# Community Health Access and Rural Transformation (CHART) Model

## Montana Hospital Association Annual
## September 15-16, 2020

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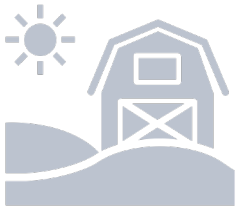
# Agenda

August 2020 Executive Order



Community Transformation Track

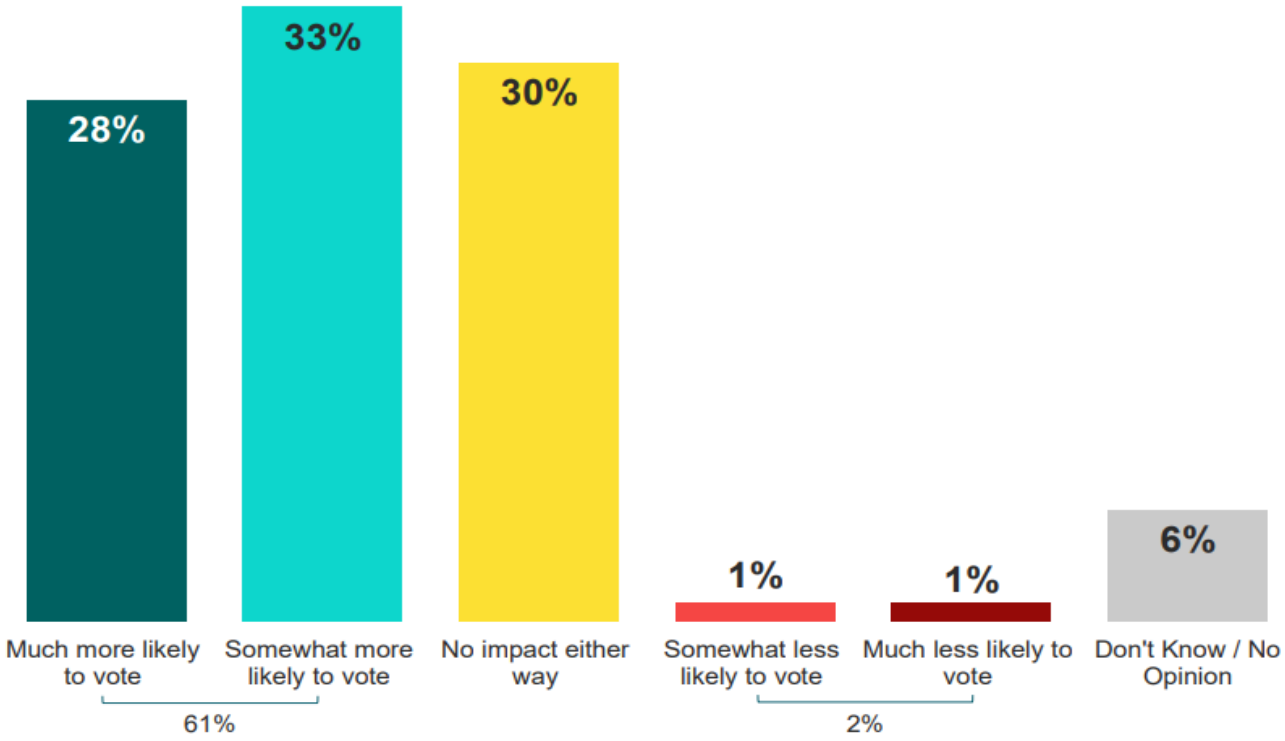
ACO Transformation Track

# Voters Concerned About Rural Access to Care

**Three in five voters (61%) would be more likely to vote for a candidate in the 2020 election cycle who says he or she will address access to health care in rural America.**

