Bridging Policy, Practice, and Education: Preparing the Next Generation of Family Physicians to Lead

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The Farley Center strives to bridge the gap between research and policy.

- Study policy to expand knowledge and investigate issues to improve health systems
- Partner with researchers to translate findings and outcomes that inform action and policy change
- Educate the next generation of policy and advocacy-focused health professionals
- Provide decision makers high-quality evidence to develop more equitable systems and policies
- Convene diverse and inclusive cohorts to identify policy levers for shared solutions
- Make policies actionable by supporting effective implementation

Disclosures

- Dr. Lauren Hughes has no financial disclosures or conflicts of interest related to the material presented in this session.

Learning objectives

After today's keynote, attendees will be able to:

- Describe how physician leaders can influence health policy at the state and federal levels by exploring examples focused on rural health and primary care.
- Identify effective strategies to teach residents about the evolving health policy and value-based care landscape, especially in rural and underserved communities.
- Discuss the potential impact of the current federal administration's policies on value-based care initiatives and residency training.

Influencing health policy at the state and federal levels

VIEWPOINT

A Path to Sustain Rural Hospitals

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Related article
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On January 12, 2017, the Centers for Medicare & Medicaid Services (CMS) and the Commonwealth of Pennsylvania announced the launch of the Pennsylvania Rural Health Model. The program provides rural hospitals an opportunity to transition from a fee-for-service reimbursement system based on volume to a multipayer global budget payment method that is intended to improve population health outcomes and quality of care while lowering costs.

While rural hospitals provide essential health care services for 57 million people across the country, the ability to achieve financial stability is difficult for some hospitals.[1] The reasons for the instability are multifaceted. Nationally, the number of inpatient admissions is declining, a trend that is also prevalent in rural hospitals. Rural hospitals frequently lack the financial and human resources to offer complex, highly specialized inpatient care that is required for most admissions today. In addition, reimbursement for rural hospitals remains predominantly fee for service, with public payers contributing a sizable percentage of the hospitals' revenue. The combination of declining inpatient admissions resulting in decreased reimbursement and a payer mix that yields a lower price per service has been challenges as rural hospitals nationwide. More than 58% of the hospitals have mounting financial pressures resulting in break even or negative operating margins.[6]

> The financial challenges of rural hospitals today are the result of a changing health care industry.

Pennsylvania recognized the health and socioeconomic imperative involving rural communities. The objectives of the model are to provide a path to improving health and health care delivery in rural communities. The state has developed a plan to change the way participating hospitals will be reimbursed by replacing the current fee-for-service system with a multipayer global budget based on hospitals' historic net revenue. The approach of using a global payment was first introduced in Maryland. In 2010, Maryland began to reimburse rural hospitals using a global budget, resulting in considerable success. In 2014, Maryland expanded global budgeting to all hospitals and to date has demonstrated continued improvement in quality and cost outcomes.[7]

The payment model in Pennsylvania is designed to include Medicare, Medicaid, and commercial payers. The plan provides that the hospital budget will be prospectively calculated, and each month the hospital will be paid 1/12 of the total budget amount. This approach is expected to provide rural hospitals with a predictable revenue stream that could support the transformation of health care delivery services. The global budget is intended to incentivize rural hospitals to retain the established revenue base regardless of hospital use. Payers are expected to invest in the health of the population re-

What is the PA Rural Health Model?

<u>Two major components</u>:

- Hospital global budgets
- Care delivery transformation

Six performance years, 2019 – 2024, now in first transition year

Ultimately 18 hospitals participated

<u>Targets to achieve under the Model</u>:

- Payer and rural hospital participation targets
- Financial savings
- Population health outcomes, access, and quality targets

This Model was the fourth state-specific model tested by CMMI.

