

Centers for Medicare & Medicaid Services
Rural Health Open Door Forum
Thursday, August 29, 2024
2:00 – 3:00 p.m. ET

Webinar recording:

https://cms.zoomgov.com/rec/share/E2HyG66sFqdGB_bpZT6IN_FzIFNon7Iypp8qv2OTXMuaCaHUZ5xcLeQTW8KyeVdv.RGtNF0YGkE43S8eo?startTime=1724954650000

Jill Darling: *[Not recorded]* Good morning and good afternoon, everyone. My name is Jill Darling and I'm in the CMS Office of Communications. Welcome to today's Rural Health Open Door Forum. Before we begin our agenda, I have a few announcements.

[Recording in progress]

Jill Darling: For those who need closed captioning, a link was provided in the chat, and you may also utilize the Zoom captions as well at the bottom of your screen. This webinar is being recorded. The recording and transcript will be available on the CMS Open Door Forum podcast and transcript webpage. That link was on the agenda, and I will share it with you in the chat as well. If you are a member of the press, please refrain from asking questions during the webinar. If you do have any questions, please email press@cms.hhs.gov. All participants are muted upon entry. For today's webinar, I will be displaying the agenda side that you see in front, and one of our speakers today will be sharing her screen as well. And then we will go into our Q&A. So, like I just said, taking questions at the end of the agenda today. We note that we will be presenting and answering questions on the topics listed on the agenda. We ask that any live questions relate to the topics presented during today's call. If you have any questions unrelated to these agenda items, we may not have the appropriate person on the call to answer your question. As such, we ask that you send any of your unrelated questions to the appropriate policy component, or you can send your email to the Rural Health ODF resource mailbox that I will provide, and we'll get your question to the appropriate component for a response. You may use the raise hand feature at the bottom of your screen, and we will call on you when it's time for Q&A. Please introduce yourself with your organization or business you're calling from. When the moderator says your name, please unmute yourself on your end to ask your question and one follow-up question. And we'll do our best to get to all your questions today. I will hand the call off to our Co-Chair, John Hammarlund.

John Hammarlund: Thank you so much, Jill. Hi, everybody. We are delighted you are joining us today. Thank you so much for being a part of this important meeting. We always look forward to having a large audience, and we look forward to trying to give you the right information you need. I'll speak in just a moment about today's agenda, but first I want to ask you, I don't know if it's feeling like fall where you may be. I can tell you here in Seattle, it's starting to get a little nippy, kind of like fall. I think where my fabulous Co-Chair Heather is located, however, in the Baltimore region, it's still downright balmy. So, it just tells you a little bit about how vast a country we have when we're experiencing such variations in temperatures. But we're feeling fall

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out here in Seattle, where I'm based. We have a great agenda for you today, built on some suggestions we've received from across the agency.

We think this is information that's timely and the sort of thing you need to know, but I want to remind you that we always seek your input on how to build out the agendas in the future. So, at the end of today's call, we're going to give you an address where you can write to us and let us know what sorts of topics you would like to have us address in future calls. But today's topics we think are very relevant to you all. Thanks, Jill, there you go. As Jill said, at the end of the presentations today, we look forward to receiving your questions and comments related to today's topics, and I want to thank all the presenters who are joining us today. So once again, thanks for joining this call, and with that, I'll hand it back to Jill so she can get us rolling.

Jill Darling: Great, thank you, John. First, we have Renate Rockwell-Dombrowski, who will speak on the Section 4122 Distribution of Additional Residency Positions for fiscal year '26.

Renate Rockwell-Dombrowski: Thanks, Jill. I have a brief announcement that the fiscal year 2025 IPPS (Inpatient Prospective Payment System) final rule includes the finalized policies for Section 4122 of the Consolidated Appropriations Act (CAA) of 2023. Section 4122 is a one-time distribution of 200 residency training positions effective for fiscal year 2026. The slots are effective July 1 of that year. The provision requires the distribution of 200 residency positions to qualifying hospitals, including rural hospitals. The law also requires that at least half of the slots be distributed to psychiatry programs and subspecialties of psychiatry and that each qualifying hospital receive at least one or a fraction of one slot. To meet the statutory requirement of distributing at least one slot or a fraction of one to each qualifying hospital and to maintain consistency when possible that slots should be focused on underserved populations in areas with the most need, we finalized our proposal to distribute up to one slot to each qualifying hospital. If there are any slots remaining, we will distribute those remaining slots based on the health professional shortage area, or HPSA, score of the program for which the hospital is applying. The Section 4122 application process will use the electronic mirrors application system that is currently used for Section 126 applications, and the application will open in early 2025. I will now turn over to Sacha Wolf. Thank you.

