Community Health Access and Rural Transformation (CHART) Model

Model Overview Webinar

The Centers for Medicare & Medicaid Services (CMS)
Innovation Center

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Today's Presenters

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Agenda

This webinar will provide an introduction of the CHART Model and its two tracks. The following topics will be discussed:

1. The CMS Innovation Center Introduction
2. Health Care in Rural America
3. CHART Model Goals and Design
4. Timeline and Next Steps
5. Q&A

The CMS Innovation Center

The CMS Innovation Center

The CMS Innovation Center Statute:

> The purpose of the [Center] is to test innovative payment and service delivery models to reduce program expenditures…while preserving or enhancing the quality of care furnished to individuals under such titles.

The Innovation Center was established by section 1115A of the Social Security Act (the "Act") (as added by section 3021 of the Affordable Care Act).

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The CMS Innovation Center (*continued*)

If a model meets **one of the three below criteria** and other statutory prerequisites, the statute allows the Secretary to **expand the duration and scope of a model** through rulemaking.

Scenarios for success from the statute

Scenario One	Scenario Two	Scenario Three
⬆ Quality improves	➡ Quality neutral	⬆ Quality improves
➡ Cost neutral	⬇ Cost reduced	⬇ Cost reduced
		Best Case

Health Care in Rural America

Health Care in Rural America - People

1 in 5 Americans live in rural areas

Americans living in rural areas face numerous health disparities compared to those living in urban areas.

Rural Populations:

- Tend to have **worse health outcomes** and more likely to die from preventable causes.
- Are **more likely to experience adverse social determinates of health** that impact health.
- Have **high rates of substance use disorders**, including alcohol use disorder and tobacco use disorder, **and significant behavioral health needs**.

Health Care in Rural America - Providers

Rural health providers are struggling even as many rural residents have worsening health and need more care.

Rural markets are more likely to be subject to challenges including:

- Hospital and other facility closures
- Financial barriers
- Workforce constraints

Health Care in Rural America – Service Delivery

Rural health care systems are struggling, which limits access to care and patient choice.

- Distance/transportation challenges
- Limited plan choice
- Narrow health plan networks

The current volume-based system will not address these issues. The state of rural health care today:

1. Needs a community-based solution that reimagines service delivery, is customizable to fit each unique community's needs, addresses the financial instability that many health care providers face, and incorporates multiple payers.
2. The solution should build on previous successes, and should support health care providers across the community that are adopting value-based models.

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Community Health Access and Rural Transformation (CHART) Model

Introduction and Model Goals

The Community Health Access and Rural Transformation (CHART) Model is a voluntary model that will test whether **aligned financial incentives, operational & regulatory flexibility**, and **robust technical support** will help rural providers transform care on a broad scale to achieve the following goals:

Improve access to care in rural areas	**Improve quality of care and health outcomes for rural beneficiaries**	**Increase adoption of alternative payment models (APMs) among rural providers**	**Improve rural provider financial sustainability**

CHART Model Theory of Change

The CHART Model creates a pathway for providers, purchasers, and payers to invest collectively in improving access, quality, and the economics of rural health care delivery. The Model will drive change through **3 core elements**:

UPFRONT FUNDING WITH VALUE-BASED PAYMENT

Provide seed money for upfront investment and introduce two value-based APM choices for planning in care redesign and care coordination:

1. Capitated payments to stabilize hospital financing and incent community-based, preventive care
2. Advance payments to accountable care organizations (ACOs) to improve care for rural beneficiaries

OPERATIONAL FLEXIBILITIES

Relieve regulatory burden, emphasize high-value services, support providers in beneficiary care management, and catalyze care transformation

TECHNICAL & LEARNING SYSTEM SUPPORT

Enable both payment and clinical transformation. The CHART Model's flexible funding provides for technical assistance and learning diffusion opportunities for transformation

Participation Options

The CHART Model consists of two tracks for rural communities to implement APMs to improve access to high quality care and reduce costs.