Launching the Pennsylvania Rural Health Model

- **Why is this work important?**
  - Rural hospitals provide access to health care and high-paying jobs in rural communities.
  - 195 rural hospitals have closed or converted to other provider types since January 2005.
- **What were my roles?** I helped design the Model and led the 18-month pre-implementation phase by:
  - Partnering with payers, government officials, rural hospitals, foundations, the state hospital association, contractors, and rural health organizations through regular stakeholder meetings to share best practices and make methodology decisions
  - Educating C-suite executives and hospital boards about the Model
  - Drafting legislation to create an independent Rural Health Redesign Center
  - Obtaining $10M in federal support from CMS Innovation Center
  - Representing the Department of Health to peer sister agencies, the federal government, state and national rural health organizations, and other states wanting to learn about our work

Implementing High-Quality Primary Care (NASEM, 2021)

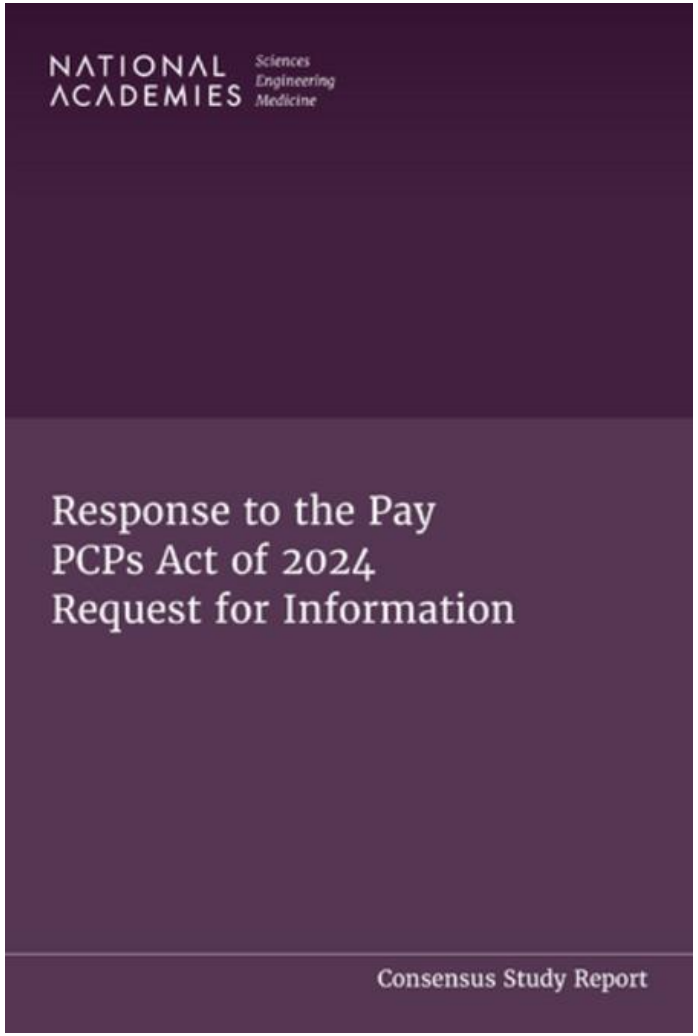
How the Standing Committee does its work

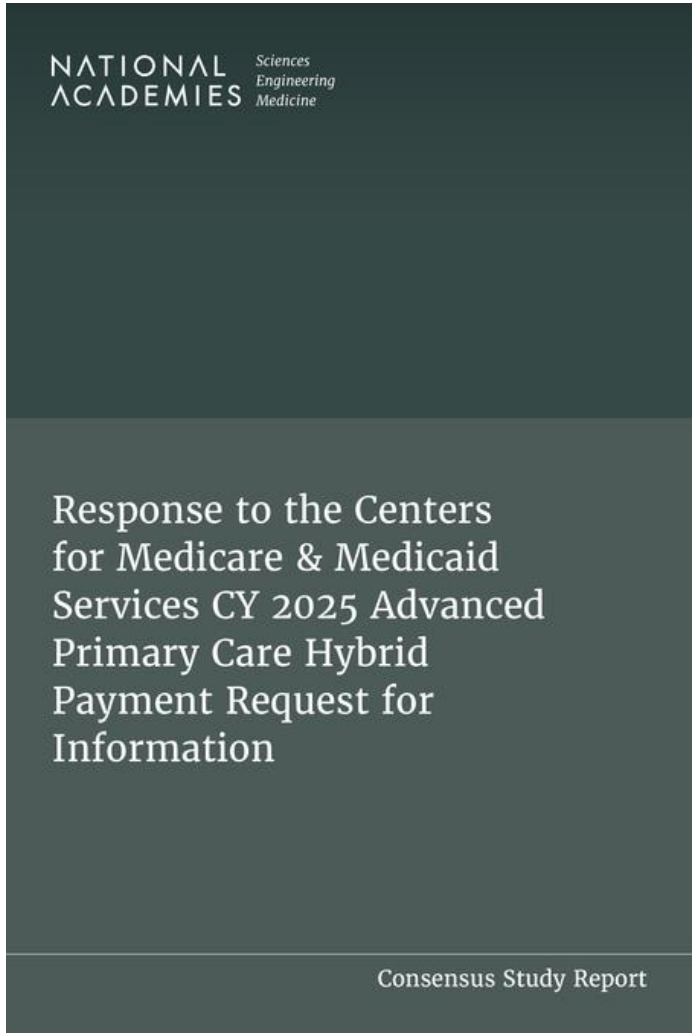
- **Our group:** National clinical, research, policy, and patient experts
- **Our purpose:** To advise the federal government on a wide range of primary care policy issues
- **Two main public work streams:** Meetings and publications focused on advising federal actions
- **Areas of focus for 2025:**
  - Payment
  - Workforce
  - Digital health

