Evaluation of the Community Health Access and Rural Transformation (CHART) Model

Center for Medicare and Medicaid Innovation (Innovation Center)

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Executive Summary

The Community Health Access and Rural Transformation (CHART) Model's implementation across Alabama, Texas, South Dakota, and Washington from 2021 to 2023 showed that rural health care transformation is challenging and not just limited to payment structure. State agencies found that demographic trends such as outmigration, Medicare Advantage growth, and historical provider relationships created barriers to achieving the collaborative care models and cost savings envisioned by the CHART Model. The CMS Innovation Center's success criteria require models to achieve cost-neutral quality improvements, quality-neutral cost reductions, or both quality improvements and cost reductions —benchmarks that proved challenging given the structural impediments rural providers faced. Baseline conditions in rural contexts differ significantly from urban health care markets. Participants reported that health care transformation in rural areas is fundamentally a community development challenge requiring coordination across multiple sectors. Participants noted the benefits of enhanced technical assistance, telemedicine flexibilities, recognition, and desire longer timelines for implementation. The recently authorized Rural Health Transformation (RHT) Program addresses these concerns and empowers states to strengthen rural communities across America by improving healthcare access, quality, and outcomes by transforming the healthcare delivery ecosystem.

Model Description:

The CHART Model was a voluntary model test designed to meet the unique needs of rural communities. CHART tested whether aligned financial incentives, increased operational flexibility, and robust technical support would promote rural healthcare provider's ability to implement healthcare delivery redesign on a broad scale. CHART goals included:

- Increase rural provider's financial sustainability
- Increase beneficiary access to care
- Improve the quality of health care and outcomes

Model Announcement

CHART was announced August 11, 2020 with two tracks, the Community Transformation track and the Accountable Care Organization (ACO) track and intended to run for five years. In February 2022, CMS announced the removal of the ACO Transformation Track. The decision to remove the ACO Transformation Track was primarily due to CMS developing an agency-wide vision and strategy for accountable care, including increasing opportunities for ACO adoption and participation in rural areas. In the fall of 2021, CMS awarded cooperative agreement funding to four entities under the CHART Community Transformation Track: University of Alabama Birmingham, State of South Dakota Department of Social Services, Texas Health and Human Services Commission, and Washington State Healthcare Authority. The awarded entities would have served as Lead Organizations in the respective states of Alabama, South Dakota, Texas, and Washington. Lead Organizations (could include state Medicaid agencies and academic medical centers) would recruit participant hospitals (could include acute care hospitals, critical access hospitals, and rural emergency hospitals). In November 2022, Lead Organizations notified CMS that no hospitals signed up to join the Community Transformation track in the model's first performance year. Due to insufficient hospital participation and stakeholder feedback, CMS made the decision to end CHART early, effective September 30, 2023.

Model Review Performance Period:

October 1, 2021 – September 30, 2023 (Model early termination)

Geographic Scope:

Nationwide eligibility to participate. Model test focused on rural communities in the states of Alabama, South Dakota, Texas, and Washington

Key Terms:

TERM	DEFINITION
ACUTE CARE HOSPITAL	A hospital that provides inpatient medical care and other related services for surgery, acute medical conditions, or injuries (usually for a short-term illness or condition).
ADVISORY COUNCIL	The Advisory Council is a multi-stakeholder organization that would have played an advisory role to the Lead Organization as they carried out their funded activities, such as providing critical feedback in the development and implementation of Transformation Plans and assistance with collaboration efforts with Participant Hospitals, the State Medicaid Agency (SMA), and other key Community stakeholders.
COMMUNITY	The Community is the defined geographic area in which Lead Organizations intended to implement CHART.
COMMUNITY TRANSFORMATION TRACK	The Community Transformation Track includes the following: cooperative agreement funding, operational flexibilities, and the Community Transformation Track APM, which prospectively sets an annual payment amount for a defined set of Eligible Hospital Services for Participant Hospitals.
CRITICAL ACCESS HOSPITAL	A state that has established a Medicare Rural Hospital Flexibility Program may designate certain facilities as Critical Access Hospitals (CAH). CMS will then certify a state-designated facility as a CAH if the facility meets certain requirements. CAHs receive cost-based reimbursement for most Medicare Part A and Part B services. Eligible hospitals must, among other requirements, meet the following conditions to obtain CAH designation: 1. Have 25 or fewer acute care inpatient beds 2. Be located more than 35 miles from another hospital or CAH or 15 miles if mountainous terrain with only secondary roads (some exceptions apply) 3. Maintain an annual average length of stay of 96 hours or less for acute care patients 4. Provide 24/7 emergency care services CAHs are defined in section 1861(mm)(1) of the Social Security Act.