Sacha Wolf: Thank you. Let me share my screen here. OK, so thank you, Renate. So, my name's Sacha Wolf, and I work at CMS in the CMS Innovation Center. And what we do at the CMS Innovation Center is we help to drive value-based care and improve care for beneficiaries by testing innovative payment and service delivery models for Medicare, Medicaid, and CHIP (Children's Health Insurance Program) beneficiaries. So, in direct support of this work, we're excited to implement a new alternative payment model called the Transforming Episode Accountability Model, or we call it TEAM for short. So, just a little bit of background. TEAM is an episode-based payment model that builds upon lessons learned from previous CMS Innovation Center models, such as the Comprehensive Care for Joint Replacement Model, or CJR model, and the Bundled Payments for Care Improvement Advanced Model, the BPCI Advanced model. We also designed TEAM from the information that we had received from

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public comments during the proposed rule, and we also released a request for information last year during the summer of 2023 to help guide the design of TEAM.

So, when we think about model purpose, we are aware that some beneficiaries who undergo a surgical procedure in a hospital may experience fragmented care that can lead to complications, avoidable hospitalizations, and increased spending. So, TEAM would try to aim to solve this issue by holding hospitals accountable for spending and quality performance during a patient's initial hospital admission or hospital outpatient procedure and the 30-day period following that hospital discharge. When we think of model goals, we anticipate TEAM will benefit Medicare beneficiaries by improving care transitions, encouraging provider investment in health care infrastructure and redesign care processes, and incentivizing higher value care across the inpatient and post-acute care settings. So as a result, we anticipate TEAM will help lower Medicare spending and drive equitable outcomes. Additionally, by holding participants accountable for quality and cost of the episodes in TEAM and ensuring those patients are referred to primary care services, the model will also support CMS' efforts to have all people with Medicare in a care relationship with accountability for quality and total cost by 2030.

When we think about model approach, TEAM is a five-year mandatory model test. So, the model will begin on January 1, 2026, and it will end on December 31, 2030. Acute care hospitals located in certain geographic regions—specifically core-based statistical areas, or CBSAs—will be required to participate in the model. I'll note, though, that we are allowing hospitals that are not required to participate the option to voluntarily opt into TEAM. Now, this voluntary opt-in opportunity is limited to hospitals that currently participate in BPCI Advanced and CJR models until the end of those models. This voluntary opt-in opportunity is to encourage those hospitals in those models to maintain their momentum and value-based care.

When we were designing TEAM, we recognized that TEAM is going to capture a whole bunch of different hospitals with varying levels of experience with respect to value-based care. So, we purposely designed TEAM to have three participation tracks. So, Track 1 is a track with no downside risk and upside risk only. That means if a participant in Track 1 will not be required to pay CMS if their spending is above the target price. All TEAM participants are eligible for this track in the first performance year, and then TEAM participants that are safety net hospitals are eligible to stay in Track 1 for the first three performance years. Track 2 is a track with upside and downside risk, but the level of risk and reward is lower as compared to Track 3. Track 2 is available starting in performance year two, and it's limited to certain types of hospitals. Those hospitals would be your safety net hospitals, rural hospitals, rural community hospitals, Medicare-dependent hospitals, and essential access community hospitals. Track 3 is the track with the highest level of risk and reward, and it does have upside and downside risk. This track is open to all TEAM participants and is available all performance years of the model.

