets to the point that
19 I made earlier is that we need more multi-
20 disciplinary academic health centers in those
21 communities of need, in those rural communities
22 of need, much like the teaching health center
23 program for Federally Qualified Health Centers
24 of standing up graduate medical education
25 programs within primary care disciplines within

56 Association of American Medical Colleges

1 FQHCs that are both urban and rural.
2 There needs -- in my view, the
3 investment that is needed that really builds
4 access to care is that pathway and that pathway
5 program of having rural academic health centers
6 and enabling rural students to have an
7 opportunity to matriculate into health care
8 training programs whether it be in social work
9 or whether it be in medical school or
10 dentistry.
11 All of those teams, we -- I think we
12 can all agree that the best patient care is
13 delivered in teams. But that is what is
14 lacking in rural communities.
15 I can't tell you how often I have
16 done the work of a social worker. My
17 receptionist has tried to do the work of a
18 social worker because that discipline has not
19 been present for me in the past 17 years of my
20 entire rural practice.
21 And the best way to build that team
22 is enabling our rural high school students to
23 have an opportunity to go to undergraduate
24 school to do -- be successful and to get into a
25 health care training program and building more
26 dual-credit programs in rural high schools and

1 building up the rural public education system.
2 And bringing that from the
3 perspective that rural school board trustee, as
4 well as the father of three rurally educated
5 sons, two of which are pre-med right now and
6 hope to be rural physicians.
7 But we have to enable these rural
8 students to give them information, to give them
9 a pathway.
10 And you know, if 15 percent of our
11 population is rural, you can we all agree that
12 maybe 15 percent of your matriculates into our
13 health care training programs should be from
14 rural communities?
15 And then, how can we get them back
16 home? Or how can we keep them at home via
17 distance learning so they never have to leave
18 their rural community and they don't grow roots
19 in an urban area?
20 So, more investment in the rural
21 public education system K-12, more enabling of
22 rural students, and again, pushing out our
23 health care training programs into our rural
24 communities.
25 CO-CHAIR SINOPOLI: Perfect, good.
26 DR. PULLURU: Thank you.

1 As a follow-up to that, and just if
2 you'll humor me, any thought to, you know, as
3 much as we've heard, yes, invest in primary
4 care, invest in, you know, physician-based team
5 model leadership.
6 Any thought to scope of licensure
7 expansion, particularly in rural areas in order
8 to allow for more access?
9 And especially if value-based care
10 payments were tied to utilization of multi-
11 disciplinary teams?
12 And I'll throw it out there for
13 everybody.
14 DR. HAFT: Yes, I'll make a brief
15 comment on that.
16 One, I think, you know, some scope
17 of practice expansions is, you know, is always
18 a turf battle issue.
19 But I think there's one clear place
20 where there's a great opportunity, and that's
21 with pharmacists, you know, to be able to
22 expand their services, you know, with, you
23 know, and provide more care.
24 They already are doing more in terms
25 of vaccinations and things. But they're, you
26 know, wonderfully trained, certainly manage

1 medications very well and other things. So,
2 that's one area.
3 I think, in general, having everyone
4 work to the highest level of whatever their
5 license, their certificate is a first good
6 first step. Because we don't even do that now.
7 And then, looking carefully at, you
8 know, where expansions can be done.
9 And then, fight the political
10 battles.
11 Because, you know, it's so
12 antithetical, but even in places where there
13 are shortages of health care providers, there's
14 still a battle that wants to keep one group of
15 providers from being able to expand their
16 services to serve the community because of
17 encroachment on services.
18 So, we need to get over that a
19 little bit and then, expand.
20 But I think one great place would be
21 with pharmacists.
22 DR. MURPHY: I think I'll add to
23 that, Howard.
24 And not only for scope of license,
25 but we also have to look at the regulations.
26 Essentially, rural health care has

