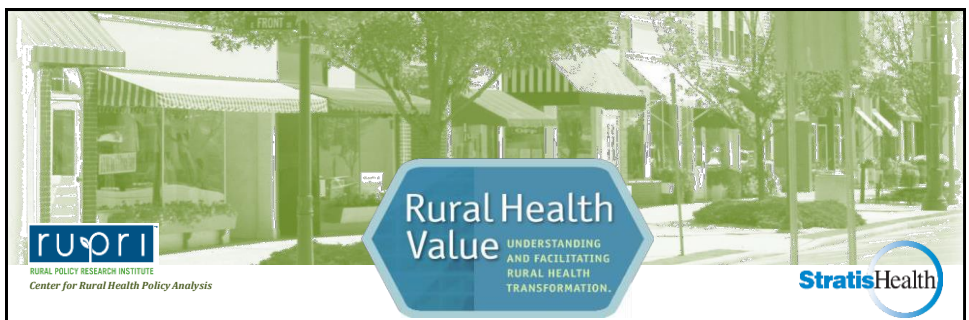
Community Health Access and Rural Transformation (CHART) Model Community Transformation Track

Rural Health Value

Session #1 for Prospective Applicants and Stakeholders

October 28, 2020

1



Rural Health Value

- Understanding and Facilitating Rural Health Transformation
  - To build and distribute an actionable knowledge base through research, practice, and collaboration that helps create high performance rural health systems.
- Led by the University of Iowa RUPRI Center for Health Policy Analysis and Stratis Health
- Funded by the Federal Office of Rural Health Policy

2

2

Today's CHART Session

Purpose	Overview	Gather
Purpose: To identify opportunities, questions, and potential next steps for interested organizations regarding the CHART Community Track application.	Overview of Community Transformation Track and its four core components: • Lead Organization • Transformation Plan • Hospital Payment • Partners	Gather questions and input to shape upcoming Rural Health Value CHART sessions

Rural Health Value

3

3

Brief Overview

- Community Health Access and Rural Transformation (CHART)
- *Community:* Engagement of broad community (beyond health care organizations)
- *Health Access:* Address priority health needs of the residents of the community (drivers of morbidity and mortality)

Rural Health Value

4

Brief Overview

- *Rural*: Federal Office or Rural Health Policy list of counties and census tracts; in any combination
- *Transformation*: Changes to delivery system based on community needs; achieved by implementing a plan developed by lead Organization in collaboration with Advisory Council, Participant Hospital, and State Medicaid Agency

Rural Health Value

5

5

Overview: Key Participants in the Model

- Lead Organization
- State Medicaid Agencies (could be Lead Organization)
- Participating Hospitals
- Other payers
- Members of Advisory Council

Rural Health Value

6

6

Overview: Key Elements of the Model

- Organizing community entities
- Developing transformation plans
- Changing hospital payment to capitated payment for eligible hospital services

7

Overview: Timeline

The Community Transformation Track Timeline

Activity	Timing	Duration
Application Period	September 15, 2020 – February 16, 2021	100 business days
Application Evaluation	Spring 2021	
Anticipated Notice of Award	June 16, 2021	
Pre-Implementation Period	July 1, 2021 – June 30, 2022	1 year
Performance Period 1	July 1, 2022 – June 30, 2023	1 year
Performance Period 2	July 1, 2023 – June 30, 2024	1 year
Performance Period 3	July 1, 2024 – June 30, 2025	1 year
Performance Period 4	July 1, 2025 – June 30, 2026	1 year
Performance Period 5	July 1, 2026 – June 30, 2027	1 year
Performance Period 6	July 1, 2027 – June 30, 2028	1 year
Transition Period*	July 1, 2028 – June 30, 2030	2 years
*Transition Period back to FFS reimbursement in the absence of expansion or extension of CHART		

NOTE: The Model timeline may be subject to change.