TERM	DEFINITION
LEAD ORGANIZATION	Lead Organization is a CHART Model award recipient under the Community Transformation Track. It is responsible for forming the Advisory Council, recruiting Participant Hospitals, engaging with the SMA, developing and implementing the Transformation Plan, and overseeing the implementation of the Community Transformation Track APM. There can only be one Lead Organization per Community.
PARTICIPANT HOSPITAL	A Participant Hospital is an acute care hospital (defined as a "subsection (d) hospital" in section 1886(d)(1)(B) of the Social Security Act) or CAH.
TRANSFORMATION PLAN	A Transformation Plan is a detailed description of the health care delivery system redesign strategy that will be carried out under the Community Transformation Track of the CHART Model.

Participant Activities Required under CHART

During the Pre-Implementation Period, the four CHART Community Transformation Track Lead Organizations — the University of Alabama at Birmingham, the State of South Dakota Department of Social Services, the Texas Health and Human Services Commission, and the Washington State Healthcare Authority — completed a series of required activities designed to lay the groundwork for community-level healthcare transformation.

Needs Assessment and Asset Mapping. All Lead Organizations successfully submitted their Needs Assessment and Asset Mapping tools, fulfilling this foundational deliverable. The process surfaced challenges that are characteristic of rural healthcare environments, including limited access to care, workforce shortages, and difficulties with staff recruitment, retention, and burnout. Lead Organizations also identified inadequate infrastructure and transportation as persistent barriers, alongside elevated rates of mental health and substance use disorder treatment needs, a significant burden of chronic disease, and populations experiencing substantial health disparities. These findings reflected the complex, interconnected challenges that the CHART Model was designed to address.

Community Transformation Plans. Lead Organizations also met the Community Transformation Plan deliverable, developing strategic priorities tailored to their communities' needs. Across the four organizations, priorities included investments in telemedicine, improved care coordination through partnerships with primary care providers, enhanced data sharing capabilities, behavioral health triage, and mobile integrated

healthcare. Lead Organizations additionally identified opportunities to build long-term capacity through the creation of resource libraries and the offering of training and conferences to support ongoing healthcare innovation.

State Medicaid Agency Engagement. Three of the four Lead Organizations were themselves state Medicaid agencies, ensuring direct alignment between CHART activities and state Medicaid priorities. The fourth Lead Organization, the University of Alabama at Birmingham, maintained regular engagement with the Alabama State Medicaid Agency throughout the Pre-Implementation Period. All four Lead Organizations also engaged consistently with the Center for Medicaid and CHIP Services (CMCS), reflecting a sustained federal-state partnership across the duration of this phase.

Community Partnership Meetings. Each Lead Organization was required to convene an Advisory Council to ensure that community perspectives informed the development and implementation of their healthcare delivery redesign strategies. Advisory Councils included representation from hospitals, payers, beneficiaries or unpaid caregivers, and additional providers. All Lead Organizations fulfilled this requirement, convening their Advisory Councils to discuss model design, implementation timelines, key milestones, and hospital recruitment plans — ensuring that local voices remained central to the transformation process.

Evaluation

In compliance with the CMS Innovation Center's statutory requirement to evaluate the effects of each model, this evaluation report uses a summary of the experiences and lessons learned from the CHART Community Transformation Track implementation. The model ended early and no outcome estimates were generated.

