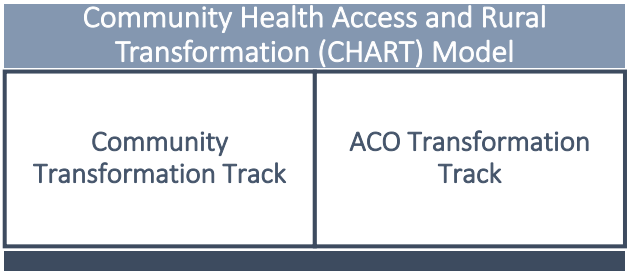
CMMI Announces New Model to Support Rural Value Transformation

Community Health Access and Rural Transformation (CHART) Model

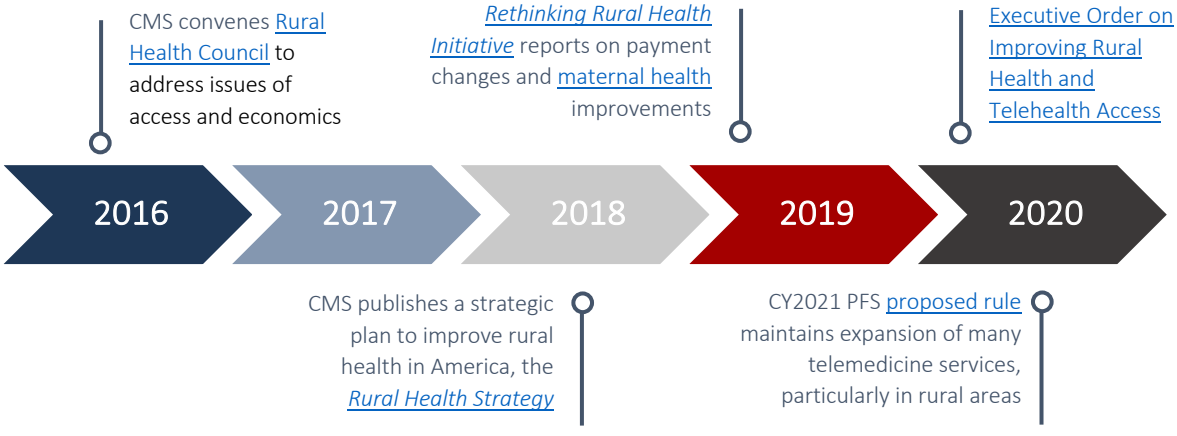
August 13, 2020 – Earlier this week, the Centers for Medicare & Medicaid Services (CMS) announced a new model designed to test approaches to supporting rural providers and communities in their efforts to transform their care delivery systems to promote accessible, high-value care. The new Innovation Center (CMMI) initiative, called the Community Health Access and Rural Transformation (CHART) Model, includes two participation tracks which will offer upfront investments, predictable capitated payments, and operational and regulatory flexibilities to enable value transformation for rural communities and rural ACOs.



Federal Rural Health Action

The CHART Model delivers on President Trump's executive order *Improving Rural Health and Telehealth Access* issued earlier this month, which called on Medicare leaders to announce a new CMMI value-based model for rural providers, along with other telehealth-related provisions that were proposed in the CY2021 Physician Fee Schedule just days later.

While strengthening rural health has been the focus this recent attention from the Trump administration and CMS in light of COVID-19, these announcements are part of a much larger, years-long federal effort to improve the payment and delivery systems of rural providers. The timeline below highlights just a few Medicare's major rural milestones that have been building to the CHART Model long before the pandemic.



Community Transformation Track

CMS officials have been alluding to CHART's Community Transformation Track for some time, with Administrator Seema Verma referencing an upcoming pathway for rural community coalitions to collaboratively design custom approaches to value transformation in speeches and blog posts last spring. While both of the CHART Model's tracks include some form of upfront payment to enable investment in the care delivery competencies necessary for success under value, the Community Transformation Track will test this approach on a much larger scale and with more flexibility for participants.

