RURAL REVITALIZATION: THE CMS COMMUNITY HEALTH ACCESS AND RURAL TRANSFORMATION MODEL

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Union County is in the heart of North Central Florida, nestled among bucolic farms, vast timberlands and trucking industry command centers. The smallest county in Florida, Union County is also by some measures one of the poorest in the nation.[1] Lake Butler, Florida serves as the county seat; and at the top of Main Street in Lake Butler is Lake Butler Hospital, a 25-bed critical access hospital and lifeline for the town's 2,000 residents and those in surrounding areas. With the only emergency department and CT scanner in the region, swing beds to help inpatients transition back to life at home, and an affiliated family and pediatric practice, Lake Butler Hospital is an indispensable healthcare resource to the community it serves.

"We are not only vital to the accessibility of healthcare for our community, which is especially evident during today's pandemic, but as a major employer, our economic impact on the community's long-term growth and stability is substantial," observes Paula Webb, Lake Butler Hospital's President and Chief Executive Officer. "Having previously served as the hospital's Chief Financial Officer for the past 30+ years, I have personally witnessed the many financial and regulatory challenges the hospital has faced while ensuring we continue to meet the healthcare needs of our community. Unfortunately, these challenges limit the availability of our already scarce time and resources. I believe our long-term sustainability is dependent upon our ability to look outside our own walls and to collaborate and work together in partnership with other rural providers, businesses and community leaders to build together a cooperative framework and to develop

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[1] *See* https://fred.stlouisfed.org/series/PCPI12125, citing data from the U.S. Bureau of Economic Analysis showing that 2018 per capita income in Union County, Florida was $22,227.00. This ranks it the 7th poorest county in the nation. *See* https://en.wikipedia.org/wiki/List_of_lowest-income_counties_in_the_United_States.

programs focused on improving the overall health and wellness of our citizens, but to do this successfully, we will need additional financial assistance and resources."

In recent years, however, Lake Butler Hospital and other rural hospitals across the country have faced a battery of pressures: encroachment by larger health systems into their catchment area and siphoning off of complex, higher paying cases; a marked rural population health gap;[2] shrinking government program reimbursement (particularly if a facility is not designated by the Centers for Medicare & Medicaid Services (CMS) as a critical access hospital and eligible for cost-based reimbursement); and outmigration of younger residents in search of urban area jobs, leading to a dwindling and aging patient population.[3] These pressures have caused 120 rural hospitals to close in the 10-year period leading up to January 1, 2020, with an estimated one out of four rural hospitals on the brink of the same fate.[4] Lake Butler Hospital witnessed the effects of these pressures up close: three of the four rural hospitals that have closed in Florida in the past decade were within an hour's drive.[5] Failure was not an option if Union County and the surrounding areas wanted to keep healthcare accessible.

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[2] The Centers for Disease Control and Prevention (CDC) notes that "in a striking example of the health gap between rural and urban America, data from the CDC demonstrates that Americans living in rural areas are more likely to die from five leading causes than their urban counterparts." Factors such as increased incidence of smoking, industry work hazards, food deserts, high poverty rates, and lack of healthcare coverage (and thus reluctance of individuals to seek preventative care) contribute to this health gap. *See* https://www.cdc.gov/ruralhealth/cause-of-death.html.

[3] Wishner, J. and Solleveld, P. (July 7, 2016). A Look at Rural Hospital Closures and Implications for Access to Care: Three Case Studies, *Kaiser Family Foundation, The Kaiser Commission on Medicaid and the Uninsured, Issue Briefs,* https://www.kff.org/report-section/a-look-at-rural-hospital-closures-and-implications-for-access-to-care-three-case-studies-issue-brief/.

[4] Estes, C. (February 2020). 1 In 4 Rural Hospitals are at Risk of Closure and the Problem is Getting Worse, *Forbes*, https://www.forbes.com/sites/claryestes/2020/02/24/1-4-rural-hospitals-are-at-risk-of-closure-and-the-problem-is-getting-worse/#451aedfe1bc0.

[5] Ellison, A. (June 8, 2020). State-by-State Breakdown of 130 Rural Hospital Closures, *Becker's Hospital Report*, https://www.beckershospitalreview.com/finance/state-by-state-breakdown-of-130-rural-hospital-closures.html. Note that by June 8, 2020, the publication date of this article, an additional 10 rural hospitals had closed, which was defined in the article as cessation of inpatient care.