Thinking about the episodes tested in TEAM. So, like I said, TEAM is an episode-based payment model, and will test five clinical episodes amongst traditional Medicare fee-for-service beneficiaries. So, the clinical episodes focus on the following acute care procedures: so, the lower extremity joint replacement, surgical hip and femur fracture treatment, spinal fusion,

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coronary artery bypass graft, and major bowel procedure. An episode starts with the inpatient hospital admission or hospital outpatient department procedure for one of those five episode categories. The episode of care is going to end 30 days after the discharge from the hospital, and the episode includes all Medicare Parts A and B spending for items and services with limited exceptions. I'm going to skip this because we already talked about voluntary opt-in, but I'll sort of talk about how TEAM will be implemented. So, hospitals in the model or TEAM participants will continue to bill Medicare fee-for-service as usual, but they will receive a target price based on all the included items and services in an episode, and those target prices are going to be provided prior to each performance year. A participant's performance in the model will be assessed by comparing the hospital's actual Medicare fee-for-service spending against their target price as well as assessing performance on quality measures. So, a participant may earn a payment from CMS subject to a quality performance adjustment if their Medicare spending is below the target price, or a participant may owe CMS a repayment amount subject to a quality performance adjustment if their Medicare spending was above the target price.

I'm just going to move along here. TEAM will be evaluated. We will have a formal evaluation and the model is going to be evaluated to determine if the model's maintaining or improving quality of care and reducing Medicare spending. Our evaluation is going to assess the quality and access to care, utilization, spending, and patient experience. We anticipate releasing evaluation reports on an annual basis, and once they are available, they will be posted to the TEAM website. With respect to model participation, we sort of already went over some of this. I'll quickly go through this. Like I said, acute care hospitals that are located in certain geographic regions—so those core-based statistical areas across the U.S. are going to be required to participate. Those selected CBSAs were included in our final rule or in the final rule. TEAM was a part of the fiscal year 2025 IPPS final rule and that was actually published yesterday, August 28. It was originally in the Federal Register, I think August 1. Like I said, it's going to capture a mix of different types of hospitals with different value-based care experiences. We are having that opportunity for hospitals that aren't required to participate, the ability to voluntarily opt in, and like I said, that opt-in opportunity is just limited to hospitals that currently participate in the BPCI Advanced model or CJR models until those models end. And then how an episode is initiated. So, people with traditional Medicare may initiate an episode if they're admitted to a hospital that is in the model for one of those five surgical episodes being tested.

When we think about health equity for TEAM, TEAM is going to address health equity in multiple ways. So first, as a mandatory model, we're able to capture more beneficiaries and a wider variety of providers across the U.S., including those who may not have participated in value-based care before. Secondly, TEAM is going to allow hospitals who care for a higher proportion of underserved beneficiaries, such as safety net hospitals, to participate in a track with lower financial risk and rewards. Thirdly, the model's pricing methodology includes beneficiary social risk adjustment to ensure target prices properly reflect additional financial investment needed to care for underserved beneficiaries. And then lastly, to address disparities and support continuous quality improvement, hospitals may voluntarily submit health equity plans and report on demographic data, and screen beneficiaries for health-related social needs. And then this is just the model timeline. Like I said, it's a five-year model. It'll start on January 1,

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2026, and end on December 31, 2030. Our first performance year follows the calendar year of 2026, and you can see there are five performance years. This fact sheet that I'm showing you right now is on our model website, along with some other information. So, I highly recommend that you take a look at our website and view the information that we have posted there. I think Jill also had on the slides that she was sharing the inquiry inbox that you can email us as well if you have any questions. So that's all I have for right now, and I will hand it over to Andrew.

Jill Darling: Hi, Andrew. We cannot hear you.

Andrew Phillip: Can you hear me now?

Jill Darling: There we go. Thank you. Go ahead.

Andrew Phillip: Do you mind if I, I'm just going to pull up another slide of my own here? Can you see that OK?

Jill Darling: Yes.