As part of this track, CMS will invest up to $75 million in seed money across 15 participating communities, offering this financial support as well as certain regulatory flexibilities and technical assistance to enable community transformation. However, rather than prescribing a standardized approach to payment and delivery transformation for rural communities, this CHART Model track invites multi-stakeholder community coalitions to collaboratively design a model that meets the needs of the market.

TARGET PARTICIPANTS

Participation in the Community Transformation Track of the CHART model is open to **Lead Organizations** and their **Community Partners**. Lead Organizations represent a rural community[1] and guide Community Partners through the development and implementation of a Transformation Plan, outlining the health care delivery redesign strategy for the community.

- Lead Organizations – 15 Lead Organizations will be selected to participate in this model. Examples of Lead Organizations are state Medicaid agencies, State Offices of Rural Health, local public health departments, independent practice associations, and academic medical centers, but other organizations may also apply. In addition to leading the development of the Transformation Plan, the Lead Organization coordinates community-wide efforts and participation in the model. This includes managing Cooperative Agreement Funding (see details of Payment Model below), establishing and managing relationships with key model participants, and convening the Advisory Council.
- Community Partners – There are several roles Community Partners play in model participation:
    - **Participant Hospital:** An acute care hospital, Critical Access Hospital (CAH), or special rural designation hospital that signs a Participation Agreement with CMS. This partner is the recipient of the Capitated Payment Amount (see details of Payment Model below).
    - **State Medicaid Agency:** This is a required partner and must be a recipient of a portion of the Cooperative Agreement Funding. The agency ensures payment to Participant Hospitals is aligned with Medicaid.
    - **Advisory Council:** These partners assist with recruitment and relationship-building and help to ensure the design of the Transformation Plan aligns with the needs of the community.

PAYMENT MODEL

Awardees and their partners receive two forms of payment, upfront cooperative agreement funding and annual capitated payments. These funding streams help support initial investment in infrastructure, recruitment, and strategic planning, as well as ongoing investments throughout the model.

[1] A single county or census tract, or several (contiguous or non-contiguous) counties or census tracts, classified as rural by FORHP

1. **Cooperative Agreement Funding –** Lead Organizations receive an initial $2 million upon acceptance to the model with additional funds available throughout participation, up to $5 million total.
2. **Capitated Payment Amount (CPA) –** Participant Hospitals receive an annual prospectively set payment, providing predictable revenue and encouraging these hospitals to reduce avoidable expenditures.

FLEXIBILITIES

Numerous operational and regulatory flexibilities are available to Community Transformation Track awardees, allowing participants to tailor Transformation Plans to the needs of their unique patient populations. Through waivers of the 3-day SNF requirement and Critical Access Hospital 96-hour rule, and expansions of telehealth and home visits, providers can ensure patients receive care at the most appropriate site. Further enhancements allow participants to waive Part B cost sharing, provide beneficiaries with transportation, and offer beneficiaries rewards for participating in Chronic Disease Management Programs.

ACO Transformation Track

The second CHART Model participation option, the ACO Transformation Track, builds on the success of the ACO Investment Model (AIM) and, like its predecessor, aims to make participation in the Medicare Shared Savings Program (MSSP) more accessible for undercapitalized ACOs. Though participation in the AIM was not offered exclusively to rural ACOs, many participating providers do serve rural patients. Of the 45 ACOs currently participating, 36 operate primarily in rural areas and 27 include a critical access or small hospital.

The payment mechanisms within the ACO Transformation Track are designed to support ACOs in rural and underserved areas with seed funding to improve their infrastructures and redesign care processes to manage population health. Its two-part 'advanced shared savings' payment model offers upfront and predictable non-FFS revenue for ACOs, while also encouraging participants to remain in the program and adopt downside risk.

TARGET PARTICIPANTS

CMS will select up to 20 rural-focused ACOs joining the MSSP for the 2022 start year to participate in the ACO Transformation Track of the CHART Model – less than half of the size of the AIM, which includes 45 ACOs.

