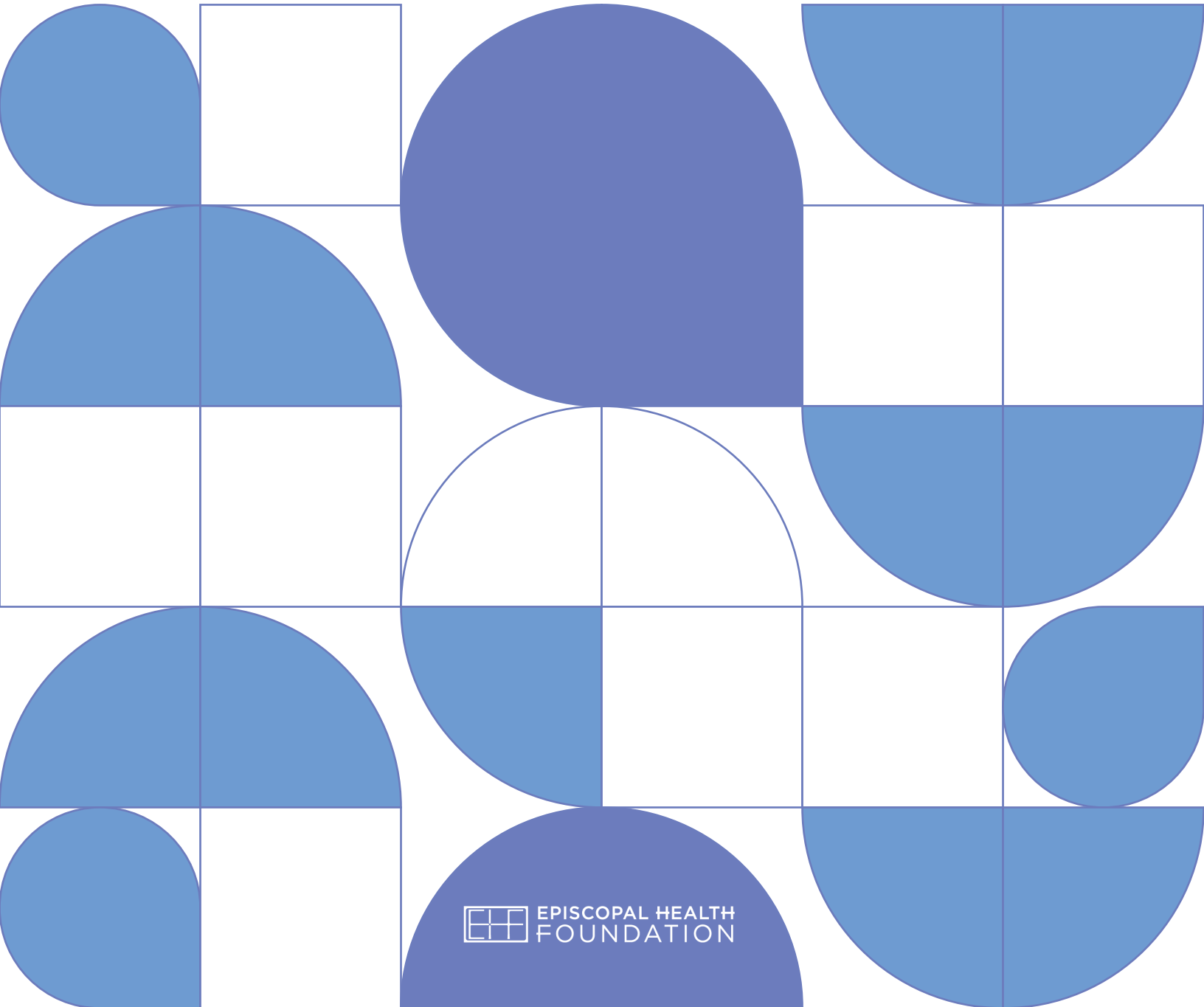
Rural Health Innovations
National Rural Health Resource Center

# Texas Community Health Access and Rural Transformation (CHART) Model Review



## This report was funded by

Episcopal Health Foundation

## Prepared by

## Acknowledgements

NORC Walsh Center for Rural Health Analysis (NORC)

Texas Health and Human Services Commission

Texas Organization of Rural and Community Hospitals

All of the interviewees in Texas and nationally who expressed their knowledge, experiences, and perspectives included in this review.

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# Executive

In September 2023, Rural Health Innovations (RHI) was contracted by the Episcopal Health Foundation (EHF) to conduct a review of the Community Health Access and Rural Transformation (CHART) Community Transformation Track Model design and rollout in Texas. This model introduced restructured financial arrangements for hospitals to utilize operational and regulatory flexibility to realign how they coordinate and provide care to address health disparities. The review by RHI provided an objective assessment of the Texas CHART model awarded by the Centers for Medicare and Medicaid Innovation (CMMI). This review was important due to the discontinuation of the Community Transformation Track by CMMI in 2023 due to a lack of hospital engagement nationally.

RHI's methodology included a high-level overview of CMMI initiatives in practice in rural communities through a literature review, a review of the Texas CHART Model transformation plan design and communications with hospitals and partners, and an analysis of the status of Texas hospital finances in 2022. Finally, thirteen key informant interviews were performed to identify the disrupters that impacted CHART adoption in Texas. RHI then developed policy, model, lead organization, and hospital recommendations.

In Texas, the Health and Human Services Commission (HHSC) was awarded the cooperative agreement in September 2021 as the lead to coordinate efforts to preserve access to care and ensure all stakeholders' needs (hospitals and state Medicaid agency) were accounted for in the development and implementation of the transformation plan. The operational and regulatory flexibility of CHART intended to increase financial stability by providing upfront and predictable capitated payments for hospitals that incentivize the community's approach to care. It had a high focus on quality and population health outcomes in addition to expanding telehealth. Through October 2022, HHSC recruited 61 hospitals potentially interested to participate in the CHART Model. HHSC's recruiting efforts included frequent communication with hospitals and stakeholders as well as developing and posting several resource documents to their website. HHSC convened an

Advisory Committee with payors and EHF committed funding for technical assistance to hospitals. Despite these efforts, the potential waivers that would drive a proactive approach to care while adapting delivery and the predicable funding as Texas hospitals faced low operating margins, limited liquidity and market share, and high levels of uncompensated care, several negative disrupters occurred that influenced implementation of CHART in 2023. These included the rapid time to commit with a lack of hospital capacity for infrastructure changes, a complicated capitated payment amount for Medicare beneficiaries that was not sustainable with the increasing Medicare Advantage penetration, the uncertainty of the Medicaid Managed Care Organization participation, and the perspective that financial stability would decrease.

RHI identified several policy and education recommendations for consideration in future value-based models with suggestions for state lead organizations and rural providers to prepare and participate. Successful implementation of a rural value-based payment model requires a tiered approach. First models need a rural relevant design on the front end; a trusted state organization for communication, engagement of partners and payors, and technical assistance; and all health care provider types need to participate with knowledge and experience in value-based payment. Health care organizations, especially rural hospitals, need to be ready for change with financial stability, visionary leadership, and a change ready culture with network or system affiliation for the supported infrastructure and risk.

# Introduction

Rural Health Innovations (RHI), in partnership with the National Rural Health Resource Center (The Center), was contracted by the Episcopal Health Foundation (EHF) to conduct an assessment of the Texas Community Health Access and Rural Transformation (CHART) Community Transformation Track Model design and lack of implementation. This model introduced restructured financial arrangements for hospitals to utilize operational and regulatory flexibility to realign how they coordinate and provide care to address health disparities. An objective review of the Texas CHART program, awarded by the Centers for Medicare and Medicaid (CMS) Innovation Center, is especially important due to low hospital engagement and discontinuation of the Community Transformation Track by the CMS Innovation Center in 2023. An objective review provides forward thinking policy and program recommendations and prepares EHF, Texas hospitals, and communities with strategies to inform future initiatives for value-based care and payment.

In 2019, the American Hospital Association's "Rural Report: Challenges Facing Rural Communities and the Roadmap to Ensure Local Access to High-Quality, Affordable Care" noted that "As the health care industry engages in its most significant transformation to date, many hospitals are fighting to survive."[1] Accordingly, small rural hospitals (SRH) face persistent challenges, including low financial margins, workforce shortages, and geographic isolation. Even so, CMS, the primary payer for SRHs, is moving towards value-based care (VBC) that requires quality care, efficiency, financial stability for risk, and a focus on patient outcomes. The transformation of health care and payment in rural communities is important to advance equitable access to the VBC outcomes. Although participation in CMS Advanced Payment Models (APM) is occurring among critical access

[1] American Hospital Association. (2019). Rural Report: Challenges Facing Rural Communities and the Roadmap to Ensure Local Access to High-quality, Affordable Care [e-book]. https://www.aha.org/system/files/2019-02/rural-report-2019.pdf

hospitals (CAHs), as of January 2024, CMS reported that 513 CAHs (38%) were participating in a Medicare Shared Savings Program Accountable Care Organization (ACO).[2] These numbers represent an increase of 108 participating CAHs in 2021 (up from 405). In January 2024 the total number of ACOs in the country was 480, an increase of three since 2021. Through direct technical assistance with hundreds of SRHs via US Department of Health and Human Services programs over the past 10 years, The Center finds that maintaining financial stability is a key element in transitioning to VBC.

RHI's objective review methodology included a high-level overview of CMMI initiatives in practice in rural communities through a literature review. In addition, RHI conducted a review of the Texas CHART Model transformation plan design and communications with hospitals and partners, and analyzed the status of Texas hospital finances in 2022. Finally, thirteen key informant interviews were performed with 17 individuals, seven in Austin, Texas, to identify the disrupters that impacted CHART adoption in Texas. Further details of the methodology for the review are provided in Appendix A. Following the analysis of the environmental scan and interviews RHI developed policy, program, and hospital recommendations. The objective review findings are presented in the remainder of this report.

# Environmental Scan

## Literature Review

The literature review provided a framework for testing some assumptions and discovering new information. Literature review findings were used for identification of disrupters to

[2] CMS. 2024 Shared Savings Program Fact Facts. 2024_Kickoff_Rollout-Shared_Savings_Program_Fast_Facts.pdf (cms.gov)

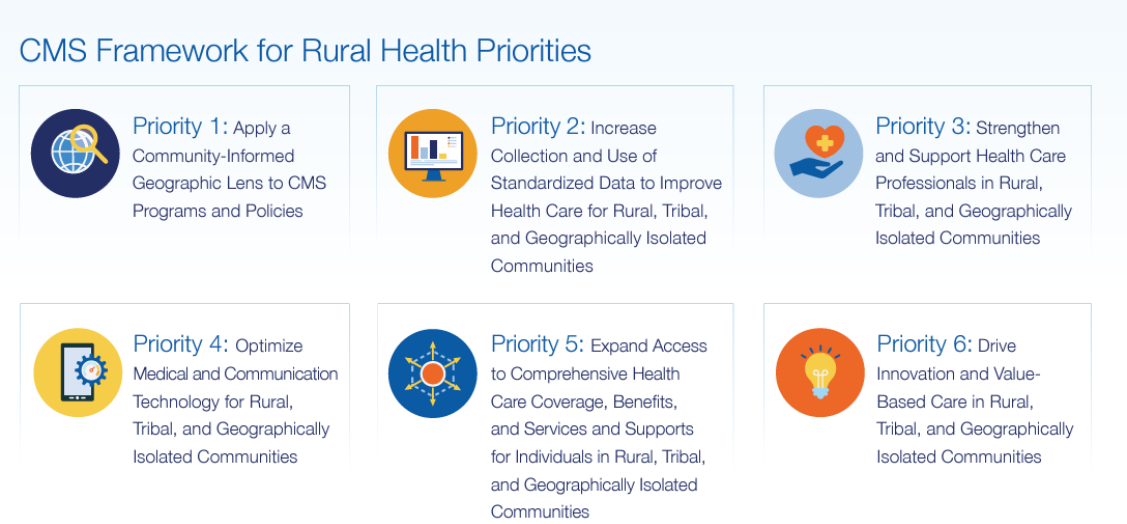
VBC for rural providers to ensure uniform and shared understanding of the current state of health care models.

## Rural Health at the Centers for Medicare and Medicaid (CMS) Innovation Center

Rural health is one the focus areas in the Health Equity Programs of the CMS Office of Minority Health. Since 2023, under the rural health focus CMS uses a framework for advancing health care in rural, tribal, and geographical isolated communities.[3] As illustrated in Figure 1, there are six focused priority areas to improve quality, access, and outcomes, which were developed with the input of individuals with lived experience receiving or supporting the delivery of health care services in rural areas. CMS is using this input to better inform the needs and impacts of its programs and policies.

[3] Centers for Medicare and Medicaid. "CMS Framework for Advancing Health Care in Rural, Tribal, and Geographically Isolated Communities" November 2022.

