December 22, 2020

Mr. Brad Smith
Deputy Administrator and Director of CMMI
Centers for Medicare & Medicaid Services
U.S. Department of Health and Human Services
Hubert H. Humphrey Building
200 Independence Avenue, SW
Washington, DC 20201

Re: Community Health Access and Rural Transformation (CHART) Model – Community Transformation Track

Dear Deputy Administrator Smith:

On behalf of the Premier healthcare alliance serving approximately 4,100 hospitals and health systems, hundreds of thousands of clinicians and 200,000 other provider organizations, we appreciate the opportunity to submit feedback on the recently announced Community Transformation Track of the Community Health Access and Rural Transformation (CHART) model. Premier maintains the nation's most comprehensive repository of hospital clinical, financial and operational information and operates one of the leading healthcare purchasing networks. Our comments primarily reflect the concerns of our hospitals and health systems, their employed physicians and independent physicians aligned with them. Premier runs the largest population health collaboratives in the country, the Population Health Management Collaborative, has worked with well over 200 ACOs and is currently comprised of more than 70 ACOs.

We appreciate the Administration's commitment to addressing the healthcare needs of rural Americans and for you and your staff's ongoing engagement with Premier on development of rural-focused alternative payment models (APMs). The CHART model offers the unique opportunity for providers to transform healthcare in their communities by repurposing rural facilities. However, we believe there are several opportunities to build on features of the model to ensure rural providers can succeed:

- Provide options for Medicaid participation
- Reduce the discounts and, at a minimum, alter how discounts are tied to population threshold
- Clarify how population shifts may impact the capitated payment
- Provide options for incorporating providers across the continuum
- Engage with participants early to develop end of model transitions

We have detailed these recommendations below and suggest that CMMI consider delaying the application deadline. While the model offers an implementation period, significant coordination is required among lead organizations, hospital participants, State Medicaid agencies, and Medicaid managed care organizations (MCOs) to apply to the model. With a continued focus on managing the coronavirus pandemic, it is difficult for these organizations to engage in even preliminary discussions regarding this model.

MEDICAID PARTICIPATION OPTIONS

The Community Transformation Track requires a Lead Organization to secure participation from its State's Medicaid agency at the time of its application. Additionally, the model sets thresholds for the amount of Medicaid payments in the community that must be paid under a capitated arrangement in this model, starting with 50 percent in performance period 2 and increasing to 75 percent. Accordingly, **a**

community's ability to participate and succeed in the model is dependent on its State's readiness and willingness to participate. Moreover, the ongoing COVID-19 pandemic has required an unprecedented response across the entire healthcare system and various levels of government, consuming what limited time and resources that providers and governments have available. Many states may not be ready to commit to participating in this model by the February application deadline as they continue to focus efforts on their COVID-19 response.

We appreciate the guidance that CMMI has released to State Medicaid agencies on the model, which is aligned with Premier's ongoing efforts to support more value-based arrangements in Medicaid. However, **we recommend that CMS make Medicaid participation optional.** Several aspects of Medicaid can be a roadblock for hospitals and health systems interested in adopting this model:

- *State readiness.* Once the public health emergency has concluded, many states may not be ready to participate in models that implement capitation, limiting the number of regions in which the CHART model can be tested. States are facing significant budget constraints and will have to consider broad Medicaid cuts. While the CHART model is an option for inclusion of Medicaid reform it will be among a host of other payment approaches states may consider. The timeline to decide on CHART by February will not realistically be met by many States.

- *Multi-state rural regions.* Many rural regional health systems span multiple states, requiring participation among multiple State Medicaid agencies. It is feasible that one State Medicaid agency could be prepared to participate in the model while others are not. Hospitals and health systems in multi-state rural regions aim to develop regional strategies that cross state lines. If hospitals and health systems are unable to secure participation from all State Medicaid agencies in their regions, they will only be able to develop a disjointed rural health strategy or not participate in the model.

- *MCOs in the region.* Most state Medicaid agencies enter multi-year contracts with MCOs. Altering these contracts to participate in the model will require payer interest, as well as force the state to renegotiate existing contracts. As demonstrated by other states with multi-payer models (e.g. Maryland, Pennsylvania), significant lead up time was required at the start of the model. It is unrealistic to expect that a State Medicaid agency could bring payers on board and renegotiate MCO contracts by January 1, 2022.

FINANCIAL METHODOLOGY

The concept of the CHART Community Track addresses several challenges in rural hospitals and health systems. Providing a stable budget while allowing hospitals to develop a regional strategy that includes flexibilities to reimagine hospital use (e.g. converting outpatient departments to standalone emergency departments) presents a unique and innovative opportunity to transform rural healthcare. While we understand that CMMI intends to release additional details in the coming months, several aspects of the financial methodology are concerning or there is insufficient detail to allow health systems to adequately assess their participation in the model.

The discounts should be reduced

Rural providers currently face budget shortfalls and are struggling to maintain access. Under the model, CMMI will apply a discount to historical spending, which will increase overtime and vary based on the amount of total revenue in the community that is under a capitated payment, from 0.5 to 4 percent. The

discounts will also be particularly challenging for Critical Access Hospitals (CAHs), who are currently paid under cost-based reimbursement.

A rural model must focus on sustainability of healthcare in rural communities by ensuring access and stable funding. While most Innovation Center models have focused on savings to the Medicare program, its statutory authority does allow it to pursue models that are expected to improve quality of care without increasing spending. Additionally, such models do not need to be budget neutral initially. Models for our most vulnerable aspects of the health care system, such as rural health care, should focus on improved outcomes rather than significant savings to Medicare.

