Frontier Community Health Integration Project (FCHIP)

Introduction and Overview of the Frontier Community Health Integration Project (FCHIP) Demonstration

CMS
CENTERS FOR MEDICARE & MEDICAID SERVICES
CENTER FOR MEDICARE & MEDICAID INNOVATION

The CMS Mission

CMS is a constructive force and a trustworthy partner for the continuous improvement of health and health care for all Americans.

FCHIP Demonstration: Authorizing Legislation

- Section 123 of the Medicare Improvements for Patients and Providers Act of 2008 (MIPPA), as amended by section 3126 of the Affordable Care Act (ACA), authorized a 3 year demonstration.

- This demonstration is administered by the Innovation Center to test interventions aimed to improve ***access*** to care for beneficiaries residing in very sparsely populated areas.

- The demonstration is required to be budget neutral: the aggregate payments should not exceed the amount which would have been paid if the demonstration project was not implemented.

Frontier Critical Access Hospitals "Eco-System"

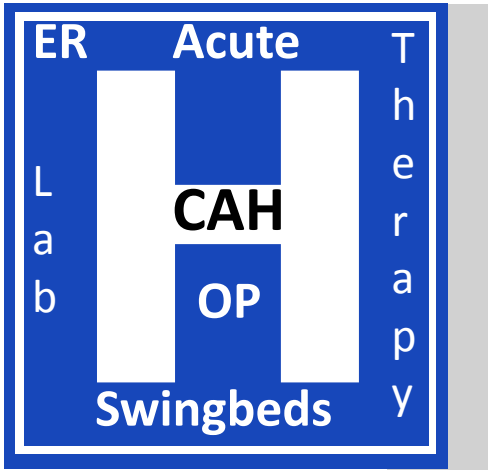
$$$

"Resource-Centered Care"

EMS

Transfers

"High Volume-Resource rich"



RHC

Home Health

Nursing Home

"Low volume-Relationship rich"

VNS

Local "By-pass" (for lack of services)

FCHIP "Eco-System"

"Person-Centered Care"

Appropriate Transfers

Telemedicine

- **e-Emergency, e-ICU**
- **Specialty physicians**
- **Services (mental health, Pharmacist, IP, nutritionist, etc.)**

ER **Acute** **Therapy** **Lab** **CAH** **OP** **Swingbeds**

Home- Based Therapy Services

Home Health

RHC

LTC Beds in critical access hospitals

Accessing services "Locally"

Demonstration Objectives

- Improve access to services that are not financially feasible under current Medicare reimbursement given the low patient volumes for frontier critical access hospitals:
  - Nursing facility care
  - Telemedicine
  - Ambulance
  - Home health
- Decrease avoidable hospital admissions, readmissions, and avoidable transfers.

Eligibility Requirements

Eligible Entities:

- A Rural Hospital Flexibility Program grantee.
- Located in a State in which at least 65 percent of the counties in the State are counties that have 6 or less residents per square mile.
- Eligible States: Alaska, Montana, Nevada, North Dakota, and Wyoming.
- CMS will choose participating providers from no more than 4 of these States.

Provider Coordination

- Applicants must show that access to care is affected by sparse population and low volumes for providers.
- Applicants will be required to provide evidence for linkages (either ownership or contractual) with the providers of these services – nursing facility, home health agency, ambulance services.
- For **telemedicine**, applicants must show arrangements with distant site providers.
- For **ambulance**, applicants must show transfer relationships with essential providers.
- **Applicants may propose to participate in one or more of the four interventions.**

Waivers: Telemedicine – Originating Site

- CMS will modify payment to originating site to allow for cost-based payment of the facility fee.
- Limited to staffing and overhead costs associated with providing this service.
- Not allowed for purchases of new equipment.
- Payment to distant site provider will be made under the current physician fee schedule.
- Provision of telemedicine services will be limited to currently approved physicians and practitioners and allowed telehealth services.

Waivers: Telehealth – Store and Forward

- CMS will allow reimbursement for:
  - A critical access hospital serving as the originating site.
  - A distant site provider for telehealth services furnished using asynchronous “store and forward” technology.

- Apart from the waiver allowing these services to be provided in the States eligible for FCHIP, the provisions of the Social Security Act and the corresponding regulations will apply.

Waivers: Ambulance Services – Waive the 35-mile Rule

- Cost-based reimbursement of ambulance services furnished by a critical access hospital or by an entity that is owned and operated by the critical access hospital, even if there is another ambulance service within a 35-mile drive of the critical access hospital or the entity is owned and operated by the critical access hospital.

- Cost-based reimbursement will not be allowed for any new capital expenditures (e.g., vehicles) associated with ambulance services.