Key functions of the Standing Committee

- Extends the 2021 *Implementing High-Quality Primary Care* report by advancing implementation of its recommendations
- Produces high-quality, nonpartisan evidence synthesis and recommendations
- Responds to evolving federal primary care policy needs
- Informs federal policy change in near real time via fast-track consensus studies
- Uses public meetings to feature patient perspectives on primary care access, quality, and cost, as well as clinician experiences with the organization, financing, and delivery of primary care

Consensus study reports released to date





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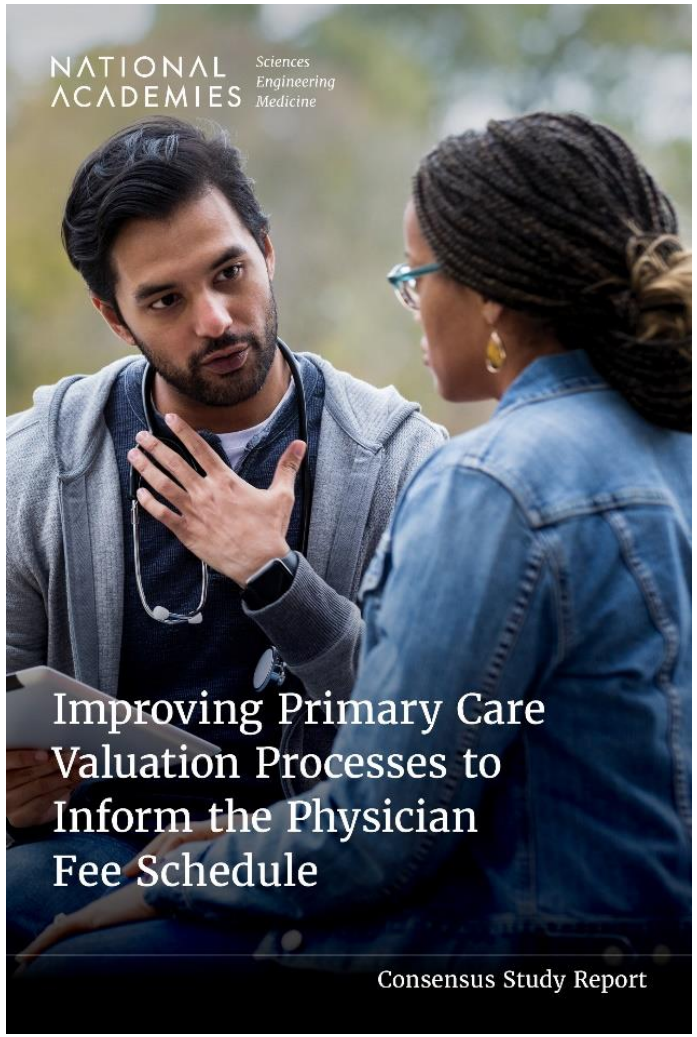
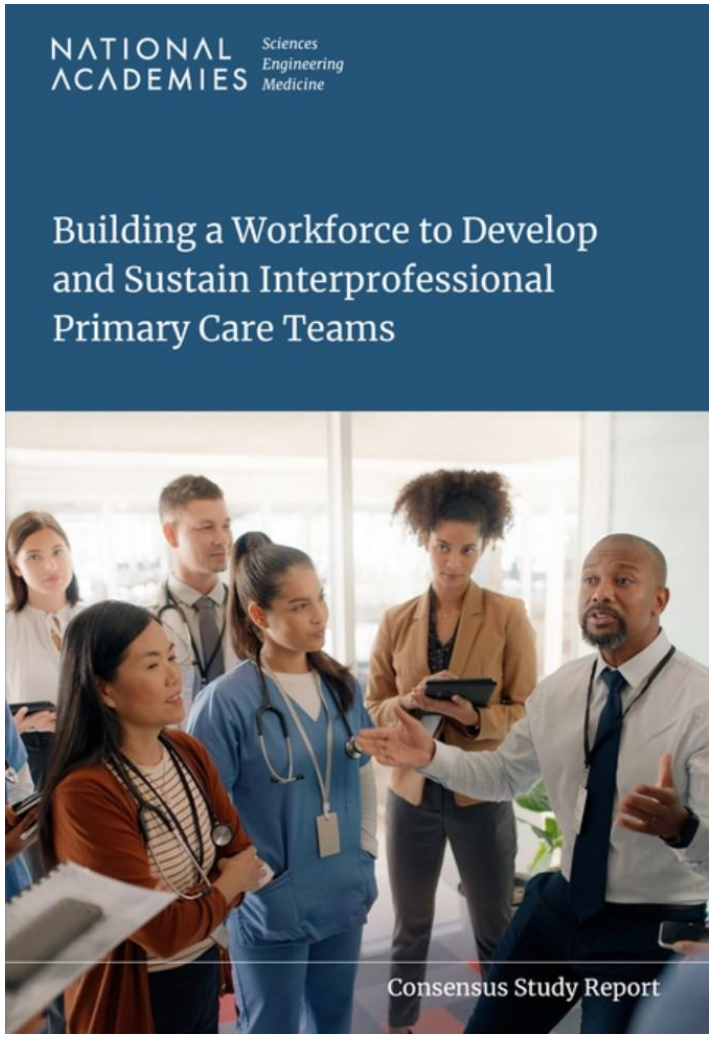