Cooperative Agreement Award Recipients of the Community Transformation Track may not participate in the ACO Transformation Track

Community Transformation Track

Communities receive **upfront funding**, **financial flexibilities** through a predictable capitated payment amount (CPA), and **operational flexibilities** through benefit enhancements and beneficiary engagement incentives.

This track builds on lessons learned from:

- *Maryland Total Cost of Care Model*
- *Pennsylvania Rural Health Model*

ACO Transformation Track

Rural ACOs receive **advance shared savings payments** to participate in one-sided or two-sided risk arrangements in the Medicare Shared Savings Program (Shared Savings Program).

This track builds on lessons learned from:

- *ACO Investment Model (AIM)*

Community Transformation Track

Participation Highlights

Operational flexibilities under the Community Transformation Track may be provided by CMS authority under Section 1115A of the Act to waive certain Medicare payment rules solely as may be necessary to test the Model.

Model Design Flexibilities

- Flexibility in amount of Cooperative Agreement funding
- Flexibility in Cooperative Agreement funding use
- Flexibility in applying discounts
- Flexibility for service line adjustments
- Flexibility to include or exclude outliers
- Flexibility in care transformation strategy

CMMI Waivers

- Medicare and Critical Access Hospital (CAH) Conditions of Payment or Conditions of Participation (CoP) waivers
- CAH 96-hour certification rule
- Care management home visits
- Telehealth flexibilities
- SNF 3-day rule waiver
- Gift card reward for chronic disease management programs
- Cost sharing support for Part B service
- Transportation

Operational flexibilities further emphasize high-value services and support the ability of Participant Hospitals to manage the care of rural beneficiaries.

Award Recipient Eligibility

CMS anticipates selecting up to 15 Award Recipients (**Lead Organizations**) for the Community Transformation Track.

Examples of entities eligible to apply to be a Lead Organization **include but are not limited to**:

- State Medicaid Agencies (SMAs)
- State Offices of Rural Health
- Local Public Health Departments
- Independent Practice Associations
- Academic Medical Centers
- Health Systems

Each Lead Organization must delineate the boundaries of its "Community," which **must meet the following criteria**:

Encompass **either** (1) a single county or census tract; **or** (2) a set of contiguous or non-contiguous counties or census tracts. Each county or census tract must be classified as rural, as defined by the Federal Office of Rural Health Policy's grant program eligibility criterion.

Include **at least** 10,000 Medicare Fee-for-Service (FFS) beneficiaries with a primary residence located within the Community.

Funding and Timeline

CMS will award cooperative agreements of up to $5 million to each Lead Organization on behalf of their respective Community.

During the Pre-Implementation Period, each Lead Organization will work with community partners to develop a strategy to implement health care delivery system redesign.

During each of the six Performance Periods, Lead Organizations and Participant Hospitals will implement their Transformation Plan.

All cooperative agreement funding is tied to performance requirements including but not limited to the following:

Funding Amount	Performance Requirements
Up to $2 million for the Pre-Implementation Period	Awarded upon selection into the Community Transformation Track and acceptance of the Terms & Conditions.
Up to $500,000 per Performance Period	Awarded upon CMS approval of Transformation Plans and a sufficient amount of Participant Hospitals' revenue in a CPA arrangement in each Performance Period.

Transformation Plan

The Transformation Plan is a detailed description of the care delivery transformation that a Community will undergo. Lead organizations and community partners will **develop the plan** during the pre-implementation period, **implement the plan** during the performance periods, and **update the plan** annually.

Transformation Plans require:

Assessment

An assessment of the existing state of the Community (assets and areas for improvement)

Strategy

A description of the service delivery and payment redesign strategy

The CHART Model Team will review and provide feedback on all Transformation Plans on an annual basis.

Community Partners

Each Lead Organization will form an **Advisory Council**, recruit **Participant Hospitals**, engage the **SMA and Aligned Payers**, and develop and implement the Transformation Plan.