https://innovation.cms.gov/media/document/chart-model-faqs

8

Lead Organization

Keith Mueller

9

The Applicant: Lead Organization

Eligibility requirements

Capabilities

10

10

Lead Organization Eligibility Requirements

Must meet all of the following

Presence in the Community for at least the prior year: minimum is relationship with the community (not necessarily physical presence)

Expertise in rural *health issues* – health conditions, barriers to access, policy and other factors that influence outcomes

Experience in designing and implementing alternative payment models (APMs): direct management or through partnership

Rural Health Value

11

11

Lead Organization Eligibility Requirements

- Received and managed one or more health-related grants or cooperative agreements totaling at least $500,000 over last three years
- Experience in:
  - Maintaining provider participation in APMs or CMMI demonstration projects/models
  - Establishing and maintaining agreements between health care providers
  - Conducting outreach and managing relationships with diverse health care-related stakeholders

Rural Health Value

12

12

Lead Organization Capabilities

- Define the community
- Ability to develop transformation plan for the community, with participating hospitals and State Medicaid Agency (SMA) – means having relationships with them in advance
- If not the SMA, ability (skill and resources) to enter into a Memorandum of Understanding with the SMA, who will be a subrecipient of cooperative agreement funding

Rural Health Value

13

13

Lead Organization Capabilities

- Enrolling participating hospitals – at least one prior to the application, reaching the minimum 10,000 *fee-for-service* beneficiaries most likely requires more
- Form and convene the Advisory Council
- Capacity to manage this project over a seven-year period

Rural Health Value

14

14

Who Might be Lead Organizations?

- Direct examples: SMAs, State Offices of Rural Health, local public health departments, Independent Practice Associations, Academic Medical Centers
- From FAQs version 1 (October 2020): nonprofits with 501(c)(3) status, other government entities, small businesses, Indian Tribes or Tribal organizations, faith-based organizations

15

Transformation Plan

Karla Weng

16

Transformation Plan Definition

"A Transformation Plan is a detailed description of the health care delivery system redesign strategy that will be carried out under the Community Transformation Track of the CHART model."

- CHART NOFO, pg. 13

17

17

Transformation Plan Summary

- Lead Organization's description of their health care delivery system redesign strategy
  - Developed in collaboration with Advisory Council (including SMA) and participant hospitals
  - Initial Transformation Plan submitted during the pre-implementation period and implementation must begin in performance period one.
  - Transformation Plan must be reviewed and approved by CMMI, updates will be submitted at least annually
- Transformation Plans are required to focus on population health disparities present in the Community, and must address at least one of the following:
  - Behavioral health treatment
  - Substance use disorder treatment
  - Chronic disease management and prevention
  - Maternal and infant health
- Transformation Plans are required to include strategies to expand use of telehealth and other technology to support care delivery improvement
  - May leverage regulatory flexibilities
  - Encouraged to address social determinants of health

18

18

Benefit Enhancements and Beneficiary Engagement Incentives

- CHART Medicare Program and Payment Policy Waivers:
  - SNF 3-Day Rule Waiver
  - Telehealth Expansion
  - Care Management Home Visits
  - Waiver of certain Medicare Hospital and/or CAH CoPs
  - CAH 96 Hour Certification Rule
- CHART Beneficiary Engagement Incentives:
  - Cost sharing for Part B services
  - Transportation
  - Gift card reward for chronic disease management programs

Rural Health Value

19

19

CHART Quality Strategy

- Lead Organizations and Participant Hospitals will be required to report on the same six quality measures for the duration of the model
- Three CMMI Selected Measures:
  - AHRQ PQI 92 – Inpatient and ED visits for ambulatory care sensitive conditions
  - Hospital Wide All-Cause Unplanned Readmission
  - HCAHPS – Patient Experience
- Three measures selected from a list of options from CMMI:

Focus area	Measures
Substance Use	Use of pharmacotherapy for OUD
	Use of opioids at high dosage in persons without cancer
Maternal Health	PC-02: Cesarean Birth
	Contraceptive care post-partum
Prevention	Influenza vaccination
	Screening for depression and follow-up plan
	Continuity of primary care for children with medical complexity

- Participant hospitals continue reporting on core measures in Medicaid, Medicare, and other existing CMS quality programs
- CMMI reserves the right to modify or add to the list of measures

Rural Health Value

20

20

Transformation Plan Requirements

"Core components outlined for informational purposes and may change at CMMI sole discretion."