**Figure 1. CMS Framework for Rural Health Priorities**



[4]

These six rural health priorities are reflected in some of the CMS Innovation Center Models summarized below. The purpose of the CMS Innovation Center is to "develop and test health care payment and service delivery Models to improve patient care, lower costs, and align payment systems to promote patient-centered practices" with a vision of *A health system that achieves equitable outcomes through high quality, affordable, person-centered care.* The Congressional direction to improve health care quality and reduce costs in Medicare, Medicaid, and the Children's Health Insurance Program in new ways began in 2010.[5]

## Community Health Access and Rural Transformation (CHART) Model

The Community Transformation Track of CHART was a specific rural Model developed by the CMS Innovation Center in 2021 and awarded in 2022. It was designed to allow innovative financial arrangements for hospitals to utilize operational and regulatory

[4] Ibid
[5] Centers for Medicare and Medicaid. "About the CMS Innovation Center | CMS". Accessed 4 March 2024.

flexibility to realign how they coordinate and provide care to address health disparities.[6] There were four statewide cooperative agreements awarded through the pre-implementation period of December 31, 2022. The first performance period was to begin January 1, 2023, and last through December 31, 2028, however the program was cancelled by the Innovation Center in September 2023 due to lack of hospital participation.

The operational and regulatory flexibility of CHART intended to increase financial stability by providing upfront and predictable capitated payments that incentivized the community's approach to care. It had a high focus on quality and patient outcomes. Waivers were provided to allow flexibility in regulatory and operational efficiencies that would drive a proactive approach to care while adapting delivery. In addition, CHART offered services to support and increase access to services that address social drivers of health (SDoH). The cooperative agreements provided a year of funding to the lead agency for planning and establishment of infrastructure such as funding to recruit hospitals, develop a community Transformation Plan, and engage the state Medicaid agency and other aligned payers. CHART required a community lead organization with a role of coordinating efforts across the state or community to safeguard access to care and ensure the needs of all stakeholders were heard and accounted for in the development and implementation of the transformation plan. Participating hospitals were to receive a predictable capitated payment amount (CPA) and opportunities for operation and regulatory flexibilities. This CPA would replace the hospital's fee-for-service (FFS) payments. It was CHART's intention that by performance year two, each lead organization would include payer alignment with the State Medicaid Agency with encouragement to include commercial payers too, but not required.

[6] Mitchell, Meller, Nostrant. Center for Medicare & Medicaid Innovation initiatives to address rural health and health disparities. National Rural Association Policy Brief, February 2023. NRHA-Policy-Brief-Final-CMMI.pdf (ruralhealth.us)

The intended benefits of CHART included that it was dedicated to rural providers and their communities who sought a proactive approach to population health. It allowed options on how the lead organizations could establish a geographic region. The goal for CHART was to support improved health outcomes that are in line with CMS/CMMI's strategic focus areas and include State Medicaid agencies. This would allow for enhanced coordination of services through Medicare and/or Medicaid to address a wider range of SDoH. This Model only included the capitated payments for hospitals. Primary care, specialty care, behavioral health, and community service providers were not included in the CPA process or formula.

## Pennsylvania Rural Health Model (PARHM) Summary

Together, CMS and the Pennsylvania Department of Health developed the Pennsylvania Rural Health Model (PARHM). PARHM's purpose is to test if by receiving monthly all payer global budget payments, participating rural hospitals will invest in resources, coordination, and/or infrastructure to improve quality and preventive care to their target populations.[7] This eight-year Model began in January 2018 and concludes in December 2024.Critical Access and acute care hospitals located in rural Pennsylvania with Medicare, Medicaid, and Commercial Payors are eligible to participate in this Model. Rural is defined by the Pennsylvania General Assembly as a county with less than 284 people per square mile. Participating hospitals are required to create a Rural Hospital Transformation Plan that describes their approach to use the monthly payment to improve health outcomes, while decreasing the growth of inpatient and outpatient hospital expenses for their target population all the while sustaining and/or improving the financial stability of their organization. During the first five years, Pennsylvania received payment from CMS to recruit and sign participation agreements with hospitals and develop Rural Hospital Transformation Plans. The monthly global budget payments began in year two, or 2019,

[7] CMS. "Pennsylvania Rural Health Model (PARHM) Evaluation of Performance Years 1-3 (2019-2021)". 2023. Accessed 15 December 2023. Findings at a Glance Full Report

and continue through year seven, or 2024. According to the report published in December 2023 the goals, outcomes, and transformation price areas include:

PARMH Goals

- Have 30 eligible hospitals participate
- Intended to have 75 percent of participating hospitals eligible revenue come from global budget by 2019 and 90 percent for later performance years
- Have hospital spending (across all payers) for inpatient and outpatient services per resident cap at 3.8% (Pennsylvania gross state product growth 1997-2015) growth
- Save $35 million in Medicare hospital savings from participants across all seven years of the program

Key Components - Transformation Practice areas

- Care management focused on chronic illnesses
- Strategies to improve access to primary care, wellness care, emergency and specialty care
- Behavioral health and substance use program implementation, offer increased services and training or education programs
- Plans created to improve operational efficiency

Outcomes (through 2021)

- 18 hospitals are participating
- Six payors (inclusive of Medicare fee-for-services) participating
- Spending and utilization trends started before but continued in implementation period
- Spending on and use of inpatient and outpatient global budget services decreased in Medicare fee for service and Medicaid/Chip populations in participating hospital market areas
- Participating hospitals had improvements to financial sustainability metrics (total and operating margins and liquidity)

## Maryland Total Cost of Care (MD TCOC) Model

The Maryland Total Cost of Care (MD TCOC) Model is built upon the existing Maryland All Payer Model.

The Maryland All Payer Model began in 2014 with an all-payer global budget for urban and rural hospitals in the state. The state was fully at risk for Medicare beneficiaries. When the MD TCOC Model began in 2019 as a state led initiative, Maryland took on more ownership

of cost and quality. With MD TCOC incentives were expanded with support to engage more provider types in care transformation. The MD TCOC Model included Primary Care Practice transformation through the Maryland primary care program (MD PCP) in addition to the all-payer global budget for hospitals. By including these other provider types, this Model supports person-centered care redesign and provided new tools and resources for providers to better meet the needs of complex patients. [8] MD TOCO has an eight-year performance period (2019-December 2026). In 2023, MD TCOC introduced an additional track to increase accountability with primary care providers (PCPs) to include upside and downside risk to participating PCPs. There were 52 urban and rural hospitals that participated in the Model. The majority (85%) participated in an episode incentive program, called Outcomes-based credits. As of 2021, 27% (524) of all PCP participated in MDPCP.

Maryland Total Cost of Care (MD TCOC) Goals

- Across all payors, hospital cost growth per capita must not be greater than 3.58% each year
- Maryland committed to save 300 million in Medicare Parts A & B by 2023
- Federal level will provide/invest in primary care and delivery innovation
- Providers will leverage the activities and Federal programs to align the services and participation under this Model to improve outcomes and coordination of care
- Maryland will have aggressive quality of care and population health goals

[8] Rotter, J, et al. "Evaluation of the Maryland Total Cost of Care Model: Quantitative-Only Report for the Model's First Three Years (2019 to 2021). 2022. MD_TCOC_Quantitative_Report_first_three_years.pdf (cms.gov)

Key Components

- Hospitals receive a global based payment - population based payment amount to cover all hospital services throughout the year
- Care redesign allows hospitals to provide incentive payments to non-hospital providers who partner and collaborate with the hospital. The incentive is paid only when and if the hospital receives savings under the fixed global payment. The incentive cannot be greater than the savings
- Maryland primary care providers and federally qualified health centers (FQHCs) receive an additional per beneficiary per month payment from CMS to cover care management. This is to provide advanced primary care services

Outcomes

- Many of the target outcomes improved during the first three years (2019 – 2021)
- Total Medicare spending decreased because hospital spending decreased. These decreases were greater than the non-hospital spending increases
- Hospital admissions and emergency department visits decreased. Unplanned readmissions decreased and appropriate follow up post discharge increased
- The improvements for most of the outcomes realized were greater than the Maryland All Payer Model program period

## States Advancing All-Payer Health Equity Approaches and Development Model (AHEAD)

In 2023, CMS released the States Advancing All-Payer Health Equity Approaches and Development (AHEAD) Model. The purpose of this competitive, state-led Model is to test population health and health equity impacts when states (or state subregions) are held accountable for controlling health care cost growth. Up to eight states will be selected from 2024 application deadlines to participate across three cohorts. [9]

AHEAD Goals

- Curb the growth in health care costs
- Improve population health
- Advance health equity

Key Components

[9] Chhean, E. and Veltri, V. National Academy for State Health Policy. "Thinking Ahead on the AHEAD Model: Hospital Global Budgets". 29 April 2024.

- Hospital global budgets for Medicare FFS and Medicaid
- Primary care investment
- State Health Equity Plan
- Up to eight states and $12 million per state for first six years
    - Support planning activities during the pre-implementation period and initial performance years
    - Establish a model governance structure to guide implementation and partnerships between the state, providers, payers, and the community
    - Develop performance benchmarks, Primary Care Investment Plan, and Statewide Health Equity Plan
- 11-year Model duration
- Minimum 10,000 Traditional (FFS) Medicare beneficiaries

AHEAD Rural Applicability[10]

- The next iteration of three state-based value Models with rural participants - Maryland Total Cost of Care Model, Vermont All-Payer ACO Model, and Pennsylvania Rural Health Model
- Focus on primary care –the predominant form of rural health care
- Goal of health equity requires focus on rural disparities
- Most state-wide applicants will need to include rural hospitals and primary care practices (PPS hospitals, CAHs, and Rural Emergency Hospitals (REHs))

## ACO Realizing Equity, Access and Community Health Model (REACH)

The ACO Realizing Equity, Access and Community Health (REACH) Model was launched in 2022 as CMS redesigned the Global and Professional Direct Contracting (GPDC) Model to advance health equity and encourage health care providers to coordinate care to improve the care offered to people with Medicare. The ACO REACH Model made changes to the GDPC Model in three key areas: 1) Advancing health equity by testing an innovative payment approach to better support care delivery and coordination for patients in underserved communities including a focus on reducing health disparities, 2) Promoting provider leadership and governance through increased board representation requirements for providers and beneficiary advocates, and 3) Protecting beneficiaries with more

[10]Rural Health Value. Catalog of Value-Based Initiatives for Rural Providers. Updated March 2024. Accessed 15 December 2023 and 12 March 2024 https://ruralhealthvalue.public-health.uiowa.edu/files/

participant vetting, monitoring, and greater transparency. ACO REACH provides opportunities for different health care organizations to participate in Medicare FFS value-based care arrangements.[11] Types of ACOs include:

- Standard ACOs – organizations that have substantial experience serving Original Medicare beneficiaries
- New Entrant ACOs – organizations with less experience serving an Original Medicare population
- High Needs Population ACOs – Organizations that serve Original Medicare beneficiaries with complex needs

CMS announced changes to ACO REACH starting in 2024 that increased predictability for Model participants, protected against inappropriate risk score growth, and furthered advancing health equity.

## Making Primary Care Primary

Recently introduced by CMMI, the Making Care Primary (MCP) Model is a voluntary primary care Model that began testing in July 2024 for 10.5 years in eight states: Colorado, Massachusetts, Minnesota, New Jersey, New Mexico, New York, North Carolina, and Washington.[12] It is designed as a multi-payer Model with three participation tracks that build upon previous primary care Models, such as the Comprehensive Primary Care (CPC), CPC+, Primary Care First (PCF), and the Maryland Primary Care Program (MDPCP). It provides a pathway for primary care clinicians with varying levels of experience in value-based care to gradually adopt prospective, population-based payments while building infrastructure to improve behavioral health and specialty integration, address patient's health related-social needs, and drive equitable access to care. The MCP communicates its vision for care delivery through three domains: 1) Care Management, 2) Care Integration, and 3) Community Connection.

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[11] Rural Health Value. Catalog of Value-Based Initiatives for Rural Providers. Updated March 2024. Accessed 15 December 2023 and 12 March 2024 https://ruralhealthvalue.public-health.uiowa.edu/files/

[12] Centers for Medicare and Medicaid. Making Care Primary (MCP) Model; *Model Overview*; Accessed 18 June 2024.