1 as many regulations as their urban counterparts
2 that have 10 times more resources dedicated to
3 manage those regulations. Right?
4 So, even things like requirements to
5 sit on committees. When I was Secretary of
6 Health in Pennsylvania, I had a hospital come
7 to me and say, I don't have enough physicians
8 to populate the committees that I need to have.
9 And we want our advance practice
10 nurses and physicians assistants to be able to
11 feed into those committees so that we can meet
12 the necessary criteria.
13 And to Howard's point, there was,
14 you know, there was pushback. I mean, not -- I
15 thought it made perfect sense if you don't
16 have, you know, if you really don't have the
17 resources, then you have to extend the
18 resources you have.
19 But I think we have to, again, I
20 think we have to take a look at when we're
21 talking about a very holistic approach, and
22 that's an example of what would be included in
23 the holistic approach.
24 Let's see what we can do to maximize
25 the resources we have.
26 CO-CHAIR SINOPOLI: Great.

1 I want to thank the panelists today
2 for another great panel today with a lot to
3 think about and lots of great information for
4 us.
5 And so, again, just can't
6 overemphasize how much we appreciate the time
7 you've dedicated to this.
8 And so, that concludes our time for
9 this session, and we're going to take a 10-
10 minute break and be back in 10 minutes. Thank
11 you.
12 (Whereupon, the above-entitled
13 matter went off the record at 4:10 p.m. and
14 resumed at 4:22 p.m.)
15 * **Committee Discussion**
16 CO-CHAIR SINOPOLI: Everybody want
17 to take a seat? We're about to get started.
18 Okay, welcome back.
19 As you know, PTAC will issue a
20 report to the Secretary of Health and Human
21 Services that will describe our key findings
22 from the public meeting on encouraging rural
23 participation in population-based total cost of
24 care models.
25 We'll now take some time for the
26 Committee to reflect on what we've learned from

1 our sessions today.
2 We'll hear from more experts
3 tomorrow, but wanted to take some time today to
4 gather our thoughts before adjourning for the
5 day.
6 Committee members, I'm going to ask
7 you to find the potential topics for
8 deliberation document that's tucked in the left
9 front pocket of your binder.
10 To indicate that you have a comment,
11 please flip your name tent.
12 And I'll ask, who would like to
13 start? And I'm probably going to go around the
14 table and ask people for their input.
15 No volunteers yet, so, I'll ask Jay,
16 what are your thoughts of today?
17 DR. FELDSTEIN: A lot of thoughts
18 for today, but obviously, I think the
19 overwhelming theme is the requirement for
20 capital investment for infrastructure of team-
21 based care and primary care and everything that
22 encompasses, not just primary care physicians.
23 I think the other aspect, which we
24 heard, but we didn't spend a lot of time on is
25 the fact that, you know, rural communities are
26 ecosystems.

1 And you know, primary care doesn't
2 exist in a vacuum.
3 And as well as we have to ensure the
4 survival of primary care physicians and team-
5 based care, we've got to ensure the survival of
6 rural hospitals.
7 Not necessarily meaning they need to
8 be 50 or 100 beds and inpatient.
9 And I think just, you know, what is
10 a hospital in a rural setting in today's world?
11 Maybe, you know, it's critical
12 access. It's an emergency - Rural Emergency
13 Hospital, whatever it is. Maybe it's a micro-
14 hospital, you know, with five or 10 beds.
15 But you know, they're economic
16 engines for these rural communities. It's very
17 difficult to recruit a primary care physician
18 without a hospital. You sure are not going to
19 recruit specialists without a hospital.
20 And a hospital takes on a health
21 care center where, outpatient services,
22 surgical services, whatever they may be.
23 But somehow, we need to work that
24 into this report because one cannot exist
25 without the other.
26 And, you know, if we lose another