Survey of the Community's key strengths and challenges to be leveraged and address through CHART, including preliminary assessment of population health, access, and quality outcomes of greatest interest to the community

Rural Health Value

21

21

Transformation Plan Requirements (2)

2. Description of the health care delivery system redesign strategy including:
   - Role of each Participant Hospital:
     - Recruitment and engagement plan *AND*
     - Plan for reverting back to Medicare FFS including mitigation strategy to address risks to beneficiaries and other health care providers
   - Description of planned changes to heath care services
   - Description of how approved operational flexibilities will be implemented
   - Quality strategy identifying measures for hospital reporting, and additional measures used for monitoring potential unintended or undesired impacts on quality

Rural Health Value

22

22

Transformation Plan Requirements (3)

3. Plan for potential aligned payers and participant hospitals to implement APM
4. Description of the agreed upon support and/or participation in health care delivery system redesign strategy
5. Description of existing programs and models in the Community that identifies potential for duplicative overlaps and an explanation of strategies to ensure CHART funding will not be duplicative or supplant funds from other CMMI models or CMS programs.

23

Hospital Payment

Clint MacKinney

24

Capitated Payment Amount (CPA)

- **"For informational purposes only and may change at CMMI's sole discretion."**
- Determines each Participant Hospital's budget
- Regular, lump sum payments paid over performance period equal the CPA
- Calculated by CMMI (presumably Medicare only)

Rural Health Value

25

25

Included and Excluded Services

- Inclusions
  - Inpatient (including, but not limited to, PT and drugs)
  - Outpatient (including, but not limited to, observation, ED, imaging, drugs)
  - Swing bed (CAH only)
- Exclusions
  - Physician services
  - DME
  - Hospice
  - Home Health
  - Non-CAH Swing bed

Rural Health Value

26

26

Capitated Payment Amount (CPA)

1. Determine baseline revenue
2. Apply prospective adjustment
3. Apply discount
4. Apply mid-year adjustments
5. Apply end-of-year adjustments

27

1. Baseline Revenue

A. Average of two years Medicare FFS expenditures starting three years prior to program

B. E.g., average of CYs 2019/2020 for CY 2022

28

2A. Prospective Adjustments

A. Acute Care hospitals
   I. Unit price
      a) Medicare expenditure trend
      b) Geographic adjustment: wage index and capital expenditure
   II. Quality
      a) VBP, HAC, HRRP
      b) CHART quality measures starting PP2 (up to -2%) – applied at Community level to encourage collaboration
   III. Population
      a) Captures differences in population size and demographics
      b) Captures market share shifts between hospitals

Rural Health Value

29

2B. Prospective Adjustments

A. CAHs – additional or different prospective adjustment
   I. Unit price – Change between baseline cost report and most recent cost report
   II. Quality – CHART quality measures applied starting PP2 (up to -2%)

Rural Health Value

30

3. Discount

A. For payers to realize savings

B. 0.5% to 4.0%

I. Greater discount to CPA over time

II. Greater discount if less total Medicare FFS revenue in the Community under CPA

C. Sample discounts (25 levels of discount)

	Performance Period					
FFS Revenue	1	2	3	4	5	6
0 – 15 M	0.5%	1.0%	2.5%	3.0%	3.5%	4.0%
90 – 100 M	0.5%	1.0%	1.2%	1.7%	2.1%	2.3%
> 300 M	0.5%	1.0%	1.0%	1.0%	1.0%	1.0%