CHARTing a Way Forward

On August 11, 2020, the CMS Innovation Center[6] announced its Community Health Access and Rural Transformation Model (CHART), with an aim to reinvest in the rural health systems that serve nearly 57 million Americans.[7] In designing CHART, CMS was moved particularly by the impact of rural hospital closures. Recent studies by healthcare economists show that rural hospital closures cause increased patient transportation time to outlying hospitals and treatment delay, particularly for emergent conditions. Inpatient mortality increases by 8.7 percent, in comparison to urban hospital closures which appear to have no similar measurable impact; and this is disproportionately felt by Medicaid beneficiaries and racial minorities.[8] There is a "spillover effect" as well in that inpatient mortality increases in adjacent *urban* zip codes by 7.6 percent, likely attributable to the overall stress on shared healthcare resources following a rural hospital closure.[9] CMS states that the objectives of CHART are:

- Increasing financial stability for rural healthcare providers through multiple new funding approaches, including the use of upfront investments and predictable, capitated payments that pay for quality and patient outcomes over volume;[10]

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[6] The CMS Innovation Center is a division within CMS, charged with developing and testing new healthcare delivery and payment models.

[7] *See* https://www.cms.gov/newsroom/fact-sheets/community-health-access-and-rural-transformation-chart-model-fact-sheet.

[8] Gujral, K. (2020, June 10). Rural Hospital Closures Increase Mortality. *VoxEU*. Retrieved from: https://voxeu.org/article/rural-hospital-closures-increase-mortality.

[9] *Id.*

[10] There have been previous efforts by CMS to boot financial viability of rural healthcare providers. This includes critical access hospital designations, boosts to reimbursement for professionals practicing in a federally designated Health Professional Shortage Area, and more recently, addressing wage index disparities by increasing payments to certain low-wage hospitals. CHART is an additional and novel approach to the issues faced by many rural hospitals.

- Providing the necessary operational and regulatory flexibilities to allow healthcare providers and CMS to test CHART in their local communities and successfully transform themselves; and
- Supporting local rural communities' transformation efforts by being directly engaged at CMS, offering real-time technical expertise and other learning when needed to foster success.[11]

As with other alternative payment models developed by the CMS Innovation Center, CHART is in "test mode" — adjustments could be made in future iterations or larger rollouts of the CHART, if any. CHART participant performance will be carefully monitored by the agency, and testing or implementation of CHART nationwide will occur only if CHART proves that it either (1) reduces spending without reducing the quality of care, (2) improves the quality of care without increasing spending, or (3) in the best scenario, improves quality of care while simultaneously reducing spending.[12]

CHART Track 1: Community Transformation Track

Just how does CMS envision revitalizing rural healthcare in America? CHART introduces two distinct modes of attacking the current strains on rural healthcare: (1) a Community Transformation Track, whereby direct infusions of financial support will be made to select rural communities for their healthcare needs; and (2) an Accountable Care Organization (ACO) Track, whereby confederations of hospitals, physicians, and other healthcare industry players will cooperate to improve patient outcomes and reduce overall healthcare costs in a rural community by participating in the Medicare Shared Savings Program (MSSP).

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[11] *See* https://www.cms.gov/newsroom/fact-sheets/community-health-access-and-rural-transformation-chart-model-fact-sheet.

[12] 42 U.S.C. § 1315a(b)(3)(B).

In the CHART Community Transformation Track, CMS will divide a total available $75 million equally among 15 selected Lead Organizations — single entities that represent a rural county or census tract, or a coalition of rural counties or census tracts (either contiguous or non-contiguous), with a minimum of 10,000 Medicare beneficiaries whose primary residences are located within the rural community. Lead Organizations that can apply for CHART include, but are not limited to, state Medicaid agencies, state rural health offices, local public health departments, independent practice associations, academic medical centers, or rural health systems.[13]

If selected, a Lead Organization will receive up to $2 million in more immediate funding to seed healthcare-related projects in the rural community; the balance of the up to $5 million in funding available to each Lead Organization will be paid out in $500,000 increments in each of six performance periods, depending upon the Lead Organization's success under CHART.[14] It is important to note that the $5 million available to each of the 15 Lead Organizations selected for CHART is for administration and implementation of CHART in the particular rural community only. This $5 million is *not* for paying participating hospitals in the Lead Organization's rural community for services furnished to patients. Rather, hospitals that choose to participate in a CHART Lead Organization will stop receiving Medicare fee-for-service reimbursement, and start receiving bi-weekly capitated payments — the aim being to provide the steady, predictable income streams that are currently the exception, rather than the rule, for rural hospitals.[15] CHART participating hospitals will also continue to receive reimbursement from commercial payors, although the expectation is that commercial payor reimbursement may eventually also be adjusted to

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[13] Centers for Medicare and Medicaid Services Innovation Center, Community Health Access and Rural Transformation (CHART) Model Webinar, August 18, 2020, Slide 17, *available at* https://innovation.cms.gov/media/document/chart-model-overview-webinar-slides.

[14] *Id.* at Slide 18.