1 100 to 150 rural hospitals this year, we're
2 going to even have bigger problems with rural
3 health care.
4 So, we need to work that in in some
5 way to the report.
6 CO-CHAIR SINOPOLI: Jen?
7 DR. WILER: I agree with those
8 comments. And there were a couple things that I
9 took away. The first dovetails a little bit on
10 Jay's comment.
11 I was struck by, in our first panel,
12 the comment around aligning incentives in other
13 rural communities, is that one singular focus
14 could be keeping the community healthy.
15 And in order to do that, it's
16 preserving access to acute potentially
17 inpatient care and specialists. And it's
18 creating a care model that focuses on improving
19 the health of the community with partnerships.
20 And so, really reverse-engineering
21 what we think of as payment models that focus
22 on decreasing total cost of care.
23 And that there's some innovative
24 care models that can happen if we leverage the
25 assets that are in those communities like
26 paramedicine, working with, you know, community

1 health workers, and expanding scopes of
2 practice, the idea around mobile clinic, just
3 some really innovative care models.
4 And thinking about how do we help
5 subsidize and incent that innovation and care
6 delivery?
7 The other thing that, again, then
8 relates to that is, we heard over and over that
9 the current focus on quality measurement, and
10 particularly, that total cost of care is
11 problematic.
12 And that our quality measurement and
13 programs need to incent process measures like
14 access to care.
15 And that there's a real opportunity
16 around protecting human capital and creating a
17 sustainable workforce.
18 And Chinni asked a great question of
19 our most recent panel around how to create that
20 inter-professional interdisciplinary workforce.
21 And I think there's a real
22 opportunity for us to continue to, as we move
23 into our experts panels tomorrow, to understand
24 a little bit better what that workforce
25 strategy might look like.
26 And the last thing I'll comment on

1 is, I was also struck by the differentiation
2 within the definition of rural versus frontier,
3 and that those are very different archetypes
4 and they are different care models and require
5 different incentive payment models.
6 CO-CHAIR SINOPOLI: Great. Jim?
7 DR. WALTON: Yes, I think there was
8 some discovery around the definition of rural
9 from a time and distance. I thought that was
10 very, very helpful.
11 I also got a sense that there was a
12 little bit of a disconnect between what these
13 brave, courageous, tenacious people are doing
14 out in the rural area caring for people.
15 And the disconnect between the
16 social contract that has been struck with them
17 about what's going -- how the nation is going
18 to support them in accomplishing their goals.
19 So, that leads to me this kind of --
20 I have this just, I was telling Jen, it was
21 like this kind of wash over me moment where
22 like these people, without question, that spoke
23 with us today were sounding an alarm. It has
24 been a while since I heard that alarm, in a way
25 that made me think that there is a perceived
26 domestic threat to the core infrastructure or

1 the core fabric of our country.
2 And we're here listening to that.
3 We're on the frontline. We're in the
4 Committee. We're in the room when it happened,
5 to take a line out of Hamilton.
6 And so, you think a little bit like
7 there's a population health race kind of like
8 analogous to the space race, that there's a
9 threat, it's domestic. There's an
10 infrastructure thing.
11 We've got our SMEs are telling us
12 that they're ringing the alarm.
13 And so, we, as a Committee, can
14 certainly be forthright in communicating that
15 in writing to -- in our report to the
16 Secretary.
17 I was struck by this idea, and I
18 think, Walter, you brought it up, this idea of
19 there's a social contract, but there's also
20 social accountability.
21 There's a need for, if we make a
22 contract from the government to the provider or
23 communities, that there needs to be
24 accountability back.
25 And I think you hit the nail on the
26 head with that.