## Accountable Care Organization (ACO) Primary Care Flex Model

The newest CMMI model for potential impact on rural providers is the ACO Primary Care Flex Model (ACO PC Flex Model). It is a five-year voluntary model that will focus on primary care delivery in the Medicare Shared Savings Program (Shared Savings Program). Beginning in January 2025, ACO PC Flex will test how prospective payments and increased funding for primary care in ACOs impact health outcomes, quality, and costs of care.[13] The flexible payment design will empower participating ACOs and their primary care providers to use more innovative, team-based, person-centered and proactive approaches to care and features an advanced payment for preparation and transitioning. Participants who are now in Shared Savings Programs and organizations with less than 35% of Medicare beneficiaries in ACOs are not eligible. Applications are due in August 2024 and CMS anticipates approximately 130 ACOs will participate.[14]

ACO PC Flex Model Goals

- Grow participation in ACOs and the Shared Savings Program; particularly in those that will support underserved communities, and can help address health disparities
- Deliver evidence-based, person-centered care that provides coordination and continuity and is comprehensive
- Improve access to preventive health services and screenings and for improved health outcomes related to mortality, disease progression, and chronic condition management
- Increase access to high-quality primary care for people with Medicare by improving funding and other resources to enhance primary care in ACOs

Key Components

- Provides one-time advanced shared savings payment ($250,000) and monthly payments thereafter (not based on historical financial data)
- Promote team-based care and reduce incentives for high volumes
- Advanced shared savings and prospective population-based payments. (Provides more funding for primary care of older, sicker, poorer populations)

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[13] Centers for Medicare and Medicaid. ACO Primary Care Flex Model | CMS, Accessed 18 June 2024.
[14] Rural Health Value. Catalog of Value-Based Initiatives for Rural Providers. Updated March 2024. Accessed 15 December 2023 and March 12, 2024 https://ruralhealthvalue.public-health.uiowa.edu/files/

- Provides a regionally consistent role for primary care
- Guaranteed primary care revenue that is not risk-based
- Physicians, nurse practitioners, and physician assistants are eligible as primary care providers
  Monthly payments will be based on four components: 1) A county base rate, 2) Calculated enhancements, 3) Adjustments, and 4) Primary care provider prospective administrative trends.

The CMMI and state models reviewed reflect a variety of provider and state led payment options that are applicable to small rural hospitals. Some models provide a budget or fixed amount for providers to develop a preventive focus on care with improved patient outcomes while meeting other CMS priorities of efficiency, quality, and cost. Other models continue payment for services with the incentive of sharing the realized savings of CMS priorities. Newer models emphasize health equity in access and outcomes as well as primary care provider involvement.

## Current Texas CMMI Initiatives

CMMI has six innovation model categories: Accountable care Models; Disease Specific & Episode -based Models; Health Plan Models; Prescription Drug Models; State & Community based Models; Statutory Models. Currently, Texas has health care providers participating in two of these categories - Accountable Care and Disease Specific & Episode based Models.[15] As shown in Table 1, there are many different CMMI models with ACOs that may include rural providers.

Table 1. Texas Innovation Models

| Model | Number of Health Care Facilities |
|---|---|
| Bundled Payments for Care Improvement (BPCI) - Advanced | 28 |

[15] CMS.gov, Innovation Center. "Where Innovation is Happening", accessed 12 March 2024. https://www.cms.gov/priorities/innovation/where-innovation-happening#state=TX

| | |
|---|---|
| ACO Realizing Equity, Access and Community Health Model (REACH) | 4 |
| Enhancing Oncology | 165 |
| Next Generation ACO | 3 |
| Care Network | 1 |
| Maternal Opioid Misuse (MOM) Model - Managed by State | 1 |

# Analysis of the Texas CHART Model

RHI reviewed the Texas CHART Model design, partners, outputs, and barriers for small rural hospitals. The Texas Health and Human Services Commission (HHSC) provided to RHI a comprehensive catalog of CHART documentation that included the communication materials for hospitals and partners, progress reports, and the Texas CHART transformation plan and project timeline.

## Texas CHART Model and Required Components

### CHART Model Funding Opportunity and Elements

As previously described, CMMI presented the Community Transformation CHART Model as a pathway for a collective investment from providers, purchasers, and payers to improve access, quality, and the economics of rural health care delivery.[16] CHART sought to drive change through three core elements:

1. Upfront funding with value-based payment (capitated payments to stabilize hospital financing and incent community-based, preventive care)

[16] The Centers for Medicare & Medicaid Services (CMS) Innovation Center. "Community Health Access and Rural Transformation (CHART) Model Overview Webinar." 18 August 2020.

2. Operational flexibilities to emphasize high-value services, relieve regulatory burden, and support beneficiary care management
3. Technical and learning system support to enable both payment and clinical transformation

CHART was an opportunity for rural hospitals to realize alternative payment methods through CMS for Medicare services in traditional FFS plans with the goal over seven years to receive the capitated payment amount (CPA) through State Medicaid Agencies (SMA) and commercial payors in Texas. This Model was released through CMMI fitting within their statute: "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". Ultimately, through CHART, rural providers would utilize operational and regulatory flexibility to realign how they coordinate and provide care to address health disparities with technical support and aligned financial incentives.[17] The Community Transformation Track CHART Model aimed to:

- Improve financial stability with new payment methods to rural providers through support of up-front investments and predictable, capitated payments based on quality and patient outcomes,
- Remove regulatory burden by supporting waivers that increased operational and regulatory flexibility for rural providers; and
- Enhance access to health care services by ensuring rural providers remained financially sustainable and addressed social determinants of health including food and housing by providing additional services.

The CHART funding and payment Model opportunity was designed to organize community entities, develop transformation plans that included SMA, and change hospital payment to capitated payment for eligible services. CMMI noted that CHART was focused on rural providers and communities to support a proactive approach to population health. The CHART opportunity was released in fall 2020 for up to 15 awards. Funding was provided

[17] Rural Health Value. Catalog of Value-Based Initiatives for Rural Providers, October 2023. Accessed Dec 28 2023. Catalog of Value-Based Initiatives for Rural Providers (uiowa.edu)

up to $2,000,000 to a Lead Organization through a cooperative agreement award for the pre-implementation period (one year) to recruit rural hospitals to participate, develop a community Transformation Plan, engage the SMA and other aligned payers, convene an Advisory Council, and ensure compliance with Model requirements. The amount and use of funding was flexible Additional funding to the Lead Organization of up to $500,000 was available per performance period for technical assistance. The first performance year would begin January 1, 2023, and continue through December 31, 2028. Participant hospitals would receive a predictable CPA with opportunities for operational and regulatory flexibilities. Those operational and regulatory flexibilities included:

- CMS would replace Participant Hospitals' FFS claim reimbursement with biweekly payments that equal the annual CPA
- CMMI waivers included: Medicare and CAH conditions of payment or Conditions of Participation (CoP); CAH 96-hour certification rule; care management home visits; telehealth flexibilities; Skilled Nursing Facility (SNF) 3-day rule waiver; gift care report for chronic disease management programs; cost sharing support for Part B service, and transportation[18]

The CHART CPA combined concepts from a global budget and from an ACO into a single hospital payment methodology. The CPA for participant hospitals is calculated based on Medicare FFS revenue using historical expenditures for Eligible Hospital Services. By Performance Period 2 (CY 2024), each Lead Organization must secure multi-payer alignment from the SMA. Multi-payer alignment from commercial payers is recommended but not required.

## Transformation Plan

A key element of the CMMI CHART Model was to transform the health care delivery system by making changes based on community needs, representing the "T" in CHART.[19] Through

[18]Texas.gov. CHART Model Operational Flexibilities Exercise. 2022. Accessed, 4 August 2024. chart-model-operational-flexibilities-exercise.pdf (texas.gov)
[19] Rural Health Value. "Community Health Access and Rural Transformation (CHART) Model Community Transformation Track. Session #3 Transformation Planning. 14 December, 2020.

the award of CHART, each state recipient would develop and submit 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. The first submission was due in the pre-implementation period (2022) for review and approval by CMMI. The plan would be used by CMMI to track, monitor, and evaluate the Lead Organization's CHART Model goals. Population health disparities and strategies to expand telehealth use were to be addressed in the Plan and at least one of the following: behavioral health treatment, substance use disorder, chronic disease management and prevention, or maternal and infant health. Social determinants of health were also encouraged to be addressed. CMMI indicated support of Transformation Plans through Medicare program, payment, and policy waivers.

## Lead Organization

The eligibility for the Lead Organization could include the SMA, state offices of rural health, local public health departments, as well as academic medical centers, health systems, and independent practices. The organizations had to demonstrate experience with rural health issues, relationship with the community, experience in designing and implementing alternative payment models, and grant management. Moreover, the Lead Organization needed experience establishing and maintaining agreements between health care providers and conducting outreach to manage relationships with diverse health care-related stakeholders. The CHART Model defined the Lead Organization Capabilities as:

- Define the Community
- Develop the transformation plan for the community with participating hospitals and the SMA
- Enroll participating hospital reaching the minimum of 10,000 FFS Medicare beneficiaries
- Form and convene the Advisory Council
- Capacity to manage the CHART project through the seven-year period

Additionally, the Lead Organizations was to ensure that each participant hospital signs a participation agreement with CMMI committing the participant hospital to, among other things, assume accountability for hospital expenditures for the Medicare beneficiaries they

serve that reside in the Community for the full duration of each Performance Period, and report necessary quality and other data to CMMI.

The funding opportunity was released in 2020 during the COVID-19 Public Health Emergency. CMS awarded cooperative agreements in September 2021 to four lead agencies from Alabama, South Dakota, Texas, and Washington. The cooperative agreements provided funding for a 15-month pre-implementation period. An important component of CHART was the role of the community Lead Organization(s). The community Lead Organization's role was to coordinate efforts to preserve access to care and ensure all stakeholders' needs (hospitals and the SMA) were accounted for in the development and implementation of the transformation plan. In Texas, the community lead was the HHSC (project abstract located in Appendix B).

## Texas Health and Human Services Commission (HHSC) Key Components

**Timeline - TX CHART Model Stakeholder Significant points and signals of disrupters, barriers, or assets**

1. September 2021 - Application submitted by HHSC with 13 interested hospitals, awarded by CMS
2. December 14, 2021 - Stakeholder outreach through webinar
3. January 14, 2022 - Letters of interest due by prospective participant hospitals (#)
4. January 3 - February 14, 2022 – Asset Mapping and Needs Assessments (submitted to CMS for review and approval)
5. May 18, 2022 – HHSC submits initial Transformation Plan, Medicaid alignment pathway, and how to use Alternative Payment Model savings and cooperative agreement funding to advance CHART Model goals
6. June 2022 - Estimated Capitated Payment Amount released from CMS
7. July 2022 – List of Texas prospective hospitals (61)
8. July 28, 2022 – Final Transformation Plan revisions
9. September 30, 2022 - Transformation Plan approved
10. October 2022 – Final CPA released
11. November 1, 2022 - Signed hospital participation agreements due to CMS (0 hospitals)

**Defining the community**

HHSC defined the geographic boundaries of Texas' chosen Community as 13 noncontiguous rural counties and census tracts spread across the state representing the 13 interested hospitals at the time of submission in September 2021. The potential Community expanded with hospital recruitment in 2022.Community Assessments revealed common challenges:

- Lack of coordinated care
- Uncoordinated care transitions resulting in unplanned hospital readmissions
- Improved treatment and prevention of chronic conditions like diabetes, cardiovascular disease and congestive heart failure, and
- Limited or no access to primary and specialty care

Participating hospitals would customize their role in the CHART Model Transformation Plan by selecting one or more of the community health challenges to address through a

telemedicine project that fits the needs of their county.[20] HHSC allocated up to $2.7 million to hospitals for telemedicine equipment, training, staff, and software with flexibility of service line adjustments (future years).

[20] Texas Health and Services Commission. "CHART Model Operational Flexibilities Exercise". (April 2022). https://www.hhs.texas.gov/sites/default/files/documents/chart-model-operational-flexibilities-exercise.pdf

**Developing the Transformation Plan for the community with Participating Hospitals and the SMA**

HHSC proposed to transform Medicaid payment arrangements for CHART by developing an outpatient prospective payment system model using a bundled payment arrangement like enhanced ambulatory patient groups. If beneficial to Participating Hospitals, Texas might expand them each performance period to meet Medicaid participation targets and address community health goals. Over 90% of Medicaid providers were in a managed care plan in 2022.

HHSC administers the Hospital Quality-Based Payment (HQBP) Program for all hospitals in Medicaid and CHIP in Texas. Due to its administration of the HQBP program, HHSC considers all payments for inpatient Medicaid and CHIP services to be part of an APM. HHSC worked to start implementing an Outpatient Prospective Payment System (OPPS) based on Enhanced Ambulatory Payment Group (EAPG) statewide by September 1, 2023.[21]

HHSC presented in its Initial Transformation Plan that leveraging existing managed care contracting strategies to promote APMs between Medicaid managed care organizations (MCOs) and Participant Hospitals could present an administrative burden on both parties. Through conversations with MCOs, a review of publications, and conversations with potential Participant Hospitals, HHSC identified several obstacles to APM adoption in rural areas for consideration in planning HHSC's approach to help Participant Hospitals transition to APMs and achieve Medicaid Alignment. HHSC identified the following barriers:

- Contracting with outside firms can be cost prohibitive for small providers. Providers in rural, shortage, or underserved areas may ack the capability or time to conduct the financial modeling allowing them to predict how they may perform in an APM before committing to joining one.
- It can be difficult for rural providers to find the time to learn new requirements and perform additional financial calculations when an APM's targets change.