A great overview of our work was just released

DISCUSSION PAPER

Implementing High-Quality Primary Care in 2025:
Key Policy Priorities

Alex H. Krist, MD, MPH, Virginia Commonwealth University; **Eboni Winford, PhD, MPH,** River Valley Health; **Mary Wakefield, PhD, RN, FAAN; Yalda Jabbarpour, MD,** Robert Graham Center for Policy Studies; **Deborah J. Cohen, PhD,** Oregon Health and Science University; **Kevin Grumbach, MD,** University of California, San Francisco; **Michael J. Hasselberg, NP, MS, PhD,** University of Rochester Medical Center; **Beth Bortz, MPP,** Virginia Center for Health Innovation; **Karen L. Fortuna, PhD, MSW,** Dartmouth Geisel School of Medicine; **Ramon Cancino, MD, MBA, MS, FAAFP,** University of Texas Health San Antonio; **Stephanie Gold, MD,** Farley Health Policy Center; **Sebastian Tong, MD, MPH,** University of Washington; **Marc Meisnere, MHS,** National Academies of Sciences, Engineering, and Medicine; and **Lauren S. Hughes, MD, MPH, MSc, MHCDS, FAAFP,** Farley Health Policy Center

August 25, 2025

Primary care is commonly the first point of contact for patients and is pivotal in the prevention and management of chronic disease. Yet despite primary care's essential value for the health of the nation, more than 100 million people across rural and urban communities in the United States are experiencing a calamitous lack of access to primary care (National Association of Community Health Centers, 2023; Jabbarpour et al., 2025). Even among those fortunate to have a regular source of primary care, the average wait time to schedule a family medicine appointment is 20.6 days, a delay that puts the health of individuals at risk and can increase costs through use of more expensive care, including emergency rooms (Jabbarpour et al., 2024). For the 60 percent of Americans who live with a chronic illness and the 40 percent who have two or more chronic illnesses, delays in care can lead to worsening underlying conditions and missed opportunities for early detection of preventable diseases (Buttorff et al., 2017; Gertz et al., 2022). Pressure on practices is driving many primary care clinicians to move to part-time practice, retire early, change which insurance plans they accept, or pursue membership-based models (e.g., concierge, direct primary care), leaving patients in a bind (Rosenthal, 2023). This access crisis is especially concerning given that life expectancy in the United States is lower than other Organisation for Economic Co-operation and Development nations, and primary care is the only component of the health care system that has been shown to increase life expectancy of the US population (Woolf, 2023; NASEM, 2021).