[15] *Id.* at Slide 23.

align with the hospital's performance under the CHART program.[16] CHART participating hospitals must continue to participate in Medicaid, and thus will continue to receive Medicaid reimbursement; this makes sense, as rural communities often have a high population of Medicaid-eligible patients.

The beauty of CHART is that Lead Organizations will have some freedom in designing healthcare initiatives tailored to the needs of their rural communities. This is a departure from other CMS Innovation Center alternative payment models, in which very specific clinical, quality, financial or other performance measures have been adopted on a nationwide basis, or across participants in the alternative payment model. Each Lead Organization must be led by an Advisory Council that includes representatives from the state Medicaid agency, at least one participating hospital, commercial payors, and a patient or patient representative — together with other rural community healthcare stakeholders (e.g., physicians, mental health organizations, long term care facilities, home health agencies, and local U.S. Department of Veteran's Affairs or Indian Health Service representatives, where appropriate).[17] With their intimate knowledge of the healthcare landscape in the rural community, the Advisory Council is tasked with developing what is termed under CHART as a Transformation Plan, and updating it annually. The Transformation Plan involves identifying healthcare opportunities for improvement in the rural community, and designing specific measures to address such healthcare issues. With applications for the CHART Community Transformation Track having just opened on September 15, 2020[18] and no Lead Organizations yet named, the

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[16] Because CHART is so new, it is not yet known how commercial payors may configure reimbursement for CHART participating hospitals.

[17] Centers for Medicare and Medicaid Services Innovation Center, Community Health Access and Rural Transformation (CHART) Model Webinar, August 18, 2020, Slide 21, *available at* https://innovation.cms.gov/media/document/chart-model-overview-webinar-slides.

[18] CMS announced the Notice of Funding Opportunity for the CHART Community Transformation Track on September 15, 2020, and applications for the program are due by February 16, 2021. *See* https://www.grants.gov/web/grants/search-grants.html?keywords=93.624 for a copy of the Notice of Funding Opportunity, which contains a link to the application.

industry does not have examples of CMS-approved Transformation Plans. What is clear is that CMS will demand that some traditional benchmarks of alternative payment models be reflected in a Lead Organization's Transformation Plan: reduction of inpatient and emergency department visits for chronic conditions; reduction of unplanned readmissions; and patient experience surveys.[19] It is also known that CMS will ask that each Transformation Plan address four key areas of clinical concern for rural communities: effective management of chronic conditions; reduction of substance abuse; addressing maternal health issues; and preventative healthcare.[20]

How each Lead Organization decides to tackle these objectives will largely depend upon the makeup of the population in the rural community, local economy, and other related factors. A rural community with a large pediatric population and parents who, due to work obligations, find it difficult to attend to their children's medical appointments may examine strategies to make pediatric telemedicine appointments more readily available. A rural community supported by industry could benefit from healthcare services being furnished in a clinic located on factory grounds. A rural community with a significant elderly, non-driving population could develop a patient transport or pharmacy delivery program to ensure compliance with medical appointments and medication regimens. A rural community that is a food desert, contributing to poor nutrition and related health conditions, could explore starting a mobile greengrocer program. The point is that CHART is astute to recognize that the salve for each rural community's healthcare Achilles' heel may be different, and that flexibility in each Lead Organization's Transformation Plan is key to CHART's success.

Of course, healthcare regulatory counsel may be concerned about how hospitals, physicians, and other providers "thinking outside the box" to attain success under CHART might trigger

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[19] Centers for Medicare and Medicaid Services Innovation Center, Community Health Access and Rural Transformation (CHART) Model Webinar, August 18, 2020, Slide 26, *available at* https://innovation.cms.gov/media/document/chart-model-overview-webinar-slides.

[20] *Id.*

compliance concerns. To this end, CMS has noted[21] that it will offer operational and regulatory flexibilities under CHART to include, but not be limited to, the following:

- Medicare waivers as necessary to test CHART and allow participating hospitals to waive cost sharing for Part B services, provide beneficiaries with transportation, and offer gift card rewards and incentives for chronic disease management programs.
- Waiver of Medicare hospital conditions of participation, including allowing a rural outpatient department and emergency room to be paid as if they were classified as a hospital.
- Waiver of the requirement for a 3-day inpatient stay prior to admission to a skilled nursing facility (SNF)
- Continued expansion of telehealth services
- Post-discharge home visits
- Care management home visits
- Flexibility under the Critical Access Hospital (CAH) 96 Hour Rule[22]

It is anticipated that CMS will issue additional details about operational and regulatory flexibilities in the coming weeks. Healthcare regulatory counsel should stay attuned to issuances on the CMS CHART website.[23]

CHART Track 2: ACO Transformation Track

For those already versed in the MSSP, CHART's ACO Transformation Track will look familiar.