Design

A qualitative approach was employed for evaluation of CHART implementation, utilizing reports and model deliverables from the four Lead Organizations. The reports used for this evaluation included quarterly progress reports, annual progress reports, and final progress reports. Model deliverables used for this evaluation include community transformation plans, needs assessments, asset maps, and feedback shared from the Lead Organization's engaged hospitals and local leaders.

An Analysis of CHART Model Implementation

Lead Organization Motivations to Participate. The four Lead Organizations each pursued participation in CHART for reasons that reflected both their state-specific priorities and the broader challenges facing rural healthcare delivery. Across the cohort, Lead Organizations cited the model's alignment with existing state priorities as a primary motivating factor, particularly its focus on directing investment toward rural hospitals. They were also drawn

to the model's flexibility in care delivery interventions and its potential to support broad healthcare delivery redesign at the community level. Financial stability was another key consideration: the model's bi-weekly payment structure offered a mechanism to stabilize rural hospitals that often operate on thin or negative margins under traditional fee-for-service arrangements. Lead Organizations also identified the model's potential to expand access to and use of telemedicine, its requirement for Medicaid payer alignment — which offered an opportunity to advance state Medicaid goals — and its explicit focus on non-cost-related healthcare challenges, including health disparities, as important factors in their decision to participate.

Hospital Interest. Interest among rural hospitals in the CHART Model was substantial. During the pre-implementation period, Lead Organizations collectively identified 89 hospitals with potential interest in participation. This included 61 hospitals identified by the Texas Health and Human Services Commission, 18 by the University of Alabama at Birmingham, 5 by the South Dakota Department of Social Services, and 5 by the Washington State Health Care Authority. While no hospitals ultimately executed participation agreements — a key factor in the model's early conclusion — the breadth of initial engagement across four states reflects meaningful interest among rural providers for value-based care approaches, with the key caveat that these approaches must be tailored to fit their operating environment. The high level of expressed interest underscores both the relevance of the CHART Model's design to rural hospital needs and the persistent challenges that can impede rural providers from formalizing participation in complex payment reform initiatives.

Implementation Experience. The CHART Model implementation experiences across participating states revealed that rural health care transformation requires addressing fundamental structural challenges that extend far beyond payment model mechanics. The University of Alabama at Birmingham (Alabama) team discovered that "outmigration is the biggest threat to rural Health Equity and the [upstream drivers of health]," identifying a core demographic challenge that undermines the sustainability of any payment reform.[1] This population decline created a cascading effect where state agencies and recruited hospitals shared significant concern associated with the forecasting of the capitated payment amounts (CPAs) and the impact of reconciliation due to the reduced patient volumes and unpredictable patient enrollment shifts. The aforementioned factors made it increasingly difficult for rural hospitals to envision achieving the economies of scale necessary for financial viability under capitated payment arrangements, forcing states to reconsider their assumptions about rural market dynamics and the Innovation Center's success scenarios that require either quality improvements with cost neutrality or cost reductions with quality neutrality.[3]

The complexity of implementing the CPA model emerged as a central challenge across all participating states, with Alabama noting that rural hospitals struggled with "management

of the guaranteed CPA model in lieu of their current financial vulnerabilities."[1] Texas Health and Human Services (Texas) experience emphasized that hospitals needed to "clearly understand the benefits [business case] of participating in the CHART Model" and required "more clarification related to the Medicare CPA (beneficiary [patient] data, limit to downward adjustments, etc.)" to assess financial risks and benefits.[2] The CHART Model's design allowed for operational flexibilities and customized care redesign approaches, as CMS recognized that "a one-size-fits-all approach may not be best for rural communities," yet the rapid growth of Medicare Advantage plans —reaching 46% of rural Medicare patients in Alabama —created unexpected complications for CPA calculations and revenue predictability that the original model design had not fully anticipated.[4]