1 I was -- Jackson Griggs and I have
2 talked a couple times, and the
3 interdisciplinary primary care team just makes
4 kind of like the most sense as far as what key
5 factor -- this is what Dr. Fowler asked.
6 What key factors should be
7 financially included to increase participation?
8 Interdisciplinary primary care teams
9 funding, that would be kind of like, so you
10 start to address intrinsic motivation of human
11 beings, and particularly providers, instead of
12 just thinking about it through the lens of
13 extrinsic motivation, which is always thought
14 of as money.
15 It's like I just need for you to pay
16 me a higher salary.
17 When in reality, I think what I
18 heard from a number of those speakers was, no,
19 what we really need are the tools to do our job
20 so that we can be successful and fulfill this
21 as human beings.
22 I think there was a big comment
23 about changing the measures, period. And I
24 think Liz asked that question, too.
25 What to measure that -- we didn't
26 talk too much about how to measure it, but we

1 did talk about what to measure, which is, I
2 think you bring this up, Jen, which is, you
3 know, measuring -- how much integration are you
4 getting done?
5 How are the patients responding?
6 What's the burnout rate? Tell me what your net
7 promoter score is from your provider network,
8 let alone your patients?
9 How are you doing on transformation
10 of increasing access to care?
11 And I think the labor retention
12 issue is enormous and should be rewarded for
13 those organizations that find a path to that.
14 Finally, and I'm going to just --
15 I'll stop because I can't go on and on.
16 I was struck by this idea that the
17 thing that they were describing that was
18 necessary to do this work well would be the
19 requirement of multiple agencies or departments
20 within the federal government stacking their
21 investments and focusing on communities that
22 are disproportionately being affected by
23 increased morbidity and mortality by virtue of
24 whatever those elements are.
25 You know, just the -- just
26 infrastructure, history, culture, lack of a

1 cool place to live, the weather's bad, who
2 knows.
3 But I think this idea that it's
4 going to take a concerted leader somewhere to
5 pull together the entire federal government's
6 assets that affect health.
7 And examples that I wrote down were,
8 you know, the Education Department, the Labor
9 Department, USDA, Transportation Department,
10 Economic Development, and we could just go on
11 and on and on.
12 But all of those entities have
13 funding and have missions that are health-
14 related, even though they're targeted and
15 siloed inside their specific area.
16 So, I think there's something to be
17 said about this agency-level action plan that
18 at Health and Human Services that basically
19 tries to incorporate the assets that could be
20 brought to bear for solving some of these rural
21 problems.
22 CO-CHAIR SINOPOLI: Great, great
23 summary. Larry?
24 DR. KOSINSKI: Well, we heard a lot.
25 We heard over and over and over again that
26 primary care is underfunded. There's no

1 question about that.
2 But I felt like I was listening to a
3 climate change conference.
4 And I'm listening to the people who
5 are passionately screaming at the top of their
6 lungs, we've got a problem here, guys. Why is
7 nothing being done?
8 And at the same time, the
9 temperature's getting hotter and the hurricanes
10 are getting worse and everything and nothing's
11 getting done.
12 And so, leadership can't exist in a
13 vacuum. Something will fill it up.
14 And I feel like after listening to
15 this, we are leading from behind, from far
16 behind.
17 And we've already got Medicare
18 Advantage taking over 50 percent of Medicare.
19 And as was said, there's 300 plans, and the
20 poor primary care doc is sitting there getting
21 beat up by each and every one of them.
22 And how about the patients? They
23 don't know what to pick or what to do.
24 We don't need payment reform, what I
25 heard was, we need practice transformation.
26 We need a model. We need to define

1 what is the model of care that should be
2 followed before you can figure out what you're
3 going to pay for, you've got to figure what you
4 should have.
5 And so, we heard socialist
6 statements, and I think they're totally
7 appropriate. If you're compensating an
8 academic medical center 250 percent of RBRVS[57],
9 and you're paying a primary care doctor RBRVS,
10 maybe there's an obligation to those -- from
11 those centers that they should be doing
12 something to make sure care is being provided.
13 Why do we have specialists making a
14 million dollars year to take care of healthy
15 patients and do elective procedures? And you
16 have primary care doctors that are taking care
17 of ill patients for a tenth of that?
18 It just, to me, I'm struck with the
19 gravity of this situation, the fact that CMS is
20 leading from behind, and leadership is in a
21 vacuum right now, and we do need a moonshot.
22 I think Jim's right, we need a
23 moonshot. We need to make some -- CMS needs to
24 take some drastic measures to change this. And
25 we can't just have a 10-year plan.