	Advisory Council	Participant Hospitals	SMA† & Aligned Payers
Responsibilities*	• Represent the Community's perspective and collectively advise the Lead Organization as they carry out their required activities • Consult on development of, and modifications to, Transformation Plans • Support hospital and payer recruitment • Advise on development of arrangements with payers	• Independently decide whether to participate • Implement the Model according to the Transformation Plan	Adhere to *following **3*** alignment criteria: (1) financial (2) operational (3) quality

*Note that this list of responsibilities is not exhaustive. The Notice of Funding Opportunity (NOFO) will provide the full list of activities.
† CMS will specifically require Medicaid participation.

Advisory Council

The Advisory Council will advise the Lead Organization on activities including, but not limited to, developing and updating Transformation Plans, hospital and payer recruitment, developing arrangements with Aligned Payers governing APM alignment and data-sharing, monitoring the progress of the Model, and identifying any necessary changes.

While specific membership will differ by Community, the Advisory Council **must include the following representatives:**

- The SMA (if the Lead Organization is not the SMA) even if the SMA is physically located outside of the Community
- At least one Participant Hospital
- At least one Aligned Payer
- At least one beneficiary or caregiver

The Advisory Council must include a **representative from at least three distinct entities** from the following list:

- Primary care provider
- Health care provider of substance use disorder treatment and/or mental health services
- Additional Participant Hospital
- State Office of Rural Health
- Additional Aligned Payer
- Community stakeholder group
- Long-term care facility, home health provider, or hospice provider
- An Indian Health Service (IHS) facility or local tribal community, as applicable
- The U.S. Department of Veterans Affairs (VA)

Participant Hospital Eligibility

To participate in the Community Transformation Track, a Participant Hospital must be an acute care hospital (defined as a "subsection (d) hospital") or Critical Access Hospital that meets **at least one of the below requirements**:

1

Located within the Community and **receives at least 20%** of its eligible Medicare FFS revenue from services provided to residents of the Community

- or -

2

Regardless of facility location, provides services to residents of the Community that in **aggregate account for at least 20%** of the eligible Medicare FFS expenditures of the Community.

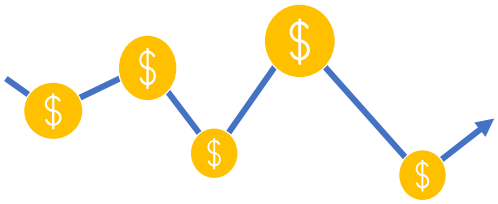
Organizations that are not eligible to participate as a Participant Hospital:

- Federally Qualified Health Centers (FQHCs)
- Rural Health Clinics (RHCs)
- Facilities providing dialysis services exclusively
- Stand-alone ambulatory surgery centers
- Stand-alone skilled nursing facilities (SNFs)
- Organizations that provide home health services exclusively

Capitated Payment Amount (CPA)

CMS will replace Participant Hospitals' FFS claim reimbursement with bi-weekly payments that equal the annual CPA over the course of the Performance Period.

FFS claims reimbursement



Bi-weekly payments provide a predictable funding stream

Capitated payments

CMS will administer each Participant Hospital's CPA through **5 steps:**

1	2	3	4	5
Determine baseline revenue using historical expenditures	Apply prospective adjustments	Apply a discount	Apply mid-year adjustments	Apply end-of-year adjustments

Aligned Payers

Each Lead Organization must secure multi-payer alignment for its Community. Aligned Payers must meet three criteria to ensure as much revenue as possible is included in the APM such that transformation is further incentivized as a rational business decision for Participant Hospitals.

Medicaid participation is required and commercial payer participation is recommended

Alignment Criteria

Criteria	Definition
Financial alignment	The payer offers a financial methodology that aligns with the selected APM.
Operational alignment	The payer offers changes to provider contracts or benefits to support care transformation
Quality alignment	To the extent practicable, payer uses the same set of quality measures to adjust payments or track performance

Medicaid Alignment

Each Lead Organization must secure Medicaid participation that meets the following targets for percent of Medicaid revenue that a Community collectively receives through the CPA arrangement.