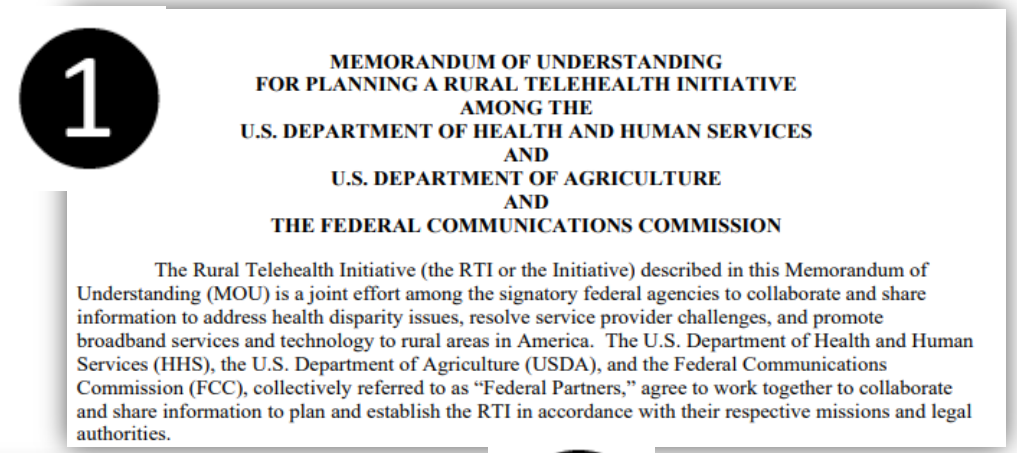
*Would you be more or less likely to vote for a candidate in the 2020 election cycle who says he or she will address access to health care in rural America, or would it have no impact on your vote either way?*

**U.S. VOTERS**



# August 3 Executive Order on Improving Rural Health & Telehealth Access

1. Publish strategy to improve rural health by improving physical and communications healthcare infrastructure
2. Submit report regarding existing and upcoming rural health policy initiatives
3. Make permanent regulatory expansion of Medicare telehealth benefits
4. **Launch innovative payment model to enable rural healthcare transformation**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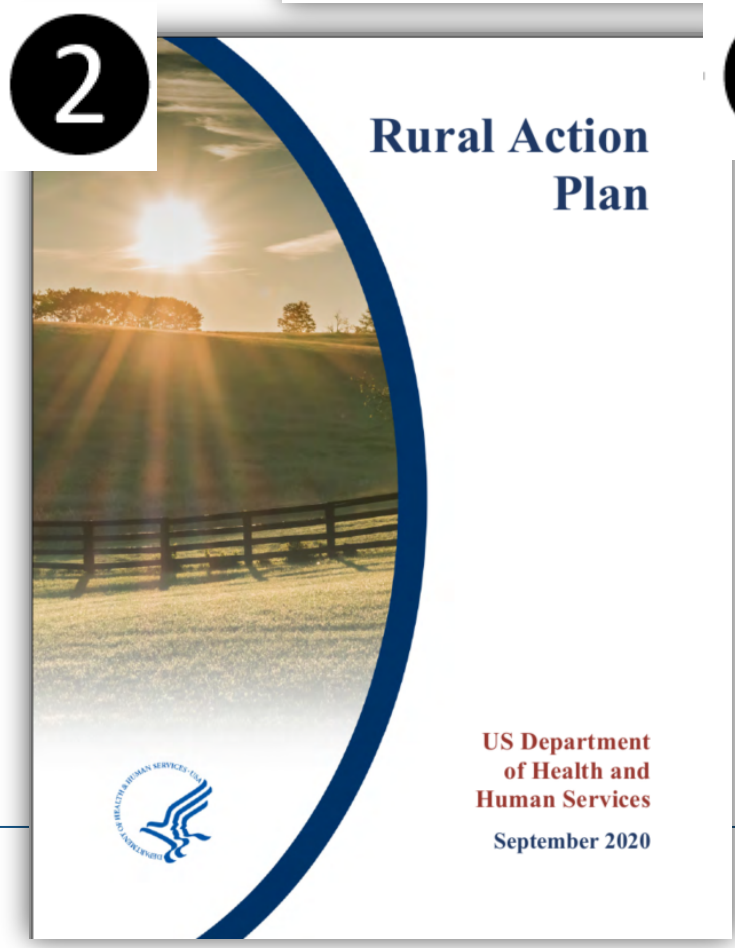
MEMORANDUM OF UNDERSTANDING
FOR PLANNING A RURAL TELEHEALTH INITIATIVE
AMONG THE
U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES
AND
U.S. DEPARTMENT OF AGRICULTURE
AND
THE FEDERAL COMMUNICATIONS COMMISSION