57 Resource-based relative value score

1 By the time those 10 years go by,
2 Medicare Advantage will be 90 percent of the
3 population.
4 CO-CHAIR SINOPOLI: Alright, thank
5 you, Larry. Walter?
6 DR. LIN: You know, I'll keep my
7 comments short.
8 I think probably the -- one of the
9 biggest takeaways for me from today's sessions
10 has been the fact that value-based care as
11 currently conceived in the United States does
12 not work in rural settings.
13 You know, and I think that was -- I
14 kind of knew that, but I think there were,
15 actually the problems run much deeper than I
16 had understood.
17 You know, the problems around
18 attribution, around lack of infrastructure,
19 around benchmarks, this whole concept of the
20 rural glitch that was spoken about.
21 You know, I think, you know, how do
22 you attribute patients to a PCP when there
23 aren't PCPs taking care of patients often,
24 there aren’t primary care physicians taking
25 care of patients because their care is being
26 directed by advanced practice providers?

1 You know, so, I think that was a
2 kind of a big ah-ha.
3 I'll just end with saying that,
4 after today's session, I feel like our task as
5 PTAC and our report to the Secretary will
6 hopefully address redesigning or developing
7 payment models to support innovation and team-
8 based care delivery models tailored to rural
9 health care.
10 You know, this idea that Larry just
11 mentioned about, you know, how do you pay for
12 something where you really don't know what the
13 carryover model looks like I think resonates
14 with me.
15 And I think we have to figure that
16 out, but we also have to figure out the payment
17 models that can support the development of
18 these team-based multi-disciplinary models.
19 CO-CHAIR SINOPOLI: Perfect, thank
20 you. Lindsay?
21 DR. BOTSFORD: Yes, lots of good
22 points already shared.
23 I think maybe the thing I'll add is,
24 you know, we've heard in previous conversations
25 in this group and other listening sessions
26 touch on the challenges that physicians and

1 groups have and reporting on a variety of
2 quality and performance measures.
3 And you know, I think that seems to
4 be magnified even more in rural areas.
5 I think some of the costs we see in
6 all places just around the variety of payers
7 and masters people have in reporting to get
8 payment, whether in value-based care
9 arrangements or otherwise.
10 And our rural areas are the least
11 positioned in terms of data, resources to throw
12 at the problem, et cetera.
13 So, hearing some of the
14 conversations about attribution and how do you
15 think about, you know, aggregating is one way
16 to do it, but would rural areas be a place to
17 see, you know, these all-payer interventions so
18 that you overcome some of those requirements of
19 small ends and attribution?
20 And could this be a way to solve
21 problems that all communities are facing with
22 some of these?
23 But ease that burden on rural
24 communities first.
25 So, I think, as we think about what
26 flexibilities do rural providers need to

1 motivate participation, you know, we heard
2 things suggested like decreasing telehealth
3 restrictions, meaningful use cited as some of
4 the things that were barriers to EMR
5 selections.
6 The ability to exclude outliers, and
7 where can you get infrastructure investments?
8 But it doesn't seem like focusing
9 just on the Medicare population, much less
10 Medicare Advantage is going to be enough.
11 I think some of the interventions in
12 payment are going to have to cross payers to
13 enable rural participation.
14 There's only so much investment
15 that'll overcome it otherwise.
16 So, I think I'll end there because I
17 think the other big themes around primary care
18 infrastructure were emphasized multiple times
19 already.
20 CO-CHAIR SINOPOLI: Perfect, thank
21 you. Chinni?
22 DR. PULLURU: Wow, what a day,
23 right?
24 So, there's a bunch of things that I
25 feel came out and are just so important.
26 So, the first is that people

