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.