The Rural Telehealth Initiative (the RTI or the Initiative) described in this Memorandum of Understanding (MOU) is a joint effort among the signatory federal agencies to collaborate and share information to address health disparity issues, resolve service provider challenges, and promote broadband services and technology to rural areas in America. The U.S. Department of Health and Human Services (HHS), the U.S. Department of Agriculture (USDA), and the Federal Communications Commission (FCC), collectively referred to as "Federal Partners," agree to work together to collaborate and share information to plan and establish the RTI in accordance with their respective missions and legal authorities.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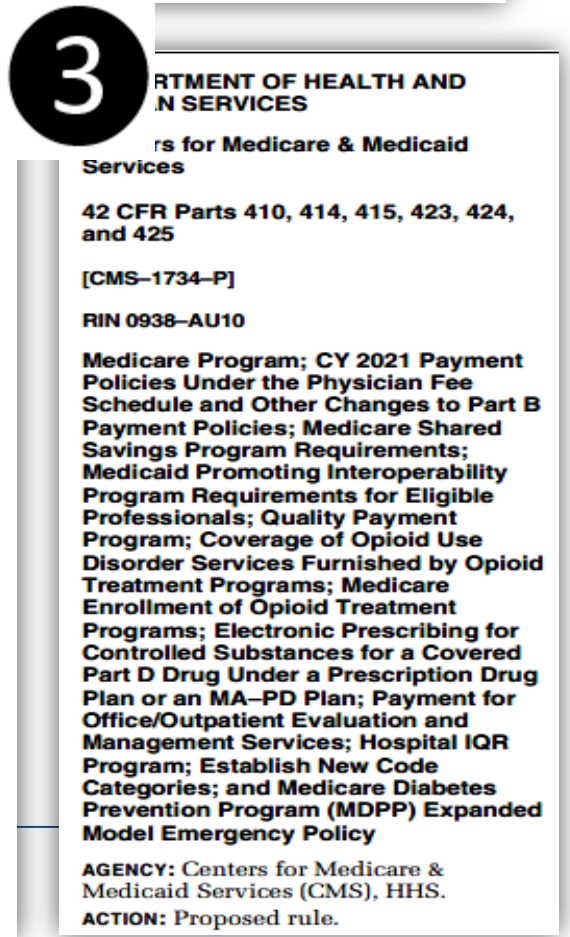
Rural Action Plan

US Department of Health and Human Services

September 2020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RTMENT OF HEALTH AND
N SERVICES

rs for Medicare & Medicaid Services

42 CFR Parts 410, 414, 415, 423, 424, and 425

[CMS–1734–P]

RIN 0938–AU10

Medicare Program; CY 2021 Payment Policies Under the Physician Fee Schedule and Other Changes to Part B Payment Policies; Medicare Shared Savings Program Requirements; Medicaid Promoting Interoperability Program Requirements for Eligible Professionals; Quality Payment Program; Coverage of Opioid Use Disorder Services Furnished by Opioid Treatment Programs; Medicare Enrollment of Opioid Treatment Programs; Electronic Prescribing for Controlled Substances for a Covered Part D Drug Under a Prescription Drug Plan or an MA–PD Plan; Payment for Office/Outpatient Evaluation and Management Services; Hospital IQR Program; Establish New Code Categories; and Medicare Diabetes Prevention Program (MDPP) Expanded Model Emergency Policy

AGENCY: Centers for Medicare & Medicaid Services (CMS), HHS.

ACTION: Proposed rule.