[21] Texas Health and Human Services. CHART Annual Progress Report Budget Period 1. December 2021.

- Providers who have lower patient volumes could face less predictable spending and utilization patterns and heightened financial risk in an APM. As a result, it is challenging for these providers to predict if they will achieve annual APM benchmarks. Specifically, a small number of patients who require costlier care can adversely affect the providers' ability to meet the financial benchmarks on which APMs measure them (i.e., their expected expenditures).
- Providers who do not obtain and use certified electronic health record (EHR) technology may be unable to participate in Advanced APMs. Stakeholders report that EHR vendors charge practices every time they interface their system with another practice's EHR, ranging in the thousands of dollars. It was also reported the vendors charge practices the same price regardless of their size.
- Providers in rural, shortage, or underserved areas may not understand how to use EHRs to their full capacity or may not know how to select the optimal software for their practice.
- Providers in rural, shortage, or underserved areas may not be part of a health system that includes specialists. They may need to refer patients to another practice to receive specialized care, resulting in costs outside of their control. Because of these challenges, HHSC plans to focus on APMs already existing and underway in Texas Medicaid, including the HQBP and EAPG OPPS implementation. HHSC plans to focus its financial alignment efforts in Medicaid on these two APMs by identifying opportunities to strengthen hospital participation in the HQBP program and prepare rural hospitals for EAPG OPPS implementation.[22]

CHART required the state Medicaid Agency as a participating stakeholder in the Transformation Plan, allowing for enhanced coordination of services to meet CMS' goal of value-bases care through improved quality, cost, and health outcomes. As described above, HHSC identified a barrier prior to implementation that the capitated payments were designed only for hospitals. Primary care, specialty care, behavioral health, and community service providers are important players to improve access, address health disparities, and lower health-related costs. Recruiting community health systems and sustaining their commitment for CHART would be challenging if CPA, or other funding mechanisms, were not allowed for regulatory and operational improvements for non-hospital providers.

[22] TX Health and Human Services. CHART Annual Progress Report Budget Period 1. December 2022.

**Enrolling Participating Hospitals to reach the minimum of 10,000 fee-for-service Medicare beneficiaries**

Sixty-one potential Participant Hospitals indicated interest in the CHART Model prior to the release of the CPA from the communication initiatives. This was a significant increase above the initial 13 hospitals interested when HHSC submitted the Texas CHART Model application. With the large number of hospitals, the minimum number of 10,000 Medicare beneficiaries was obtainable although 51% of beneficiaries were enrolled in Medicare Advantage not FFS Medicare in 2022.

**Form and convene the Advisory Council**

Texas HHSC convened its first Advisory Council meeting in January 2022, meeting again then in April and August 2022. The Advisory Council included required participants representing HHSC Office of the Chief Financial Officer and Office of the Chief Medicaid Office. Other Advisory Council participants represented the Department of Agriculture – State Office of Rural Health, small rural hospitals, payors, financial consultants, Texas Organization of Rural and Community Hospitals (TORCH), commercial payers, and Medicaid Managed Care organizations, and Department of Veterans Affairs (VISN 17).

**Improve state Medicaid telemedicine policy**

This element was not found to be developed in Texas CHART with the premature end of the program in 2023.

**Develop and implement capitated payment arrangements**

This element was not found to be developed in Texas CHART with the lack of hospital participation for program year 2023 and the end of the model in 2023.

**Capacity to manage the CHART project through the seven-year period**

HHSC described the three top successes the organization encountered while conducting activities during 2022. First, by October 2022, HHSC recruited 61 hospitals potentially interested in participating in the CHART Model. This was significantly more hospitals that submitted a Letter of Intent to participate in the CHART Model with HHSC's application

(13). Second, HHSC built strong relationships with Community Partners, including TORCH and EHF. HHSC's attendance and presentation at the TORCH spring and fall conferences strengthened HHSC's relationships with potential Participant Hospitals. In July 2022, TORCH submitted a letter to CMS to provide feedback on the CHART Model Medicare CPA on behalf of the interested hospitals. TORCH and HHSC then met with CMS to discuss. In early 2022, HHSC started meeting with EHF to discuss potential opportunities to support the CHART Model in Texas. In September 2022, EHF committed $1 million to support direct grants and technical assistance for hospitals and a process evaluation of the CHART Model. Lastly, HHSC facilitated comprehensive communication tactics throughout the Pre-Implementation Period to foster hospital recruitment and decision-making. HHSC's communication efforts helped to ensure potential Participant Hospitals and other stakeholders stayed well informed of the requirements and opportunities of the CHART Model.

## Hospital Recruitment

Through October 2022, HHSC had recruited 61 hospitals potentially interested to participate in the CHART Model. HHSC's recruiting efforts through the Pre-Implementation Period included frequent communication by establishing an email subscription topic for Texas CHART Model activities and news for stakeholders; sending multiple notices and emails to stakeholders on CHART Model updates; and developing and posting several resource documents to the HHSC CHART Model website (stakeholder timeline, responsibilities of participation document, fact sheet, operational flexibilities exercise, Telemedicine project exercise, FAQ document, and a checklist for potential Participant Hospitals). (See Appendix for CHART Medicaid Factsheet). Outreach activities by HHSC included collaborating with TORCH to host a CHART Model lunch-and-learn; attending and meeting individually with hospitals at a TORCH spring conference; presenting at the TORCH fall conference; responding to multiple stakeholder inquiries; hosting group meetings with potential Participant Hospitals such as a Financial Readiness Webinar with national subject matter experts to help hospitals assess the financial risks and benefits of participating in the CHART Model; facilitating meetings with potential Participant Hospitals

and CMS; meeting individually with hospitals to discuss the CHART Model and their Medicare CPA, and distributing and responding to inquiries regarding the estimated Medicare Payment Calculations, and final Medicare Payment Calculations (CPA). Hospital recruitment was enhanced by TORCH and EHF. In September 2022, EHF committed $1 million in support of the CHART Model to facilitate Transformation Telemedicine Grants to hospitals, technical assistance for Participant Hospitals, and a process evaluation.[23]

**CHART Model in Texas: Hospital Eligibility Criteria**

Each Participant Hospital had to be (1) an acute care hospital or (2) Critical Access Hospital that either:

- was physically located within the Community and received at least 20% of its Medicare FFS revenue from Eligible Hospital Services provided to residents of the Community; or
- was physically located inside or outside of the Community and was responsible for at least 20% of Medicare expenditures for Eligible Hospital Services provided to the residents of the Community.

The definition of eligibility followed the CMMI CHART criteria. By allowing Participating Hospitals to be located outside of the Community, yet providing services to residents of the Community, hospitals in metro or micropolitan areas and hospitals over 49 beds were eligible and represented in the 61 interested hospitals in Texas.

## Texas CHART Communication

To conduct the CHART Review for Texas, RHI requested and received a catalog of Texas CHART materials from HHSC at the initiation of the study in the Fall of 2023. The materials included examples of key communication materials shared with hospitals and stakeholders in Texas. RHI reviewed the following materials and documented the communication platform, author, key message or objectives of the materials, and summarized the content.

1. CHART Model Fact Sheet

[23] Texas CHART Model Budget Period 1 Annual Progress Report. December 2022

2. CHART Model Requirements for Participant Hospitals
3. CHART Model 101 Presentation and CHART Model 101 Talking Points
4. CHART Model Hospital Participant Checklist
5. CHART Model Operational Flexibilities Exercise
6. CHART Model Discussion with TX HHSC and CMS Webinar
7. HHSC CHART Model Hospital FAQ
8. Medicaid Managed Care Organization (MCO) FAQ: CHART Model Funding Opportunity
9. Financial Specifications Prepared by the Lewin Group for CMS (the payment model, methodology)
10. CHART Advisory Council Meeting Summary August 2022

Key materials from HHSC were shared by electronically (Appendix C). In addition, during the Pre- Implementation year (2022), prior to seeking commitments by Texas hospitals, HHSC, implemented outreach strategies at conferences and workshops to increase awareness of CHART often in collaboration with TORCH.

## Lack of Participating Hospitals

Following CMS' release of the CHART Model Participation Community Track Financial Specifications and Sample Medicare Payment Calculation in September 2022, CMS provided CHART interested hospitals with a tailored CPA for each hospital on October 10. 2022.[24] The hospitals were required to commit to CHART through a signed participation agreement due in November 2022. In Texas, HHSC conducted a survey with hospitals from October - November 2022 to determine hospitals' decisions to participate in CHART in 2023, the factors considered, and interest in participating in Performance Period 2 beginning in January 2024.[25] In addition, HHSC sought hospital feedback for HHSC and CMS

[24] Centers for Medicare and Medicaid (CMS) CHART Model Participation Community Track Financial Specifications – Revised September 2022. CMS CHART Model Sample Medicare Payment Calculation. September 2022.
[25] Texas Health and Human Services Commission (2023) *CHART Model 2023 Participation Survey Summary*.

consideration. All the 18 respondents indicated no to participation in 2023 and another 20 withdrew interest via email without completing a survey. None of the 61 interested Texas hospitals completed an agreement to participate beginning in January 2023. HHSC shared the following ranked factors for hospitals not participating in CHART that was collected from the survey in the CHART Annual Progress Report for Budget Period 1:

- Low Medicare Capitated Payment Amount (CPA): 66% 1st choice, 28% 2nd choice
- Administrative Burden: 21% 1st choice, 17% 2nd and 3rd choices
- Beneficiary Data Limitations: 6% 1st choice, 22% 2nd choice, 33% 3rd choice
- Vulnerable State of Rural Hospitals
- Model Logistics
    - CMS/Hospital Communication.
    - Participation Agreement (PA)
    - Transformation Plan.
    - Medicaid Alignment
    - Timeline

According to HHSC, the responding Texas hospitals remained interested or possibly interested in participating in the CHART Model for Performance Period 2 beginning in January 2024. Hospital survey respondents (n=18) selected from the provided options what information they would need to participate in the CHART Model in 2024.[26] The potential Participant Hospitals were requesting additional information to support their decision-making process primarily information on the CHART Model beneficiaries attributed to their hospitals, CPA financial specifications, Medicaid Alternative Payment Models and lessons learned and success stories from 2022. The survey concluded in November 2022. Specific feedback was provided in the survey or directly emailed to HHSC regarding the CHART Model and categorized into the following topic areas:

- Low Medicare Capitated Payment Amount (CPA)
- Vulnerable State of Rural Hospitals
- Beneficiary Data

*"The specifics for each hospital were clear just a few weeks before the deadline. It was very hard to determine what kind of FTE and expense effort would be required for innovative programing, tracking, compliance, reporting, revenue cycle manual handling. Could not discern the cost of the program compared to any possible financial gain."*

- Administrative Burden
- 7-Year Commitment

HHSC discussed the results of the survey with TORCH and EHF. A summary of the results of 2023 CHART Model Participation Survey was submitted to CMS on November 15, 2022, by HHSC with a list of recommended improvements for the CHART Model to CMS. HHSC and hospital representatives and TORCH met with CMMI leadership in December 2022 to discuss the recommendations to improve the CHART Model. CMS identified ideas to address the issues that various states raised about the CHART Model, including reducing risk for a reduction in revenue from fee-for-service, increasing the CPA Payment, and providing incentive payments in potentially avoidable utilization. CMS recognized other ideas that included an upfront investment, time for decision-making, the impact on Medicare Cost Report data, importance of hospital access to beneficiary data to make informed choices, hospitals need for 1-3 years as a preparation glide path and not the immediate switch to the CPA as was originally envisioned. Texas stakeholders expressed to CMS that an increase in the CPA by 5-10% above FFS, shared beneficiary data, and improved transparency about participation in the Model and its impact on the Medicare Cost Report would increase the likelihood of hospital participation in Performance Period 2 (2024).[27]

Ultimately in September 2023, following limited progress in South Dakota and Alabama and immense rural recruitment efforts in Texas and Washington, CMMI announced that there was insufficient participation from rural hospitals to proceed with the first Implementation Year in January 2023.

[27] Texas Health and Human Services Commission CHART Model /Budget Period 2 Quarter 1 Report. March 2023.

## Review of 2022 Statewide Texas Hospital Finances

The financial status of Texas hospitals was reviewed by RHI as a component of the Environmental Scan for the Texas CHART Review. A dataset of statewide Texas hospital finances from 2022 cost reports to CMS was provided to RHI by TORCH Hub for Analytics Program.[28] The dataset included the type of hospital, location, and key median financial indicators of profitability, liquidity, and service line including margin, cash on hand, payors, and market share. This data provided a snapshot of how financial status may or may not have contributed to Texas hospital hesitancy in the Fall of 2022 to accept the CHART CPA. The COVID-19 Public Health Emergency declaration by the US Department of Health and Human Services was still active at this time. Forty-eight of the 61 hospitals (79%) interested in CHART are represented in the data for CHART with half located in rural designated areas. Over two-thirds (69%) of the interested hospitals with financial data were CAHs. The 2022 financial medians of CAHs in Texas and nationally are illustrated for comparison benchmarks.[29] In the figures below, the data samples are described in Table 2.