1 articulated there are different archetypes of
2 rural. And I think we should really think
3 about that.
4 You know, if you look at the RUCC
5 codes, you know, is there a way to sub-
6 segregate those codes into different archetypes
7 and have different solutions for each one of
8 those that is a part of a policy? And so, I
9 think that's important.
10 The second thing we heard is that,
11 they don't have a lot of money and they need
12 more money. Very simple, right?
13 So, perspective payment attached to
14 potentially different things. But one of the
15 things that they screened was that they needed
16 tools.
17 And so, you know, I think back to
18 some of the things that have happened in health
19 care that we have used to transform.
20 You know, Jen brought up some of the
21 meaningful use stuff and the conversion to EMR.
22 Those were retrospective payments, but what
23 about prospective payments in order to be able
24 to pay for tools and have those payments go for
25 tools? Right? So, that's what I heard.
26 The third was really around

1 attribution and how attribution is just
2 negatively impacted in rural areas because of
3 population density.
4 And so, thinking about maybe within
5 those archetypes, how do we think about
6 attribution to a larger pool of patients and
7 get better balancing of risk?
8 And I know, this may be a longer
9 glide path so people have upside only for a
10 longer period of time while they build that
11 infrastructure.
12 The fourth thing I heard was about
13 access and specialty integration, not having
14 access and not having specialists.
15 This ties to the fifth thing I hear,
16 which was urban and rural. And you know, I
17 practiced for a long time in suburban Chicago.
18 And you know, part of being -- being
19 part of the academy there, we had a lot of
20 academy representatives on our Board and
21 whatnot that were from downstate.
22 So, I got a front row seat to
23 downstate Illinois, and Springfield, and
24 surrounding, you know, areas.
25 And I always thought, if you brought
26 the best of what Chicago had: the academic

1 centers, the multi-specialty groups, and they
2 took some responsibility, accountability in
3 return for some of their value-based care or
4 you pooled those to suburban areas or to those
5 rural areas, you know, Hattiesburg and some of
6 these places where some of my colleagues came
7 from. And I heard that today between urban and
8 rural.
9 So, I think that's really an
10 important thing that could enable practice
11 transformation, another thing that one of my --
12 one of our colleagues said here. So, you know,
13 a lot of really good things.
14 I'm optimistic that we've done
15 enough things in healthcare that have moved the
16 needle, that if you go back and look at
17 history, you can craft a future here, taking
18 little tidbits of lessons we've learned.
19 The Primary Care Medical Home Model
20 might work really well in one of the
21 archetypes. Right? So, I'm optimistic.
22 And then, the last thing I'll say
23 is, you know, I do feel that we need to
24 probably highlight this disproportionately,
25 even though 15 percent of people live there,
26 live in rural areas, medically underserved

1 areas and rural areas produce -- they're a
2 large swath of this country.
3 They produce a lot of our resources,
4 like they said.
5 But they also are the underpinnings
6 of some of our geopolitical polarization and
7 instability.
8 And so, I think, you know, health is
9 humanity and, therefore, people not having
10 access to health care, it is a huge thing for
11 people.
12 And so, if we don't solve for this,
13 I think we continue to have a country of haves
14 and have nots and thems and us's, and that's a
15 problem.
16 DR. MILLS: Appreciate that, Chinni.
17 I took several themes from all of
18 this and at times, I harken back to something
19 that we've said at a prior meeting, which was,
20 we really need to think carefully about how to
21 make it increasingly uncomfortable to practice
22 in fee-for-service medicine.
23 But then, I really got in touch with
24 that -- the flip side of that is, it -- we must
25 also simultaneously make it increasingly
26 comfortable to practice in value-based

1 practice.
2 And we heard our rural colleagues
3 saying that's not happening. All they’re
4 getting is, it's impossible to practice in any
5 economic situation almost.
6 So, I was struck that there were
7 some themes that came out of this which is, for
8 our rural practice brethren population, it's,
9 you know, critical factors are unified
10 definitions.
11 You know, I'm struck that there's,
12 you know, just CMS programs use at least three
13 different definition sets of race language
14 ethnicity data that's impossible for payers and
15 big practices to manage, much less small rural
16 practices. And that's something that policy
17 internal Medicare can take a lead on.
18 A standard defined metric set. I
19 mean, there's 2,500 measures. I don't know we
20 need to make up more measures, we need to use
21 the measures we have now better and in a
22 unified fashion.
23 In almost every facet, we hear a
24 plea for more multi-payer involvement. And I
25 represent, you know, a payer, worked for a
26 payer that's involved in both Medicare