To meaningfully and measurably improve the health status of the US population, addressing primary care access challenges should be a top priority for the new Congress and administration. While some local, state, and federal efforts have attempted to address this crisis, current restructuring in the US Department of Health and Human Services (HHS) and reductions in workforce threaten to undermine some of the primary care support currently in place (Krist et

Lessons learned from both experiences

Pennsylvania Rural Health Model:

- Define a clear problem and a feasible solution
- Build a strong and supportive coalition
- Create opportunities for joint ownership
- Prioritize data-driven decision making
- Establish robust community partnerships
- Understand local health care needs
- Develop a compelling “why”

Standing Committee on Primary Care:

- Respect stakeholder needs and interests
- Foster trust; be an honest broker
- Listen carefully to what is being asked
- Be flexible and adjust whenever possible
- Elevate patient and clinician voices
- Pursue work that builds on what has been done

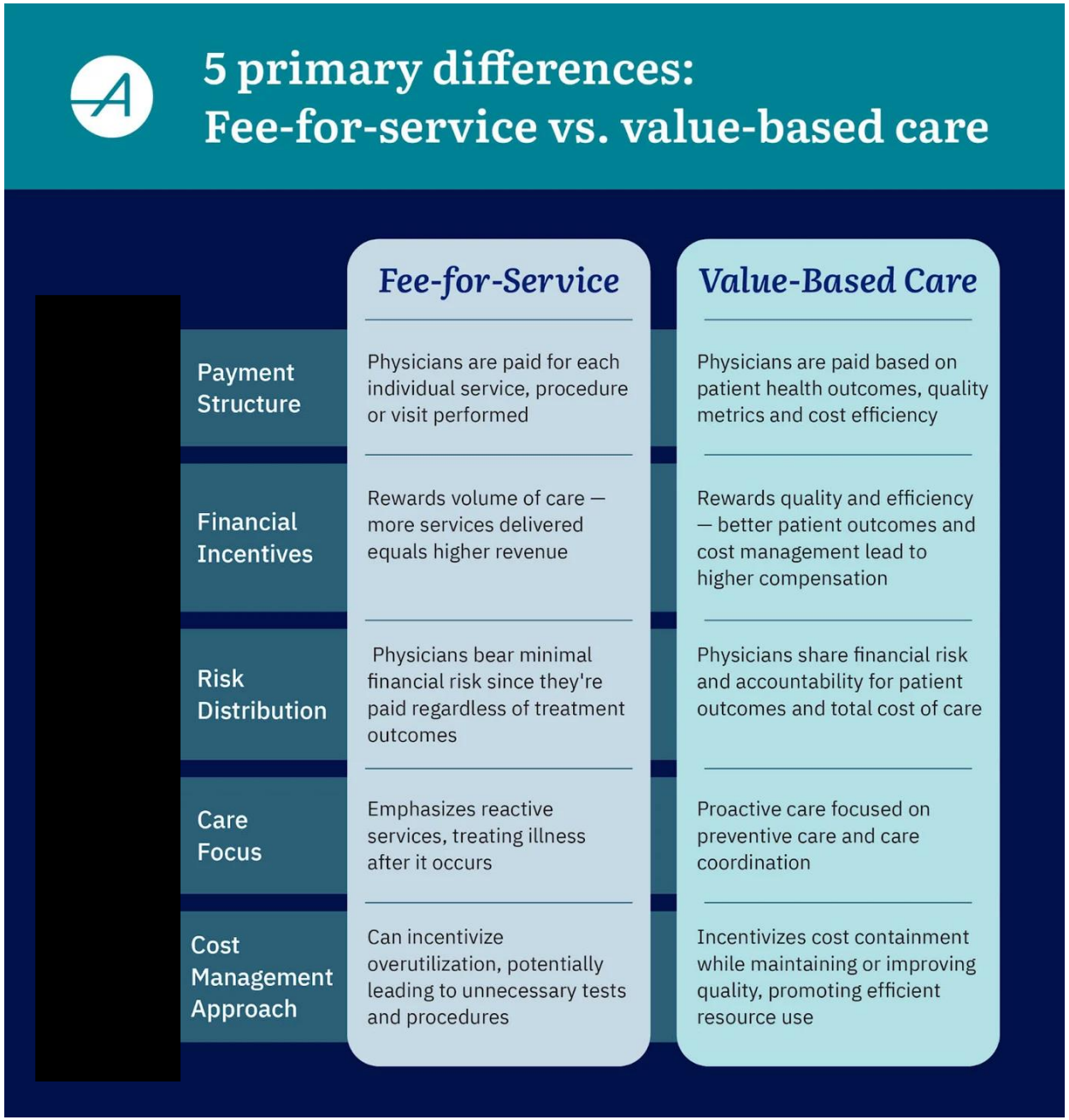
Patience.