[28] TORCH Hub for Analytics Program. 2022 Cost Report data of Texas hospitals. December 2023.
[29] Reiter, Kristin. Flex Monitoring Team, "2022 CAH Financial Indicators Report: Summary of Indicator Medians by State" April 2022. https://www.flexmonitoring.org/publication/2022-cah-financial-indicators-report-summary-indicator-medians-state

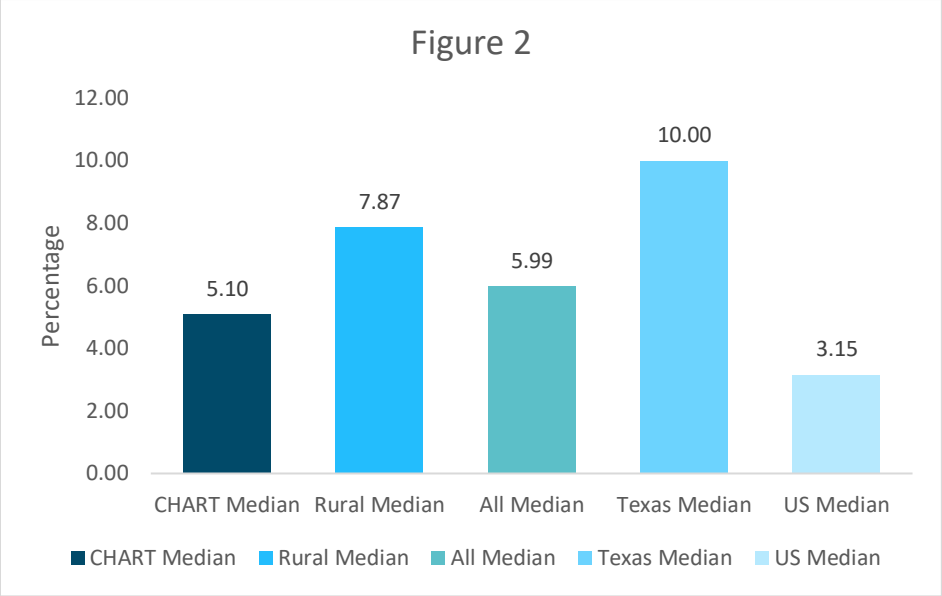
Table 2. Hospital Financial Data Groups

| Group Data Definitions | Count (n=) | Description |
|---|---|---|
| CHART | 48 | Hospitals that expressed interest (24 designated rural, 14 designated Micro as non-Metro, 10 designated Metro) |
| Rural | 83 | Texas hospitals with a census designation of rural |
| All | 156 | All Texas hospitals in TORCH Hub data set regardless of their census designation |
| Texas | 85 | Designated CAH in Texas |
| US | 1337 | Designated CAHs in United States |

The profitability indicator analyzed among Texas hospitals was operating margin. A positive operating margin reflects the ability to generate the financial return required to replace assets, meet increases in service demands, and compensate investors (in the case of a for-profit organization). It measures the control of operating expenses relative to operating revenue from net patient and other revenue. A high positive value may indicate higher patient volumes which decrease the cost per unit of service or other revenue gains. A negative margin indicates operating expenses are greater than operating revenues and high negative margins indicating financial difficulty.

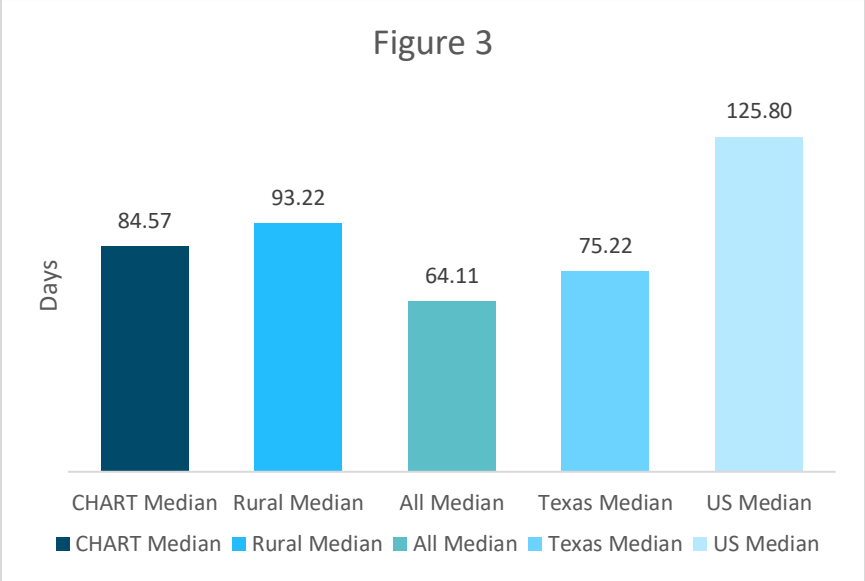
In 2022, the operating margin of all hospitals interested in CHART was 5.10% similar to all hospitals in Texas, yet lower than all Texas rural hospitals and CAHs (Figure 2). Hospitals with lower margins may have sought financial stability through CHART.

Figure 2. Median Operating Margin, Texas and US CAHs, 2022



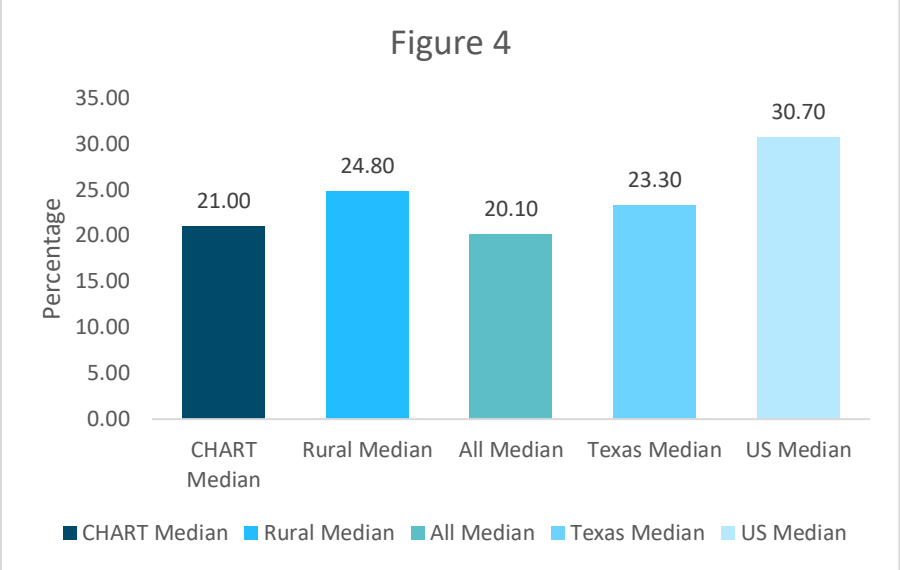

The hospital liquidity indicators recognize the ability to regularly meet cash obligations and reflect the readiness to pay off hospital debts. The days cash on hand indicator measures the number of days the hospital could operate if no cash was collected or received. A low value demonstrates only a few days of cash on hand or little reserve while high values may indicate underinvestment in longer-term assets that may yield higher returns. The data shared in Figure 3 reflects the calculation at the financial 2022-year end of hospitals. A high value impacts a hospital's readiness to absorb risk from a drop in operating margin. The individual hospital data revealed that some system-owned hospitals had a value of zero, reflecting a sweep of revenue from the individual hospital to the system owner. Therefore, the median is an important calculation compared to mean. In Figure 3, the CHART interested hospitals had a median of 84.57 days cash-on-hand or nearly three months. Although this was greater than all hospitals in Texas and the Texas CAH median of 75.22 days, it was significantly lower than the US CAH median of 125.80 days.

Figure 3. Median Days Cash on Hand, Texas and US CAHs, 2022



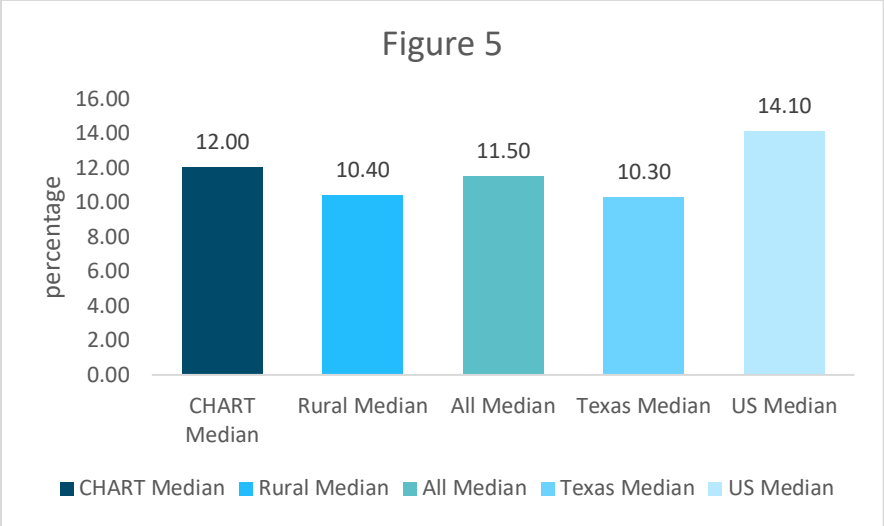

Hospitals receive a significant part of their revenue from outpatient services. Hospital Medicare outpatient payer mix measures the percentage of total outpatient charges that is for Medicare FFS patients, excluding Medicare Advantage patients. A high value over 50% may indicate the lack of financial diversification and a dependence on Medicare reimbursement. Less than 50% indicates that most outpatient charges are for Medicaid, privately insured, and other patients. The CHART Model was designed to begin CPA for Medicare FFS. The 2022 data reflects that among CHART interested hospitals and all Texas hospitals, Medicare outpatient payer mix was approximately 21% (Figure 4). Texas hospitals have a lower rate than the US CAH median of 30.70%.

Figure 4. Median Medicare Outpatient Payer Mix, Texas and US CAHs, 2022




Medicaid payer mix measures the portion of patient total patient charges for Medicaid patients. Values under 50% indicate that the majority of patient charges are not from Medicaid beneficiaries but from patients with other forms of health insurance. As shown in Figure 5, CHART interested hospitals had a slightly higher percentage of Medicaid payer mix at 12% compared to 10.40% for all rural Texas hospitals and 10.30 % of Texas CAHs. The US median is 14.10%. Texas in not a Medicaid expansion state.

Figure 5. Median Medicaid Payer Mix, Texas and US CAHs, 2022




Hospital service lines occur as either inpatient or outpatient services. Financial service line indicators measure the importance of market share the hospital is capturing in their service area. Figures 6 and 7 illustrate the differences between the hospitals interested in CHART as compared to all rural Texas and all Texas hospitals. The data was obtained through TORCH from the state mandated all-payor data in Texas. CHART interested hospitals were found to have a lower market share rate in their primary service area (Area 1) for both inpatient services and the emergency department, which is a significant outpatient service line. Area 1 Market Share as show in the figures represents 80—90% of the hospital's patients.