Year of participation in the APM	Community Transformation Track Medicaid Target *(% of each Participant Hospital's Medicaid revenue under a CPA arrangement)*
Performance Period 1	0%
Performance Period 2	50%
Performance Period 3	60%
Performance Period 4	75%
Performance Period 5	75%
Performance Period 6	75%

Quality Strategy

The CHART Model will focus on measures that target quality at both the Community and Participant Hospital levels.

Access to High Quality Care (*Required Measures*)

Model Priority: Chronic Conditions

Measure: Inpatient and emergency department visits for ambulatory care-sensitive conditions

Model Priority: Readmissions

Measure: Hospital-Wide All-Cause Unplanned Readmissions

Model Priority: Patient Experience

Measure: Hospital Consumer Assessment of Healthcare Providers and Systems

Population Health (*Measures Chosen by Participants)*

Participants will **select 3 measures** from *a menu of options in 4* distinct population health domains*:*

1. Substance Use
2. Chronic Conditions
3. Maternal Health
4. Prevention

ACO Transformation Track

Participant Eligibility

CMS anticipates selecting up to 20 ACOs to participate in the ACO Transformation Track. Under this Track, CMS will provide advanced shared savings payments to encourage these ACOs to participate in the **Shared Savings Program** and quickly advance to two-sided risk models. This track will be of interest to rural providers that want to take total cost of care accountability for their communities.

Each CHART ACO must meet the following eligibility criteria to participate in this track:

1. **Rurality Requirement**: A majority of ACO providers/suppliers are **located within rural counties or census tracts**

2. **Shared Savings Program Participation**: Must start **a new 5-year agreement period** in the Shared Savings Program at the start of the Model

Preference will be given to ACOs based on the proportion of their assigned beneficiaries residing in rural areas.

CMS will outline additional eligibility requirements in the forthcoming Request for Application (RFA).

Shared Savings Program Overview

The Shared Savings Program was established in 2012 and is an important innovation for moving CMS' payment systems away from paying for volume and towards paying for value and outcomes.

It is a voluntary national program that encourages **groups of doctors, hospitals, and other health care providers** to come together as an ACO to lower growth in expenditures and improve quality.

- An ACO agrees to be held accountable for the **quality, cost, and experience of care** of an assigned Medicare FFS beneficiary population.
- ACOs that successfully meet quality and savings requirements share a percentage of the achieved savings with Medicare. **ACOs under two-sided models are accountable for sharing in losses**.

Currently over 11.2 million beneficiaries in FFS Medicare (of the 38.5 million total FFS beneficiaries) receive care from providers participating in a Medicare ACO.

Advanced Shared Savings Payments

The ACO Transformation Track incents participants to move from shared savings-only arrangements to greater financial accountability for both shared savings and shared losses, while also maintaining or improving quality of care.

ACOs will be eligible to receive advanced shared savings payments through **two mechanisms**:

1

One-time upfront payment to participate in 5-year Shared Savings Program agreement period

2

Prospective per beneficiary per month (PBPM) payment for up to 24 months (two years)

Each CHART ACO's one-time upfront payment and PBPM payment will vary based on **the level of risk** that it accepts in the Shared Savings Program and **the number of rural beneficiaries assigned to it** based on the Shared Savings Program assignment methodology, up to a maximum of 10,000 beneficiaries.

Repayment of Advanced Shared Savings Payments

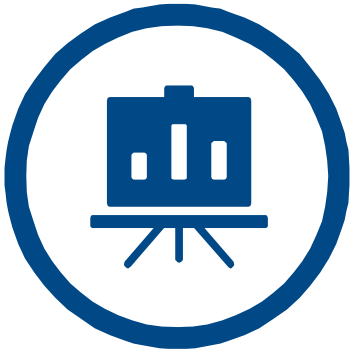
CMS will seek repayment of advance shared savings from CHART ACOs by reducing the amount of any shared savings payments that are owed to the CHART ACO upon annual reconciliation in the Shared Savings Program.