Perspective.

Persistence.

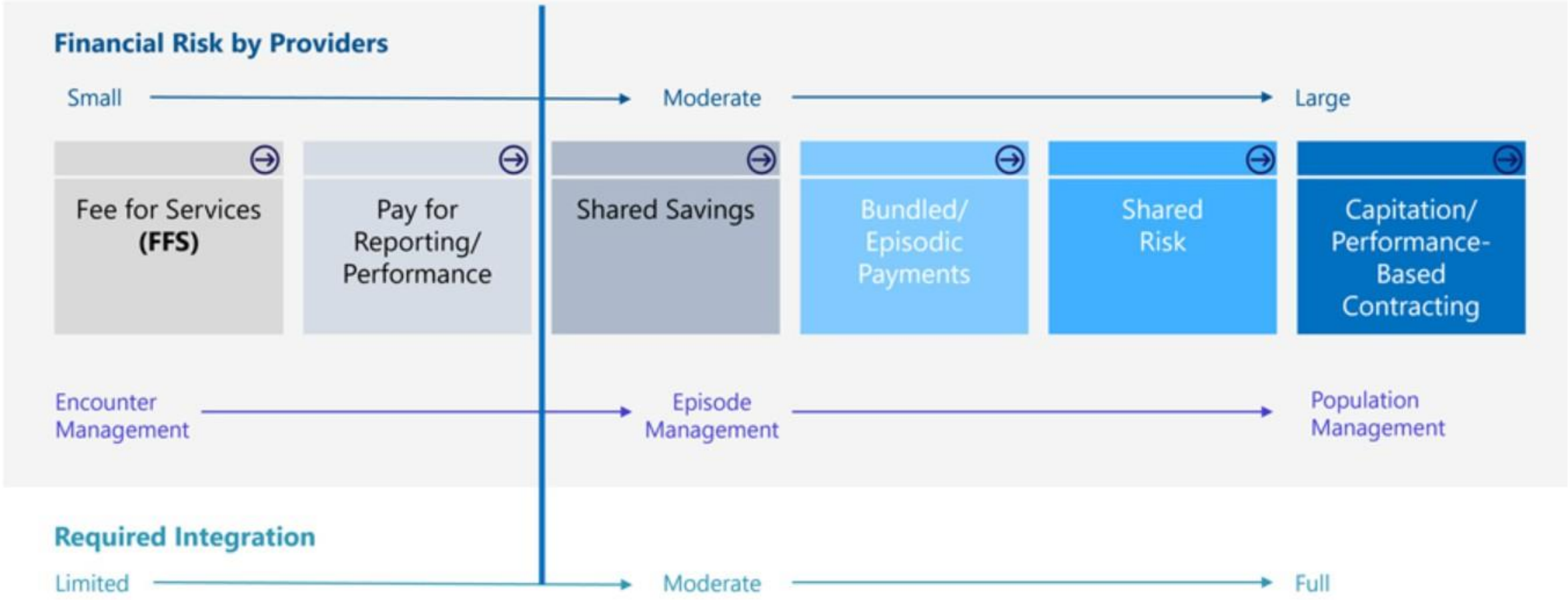
Effective strategies to teach residents about health policy and value-based care


Communications
The Courts
Evidence
Congress
Private Sector
Information Sources
Health Agencies
Public Opinion
Staffers
Regulations
Non-Profits
Federal Budgeting
Health Reform
Federal Health Policy
The Executive Branch
The States' Agenda
Polling



Citation: Fee-for-service vs. value-based care: What is the difference? (Aledade)

Continuum of Value-Based Models



Key is matching right model to provider characteristics

Citation: The Road to the Value-Based Care Promised Land (Behavioral Health News)

Key health policy content to convey to residents

Health systems:

- Health economics and financing
- Laws and regulations
- Payment models, e.g., FFS and the value-based care spectrum

Population health:

- Social drivers of poor health outcomes
- Community engagement
- Integration, e.g., public health, behavioral health

Practice management:

- Use of HIT and electronic health records
- Cost-effective care, e.g., utilization, costs
- Quality improvement methods

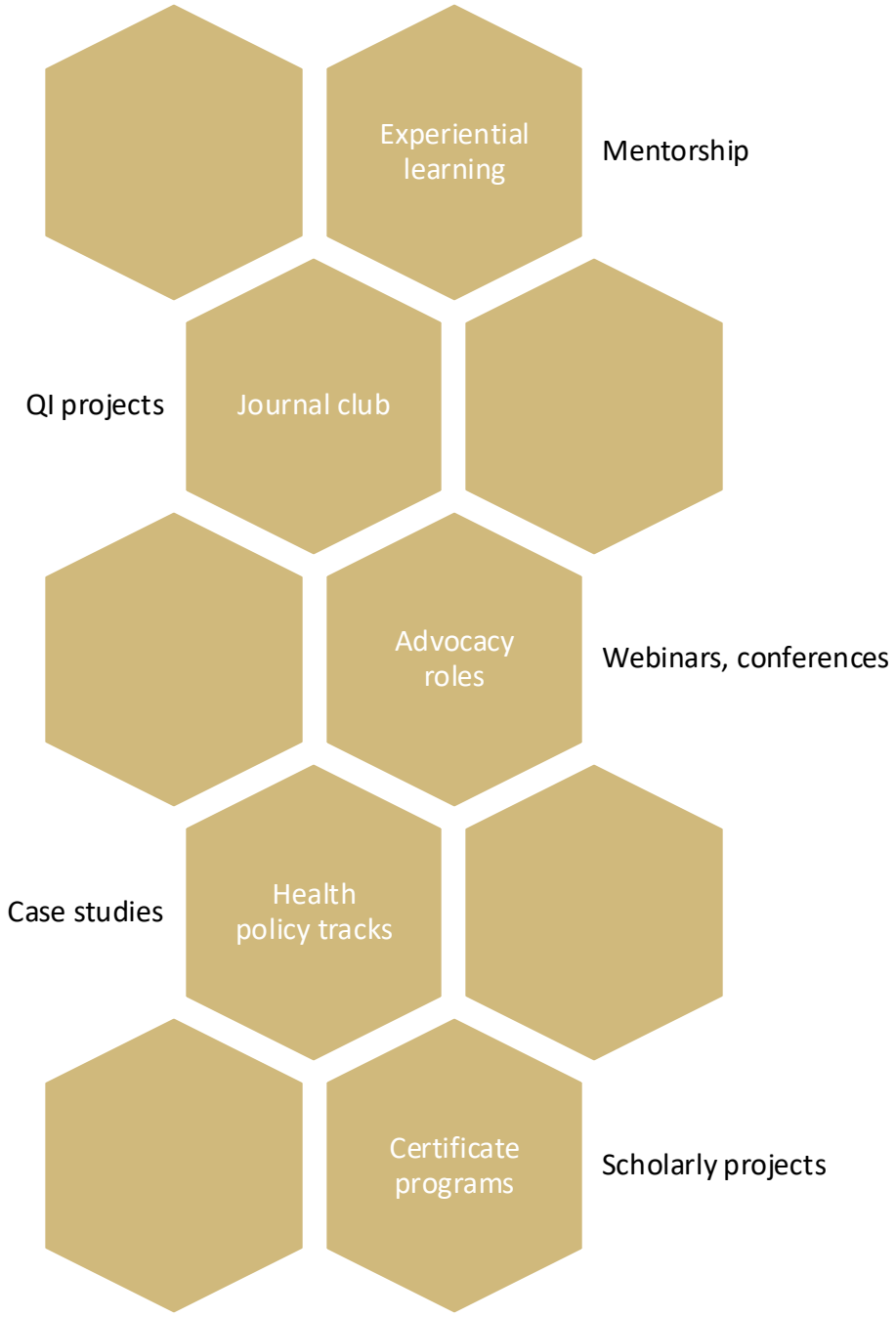
Policy, advocacy, and leadership:

- Crafting policy in a highly political environment
- Change management
- Different leadership styles for different challenges
- Advocacy skills
- Human-centered design
- Patient empowerment