According to CMS' initial announcement, CHART ACOs must meet the following criteria:

- Serve fewer than 10,000 beneficiaries
- A majority of aligned providers and suppliers located in rural areas[2]

Though additional eligibility details for the ACO Transformation Track have not yet been released, if the new model continues to borrow from the AIM, it can be expected that ACOs must also:

- Not have previously participated in the AIM
- Only include hospitals that are Critical Access Hospitals or Inpatient Prospective Payment System hospitals with fewer than 100 beds

[2] A majority of ACO providers/suppliers of the CHART ACO must be located within rural counties or census tracts as defined by FORHP

Lastly, all ACOs will enter into participation agreements for both the MSSP and the CHART Model and will sign-on for the MSSP's full 5-year agreement period – up from the program's former 3-year agreement periods introduced in the Pathways to Success overhaul .

PAYMENT MODEL

Under the ACO Transformation Track, participants submit claims and receive regular FFS payments just like all other MSSP ACOs. However, CHART ACOs will also receive two additional forms of payment to invest in transformation – a one-time upfront payment and a monthly per-beneficiary payment.

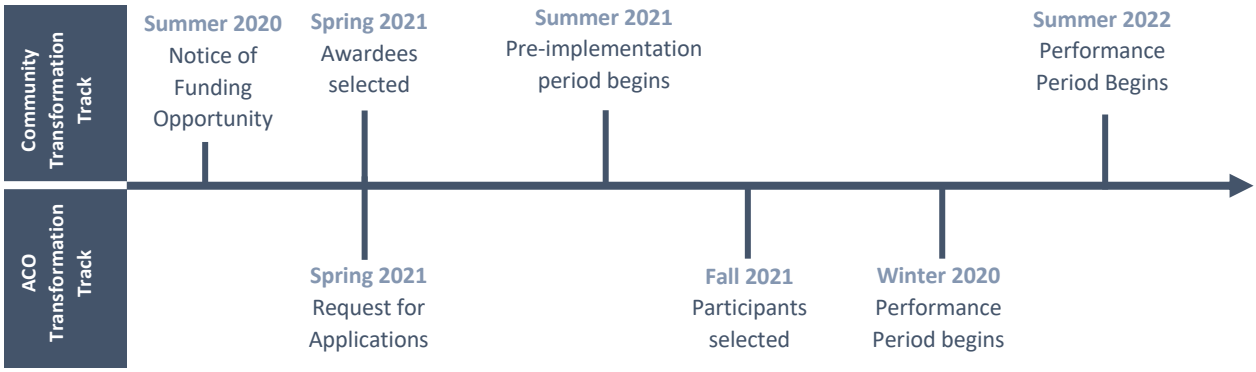
1. Upfront Lumpsum – In order to facilitate immediate investment in the capabilities necessary to manage a population under a shared savings model, CHART ACOs will receive seed funding equal to a minimum of $200,00 plus an additional $36 per aligned beneficiary.
2. Per-Beneficiary Per-Month (PBPM) – Participants also receive per-beneficiary per-month (PBPM) payment for the first 24 months of the agreement period to support ongoing investments. The PBPM is a minimum of $8 per beneficiary.

These payments are advance payments and will be recouped from shared savings earned by the participant. Like the AIM, the amount from the upfront payment and the PBPM will vary based on the size of the ACO's attributed population. Significantly, unlike its predecessor, these payments also differ by the level of risk accepted by the ACO.

FLEXIBILITIES

Participants in this track of the CHART Model are eligible for the same regulatory flexibilities available under the MSSP, namely, expanded telehealth services (which will continue even after the COVID-specific expansion has concluded), the 3-day SNF waiver, and the ability to leverage a beneficiary incentive program.

Timeline



About the ACLC

The Accountable Care Learning Collaborative (ACLC) is a non-profit organization with a mission to accelerate the readiness of healthcare organizations to assume value-based payment models. Founded by former Secretary of Health and Human Services Mike Leavitt, and former Administrator of the Centers for Medicare and Medicaid Services Mark McClellan, the ACLC serves as the foundation for healthcare stakeholders across the industry to collaborate on improving the care delivery system.

To learn more about the ACLC, visit accountablecareLC.org.