- The amount of a CHART ACO's balance deducted in this way **will not be greater than the CHART ACO's earned shared savings amount** for a given performance year.

- For example: If the CHART ACO **does not generate sufficient shared savings** for performance years 1 or 2 to fully repay advanced shared savings payments received in those performance years, CMS will **recover the balance** from shared savings earned in the **subsequent performance years**

CMS will pursue full recovery of advanced shared savings payments from any CHART ACO that does not complete its initial Shared Savings Program agreement period or the full term of the CHART participation agreement.

Audience Poll



Which track is your organization interested in applying to or participating in?

a) Community Transformation Track
b) Accountable Care Organization Transformation Track
c) Both tracks*
d) Not interested in applying/participating
e) Unsure

*The CHART Model will not allow participation overlap between the Community Transformation Track and the ACO Transformation Track.

Timeline and Next Steps

Model Timeline

The Community Transformation Track will begin July 2021 with a pre-implementation period, and the ACO Transformation Track will begin January 2022.

Milestone	Approximate Date*	
	Community Transformation Track	ACO Transformation Track
NOFO / RFA released / Application portal opens	Summer 2020 (NOFO)	Spring 2021 (RFA)
Application deadline	Late Winter 2021	Summer 2021
Participant selection	Spring 2021	Fall 2021
Pre-implementation period	July 2021 – June 2022	N/A
Performance periods	July 2022 – June 2028	Jan 2022 – Dec 2026

*Dates are subject to change.

Next Steps

Depending on the track your organization is interested in, below are some possible next steps for you to take.

- Seek opportunities for **community partnership** and gauge interest from stakeholders such as providers, payers, and potential Advisory Council members
- Engage **SMA**
- Identify **regional and local health priorities**
- Stay tuned for additional **CHART Model resources** that will be posted on our webpage and shared through our CHART Listserv
- Stay tuned for **NOFO release** and our **Application Support Office Hour** in Fall 2020

Questions?

CHART Model Q&A

How has the Coronavirus disease 2019 impacted the CHART Model?

The Coronavirus disease 2019 public health emergency (PHE) has exacerbated the needs of rural communities, such as the need for better access to healthcare and greater financial stability for health care providers.

Financial distress is the strongest driver for hospital closure. During the PHE, hospitals have curtailed elective medical procedures and limited access to in-person care. Rural hospitals may be unable or struggle to operate under the traditional fee-for-service reimbursement structure.

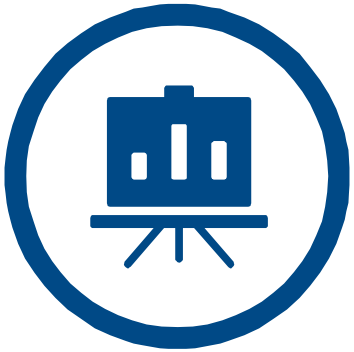
The CHART Model moves rural health care providers to APMs that pay for performance, rather than volume. With this framework, CHART will provide rural communities with the tools to succeed in maintaining or improving access to care and improving financial sustainability for health care providers both during and after the PHE.

CHART Model Open Q&A

Open Q&A

Please **submit questions via the Q&A pod** to the right of your screen.
Specific questions about your organization can be submitted to
CHARTmodel@cms.hhs.gov

Audience Poll



What other CHART Model topics do you want to learn more about?

a) Eligibility
b) Payment
c) Benefit enhancements
d) Application
e) Quality measurement
f) Model overlap

Additional Resources

Resources and Contact Info

For more information about the CHART Model and to stay up to date on upcoming model events:

Visit

https://innovation.cms.gov/innovation-models/chart-model

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