1 Advantage and exchange and commercial space.
2 And we're happy to participate, but
3 I think it is going to take some policy and
4 federal leadership to lead the way and put
5 enough carrot and stick involved that private
6 payers who are often as big as the agencies
7 making the carrots and sticks decide they want
8 to participate.
9 Usually your provider affiliated or
10 provider owned payers are always willing to go
11 with the unified community measure set. It
12 serves everybody's needs.
13 And then, a plea for data, there's
14 just needs to be more assistance. And if
15 there's a moonshot anywhere, it's a moonshot
16 around this health data ecology that's the
17 power utility for the health care system that
18 we keep hearing picked up in different strains
19 at almost every meeting.
20 So, I was struck with that.
21 And then, some -- I've got four
22 pages of comments, but just some comments I'll
23 pull out.
24 I was struck certainly by a rural
25 payment structure issue that the -- a large
26 portion of rural care is provided by Rural

1 Health Clinics, FQHCs, and Critical Access
2 Hospitals.
3 And their payment structures are
4 such that they almost never match up and let
5 them participate in any of the innovations that
6 have happened in the last 20 years.
7 And past that, not only is it, you
8 know, hard to explain to your Board of
9 Directors how your cost-plus reimbursement's
10 going to marry up against this, and they never
11 fit together and so, you just never really get
12 the light to go forward.
13 Most or many CMMI models exclude all
14 of those rural health care facilities. So,
15 essentially, we've lost 20 years of innovation
16 that have been happening in other markets which
17 is really a dearth of, I think, knowledge that
18 we need to figure out how to close.
19 I was struck by some rural
20 definition issues that have been previously
21 mentioned, especially this difference between
22 rural and frontier can't paint with a wide
23 brush. They're very, very different with the
24 same types of needs, but an order of magnitude
25 difference in severity being, you know, 40
26 miles from a larger area versus truly ultra-

1 rural.

2 I thought there were really good
3 comments about, and I'm intimately familiar
4 with Medicare's approach to and exchange
5 approach to access defined as time and distance
6 from the practice.

7 But yet, it's actually not the time
8 and distance from the practice that make
9 network adequacy, it's actually the amount of
10 resources available to that practice.

11 And so, this concept that time and
12 distance of certain key assets and care of a
13 population, whether that's -- what was
14 mentioned was OB and cardiovascular and
15 oncology services. And those are really smart,
16 as those are, you know, three of the top five
17 cost buckets for our population. So, I thought
18 that was interesting.

19 And then, similar to this idea of
20 using Medicare's policy leadership to just
21 streamline definition -- functional definitions
22 of things like race, language, ethnicity.

23 Just there's different definitions
24 of rural across different programs.

25 And so, what makes you rural and
26 qualify for one program may not qualify for a

1 different rural program.
2 It seems like we can -- there's no
3 perfect definition, but we're all served by
4 just picking one and going with it at some
5 point in time.
6 And then, lastly, there were two
7 metric things that I pulled out.
8 One is this idea of this rural
9 glitch. And that just -- my data geek is
10 saying that would just infuriate me that if I
11 was a rural provider and my dataset is being
12 used to measure my delta versus the community
13 but my practice is 72 percent of the community,
14 I'm competing against myself and can never show
15 meaningful change.
16 Somehow that's got to be fixed. And
17 that's, again, within policy leadership to
18 figure out how to do that.
19 And then, the last piece I'll bring
20 out and then turn it back to the Chair is, this
21 guidance over the reality that you've got a
22 population and a pilot, two outliers, you've
23 got, you know, one mom who's in a car wreck and
24 delivers a 26-year-old preemie, and your
25 measures are just destroyed for the year, and
26 there's no recovery.