# CHART Model Announced August 11

## Community Transformation Track

- Up to 15 Lead Organizations
- 3 core program elements
  1. Up to $5 million in “seed funding”
  2. Operational flexibilities
  3. Hospital capitated payment

## ACO Transformation Track

- Up to 20 rural-focused ACOs
- Advance shared savings payments

# Community Transformation Track
# **Timeline**

- Letter of Intent - January 18
- Full Application - February 16
- Notice of Award - June 16
- Start Date – July 1
- 1-year Pre-Implementation Period – July 1, 2021 to June 30, 2022
- 6-year Performance Period – July 1, 2022, to June 30, 2028

# Community Transformation Track
# **Lead Organization**

## Responsibilities

- Recruit participating hospitals and aligned payers
- Lead development and implementation of Transformation Plan
- Convene and engage Advisory Council
- Manage funding and compliance with all CMS requirements

## Examples

- State Medicaid Agency
- State Office of Rural Health
- Health Department
- Academic Medical Center
- Independent Practice Association
- Health System

## Minimum Qualifications

- Presence in Community
- Rural health expertise
- Experience designing/ implementing APMs
- Managed ≥ $500K in grants in last 3 years
- Engaging providers in APMs; maintaining agreements; managing relationships

# Community Transformation Track
# **Community**

- Set of contiguous/non-contiguous rural counties/census tracts in which at least 10,000 traditional Medicare beneficiaries reside
- Data required for application
  - Number of providers by type with payer mix
  - Medicare FFS revenue for 2018 and 2019
  - Number of Medicare/Medicaid beneficiaries with average annual total cost of care
  - Number of commercial beneficiaries and uninsured
  - Other relevant information
- Rationale for selection and gap analysis

# Community Transformation Track
# **Advisory Council**

- Must be established prior to application submission (signed LOIs)
- Required membership
  1. State Medicaid Agency (if Lead Organization ≠ SMA)
  2. At least one Participant Hospital
  3. At least one Aligned Payer
  4. At least one beneficiary or unpaid caregiver
  5. At least 3 of the following:
     a) Primary care provider
     b) Behavioral health provider
     c) Additional Participant Hospital
     d) Additional Aligned Payer
     e) State Office of Rural Health
     f) Community stakeholder group (e.g., AAA, CBO)
     g) Long-term care facility, home health provider, or hospice provider
     h) IHS facility or local tribal community
     i) US Department of Veterans Affairs

# Community Transformation Track
# **Transformation Plan**

- Developed between July 2021 and June 2022
  - Up to $2 million upon acceptance of Terms and Conditions
- Two elements
  - Assessment of existing assets and areas for improvement
  - Description of service delivery and payment redesign strategy
- Emphasis on shared resources, continuum of care
- Implement between July 2022 and June 2028; update and report annually
  - Up to $500K each year; dependent on sufficient percentage of participant hospitals' revenue in CPA arrangements

# Community Transformation Track
# **Participant Hospitals**

- Lead Organization recruits during Pre-Implementation Period
  - However, preference for applicants submitting multiple hospital LOIs
- Limited to PPS/CAH in Community that receive ≥ 20% of Medicare revenue for services furnished to Community residents
- **Agrees to receive bi-weekly Capitated Payment Amount (CPA) in place of FFS payments**

# Community Transformation Track
# **Capitated Payment Amount**

CMS will administer each Participant Hospital's CPA through **5 steps:**

| 1 | 2 | 3 | 4 | 5 |
|---|---|---|---|---|
| Determine baseline revenue using historical expenditures | Apply prospective adjustments | Apply a discount | Apply mid-year adjustments | Apply end-of-year adjustments |

- Service Inclusion/Exclusion Criteria
- Continue to submit FFS claims for reporting/evaluative purposes
- Adjustments account for changes in utilization, interim payment rates
- Discount
  - 0.5% in PY1 and 1.0% in PY2
  - Subsequent years' % tied to total Medicare $$ under CPA (< $15 million to > $30 million)
    - No higher than 2.5% in PY3, 3% in PY4, 3.5% in PY5, and 4% in PY6

# Community Transformation Track
# **Model Design Flexibilities**

1. Reduce funding in exchange for lower discount factor
2. Share funds with Participating Hospitals
3. Vary discount factor among Participating Hospitals
4. Shared payments for service line adjustments
5. Exclude outliers from CPA