Beginning in Performance Year 3, the discount rate will be tied to the volume of revenue that flows through the capitated payment to hospitals – with communities with higher Medicare fee-for-service (FFS) revenue in capitated payments receiving a lower discount rate. This construct will likely discourage smaller rural communities or communities that have a large Medicare Advantage (MA) penetration from participating since it will be challenging for them to accrue enough FFS revenue to achieve a lower discount rate. At a minimum, **CMMI should modify how payments are tied to volume, assessing the percentage of FFS revenue that flows through capitated payments, rather than targeted dollar amounts.** This would allow smaller rural communities or those with higher MA penetration to participate in the model without being disadvantaged by the low volume of available FFS revenue in their community.

Clarify how population shifts may impact the capitated payment

Under the Community Transformation Track, there must be at least 10,000 Medicare FFS beneficiaries whose primary residences in within the defined Community at the time of application. This threshold will be challenging to meet for smaller rural communities, especially those with a high MA penetration. The implications are also unclear for communities that may fall below this threshold once they have begun participation in the model. For example, some rural communities are seeing a large growth in their MA population and are unable to predict if they would continue to meet these thresholds in future years. **We urge CMMI to release additional guidance on its mitigation approaches for when the population minimums cannot be met in future years.**

Provide Options for Incorporating Providers Across the Continuum

Improved outcomes in this model will shift care from the inpatient setting to outpatient and ambulatory care. While the model accounts for shifts from hospital inpatient to outpatient setting, the broader community providers are not considered within this model. We are concerned that this approach may be too limiting and will not provide enough flexibility to communities to transform care across the continuum. **We urge CMMI to allow options to bring additional provider payments into the capitated arrangement or to alter other Innovation Center models to include the flexibilities provided in this model.** For example, CMMI should offer rural providers interested in the Direct Contracting model the flexibilities around hospital structure and space usage along with reduced discounts.

Engage with Participants Early to Develop End of Model Transitions.

As noted above, a key element of the model is the ability of providers to transform care in their community, which could take the form of shifting services across providers or converting hospitals into new provider types, such as rural emergency departments. Once such changes are made it will be impossible for providers to return to a FFS system. While we understand CMMI cannot commit to a new model five years away, **CMMI should begin working with participants at the start of the model to**

design a transition back to FFS if their participation or the model is terminated. The transition away from CHART should be an ongoing focus of participant communication and opportunity for stakeholder input.

Additional Payment Details are Needed

We recommend that CMMI release additional guidance on the following topics as soon as possible to ensure potential applicants can make informed decisions:

- *Capitated payments mechanism.* Based on the Notice of Funding Opportunity (NOFO), it is unclear if Lead Organizations or CMS will be responsible for paying capitated payments to participating hospitals. Potential applicants need additional information to better understand the systems and infrastructures that they will need to have in place to participate in the model.

- *Strategy to mitigate impact of COVID-19 on benchmark.* The NOFO notes that CMMI will establish the benchmarks for the hospital capitated payment using two calendar years of historical data starting three years prior to the start of the first performance year, or CYs 2019-2020 historical data for 2022. As a result, it is likely the selected baseline will be impact by the ongoing COVID-19 pandemic. **We recommend that CMMI release additional guidance on how it plans to address COVID-19 in the baseline if 2020 data is used.** We recognize that CMMI is likely still assessing the impact of the ongoing pandemic and that this information will likely be addressed in the forthcoming financial methodology document. However, as this information is essential for potential applicants to assess participation in the model, we would urge CMMI at a minimum to release principles on how it will adjust benchmarks given COVID-19 as soon as possible.

- *Model Overlap*. As noted above, the Community Transformation Track is limited to hospital services, which means there is the potential for beneficiary overlap with other models that might be operating in a given community. For example, a hospital (that is not a Lead Organization) may choose to participate in an Accountable Care Organization (ACO) in order to better impact quality and costs across a continuum of care. **We recommend that CMMI release additional details on how overlap with other models will be addressed.** This information is essential for potential applicants as they explore how to best structure model participation across all providers in the community. We also urge CMMI to allow for participants in the Community Transformation Track to participate in other models, such as Primary Care First.

ADOPT FLEXIBILITIES GRANTED UNDER THE PUBLIC HEALTH EMERGENCY

The NOFO notes several of the flexibilities and waiver that CMMI is considering for the Community Transformation Track. **We would encourage CMMI to consider broadly adopting many of the flexibilities that have been granted under the COVID-19 Public Health Emergency (PHE) as part of the CHART model and other CMMI models moving forward.**

We would encourage CMS to adopt broad telehealth flexibilities in all APMs. Telehealth services are critical to rural health providers, offering the ability to enhance medical management between patients and providers, enable remote monitoring, and greatly improve communication and education between primary and specialty care providers. Additionally, we would encourage CMMI to adopt many of the rural-specific waivers that were granted under the PHE, such as requirements for CAHs that limit number of beds to 25 and average length of stay to 96 hours. Such waivers will provide rural hospitals with important flexibilities to redesign care delivery under the CHART model.

CONCLUSION

In closing, the Premier healthcare alliance appreciates the opportunity to submit feedback on the CHART Model. If you have any questions regarding our comments or need more information, please contact Aisha Pittman, vice president, policy, at aisha_pittman@premierinc.com or 202.879.8013.

Sincerely,

Blair Childs
Senior Vice President, Public Affairs
Premier healthcare alliance