Andrew Philip: Great. All right, so thank you, Jill and John and Heather, for this invitation. Sacha gave a really nice overview of the CMS Innovation Center. My name is Andrew Philip. I'm the Deputy Group Director of the Learning and Diffusion Group here at CMMI (Center for Medicare and Medicaid Innovation), and I'm really happy to be talking about rural health here. So, as folks know, CMS, and if you're familiar with the Innovation Center, we've been engaged in work around rural health for years and are continuously thinking of ways that our models, especially within the Innovation Center, can help folks in rural areas—including beneficiaries, but also providers and communities—achieve better health and also working towards health equity. So, as we've been doing this, there's something that is actually happening today right now as we're all sitting here and speaking and that is called, as you can see on the screen here, our Rural Health Hackathon.

So, the Rural Health Hackathon, or actually hackathons, as you can see on the left-hand side of the screen here, are a series of events that we're hosting in North Carolina, Montana, and Texas to work with communities in their areas and with the help of our regional partners to learn more about what challenges they're experiencing around providing and engaging in care but also to really more importantly to source new ideas, innovations and concepts, around what we can do to be creative and help support and innovate around these areas and craft ideas that we can even incorporate into our models or even CMS programs. So, through each of the events, we've invited a number of community participants and interested parties to participate.

As we source these ideas—and you can see there's a number of different key areas—we are looking at access to care. For example, we know that transportation courses are a huge barrier, especially in rural and even frontier communities, care delivery models, things like TEAM-based care, where we try to bring together as many different provider types of practitioners to meet the needs of patients and families where they are. Workforce, this is always a challenge almost

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everywhere in the country, but especially in rural or more remote areas where they're trying to recruit and retain qualified providers. But also thinking about the policies, what types of flexibilities do we include in our models and incentives, and how do we engage rural health providers in more value-based models? So, as we gather ideas and innovations in each of these areas, we are working towards developing a policy report that is going to include some of the findings that are generated through this series of hackathons and ideas that we may incorporate moving forward. One of the things that I'm especially happy about, and especially because we're talking today, is that we also have a virtual submission portal. And I'll share the link to that, if I can, in the chat as soon as I take down my slides here. We invite members of the public to share their challenges but also think through each of our major category areas and share their own ideas, share the types of solutions that they think would be most impactful in their communities. And again, we're really looking to think about how we can incorporate these into even future models that we may be working on.

So, I'll share that link in the chat in just a moment and I'm happy to answer more questions or share more about that. Also in the link that I'll share is a general landing page that provides you with more information about exactly what we're doing in each of the hackathons. And you'll also be able to access, once it's available, our policy report that's coming out of this series of hackathons. That should be late fall or early winter I believe that we'll have that available, but we're working with our partners as we source these ideas to incorporate those into the report. So, I'll pause there. Jill, should I hand it back to you?

Jill Darling: Yes, thank you. All right, well, thank you, Andrew, Sacha, and Renate. We will go into our Q&A now. So please use the raise hand feature at the bottom of your screen, and we will call on you for one question and one follow-up. So, we'll just give it a minute. OK, Peg, you may ask your question.

Peg Tinker: Hi, I am wondering if you have more specific time frames for the TEAM model. So, I believe January, next January 2025 is when voluntary signup occurs. Do you know, for example, time frames for when you'll send out baseline material to organizations that are mandatory, as well as those voluntary participants?

Sacha Wolf: Yeah, so you're right. I didn't really touch on the voluntary opt-in. So, there is a specific time frame of when hospitals that are eligible for voluntary opt-in, when they would have to let CMS know they're interested in signing up to participate in TEAM. That voluntary opt-in period is from January 1, 2025, to January 31, 2025. It's a one-month period that those hospitals eligible for voluntary opt-in have to submit a letter to us indicating that they're interested in voluntarily participating in the model. We are doing that in 2025 because the model is supposed to start in 2026.

With respect to your question about when we would be sharing data, we'd be sharing baseline data. So, like your baseline episode information as well as preliminary target prices sometime during the calendar year 2025. We haven't ironed out a specific time frame of when that data would be shared with participants. And that data would be shared with those that are required to

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participate as well as those who would be voluntarily joining the model. We anticipate, as we are creating additional resources to provide participants, those who are voluntarily joining and those who are required to participate, better timelines in the future. I just don't have that specific time frame. I mean, what I can tell you, Peg, is that it will be before the model year starts. So, model year performance year one is 2026. All of that, the preliminary target prices, and the baseline episode data would be shared with participants before 2026. So, like I said, sometime in 2025.