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[21] *See* https://www.cms.gov/newsroom/fact-sheets/community-health-access-and-rural-transformation-chart-model-fact-sheet.

[22] The CAH 96 Hour Rule creates a Medicare condition of payment that requires a physician to certify that a patient can reasonably be expected to be discharged or transferred within 96 hours. Flexibility under this rule may be important for CHART participating rural hospitals, as many may often be the only healthcare facility in their geographical service area, with few or no step down facilities. *See* https://innovation.cms.gov/media/document/chart-model-faqs, pp. 10-11 for additional information on CHART flexibilities.

[23] *See* https://innovation.cms.gov/innovation-models/chart-model for press releases and news items related to CHART.

MSSP is Medicare's principal ACO program, with hospitals, physicians, and other healthcare providers banding together to achieve the "triple aim" goals of lowering healthcare costs, improving population health, and creating a better patient care experience (i.e., quality and satisfaction). Codified as part of the Patient Protection and Affordable Care Act (PPACA), CMS began rolling out MSSP in 2012 with two participation options: Track 1 (i.e., upside only) and Track 2 (i.e., increased upside and potential downside). Since then, CMS has changed its MSSP tracks; there are now several track variants, following issuance by the agency of its December 31, 2018 final rule creating the Pathways to Success MSSP initiative.[24] With 517 ACOs enrolled in MSSP as of January 1, 2020, serving 11.2 million Medicare beneficiaries, MSSP appears here to stay in some way, shape or form as a means of improving care under government health benefits programs, and containing costs.[25] CHART harnesses the already existing structure of MSSP to bring additional healthcare efficiencies and improvements to rural communities.

CMS will select up to 20 ACOs that are focused in the rural health space for CHART, each of which will receive advance payments as part of joining MSSP. In order to be eligible to participate in the CHART ACO Transformation Track, an ACO must meet the following criteria: (1) a majority of the providers and suppliers in the ACO must be located within rural counties or census tracts; and (2) the ACO must start a new 5-year MSSP agreement period at the start of its participation in CHART.[26] In choosing participants for the CHART ACO Transformation Track, CMS will rank and

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[24] 83 Fed. Reg. 67816 (December 31, 2018). *See* https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/sharedsavingsprogram/Downloads/ssp-aco-participation-options.pdf for a comparison chart of the various MSSP tracks, shared savings percentages, and shared losses percentages.

[25] *See* https://www.cms.gov/files/document/2020-shared-savings-program-fast-facts.pdf for specific data on ACOs enrolled in MSSP.

[26] Centers for Medicare and Medicaid Services Innovation Center, Community Health Access and Rural Transformation (CHART) Model Webinar, August 18, 2020, Slide 28, *available at* https://innovation.cms.gov/media/document/chart-model-overview-webinar-slides.

give preference to ACOs according to the proportion of their assigned beneficiaries residing in rural communities.[27]

How will payments to rural health centered ACOs differ under CHART, in comparison to other programs? CMS will pay CHART ACOs advance shared savings payments, that can be separated into two baskets:

- A one-time upfront payment equal to a minimum of $200,000, plus $36 per assigned Medicare beneficiary to participate for the 5-year periods in the CHART and MSSP agreements.
- A prospective per beneficiary per month (PBPM) payment equal to a minimum of $8, for up to 24 months.

PBPM amounts will vary as between ACO Transformation Track participants, depending upon the level of risk that a CHART ACO accepts in MSSP and the number of rural Medicare beneficiaries assigned (which shall be no more than a maximum of 10,000 Medicare beneficiaries).[28]

CHART ACOs should be aware that CMS will recoup advanced shared savings payments through offsets, to the extent a CHART ACO is not meeting program objectives[29]; but it appears that CMS will approach this in a fashion that CHART ACOs will never have to pay recoupment amounts "out of pocket" (i.e., if a CHART ACO does not generate sufficient shared savings to make a repayment, CMS will carry forward any balance still owed and offset it from future payments, until paid in full). CMS will also seek recoveries of advance shared savings payment from any CHART ACO that does not carry out the full 5-year term of its CHART or MSSP agreement.[30]

Conclusion

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[27] *Id.*

[28] *Id.* at Slide 30.

[29] *Id.* at Slide 31.

[30] *Id.*

In employing this new alternative payment model to improve healthcare outcomes and efficiencies in rural communities, CMS acknowledges the reach and importance of rural hospitals to the delicate healthcare ecosystem. CHART will be critical in incentivizing cooperation among rural healthcare stakeholders — sparking innovation to solve hard problems such as high incidence of chronic conditions, patient transportation access, licensed professional shortages, and availability of technology in rural communities. If CHART is successful, broader rural health reforms may come — perhaps earning proper recognition for rural hospitals as not being members on the periphery of the healthcare ecosystem but its sentinels.

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