# Community Transformation Track
# **Medicare Program/Payment Policy Waivers**

1. CAH Conditions of Participation waivers
   - E.g., conversion to emergency/outpatient hospital
2. CAH 96-hour certification rule
3. SNF 3-day rule waiver
4. Telehealth flexibilities
5. Care management home visits (waive homebound requirement)

# Community Transformation Track
# **Beneficiary Engagement Incentives**

1. Waiver of co-insurance for Part B services
2. Free/discounted transportation
3. Gift card rewards for chronic disease management programs

# Community Transformation Track
# **Medicaid**

- Memorandum of Understanding with State Medicaid Agency (SMA)
- Lead Organization must designate SMA as sub-recipient
- Committed transition to CPA for participating hospitals; work with CMS to implement necessary changes

| Year of participation in the APM | Community Transformation Track Medicaid Target *(% of each Participant Hospital's Medicaid revenue under a CPA arrangement)* |
|---|---|
| **Performance Period 1** | 0% |
| **Performance Period 2** | 50% |
| **Performance Period 3** | 60% |
| **Performance Period 4** | 75% |
| **Performance Period 5** | 75% |
| **Performance Period 6** | 75% |

- Other aligned payers

# Community Transformation Track
# **Quality Strategy**

- Inpatient/ER visits for ambulatory care-sensitive conditions
- All-cause unplanned readmissions
- Patient satisfaction
- Population health (select 3 measures)
  - Substance use (2 measures)
  - Maternal health (2 measures)
  - Prevention (3 measures)

# Community Transformation Track
# **Will It Work?**

- CPA includes discount on adjusted historical payments when current CAH Medicare reimbursement less than costs
- CMS track record on calculating and adjusting benchmarks, especially based on changing utilization
- Unlikely to generate significant savings from operational flexibilities
- No capital to fund transformation expenses

HOWEVER, would you rather be at the table or on the menu?

# ACO Investment Model (2016 - 2018)

*Final Evaluation Report Published 09/14/20*

**Key findings on the impacts of AIM ACOs include:**

- Overall, AIM Test 1 ACOs reduced per beneficiary per month (PBPM) total Medicare spending in each of the three AIM performance years. Estimated reductions were -$28.21 PBPM in PY1 (2016); -$36.94 PBPM in PY2 (2017); and -$38.73 in PY3 (2018). All estimates were statistically significant at the 5 percent level.
  - These reductions translated to a net aggregate reduction in spending by Medicare of $381.5M across the three AIM performance years after accounting for Medicare's payment of AIM funds and financial earned shared savings.
  - The estimated reductions in total Medicare spending were driven by reductions in utilization, most notably decreases in acute hospitalizations, emergency department visits, and days in skilled nursing facilities. These reductions were consistent across the performance years.

# ACO Transformation Track

- ACO must apply to participate in MSSP effective January 1, 2022
  - Majority of ACO providers/suppliers in rural county/census track
  - Five-year agreement; no-risk for first two years
- Advanced shared savings payments
  - Upfront payment of $200,000 + $36 per (rural?) beneficiary (up to 10,000 beneficiaries)
  - Minimum of $8 per (rural?) beneficiary per month for up to 24 months (amounts vary based on level of risk accepted)
- Benefit enhancements
  - SNF 3-day inpatient stay
  - Telehealth expansion
  - Beneficiary incentive program

# ACO Transformation Track

- Repayment
  - Deduct advance from any earned shared savings
  - Carry forward any remaining amount to subsequent performance years
  - Cannot exit program to avoid repayment
  - If owe shared losses, what happens to repayment obligation?

> CMS may wish to weigh the benefits and costs of transitioning small, rural ACOs to two-sided financial risk tracks. These ACOs may take longer than a few years in an upside-only financial track before they are willing to take accountability for potential financial losses, and our findings thus far have shown that total Medicare spending net of shared savings can decline while allowing ACOs to remain in a one-sided financial risk track.


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