1 There's got to be a way to exclude
2 outlier white swan events in a measure set.
3 And that -- the science is there, we would be
4 able to figure that out and put that into
5 practice.
6 So, that's what I pulled out from
7 today. Thank you.
8 CO-CHAIR SINOPOLI: Thank you.
9 Lauran?
10 CO-CHAIR HARDIN: Excellent
11 comments.
12 Just a couple of layers, whether
13 you're looking to the lens of Medicare,
14 Medicaid, commercial insurance, social
15 determinants of health, health equity, there's
16 a crying need for coordination and integration
17 into one ecosystem in rural communities.
18 We heard great examples of a hub and
19 spoke model connected to an FQHC, hospitals
20 operating as conveners and connectors, and
21 utilizing the diverse resources to really pull
22 people together.
23 But the need to share services and
24 really look at what is a best practice
25 connected ecosystem heading towards health was
26 really an interesting theme today.

1 A couple other things. I heard a few
2 very specific policy recommendations that I
3 thought were interesting.
4 So, removing the face-to-face
5 requirement for telehealth, waiving the one
6 visit, one service for FQ billing, and also
7 increasing access to Hospital at Home, as well
8 as looking at the ability for attribution to
9 advance practice providers or eliminating the
10 physician as a pre-step in rural health were
11 all interesting policy recommendations.
12 A lot of rich dialogue and really
13 looking forward to what else we bring out
14 tomorrow.
15 *** Closing Remarks**
16 CO-CHAIR SINOPOLI: Perfect. So,
17 thank you all.
18 So, I'm just going to have a couple
19 of closing comments. And I really want to
20 emphasize what Chinni and Jay said from my
21 experience.
22 Spent most of my career in a large
23 system that had two separate, large academic
24 medical centers, each one of them surrounded by
25 rural health for miles around, serving 1.2
26 million patients.

1 And I can tell you that even though
2 those rural areas may have only had 15 percent
3 of the population we're talking about, that
4 that 15 percent, if they did not have those
5 rural hospitals and had to move to those more
6 tertiary health centers for care, those
7 tertiary health centers would have collapsed.
8 They cannot -- in fact, we spent
9 most of our time trying to figure out how do we
10 unload the academic health centers and move
11 those out to the rural health centers for more
12 primary care kinds of issues because the ER was
13 always backed up. The hospital was full. The
14 tertiary patients couldn't get into the
15 tertiary referral centers because of that.
16 Fifteen percent is a lot of patients.
17 And so, I think this warrants more
18 attention than a 15 percent number might come
19 across as. This is a major national problem.
20 And so, I just want to emphasize the
21 importance of this discussion.
22 So, thank you all, it's been a
23 great, great day today. Kind of an
24 overwhelming amount of information, but very
25 good.
26 So, any other comments from the

1 Committee members or otherwise before we
2 adjourn?
3 DR. KOSINSKI: I forgot to say --
4 CO-CHAIR SINOPOLI: Go ahead.
5 DR. KOSINSKI: This could be budget
6 neutral. This doesn't mean we have to have new
7 taxes, new spending. This could be budget
8 neutral if the model is what you're paying for,
9 and you restructure how people are getting
10 paid.
11 CO-CHAIR SINOPOLI: Yes, I agree.
12 *** Adjourn**
13 Good, well, thank you all and we'll
14 re-adjourn tomorrow.
15 (Whereupon, the above-entitled
16 matter went off the record at 4:55 p.m.)

C E R T I F I C A T E

This is to certify that the foregoing transcript

In the matter of: Public Meeting

Before: PTAC

Date: 09-18-23

Place: Washington, DC

was duly recorded and accurately transcribed under my direction; further, that said transcript is a true and accurate complete record of the proceedings.

Court Reporter