

Physician-Focused Payment Model Technical Advisory Committee  
Office of Health Policy  
Assistant Secretary for Planning and Evaluation  
U.S. Department of Health and Human Services  
200 Independence Ave, S.W.  
Washington, D.C. 20201

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

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

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

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

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

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

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

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

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<sup>1</sup> 42 U.S.C. 1395w(d)(2)(D).

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

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

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

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

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

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

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<sup>2</sup> NATIONAL ADVISORY COMMITTEE ON RURAL HEALTH AND HUMAN SERVICES, *Social Determinants of Health*, January 2017, <https://www.hrsa.gov/sites/default/files/hrsa/advisory-committees/rural/2017-social-determinants.pdf>.

<sup>3</sup> Joel Achenbach, et al., *An Epidemic of Chronic Illness is Killing Us Too Soon*, THE WASHINGTON POST (Oct. 3, 2023), [https://www.washingtonpost.com/health/interactive/2023/american-life-expectancy-dropping/?itid=hp-top-table-main\\_p001\\_f001](https://www.washingtonpost.com/health/interactive/2023/american-life-expectancy-dropping/?itid=hp-top-table-main_p001_f001).

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

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

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

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

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

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

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

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

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

<sup>8</sup> National Advisory Committee, *supra* note 1, at 3.

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

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

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

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

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

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

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

<sup>13</sup> *Id.*

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

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

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

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

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

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

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

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

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

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

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

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

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

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

<sup>15</sup> Edmer Lazaro, Fred Ullrich, and Keith Mueller, *Medicare Advantage Enrollment Update 2022*, RUPRI CENTER FOR RURAL HEALTH POLICY ANALYSIS, UNIVERSITY OF IOWA COLLEGE OF PUBLIC HEALTH (Jan. 2023), 1, <https://rupri-public-health.uiowa.edu/publications/policybriefs/2023/Medicare%20Advantage%20Enrollment%20Update%20022.pdf>.



# National Rural Health Association

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

Sincerely,

A handwritten signature in black ink, appearing to read "Alan Morgan". The signature is fluid and cursive, with a long horizontal stroke extending to the right.

Alan Morgan  
Chief Executive Officer  
National Rural Health Association