31

31

4. Mid-Year Adjustments

A. Population – size, demographics, market share

B. CAH interim payment – adjudicated cost report

C. Adjustments from prior year – based on additional prior year data

Rural Health Value

32

32

5. End-of-Year Adjustments

A. Population – as per Mid-Year adjustment
B. Optional outlier policy – designed to protect against catastrophic utilization

33

Medicaid

- State Medicaid Agency (SMA) – mandatory partner
- SMA must be subrecipient of award funding
- SMA must develop aligned (capitated) payment system
  - Increasing % of participating Medicaid revenue required over program (0% → 75%)
  - Likely will require waiver(s); e.g., 1115A

34

Partners

Jennifer Lundblad

35

Community Partners

Section A.4.4 of the NOFO

- Lead Organizations required to establish an Advisory Council
- Lead Organization and Advisory Council will forge robust and meaningful partnerships with their Participant Hospitals and SMA

36

36

Advisory Council

Purpose is to represent the Community's perspective and collectively advise the Lead Organization, which must meet at least quarterly. Responsibilities include:

- Develop and update Transformation Plans
- Recruit hospitals and payers
- Develop arrangements with payers governing APM alignment and data-sharing
- Monitor progress of the Model and identify any necessary changes

And what the Advisory Council will *not* do:

- Manage the Lead Organization or Participant Hospitals
- Be responsible for management and oversight of Cooperative Agreement funds

Rural Health Value

37

37

Advisory Council Representatives

Four **required** representatives:

- The SMA (if the Lead Organization is not the SMA)
- At least one Participant Hospital
- At least one Aligned Payer (if the Lead Organization has recruited any commercial payers)
- At least one beneficiary or unpaid caregiver

Plus at least three of the following:

- A primary care provider
- A health care provider of substance use disorder treatment and/or mental health services
- An additional Participant Hospital
- The State Office of Rural Health
- An additional Aligned Payer
- A community stakeholder group
- A long-term care facility, home health provider, or hospice provider
- An Indian Health Service (IHS) or Tribal health provider
- The U.S. Department of Veteran's Affairs (VA)

Rural Health Value

38

38

Participant Hospitals

Lead Organizations will recruit Participant Hospitals for the Community Transformation Track APM. Each Participant Hospital is an acute care hospital or CAH that either:

- Physically located within the Community and receives at least 20% of its Medicare FFS revenue from Eligible Hospital Services provided to residents of the Community; or
- Physically located inside or outside of the Community and is responsible for at least 20% of Medicare expenditures for Eligible Hospital Services provided to residents of the Community

For health systems, each inpatient campus and outpatient location will be considered a distinct Participant Hospital as long as it separately meets the eligibility criteria.

Rural Health Value

39

39

Participant Hospitals (cont.)

Lead Organizations must ensure that each Participant Hospital signs a Participation Agreement with CMMI committing the Participant Hospital to, among other things:

- Assume accountability for hospital expenditures for the Medicare beneficiaries they serve that reside in the Community for the full duration of each Performance Period
- Implement the activities outlined in the Transformation Plan, as applicable; and
- Report necessary quality and other data to CMMI.

Rural Health Value

40

40

State Medicaid Agency

SMA participation is required under the Community Transformation Track

- If the Lead Organization is not the SMA, it must partner with the SMA to implement the CHART Model
- The SMA must participate in the Advisory Council and serve as an Aligned Payer
- SMA must be a subrecipient of cooperative agreement funding
- As a component of the Community Transformation Track application, SMAs must submit a Memorandum of Understanding (MOU) with the potential Lead Organization

Rural Health Value

41

41

Questions

Rural Health Value

42

Upcoming Rural Health Value CHART Sessions

- **Wednesday, November 18, 1:30 Eastern** — Focus on Lead Organizations
- **Monday, November 30, 1:00 Eastern** — Focus on Transformation Planning
- **Monday, December 14, 11:00 Eastern*** — Focus on financial modeling

*Tentative

Rural Health Value

43

43