It’s a tall order, but this suggested content may …

- Increase residents’ awareness of health care delivery models and payment approaches
- Help residents feel better prepared to advocate for systems change
- Create future value-based care leaders that shape, rather than react to, policy changes
- Mitigate mismatch / distress between how family medicine residents are trained and what awaits them in clinical practice

Effective strategies for teaching this content



Resources to support you

Resource category	Suggested examples
Health policy content	• The Commonwealth Fund, Milbank Memorial Fund, RWJF • Health Affairs, KFF • RAND Corporation, Urban Institute
Curriculum ideas	Curriculum for Teaching Value-Based Care to Residents STFM Health Systems Courses
Primary care policy research centers (and mentors!)	Primary Care Centers Roundtable
Borrow ideas from preventive medicine residency and other primary care disciplines	Preventive Medicine Residency – Prospective Residents SGIM Leadership in Health Policy Program APA Health Policy Scholars Program
Health policy fellowships	GWU Residency Fellowship in Health Policy Opportunities with the Primary Care Centers Roundtable

Family physicians are ideal health policy leaders

Family medicine clinical training	Health policy work
Evidence-based medicine	Evidence-based policy
Can see the big clinical picture, as well as navigate the small details	Can connect the dots for policy vision and detailed next steps
Appreciate social root causes of poor health	Understand solutions should contemplate health and health care
Comfortable navigating complexity and ambiguity	Changing health care is complicated and tedious, often in new territory
Can home in on “the” consult question	Narrow the policy problem/solution
Learn how to work in teams	Stakeholder buy-in crucial for change
Care anchored in relationships	Trusted relationships paramount
Develop patience to support our patients with lifestyle changes	Patience is a requisite for policy work

Impact of current federal priorities on value-based care and residency education

Possible impacts of H.R. 1 on value-based care and the primary care workforce

Value-based care:

- Cuts to Medicaid and Medicare → a rise in the number of uninsured individuals, uncompensated care → accelerate the adoption of VBC models to maintain financial stability?
- Given disproportionate cuts to Medicaid and rural health care providers, will our VBC attention turn more toward these resource-constrained populations?
- Under intense financial pressures, will technologies like AI rise even more quickly in prevalence and utility to optimize operations and reimbursement?
- Will these funding changes at the state and federal levels spur even more upstream partnerships to address social drivers of poor health?

The primary care workforce:

- Caps on federal student loans and changes to repayment plans → what will this mean for the diversity of our future primary care workforce?
    - How will these changes impact our current and projected workforce shortages?
- With increasing financial pressures, will service lines in public and rural hospitals reduce or eliminate services altogether? How will this impact quality of residency education?

Implementation Dates for 2025 Budget Reconciliation Law

On July 4, President Trump signed the budget reconciliation bill, previously known as "One Big Beautiful Bill Act," into law. The bill includes significant health care policy changes. This timeline provides a brief overview of the specific provisions and their effective dates. You can view **all health provisions** in the order they are implemented or can filter them by the following categories: **Medicaid**, **Medicare**, **Affordable Care Act** and **Health Savings Accounts**. You can read a detailed summary of the health provisions of the law.

Implementation Dates for Health Provisions in the 2025 Republican Tax and Spending Cut Legislation

Select tab to see all health provisions, or filter by topic area:

All health provisions | Medicaid | Affordable Care Act | Medicare | Health Savings Accounts

Search in table

Topic	Start Date	Provision	Description
Health Savings Accounts	January 1, 2025 (retroactive)	Telehealth & Other Remote Services provided before the deductible	Permanently allows HDHP to cover telehealth and other remote services before the deductible is met and still qualify as an HSA-eligible HDHP. Also allows an individual to have other coverage for telehealth and other remote services through a separate HDHP and still be eligible for an HSA.
Medicare	July 4, 2025	Restricting Certain Immigrant Eligibility for Medicare	Restricts Medicare eligibility to U.S. citizens, green card holders, Cuban-Haitian entrants, and people residing under the Compacts of Free Association, and terminates Medicare coverage no later than 18 months from enactment (January 4, 2027) for people who are currently enrolled but no longer eligible under the changes.

I would love to hear from you!

- What resonated with you about today's presentation, and what did not? What more would you like to learn about this topic?
- What will you be taking away and applying in your work?
- How could this information help you prepare family medicine residents for the evolving world of value-based care?

Contact us! And sign up for Farley's Features.

- Farley Center: www.farleyhealthpolicycenter.org
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THANK YOU!

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