Figure 6. Median Inpatient Market Share (Patients) Area 1, 2022

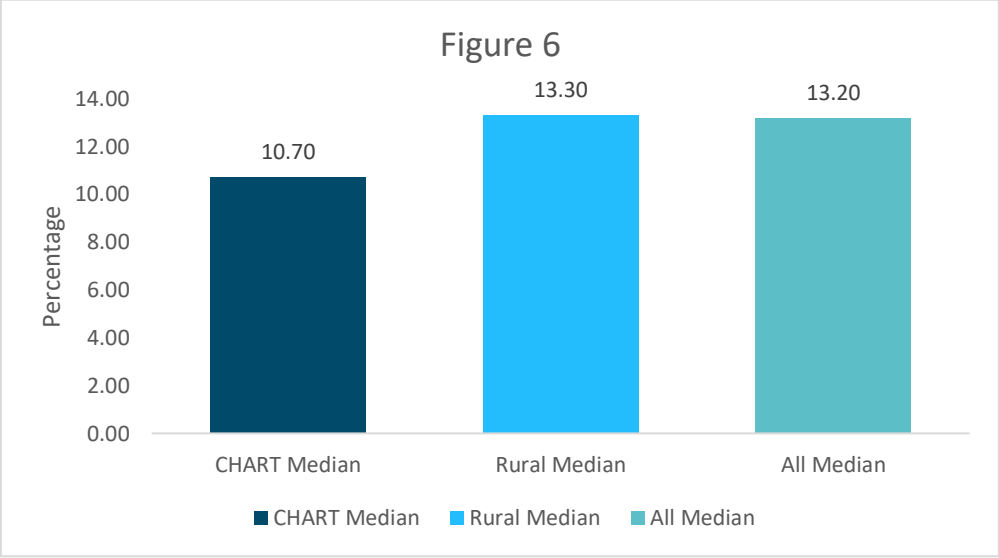
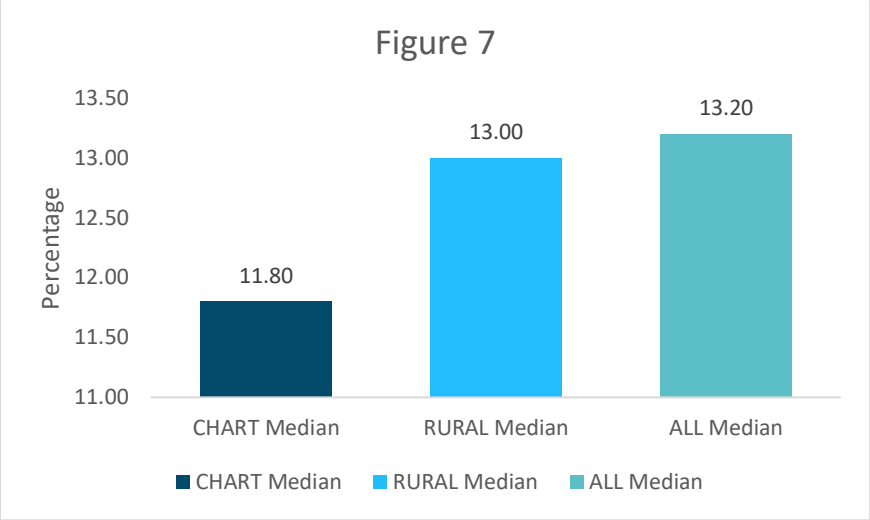


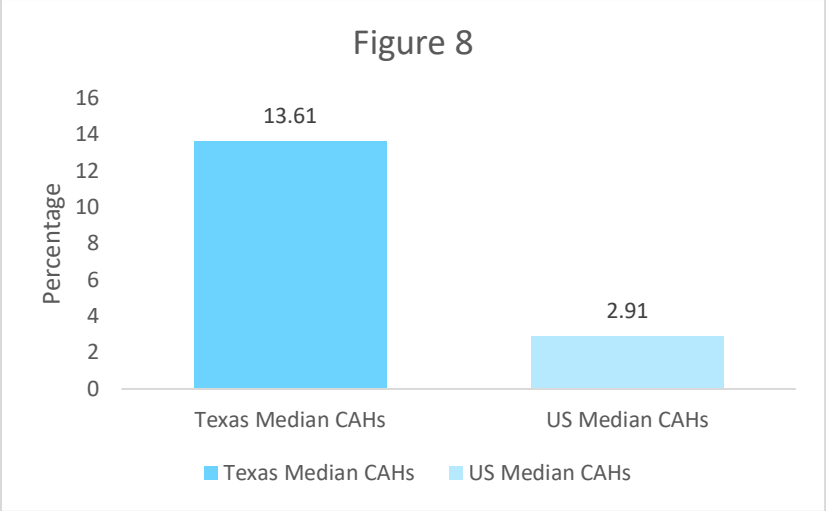
Figure 7. Median Emergency Department Market Share (Patients) Area 1, 2022




The financial impact of uncompensated care was analyzed as a potential factor of financial vulnerability for hospitals who considered CHART (Figure 8). Uncompensated care is defined as the measure of charity care and bad debt as a percentage of total operating expenses.[30] A high value indicates a greater percentage of total operating expenses for which no patient or third-party payment was received. Higher values may result from higher rates of un-insured and under-insured patients, prevalence of high deductible health plans among patients, and other payment factors. The data reported is among CAHs only. The level for Texas CAHs in 2022 was nearly five times higher than US CAHs at 13.61%. The high percentage of uncompensated care among Texas CAHs in 2022 reveals a financial vulnerability.

[30] Reiter, Kristin. Flex Monitoring Team, "2022 CAH Financial Indicators Report: Summary of Indicator Medians by State" April 2022. https://www.flexmonitoring.org/publication/2022-cah-financial-indicators-report-summary-indicator-medians-state

Figure 8. Median Uncompensated Care, Texas and US CAHs, 2022




# Interview Findings

RHI conducted key informant interviews to identify the motivation and readiness for CHART and value-based and the disrupters that impacted CHART adoption in Texas. Responses were gathered and analyzed for themes as well as differences.

## Motivators and Incentives

Texas interview participants indicated the CHART Model was intriguing due to its potential to create financial stability in a new way. Other interests included capitated payment for the hospitals, the required advisory council that would involve stakeholders, and the focus on equity. The national SMEs (non-Texas participants) were excited about any rural value-

> *"Texas has more rural hospitals than any other state in the country. There is a natural connection for wanting to find opportunities, and funding, and implement something innovative in those rural communities."*
> - Interview Participant

based care model which offered funding and incentives to make communities healthier. Participants were asked what aspect of the CHART Model presented the highest rural health care organization participation incentive. Financial stability was the most important

> *"Financial stability is what organizations were looking for. Most organizations did projects to expand access and we were looking for ways to keep doing what we were doing and expand."*
> -Interview Participant

driver for interest in the CHART Model reported by Texas hospitals, HHSC, and all stakeholders. Other important incentives included helping improve quality and patient care.

The non-Texas SMEs similarly reported hospital financial stability as the largest incentive for participation by both CAHs and PPS hospitals. In addition, SMEs shared that many rural hospitals were excited to get started on a rural value-based payment model focused on preventive health that provided with the Medicare hospital conditions of participation waivers for the transition.

## Communication

To assess awareness of the communication strategies implemented by CMS-CMMI, HHSC, and other stakeholders to increase knowledge about the CHART Model, participants were asked how the CHART Model was communicated to state health and human service departments, rural hospitals, and payors. The Model was predominantly communicated in Texas through HHSC and TORCH via emails to hospitals. Communication was also disseminated from CMS and HHSC through webinars, the Advisory Council, and the website. SMEs reported that the CHART Model was widely communicated to state health and human service departments, rural hospitals, and payors via CMMI's emails, website, and webinars. In addition, Rural Health Value, funded by the Health Resources and Services

Administration to analyze and assist communities and providers in the transition of rural health, provided four webinars in 2020 through early 2021.

## Participation Barriers and Factors

Interview participants were asked what barriers impacted participation in the Texas CHART Model as it ended in 2023 without any hospitals committing to participate. The top barriers shared by Texas participants were lack of financial expertise for a complicated model, burdensome requirements, and a rapid turnaround time for a decision. It was also

> *"If you want to test Models in the rural space, you [must] show paths to profitability, and this Model suffered in this area. This Model showed provider payments were going to decline over time, and payor profitability."*
> -Interview Participant

expressed that the overall CHART time commitment was too long (seven years) and there was a lack of explanation about the new Model CPA for hospital decision makers. Non-Texas SMEs observed the significant barrier from initiation of the Model announcement was the lack of bandwidth to understand to financial model during the workforce shortages in the COVID – 19 Public Health Emergency. They also reported the related lack of technical assistance to prepare. In addition, lack of significant Medicaid engagement in CHART was a barrier.

Participants were asked about the financial status of Texas hospitals and how that impacted participation in the Texas CHART Model. Texas participants shared that hospitals in Texas were struggling to find financial stability that affected the commitment to the CHART Model with a new payment formula. Moreover, there was not recognition that over 50% of Texas Medicare beneficiaries are in Medicare Advantage. The Model focused on inpatient traditional Medicare, which is a small sliver of revenue in Texas. Financial instability was noted by SMEs as a pressure point on participation. Analysis by one SME

organization found the Model CPA financial hospital numbers did not stabilize the hospitals with margins not allowing for a long-term buy in.

The CHART Model was designed for transformation of care for rural communities with an emphasis on population health. Participants commented on how the rural demographics influence or impact how value-based health care is delivered and paid. Texas hospitals and stakeholders noted many times that the population in Texas is elderly. The health care delivery system is complicated with the large number of small community hospitals, regional Medicaid MCOs, and vast geography. In addition, the uninsured population is large which impacts payment for provided care. SME responses were similar, noting the large population of uninsured patients. In addition, Texas rural communities face issues with lack of access due to distance from specialty care facilities.

Finally, Texas participants described external factors currently influencing rural health care now and in the future. These factors included the labor shortage needed to execute models such as CHART and challenges obtaining hospital Medicare Advantage reimbursements. SMEs shared the hardship for rural communities to retain leadership. Other common issues included workforce, technology, COVID-19, natural disasters, social determinants of health, and the lack of access to care, including telehealth due to the lack of broadband and cell service.

## Progress Towards Value-based Care

The factors that would increase rural participation in future value-based care and payment models was explored with participants. Texas participants recommended investing more in care coordination and chronic care management to increase rural participation in future value-based care models in Texas by recognizing rural needs. In addition, they recommended that the process is slower, more gradual, and easier to explain. SMEs added there needs to be more money and a feasible path to financial stability to increase rural participation in future value-based care payment models. They suggested that the goals need to be clear, involving researchers and people with local experience, and the risk needs to be more gradual.

> *"The solutions can come from folks that are closest to rural health themselves."*
> *"We need to walk the hospitals CEO and CFO towards risk instead of a sprint towards it because from a rural hospital's it is just a challenge to keep the doors open."*
> -Interview Participant

# Analysis of Key Disrupters

Through the environmental scan of the literature review and the Texas CHART Model design, hospital participation, hospital financial status, and key informant interviews, the positive disruptors that influenced the implementation of the Texas CHART Model were identified by RHI. Unfortunately, the disrupters that resulted in negative actions were greater in number and influence.

**Positive Influencing Disruptors**

- Payer alignment
- Predictable funding
- Rural value-based care model
- CMS Medicaid Quality Strategy/TX Medicaid Managed Care
- Foundation engagement and community funding support

**Negative Influencing Disruptors**

- Rapid time to commit
- Capacity at hospitals
- Medicare Advantage increasing in penetration
- Capitated Payment Amount complicated and not sustainable
- CMS vs. private payer models
- Funding lacking for infrastructure or prover start-up
- Financial stability decreasing; high level of uncompensated care
- Low leadership understanding
- Time commitment of 7 years

# Recommendations

The recommendations outlined below are based on interviews with key individuals knowledgeable about the CHART Model at the national, state, and local levels, as well as secondary analysis of the literature of other value-based payment Models, financial data, and Texas CHART documentation. The key themes emerged from the disrupters as impacting the implementation of the Texas CHART Model:

- Need for financial stability
- Hospital capacity, understanding of financial implications, and time to implement CHART
- Translation and education of CPA and how to transition
- Essential hospital startup funding and technical assistance
- Reasonable timeframe to commit and transform

The recommendations are outlined into three categories – for health policymakers and educators, state level leaders and influencers, and rural health care organizations. The recommendations directed for health policymakers and educators advancing rural VBC are based on the special needs and circumstances of rural health organizations, emphasizing the time and assistance necessary for these organizations to make informed decisions about their future and to implement associated strategies. Moreover, the consideration of payment designs that recognize that rural organizations have lower volumes, with

primarily outpatient services and revenues, and limited cash for transitions. The second category of recommendations is focused on the organization taking leadership at the state level such as HHSC in transforming heath care delivery and payment. These recommendations are based on the need for funding, inclusion, expertise, and extensive communication. The final category is intended for rural health organizations venturing into value-based payment models. This set of recommendations emphasize the need for education, information management, preparation for taking on risk, and the development of patient-centered processes and infrastructure. Together they constitute a comprehensive approach to making value-based payment work in rural Texas.

## Recommendations for Rural Value-Based Care Model Policies and Education

- Provide technical assistance and time needed to analyze the Model – capitated payment amount (CPA)
- Define assigned beneficiaries for Medicare models that exclude Medicare Advantage plans
- Engage rural leaders in designing models before opportunities are released
- Recognize that FFS Medicare is declining while Medicare Advantage grows (55% in Texas, 2023) limiting the impact for national and state programs that support safety net providers
- Include acute and ambulatory care (especially primary care and behavioral health) to improve access, address health disparities, and lower health related costs
- Consider the amount of documentation and reporting required by participating organizations and physicians
- Design a CPA with a factor for low volume to not induce a financial loss
- Provide the required upfront funding for transition to value-based care/population health
- Recognize that small rural hospitals have limited ability to assume risk

## Recommendations for State Lead Organizations

- Provide essential startup and ongoing technical assistance for rural hospitals and clinics
    - Implement care processes (care coordination and population health)
    - Engage actuarial expertise to analyze CPA offered
- Provide upfront data and operations support to aid in the transition to value-based care and population health

- Engage Medicaid, private payors, and rural networks (including clinically integrated networks) in planning
- Involve rural hospital leaders in designing state application of the Model

## Recommendations for Rural Providers

- Provide knowledge and input to CMS – CMMI before models and opportunities are released through public comments, requests for information, and listening sessions
- Learn about value-based payment models and population health
- Explore options for value-based payment and care
- Build capacity to gather and analyze quality and population health data
- Increase readiness for risk to participate in value-based care and payment

# Conclusion

The successful implementation of a rural value-based payment model requires a tiered approach. It needs a sound, rural relevant design on the front end and a trusted state organization that can effectively communicate the model to rural health organizations while engaging all payors. The implementation requires an audience of health care provider participants, not only hospitals, with knowledge and experience in value-based payment and are therefore aware of the benefits and the risks of participating in the model. Moreover, the health care organizations, especially rural hospitals, need to be ready for change with financial stability, visionary leadership, and a change ready culture with network or system affiliation for the supported infrastructure and risk. The ideal formula is complex and challenging, but the outcome for rural health organizations and their communities will be significant.