Waivers: Nursing Facility Level Care

- Increase the bed limit for critical access hospitals from 25 beds to 35 beds.
- Extra beds may only be used for nursing facility level services.
- Capital costs for new construction will not be permitted.
- Only sites demonstrating occupancy greater than 80 percent will be eligible for this waiver.
- This waiver will not be permitted for critical access hospitals that currently operate a distinct-part skilled nursing facility.
- Cost-based reimbursement principles for critical access hospital swing-bed services will apply for the staffing costs associated with additional beds in the facility.

Enhanced Home Health Payment

An enhanced payment rate will be provided to account for the costs to travel extended distances to deliver home health services to patients.

- Enhanced payment rate:
  - *$1.054* per mile traveled
- Enhanced Mileage Rate Payment Cap:
  - 1,600 miles per home health episode
    - (~*$1,680* per episode)

Conditions of Participation

- Participating providers must meet all federal and state requirements for critical access hospitals.

- For participating critical access hospitals expanding the number of beds – ***This change in Conditions of Participation will be implemented in conjunction with State licensing agencies and will also require a letter of approval from the State Medicaid Agency*.**

Application Requirements

- Applicants will be required to provide the following documents:
  1) Narrative and budget – described in RFA
  2) Letter from State Medicaid agency (if applicable)
  3) Medicare Demonstration Waiver Application

Applications are due May 5, 2014

Application Requirements: Summary of Narrative

- **Proposals are asked to provide information on:**
  - Purpose of project
    - Statement of problem and technical approach
  - Description of current delivery system
  - Technical approach to selected interventions
  - Organizational capacity
    - Ability to implement demonstration
    - Agreements with providers
    - Staffing plans
  - Budget neutrality projection

Purpose of the Project/Statement of Problem and Technical Approach (1)

- Describe purpose of the demonstration
  - Goals and objectives, including indicators to measure achievement
  - Current care delivery system operations
  - Patient experience
  - Partnership with and role of other providers
- Describe community need
  - Patient population demographics, including health status
  - Age, case mix, payer status
  - Distribution of health services and unmet needs

Purpose of the Project/Statement of Problem and Technical Approach (2)

Applicants must describe:

- Transfer patterns
  - How many, to where, for what?
  - Plan to provide integrated, patient-centered care, including impact on avoidable transfers
- Current efforts to improve patient choice, quality of care, and coordination.
- Staffing plan for selected waivers, including training and continuing education.

Purpose of the Project/Statement of Problem and Technical Approach (3)

- Telemedicine
  - Describe unmet needs and how they will be impacted
  - Present detailed plan for using telemedicine
  - Include letters of commitment from distant sites
- Ambulance
  - Describe current arrangements and utilization of ambulance services
  - Assess expected impact of waiver

Purpose of the Project/Statement of Problem and Technical Approach (4)

- Nursing Facility Care
  - Describe unmet need for long term care and justification for additional capacity
  - Describe plans to address safety issues
- Home Health
  - Describe plan for using home health services
  - Calculate average distance between providers and patients
  - Describe status of and need for home health services in the community
  - Propose staffing for home health services

Organizational Capacity/Ability to Implement

Applicants will need to:

- Demonstrate developed relationships and project plans to integrate services with other providers within the community.
- Describe arrangements for coordinating patient transfers and other health services with hospitals outside of the immediate community.
- Include letters of support from the State Medicaid agency - if the applicant's proposal requests changes to Medicaid rules for payment or survey and certification.
- Describe a commitment of administrative resources to execute and complete this project, and to work with CMS and its contractors.

Budget Neutrality Projection

Applicants should:

- Submit an analysis of how its proposed project will be budget neutral and/or achieve cost savings, including:
  - Number of patients that will gain access to services within the community;
  - Cost of these services; and
  - Cost savings from averting unnecessary transfers to out-of-area hospitals and/or avoidable hospitalizations.
- Explain any other sources of cost savings.

Medicaid-related Requirements

The demonstration requires:

- A letter of approval from the State Medicaid Agency for any proposed changes to Medicaid rules for payment or survey and certification.
- That all Medicaid-related costs will be monitored as part of the evaluation.

Medicare Waiver Demonstration Application

- Each applicant is required to fill out the Medicare Waiver Demonstration Application.
- The waiver application allows eligible organizations to participate and apply to the demonstration sponsored by the Centers for Medicare and Medicaid Services.
- This document needs to accompany the submitted application
  - The Medicare Waiver Demonstration Application is available with the other application materials on the CMS website.

FCHIP Webinar #2

- Topic: Budget Neutrality and Vignettes of proposed interventions
- When: March 3, 2014
- Time: 1:30PM – 3:30PM (EST)

Questions

Please direct all questions to:

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