Historical provider relationships and competitive dynamics within rural communities presented significant barriers to the collaborative care models envisioned in the CHART Model. Alabama's implementation team identified "contradictions between achieving cost savings while expanding rural services for chronic disease management" and noted that "historical conflicts of interest among community providers —including nursing homes, home health agencies, therapy centers, and FQHCs —created barriers to achieving the cost savings and quality outcomes required by participating hospitals."[1] This finding highlighted that rural health care markets, despite their small size, often contained entrenched competitive relationships that required careful navigation and relationship-building before transformation initiatives could succeed, particularly given the Innovation Center's requirement that successful models demonstrate measurable improvements in quality or cost outcomes.[3]

Technology infrastructure and telemedicine capabilities emerged as critical enablers for rural transformation, with Alabama identifying telemedicine as a "common link with other community providers" and recognizing that "CMS Public Health Emergency policies so promulgated for Telemedicine are the cornerstones to accelerate quantifiable progress towards [model goals]."[1] The CHART Model planned for telehealth benefit enhancements that would have waived geographic location requirements and would have made available synchronous and asynchronous telehealth services during the model performance period, this was viewed as providing regulatory flexibility that was considered essential for rural care delivery.[4] The COVID-19 pandemic's regulatory flexibilities for telehealth services provided an unexpected natural experiment that demonstrated the potential for technology-enabled care delivery in rural settings, suggesting that permanent regulatory flexibility could be crucial for achieving the Innovation Center's success criteria in rural contexts.

The health needs assessment requirements in the CHART Model revealed the interconnected nature of rural health challenges, extending well beyond traditional health care delivery systems. As documented in the needs assessment templates from Texas and the Washington Healthcare Authority (Washington), states were required to evaluate

community health needs and identify "partnerships with community organizations available to support screening and referral for [upstream drivers of health]."[5,6] This comprehensive approach helped states understand that successful rural health care transformation required addressing housing, transportation, food security, and economic development challenges that directly impacted health outcomes and health care utilization patterns, creating a more complex pathway to achieving the quality and cost improvements required.

Administrative burden and technical assistance needs proved to be significant implementation challenges that required sustained support from the Innovation Center and state agencies. Texas specifically requested that "CMS develop communication materials to educate and support interested hospitals (including financial consultants and clinicians) with making informed participation decisions while also providing an introduction on opportunities in value-based care. Texas and other states also recommended that "CMS simplify the CPA calculation and provide more transparency in its calculation."[2] Another barrier toward participation was the perception by states and interested hospitals surrounding the Model's reporting requirements. For example, the quarterly progress reporting requirements, while necessary for program oversight, were reported to create substantial documentation and compliance burdens. Additionally, state agencies shared that interested hospitals expressed significant concern regarding the Model's reporting requirements, which were perceived as adding administrative burden when hospitals already lacked dedicated administrative staff for complex alternative payment models, potentially hindering their ability to focus on the care transformation activities necessary to meet Innovation Center success benchmarks.

Quality measurement and outcome tracking in rural settings posed unique challenges that required adapting traditional quality metrics designed for larger, urban health care systems. The CHART Model's focus on improving quality of care and health outcomes for rural patients required states to develop measurement approaches that could account for the different patient populations, service mix, and resource constraints characteristic of rural providers.[5,6] States discovered that meaningful quality improvement in rural settings often required different benchmarks, risk-adjustment methodologies, and improvement strategies than those used in urban markets, raising questions about whether the Innovation Center's standard success criteria adequately account for the unique baseline conditions and improvement trajectories in rural health care settings.

The CHART Model experience indicates that sustainable rural health care transformation requires a systems approach. The recently authorized Rural Health Transformation (RHT) Program (Section 71401 of Public Law 119-21) empowers states to strengthen rural communities across America by improving healthcare access, quality, and outcomes by transforming the healthcare delivery ecosystem. Through innovative system-wide change, the RHT Program invests in the rural healthcare delivery ecosystem for future generations.

References

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