# Appendices

# Appendix A Review Methodology

## Literature Review

A focused literature review was conducted by the project team as a starting point to frame the scope value-based care and payment models with a rural provider component presented by the CMS Innovation Center in the past four years. The sources for the literature review included CMS and federally supported health care evaluation, policy, and research entities including Rural Health Value, National Rural Health Association, NORC, and the Rural Health Research Centers. Through the literature review, the project team identified the differences in the models and the commonalities trends and disruptors were identified. The review of models includes a summary of the purpose, eligibility of health care organizations, payment model, status of project and outcomes, if available. Models selected were those that are currently active or in the application phase by [Centers for Medicare and Medicaid Innovation] CMMI and identified by Rural Health Value as having a potential for rural provider participation.[31]

## Key Informant Interviews

RHI conducted key informant interviews with the 17 participants listed below to gather qualitative input for the CHART review. Participants were asked to share their perspectives and insights on environmental scan data and trends, and disruptors to the Texas CHART Model. The Texas individuals were identified for their leadership of a Texas health organization and participation in the Texas CHART Model. Individuals interviewed outside of Texas represented subject matter experts (SMEs) in hospital finance and rural health policy familiar with rural hospital APMs including CHART. An additional interview was conducted with the CHART awardee in the state of Washington.

| Interviewee | Organization | Texas or Non-Texas |
|---|---|---|
| Timothy Ols | Baylor, Scott and White Health | TX |
| Kathy Lee | Coryell Memorial Hospital | TX |
| Rebecca McCain | Elektra Hospital | TX |

[31] Rural Health Value. Catalog of Value-Based Initiatives for Rural Providers =. Updated March 2024. Accessed 12/15/2023 and March 12, 2024 https://ruralhealthvalue.public-health.uiowa.edu/files/

| | | |
|---|---|---|
| Michael Diel | Superior Health Plan | TX |
| April Ferrino, Alicia Adkins, and Robert Shaw | Texas Health and Human Services Commission | TX |
| Trenton Engledow and Eva Cruz | Texas Office of Rural Health | TX |
| John Henderson and Quang Ngo | TORCH | TX |
| LeJay Parker | CMS/CMMI | non-TX |
| Deborah Whitley | Forvis | non-TX |
| Brock Slabach | NRHA | Non-TX |
| Clint MacKinney | Rural Health Value | non-TX |
| Pat Justis & Theresa Tamura | Washington Department of Health | non-TX |

The interviews were led by an RHI Program leader and a program coordinator recorded notes. The notes were combined for identification of themes as well as differences in responses.

- *What was it about the CHART Model that was intriguing? What motivated your organization to consider participation if applicable*
- *How was the CHART Model communicated to Texas hospitals and payors?*
- *From your perspective, what aspect of the CHART Model presented the highest incentive for participation?*
    - *For example: financial stability, expanding access, community health improvement, aligning funding or payment streams*
- *What barriers impacted participation in the Texas CHART model (for hospitals, clinics, payors, other stakeholders)?*
    - *For example: Operational, financial, regulatory, public health emergency, other*
- *How did current and future financial status of Texas hospitals impact participation?*
- *What progress are you seeing in the transformation from volume (Fee for Service) to value-based care and payment in rural Texas?*
- *How do rural Texas demographics influence or impact how value-based health care is delivered and paid?*
    - *For example, workforce distribution, migration, economics, geography, density of service area*
- *What external factors are influencing health care in Texas now and into the future?*
    - *For example, leadership, COVID19, natural disasters, technology, workforce, SDoH*
- *What factors would increase rural Texas participation in future value-based care and payment models?*

# Appendix B Texas CHART Model Abstract

Texas' proposed health care delivery system redesign concept is to bring improved financial stability to participant hospitals through capitated arrangements and provide strategies to address Community health challenges through telemedicine. Using community assessments to identify gaps between services and resources available, four Community health challenges common to each Community county have been identified. They include: (1) lack of coordinated care, (2) uncoordinated care transitions resulting in unplanned hospital readmissions, (3) improved treatment and prevention of chronic conditions like diabetes, cardiovascular disease, and congestive heart failure, and (4) limited or no access to primary and specialty care. Texas envisions a framework from which participating hospitals can customize their role in the CHART Model transformation plan by selecting one or more of the Community health challenges to address through a telemedicine project(s) that fits the needs of their county. Texas is requesting $5,000,000 in funding for its proposed project. If awarded, a significant portion of the cooperative funding would be used to: (1) provide technical assistance related to transformation, (2) allow hospitals to purchase telemedicine equipment, training, software, and (3) hire additional staff, if needed, to implement transformation goals. Using the funding award for telemedicine allows hospitals to create new or expanded services to generate new or expanded revenue streams, as well as maximize the number of patients treated; thereby, leading to improved financial stability for the facility. Texas proposes to transform its Medicaid payment arrangements by developing an outpatient prospective payment system model using a bundled payment arrangement like enhanced ambulatory patient groups. If these payment systems prove beneficial to participating hospitals, Texas may expand them each performance period to meet Medicaid participation targets and address Community health goals. Additionally, Texas plans to replicate one or more bundled payment arrangements now tested in Medicare. The CHART Model Texas advisory council will play a key role in the development and implementation of capitated payment arrangements and improving state Medicaid telemedicine policy. The geographic boundaries of Texas' chosen Community are 13 noncontiguous rural counties and census tracts spread across the state. They include: (1) Angelina County, (2) Brown County, (3) Burnet County, (4) DeWitt County, (5) Dawson County, (6) Census Tract 48187210400 in Guadalupe County, (7) Haskell County, (8) Maverick County, (9) Mitchell County, (10) Polk County, (11) San Augustine County, (12) Census Tract 48485013700 in Wichita County, and (13) Young County. [32]

[32] Texas Health and Human Services. *CHARTing a Course for Rural Hospital Transformation in Texas.* Project Abstract (2021).

# Appendix C Texas CHART Communication to Hospitals and Other State Partners

TEXAS Health and Human Services

## CHART Model: Fact Sheet

The Community Healthcare Access and Rural Transformation (CHART) Model is a funding opportunity from the Centers for Medicare and Medicaid Services (CMS). The CHART Model is a voluntary opportunity for rural communities to test health care transformation supported by payment reform.

The purpose of the CHART Model purpose is to bring improved financial stability to participating rural hospitals through capitated arrangements and provide strategies to address health challenges through telemedicine. Through the CHART Model, health care providers, as well as public and private payers, can collectively invest in increasing access to care, promoting quality and improving the health outcomes of residents within their Community.

In 2021, CMS selected HHSC as one of four Lead Organizations for the CHART Model. As the Lead Organization for Texas, HHSC is responsible for driving health care delivery system redesign by leading the development and implementation of Transformation Plans and convening and engaging the Advisory Council. The estimated project period is October 1, 2021 - December 31, 2028.

As the Lead Organization, HHSC will receive up to $5 million in cooperative agreement funding to support the implementation of the CHART Model in Texas. HHSC's goal is to use much of this funding to provide technical assistance to hospitals, and allow hospitals to purchase telemedicine equipment, training, software and hire additional staff if needed to implement transformation goals.

While this document provides a high-level overview of the benefits for rural hospitals, please review the resources on the CHART Model Community Transformation Track in Texas website for more in-depth information. If you are interested in receiving additional information about the CHART Model in Texas, please sign up for the email updates on our website. Please send questions regarding the CHART Model to: HHSC_CHART@hhsc.state.tx.us.

## Benefits to Rural Hospitals

The CHART Community Transformation Track provides three ways for rural hospitals to transform their local health care system:

1. Participant Hospitals will receive regular, lump-sum payments also called a "capitated payment amount (CPA)" in place of their Medicare FFS claims reimbursement for Eligible Hospital Services[1] for the duration of the CHART Model funding opportunity. The benefit to hospitals is the CPA payment stability and predictability, as well as the freedom to invest in new service lines and utilize regulatory flexibilities offered by the CHART Model initiative. For example, hospitals may have had to focus on providing higher-reimbursing specialty services over essential primary care and behavioral health capacity or maintaining inpatient beds to meet Medicare conditions of participation, even when it may not be what is needed in the community. The CHART Model CPA payment will be calculated by CMS, not HHSC.

2. Lead Organizations will receive cooperative agreement funding to implement its health care delivery system redesign strategy that is tailored to its Community's needs. The funding may be used to establish partnerships with community stakeholders and procure technical support. Lead Organizations may also pass a portion of the funding directly to Participant Hospitals for investing in and successfully implementing care delivery redesign efforts at the hospital-level.

3. Lead Organizations, in collaboration with Participant Hospitals, will be able to leverage certain operational flexibilities available under the CHART Model to expand their ability to implement their health care delivery system redesign strategy. Operational flexibilities may include waivers of the Skilled Nursing Facility 3-day rule, telehealth [after the end of the current public health emergency (PHE) flexibilities], and care management home visits. Engagement of Medicare beneficiaries through transportation reimbursement, cost-sharing waivers and gift card rewards will be permitted. Lead Organizations are responsible for requesting operational flexibilities in their Transformation Plans in consultation with Participant Hospitals.

[1] Eligible Hospital Services include the following health care services: (a) Inpatient hospital or inpatient Critical Access Hospital (CAH) services, including but not limited to physical therapy and certain drugs and biologicals. (b) Outpatient hospital or outpatient CAH services, including but not limited to clinic, emergency department (ED) and observation services, X-rays and other radiology services billed by the Participant Hospital, and certain drugs and biologicals. (c) Swing bed services rendered by CAHs. (A.4.5.1. Capitated Payment – CHART Model Community Transformation Track Notice of Funding Opportunity).

TEXAS Health and Human Services

# CHART Community Transformation Track Requirements for Participant Hospitals

The Community Health Access and Rural Transformation (CHART) Model – Community Transformation Track is a voluntary opportunity for rural hospitals to test health care transformation supported by payment reform. It is a 7-year funding opportunity from the Centers for Medicare & Medicaid Services (CMS) that will provide Participant Hospitals with predictable payments through a Capitated Payment Amount[1] and operational flexibilities through benefit enhancements and beneficiary engagement incentives[2].

CMS announced that it has removed the ACO Transformation Track from the CHART Model; therefore, the ACO RFA will not be released as previously communicated. Please visit the CMS web site for more information. According to CMS, eligible hospitals, subject to CMS approval, may participate in the CHART Community Transformation Track, as well as other Medicare value-based programs, models or demonstrations. If a hospital chooses to participate in more than one Medicare value-based initiative, CMS may, in its sole discretion, adjust the Participant Hospital's capitated payment amount in the Community Transformation Track to avoid duplicative accounting of, and payment or penalties for, amounts received by the Participant Hospital under such Medicare program, demonstration, or model.. As the CHART Model Community Transformation Track Lead Organization for Texas, HHSC will also disperse up to $2.7 million in cooperative agreement funding to Participant Hospitals for investing in and successfully implementing care delivery redesign efforts at the hospital-level.

Texas' proposed health care delivery system redesign concept is to bring improved financial stability to participant hospitals through capitated arrangements and provide strategies to address the Community's health challenges through

[1] To learn more about the Capitated Payment Amount, please view the CHART Model Payment Policies (PDF).
[2] To learn more about the operational flexibilities available for Participant Hospitals, please view the Operational Flexibilities Fact Sheet on the HHS Website.

telemedicine. Hospitals that participate in the CHART Model will be required to complete multiple activities and reporting requirements to achieve the goals outlined in Texas' Transformation Plan. The Transformation Plan is a detailed description of the health care delivery system redesign strategy that will be carried out under the CHART Model and will be developed by HHSC, in collaboration with Participant Hospitals. To accomplish Texas' proposed health care delivery redesign concept, and meet the requirements of the CHART Model, Participant Hospitals will be required to:

- Select one or more of the community health challenges identified in Texas' Community to address.
- Select one or more Social Determinant of Health to address that impacts the chosen community health challenge(s).
- Identify a telemedicine project to address the chosen community health challenge(s).
- Participate in an alternative payment model (APM) for Medicaid payments.
- Report on at least six performance measures for the duration of the Model (three selected by CMS and three selected by HHSC).

Each requirement is described in more detail below.