Peg Tinker: Thank you.

Karen Mohr: Roger Prez, you may unmute and ask your question.

Roger Des Prez: Can you hear me now?

Karen Mohr: Yes, we hear you.

Roger Des Prez: I have a question which is not possible to answer in this forum, but I do have—I'm a cardiologist, and I have an idea that I think would be helpful for increasing cardiovascular diagnostics in rural areas and improving equity. It's way too long to discuss on this call. I just wanted to see if there's some way I can talk to somebody offline in the near future. And you now have my telephone, name, number, and my name and email, presumably.

Jill Darling: Yes, from the registration report, we have your email, but I would say in the meantime, please send it to the Rural Health Open Door Forum email. I will put it in again, and you know, with your specifics, and we can forward that along.

John Hammarlund: Feel free to fill in as much of the details as you can in that email, and we'll make sure we route it to the right person or persons in the agency. Thank you.

Roger Des Prez: OK, thank you.

John Hammarlund: We're interested in hearing your ideas.

Roger Des Prez: OK, well I will send it to somebody. I've got a PowerPoint that summarizes it. I will send it to somebody.

Jill Darling: All right, thank you so much.

Karen Mohr: All right, Sunil Agashe.

Sunil Agashe: Yes, you did say it right. Thank you. So, this is Sunil Agashe from Guidehouse. The question I had was for Track 1. It was mentioned that all TEAM participants will have one year, but safety net hospitals will have up to three years. So, can you elaborate on what exactly that means? Does it mean that safety and net hospitals will be, if they enroll in Track 1, they can

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remain there for PY (performance year) one to PY three, and then what? PY four and PY four go to Track 2 or Track 3? Is that what it means?

Sacha Wolf: Yeah, so we're giving a lot of flexibility to participants to determine which track is most appropriate for them. So, like you mentioned, in the first year TEAM for performance year one, everyone's able to sign up and join Track 1. However, a hospital could, if they really wanted to, sign up for Track 3 for the first performance year. So, we're sort of giving the flexibility for the hospital to determine which track is most appropriate for them. But when we talk about those safety net hospitals and focusing on Track 1, since that's where your question was surrounding, a safety net hospital can be in Track 1 for performance years one, two, and three—so the first three years. After performance year three, they can then choose to either go into Track 2 because they meet the eligibility for our Track 2 criteria or if they want to, they can go into Track 3. It's up to them.

Sunil Agashe: Got it. OK. Sounds good. Thank you.

Sacha Wolf: You're welcome.

Jill Darling: All right, I am seeing no further questions. So, we thank you for joining us and we thank our speakers. So, I'll hand it off to John Hammarlund for closing remarks.

John Hammarlund: Thanks a lot, Jill. Thanks for everybody for participating today, we really appreciate it and hope you found the information useful. I can tell you when I have in the past met with rural providers in my part of the country, Region 10, which is Oregon, Washington, Alaska, and Idaho, I often ask the question, are you getting the right sort of information that you need from CMS or are you getting information from CMS? And the answer typically is, “Oh my, yes, we get lots of information from CMS. We get a fire hose worth of information from CMS. What's really useful for us, though, is when you tailor it specifically for our needs in rural America and as small providers.” So that's what we try to do in these Open Door Forum calls is to try to pinpoint those topics that we think are of particular relevance to you. But as I said, we may not always have the right ideas. We really need to listen and hear what you want us to talk about. That's why we encourage you to help us build out the agendas in the future. So twice now in the chat, you see from Jill Darling, the address, which is [ruralhealthodf](mailto:ruralhealthodf@cms.hhs.gov), that's all one word I guess you call it, at cms dot hhs dot gov. That's how you can reach us and let us know what you'd like to hear from us in the future. We'd like to have your assistance in building the agenda. So, thank you again for your participation today. Delighted to have you. And with that, I'll hand it back to Jill for any final instructions.

Jill Darling: Well, thank you, John. No further instructions. We always appreciate you joining us again, ruralhealthodf@cms.hhs.gov. That concludes today's call. Thank you everyone. And that concludes today's call. Thank you, everyone.

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