## Community Health Challenge

A Lead Organization's Transformation Plan is required to focus on population health disparities present in their Community. While developing its application, HHSC reviewed community needs assessments that had been conducted in prior years. The purpose of these assessments was to inform HHSC of the gaps between services and resources available as well as to identify opportunities to improve communities through health care transformation projects across the state. HHSC identified four community health challenges (CHC) in the counties of its CHART Community.

Participant Hospitals must select one of the required CHCs that it will seek to address and may select additional CHCs to address but are not required to do so.

Required community health challenges:

1. A lack of coordinated care.
2. Uncoordinated care transitions resulting in unplanned hospital readmissions.

Optional community health challenges:

3. Improved treatment and prevention of chronic conditions like diabetes, cardiovascular disease, and congestive heart failure.

4. Limited or no access to primary and specialty care.

## Social Determinant of Health

Participant Hospitals must also select one or more social determinant of health to address that impacts the hospital's chosen community health challenge. There are five social determinants of health to choose from.

1. **Healthcare:**
   a. Access to primary coverage
   b. Health insurance coverage
   c. Health literacy

2. **Economic stability**
   a. Poverty
   b. Employment
   c. Food Security
   d. Housing Stability

3. **Education**
   a. Secondary education
   b. Higher education
   c. Language and literacy
   d. Childhood development

4. **Social and community life**
   a. Civic Participation
   b. Discrimination
   c. Incarceration
   d. Conditions within a workplace

5. **Neighborhood**
   a. Quality of housing
   b. Transportation
   c. Access to Healthy Foods
   d. Water Quality
   e. Crime and Violence

## Telemedicine Project

Participant Hospitals must identify a telemedicine project to implement to address the hospital's chosen community health challenge(s). HHSC has identified seven telemedicine models that have been implemented in other rural areas and have demonstrated success with health challenges like the four community health challenges identified in Texas' Community. The seven telemedicine projects are included in the table below. Participant Hospitals are not required to use these models but will need to provide the rationale for its telemedicine model selection.

| Telemedicine Model | Telemedicine Model Summary |
|---|---|
| **Bridges to Care Transitions-Remote Home Monitoring and Chronic Disease Self-Management** | Discharged patients use remote monitoring and get guidance from providers about disease self-management with a special focus on behavioral health wellness. |
| **eResidential Facilities Healthcare Services Access Project** | Using 2-way video, a specialized equipment, the aim is to keep nursing home residents in their own facility with the caregivers who know them best and to reduce unnecessary hospital admissions/readmissions. |
| **TelEmergency program** | Specialty trained nurse practitioners and physicians at university health science center work with local doctors via a telemedicine connection. The team works together in real-time to care for patients in ER. |
| **Hospital at Home Model** | Offers patients who need to be hospitalized the option of receiving hospital-level care at home for conditions that can be safely treated there. |
| **TeleHealth Critical Care** | Physicians and critical care nurses from a remote location can monitor patients and support the local care team to provide higher level of treatment locally. |
| **Penn Care's at Home Remote Monitoring Telehealth Program** | Technology enhances community partnerships and coordination to remotely monitor patients with chronic conditions. |
| **Electronic Health Records Platform** | Using technology to improve care coordination starts with a robust HIT system that allows real-time access and tracking of comprehensive patient plans, preferences, and service use. |

## Medicaid Alternative Payment Model

Medicaid alignment is required under the CHART model, this means Participant Hospitals must agree to transform a percentage of their Medicaid revenue to a capitated payment arrangement through an alternative payment model (APM). By the start of calendar year 2024 (performance period 2), and for each subsequent performance period, Lead Organizations must meet certain Medicaid participation targets to demonstrate Medicaid alignment. The Medicaid participation targets are:

| **Performance Period** | **Medicaid Participation Target** (% of aggregate eligible Medicaid revenue Participant Hospitals must receive from the Medicaid CPA) |
|---|---|
| Performance Period 1 (January 1, 2023 to December 31, 2023) | 0% |
| Performance Period 2 (January 1, 2024 to December 31, 2024) | 50% |
| Performance Period 3 (January 1, 2025 to December 31, 2025) | 60% |
| Performance Period 4 - 6 (January 1, 2026 to December 31, 2028) | 75% |

In the coming months, HHSC will release more information about how Medicaid participations will be met through proposed Medicaid Alternative Payment Model(s).

## CHART Performance Measures

Lead Organizations and Participant Hospitals are required to report on certain CHART quality measures for the duration of the Model. Three measures were selected by CMS and the remaining measures are selected by the Lead Organization. HHSC as the Lead Organization will select at least one additional quality domain (Substance Use, Maternal Health, or Prevention) and will be required, along with the Participant Hospitals, to report on the measures associated with the domain. CMS has updated the CHART measures since the release of the Notice of Funding Opportunity.[3] The updated measures are included in the table below.

[3] The updated measures are included in the CMS CHART Quality Strategy Fact Sheet (PDF) distributed to Lead Organizations, which is available on the HHS Website.

| Quality and Population Health Domains | Measure | Shortened Name | NQF ID | Steward | Type | Data Source |
|---|---|---|---|---|---|---|
| **Chronic Conditions (required)** | Prevention Quality Chronic Composite (Inpatient avoidable chronic disease admissions) | PQI 92 | N/A | Agency for Health Care Research and Quality | Outcome | Claims |
| **Care Coordination (required)** | Plan All-Caused Readmission | HEDIS PCR | NQF 1768 | National Committee for Quality Assurance | Outcome | Claims |
| **Patient Experience and Engagement (required)** | Hospital Consumer Assessment of Health Care Providers and Systems | HCAHPS | NQF 0166 | CMS | Outcome | Hospital Compare Reporting |
| **Substance Use** | Pharmacotherapy for Opioid Use Disorder* | HEDIS POD[4] | NQF 3400, 3175 | National Committee for Quality Assurance | Outcome | Claims |
| | Follow up after ED Visit for Alcohol Use and Other Drug Abuse or Dependence | FUA-HH | NWF 3488 | National Committee for Quality Assurance | Process | Claims |
| | Use of Opioids at High Dosage in Persons without Cancer | N/A | NQF 2940 | Pharmacy Quality Alliance | Process | Claims |
| **Maternal Health** | Prenatal and Postpartum Care | PPC-AD | NQF 1517[5] | National Committee for Quality Assurance | Process | Claims |
| | Prenatal and Postpartum Care: Timeliness of Prenatal Care | PPC-CH | NQF 1517[6] | National Committee for Quality Assurance | Process | Claims |

[4] HEDIS POD includes a combined rate from two NQF-endorsed measures.
[5] This measure is no longer endorsed by NQF.
[6] This measure is no longer endorsed by NQF.

| Quality and Population Health Domains | Measure | Shortened Name | NQF ID | Steward | Type | Data Source |
|---|---|---|---|---|---|---|
| | Contraceptive Care-Postpartum | N/A | NQF 2902 | US Office of Population Affairs | Process | Claims |
| **Prevention** | Preventive Care and Screening: Tobacco Use: Screening and Cessation Intervention | N/A | NQF 0028 | National Committee for Quality Assurance | Process | Claims |
| | Breast Cancer Screening | HEDIS BCS | NQF 2372 | National Committee for Quality Assurance | Process | Claims |
| | Adults' Access to Preventive & Ambulatory Health Services | HEDIS AAP | N/A | National Committee for Quality Assurance | Process | Claims |
| | Child and Adolescent Will-Care Visits[7] | HEDIS WCV-CH | NQF 1516 | National Committee for Quality Assurance | Process | Claims |

CMS will not adjust the Capitated Payment Amount received by Participant Hospitals based on their performance on the required CHART quality measures and selected quality domain(s). Instead, CMS will adjust a Participant Hospital's Capitated Payment Amount based on their performance in the Medicare Hospital Readmissions Reduction Program (HRRP), the Medicare Hospital-Acquired Condition Reduction Program (HACRP), the Medicare Hospital Value-Based Purchasing (VBP) Program, the Medicare Promoting Interoperability Program, the Hospital Inpatient Quality Reporting (IQR) Program, and the Hospital Outpatient Quality Reporting (OQR) Program.

[7] The Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life (W34-CH) and Adolescent Well-Care Visits (AWC-CH) measures were modified by the measure steward into a combined measure that includes rates for Ages 3 to 11, 12 to 17, 18 to 21, and a total rate. The NQF number refers to the endorsement of the W34-CH measure.

TEXAS Health and Human Services

# CHART Model: Hospital Participation Checklist

March to November 2022

The Community Transformation Track of the Community Healthcare Access and Rural Transformation (CHART) Model consist of three core program elements designed to set up rural communities for success: funding to establish partnerships and technical support, operational flexibilities, and value-based payment. The Centers for Medicare and Medicaid Services (CMS)' goals for the CHART Model are to 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, and improve rural provider financial sustainability. The CHART Model Participation Checklist is aimed at supporting you on the Roadmap to CHART Model Participation. The checklist provides a suggested estimated start date, along with an * denoting activities that may be relatively complex and require more time to complete. This checklist was revised in June 2022.

**Estimated Start Date: March 2022**

☐ At any time, notify HHSC (HHSC_CHART@hhsc.state.tx.us) if you have any questions or if your hospital reaches a decision NOT to participate in the CHART Model Community Transformation track.

☐ Visit and review HHSC's CHART Model Community Transformation Track in Texas website.

☐ Subscribe to HHSC's Gov Delivery subscription emails about the CHART Model to ensure you are notified about updates and receive the most up-to-date information.

☐ Submit Interest Form to HHSC by March 28, 2022.

☐ Begin discussions with your hospital leadership board/team about how your hospital will comply with the CHART Model Community Transformation Track requirements. Please refer to the CHART Model PowerPoint slide deck, talking points and timeline.

☐ Participate in optional HHSC hosted monthly meetings with potential Participant Hospitals.

☐ Review the CHART Model Payment Policies (PDF).

☐ Review the CHART Model Participation Community Track Financial Specifications PDF.

☐ Review the Eligible Hospital Services and services NOT included in the Eligible Hospital Services in the Medicare Capitated Payment Amount (CPA) calculation on pages 13 and 14 of the CHART Model Participation Community Track Financial Specifications PDF.

☐ Review the CMS CHART Model Sample Medicare Payment Calculation (PDF) and complete the CMS CHART Model Sample Medicare Payment Calculation Worksheet (Excel). *

**Estimated Start Date: April 2022**

☐ Review and complete the Operational Flexibilities Exercise (PDF).

**Estimated Start Date: May 2022 – June 2022**

☐ Attend or view the recorded CHART Model Discussion with Texas HHSC and CMS Webinar, along with the accompanying CHART Model Discussion with Texas HHSC and CMS Presentation slides (PDF).

☐ Review the Transformation Plan and consider any needed Operational Flexibilities for HHSC to request on your behalf.

☐ Review your CMS-provided estimated Capitated Payment Amount (CPA) and inform HHSC of your decision to continue to participate in the CHART Model by July 1. (Hospitals will not have to sign a participation agreement with CMS until October (November 1, 2022)).

☐ Meet with your hospital leadership and/or board to arrive at a preliminary decision about whether to participate in the CHART Model.

**Estimated Start Date: July 2022**

☐ Notify HHSC of your leadership's preliminary decision by July 1.

☐ Continue to educate and Inform Hospital Board and other key stakeholders. *

**Estimated Start Date: August - September 2022**

☐ Participate in optional HHSC hosted monthly meeting on financial readiness with potential Participant Hospitals and subject matter experts.

☐ Participate in optional HHSC hosted monthly meeting on Telemedicine with potential Participant Hospitals and subject matter experts.

☐ Review and complete the CHART Model Redesign Planning Exercise – Telemedicine Project worksheet. *

☐ Select the required Community Health Challenge (CHCs) that your Telemedicine Project will seek to address. Additional CHCs may be selected, if a hospital chooses to do so.

Required CHC:

1. Improved treatment and prevention of chronic conditions like diabetes, cardiovascular disease, and congestive heart failure.

Optional CHCs:

2. A lack of coordinated care.
3. Uncoordinated care transitions resulting in unplanned hospital readmissions.
4. Limited or no access to primary and specialty care.

☐ Select one or more Social Determinants of Health (SDOH) to address that impacts the hospital's chosen CHC(s). There are five SDOH from which to choose. Additional information on SDOH can be found by visiting the Healthy People 2030 website.

1. Healthcare
2. Economic stability

3. Education

4. Social and community life

5. Neighborhood

☐ Review the CHART Model quality measures and discuss needed internal policies and procedures to collect and submit selected quality measures. *

**Estimated Start Date: October 2022**

☐ Review your CMS-provided final Capitated Payment Amount (CPA) in October 2022.*

☐ Review and sign Participation Agreement with CMS by November 1, 2022. *

☐ Review and sign CHART Model award with Texas Health and Human Services Commission as provided in November 2022. *

**Contact:** Questions regarding CHART model can be emailed to: HHSC_CHART@hhsc.state.tx.us

**Website:** https://www.hhs.texas.gov/providers/medicaid-supplemental-payment-directed-payment-programs/rural-hospital-grant-facilitation