



# CHART Model

Community Transformation Plan Template  
Version 1, Last Updated: July 15, 2022

# CHART Model Community Transformation Plan Template

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## Overview

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The Lead Organization, in collaboration with its Advisory Council, State Medicaid Agency (SMA), and Participant Hospitals, will develop and submit a Transformation Plan. A Transformation Plan is a Lead Organization's description of its health care delivery system redesign strategy for its Community.

Lead Organizations should refer to the Transformation Plan Instructions for more information before filling out and submitting this Transformation Plan Template document and the Transformation Plan Workbook. The workbook is where you list out your transformation activities and Community definition, which will be needed to provide information for some of the sections in this template.

Each Lead Organization must submit a Transformation Plan and then update it annually. CMS will review and approve a Lead Organization's Transformation Plan. Please refer to the *CHART Community Transformation Track Program Terms and Conditions, Section 12* (Transformation Plan), for additional information on Transformation Plan requirements.

## Section I – Application Updates

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The purpose of this section is for your Lead Organization to update any changes since the submission of your CHART application to CMS and to provide reviewers with an understanding of your Community.

### Community Definition and Update Request

In the "Community Information" tab of the Transformation Plan Workbook, list all of the contiguous and non-contiguous rural counties and rural census tracts that comprise your current Community definition. This information can be copied from the CHART application.

If proposing a change to the Community since your CHART application, also list the added/removed counties and census tracts in the "Community Information" tab of the Transformation Plan Workbook.

**Note:** Transformation Plan deliverables should reflect the rural health care delivery system redesign strategies for your updated Community definition, if applicable.

### Clinical and Non-Clinical Provider Network

1. **Care Partners:** Describe how you are engaging hospital and non-hospital providers in the Community to achieve your Strategic Priorities. Be specific and refer to your Needs Assessment document, as applicable.

Texas Health and Human Service Commission (HHSC) will ensure robust communication occurs with Care Partners to achieve the Strategic Priorities in the revised Community (as defined in the "Community Information" tab of the Transformation Plan Workbook). To ensure all stakeholders and Model participants have current information about the Model, HHSC created web pages on its site dedicated to the CHART Model. It will continue to use them as one of its main methods of communicating information and activities about the CHART Model to stakeholders. HHSC will also continue to use topic-specific email subscription service to communicate with stakeholders

about the CHART Model. These communication methods and strategies were extremely effective in soliciting and notifying stakeholders about the CHART Model funding opportunity and HHSC’s recruitment efforts. Additionally, a specific CHART Model project email box that is monitored daily by multiple staff remains an excellent method for stakeholders to direct questions to HHSC about CHART Model developments. HHSC will continue to use these methods to communicate to Participant Hospitals, Advisory Council members, Participant Medicaid Managed Care Organizations (MCOs) and other community groups regarding the implementation of the CHART Model. HHSC may use a committee system with the CHART Model Advisory Council so members can work in smaller groups on specific topics outside of the larger council meetings and ensure meetings are efficient use of time. Additionally, a committee system helps establish member buy-in and ensures responsibility is share among members. Sub-committees could be responsible for identifying agenda topics, speakers, goals, training, quality measures and other aspects related to development of transformation plans and implementation of the CHART Model. Participant Hospitals and Participant Medicaid MCOs not on the Advisory Council could use their representatives to raise subjects or questions. Sub-committee chairs could serve as liaisons with HHSC staff regarding the council’s needs and to ensure questions and requests are addressed timely. This structure helps to ensure project coordination is occurring between HHSC staff and its community partners. A successful strategy used with hospital recruitment that HHSC may continue to use is having regular stakeholder meetings to go into additional detail about a specific aspect of the CHART Model. For hospital recruitment, HHSC created a monthly meeting timeline for Calendar Year 2022 to deliver topic specific CMS-approved tools and resources to assist the potential Participant Hospitals and their stakeholders to advance towards CHART Model participation.

2. **Community Partners:** Indicate Community Partners such as social service entities, nonprofit organizations, religious organizations, community thought leaders, etc., and how these Community Partners will contribute to the Transformation Plan.

HHSC will continue to leverage collaborative relationships with Community Partners to develop and update the Transformation Plan. Since the inception of the CHART Model application, HHSC has continued to engage and receive input from stakeholders serving rural Texans. To highlight specific rural partnerships, HHSC has partnered with the Texas Organization of Rural and Community Hospitals (TORCH), the State Office of Rural Health (SORH), the US Department of Veteran Affairs (VA), and HHSC Medicaid and CHIP Services (MCS) through the Advisory Council. TORCH was formed as a 501(c)6 trade association in 1990 and has been representing and advocating for rural Texas hospitals for more than 30 years. TORCH has experience with developing specialized programs, education, activities and services for rural hospitals and the relationships to connect HHSC to rural hospitals and community leaders. SORH is within the Office of Rural Affairs under the Texas Department of Agriculture and serves as the federally designated state contact for rural health care needs. HHSC may formalize its partnerships with TORCH and SORH through a Memorandum of Understanding to delineate their roles and responsibilities after the CHART Model implementation has begun. Each organization would serve as an unpaid resource advisor in addition to being members of the Advisory Council. As telehealth will be a major component of the transformation plan, expertise from the Veterans Affairs (VA) will be an impactful resource to the Participant Hospitals. The Advisory Council

member from the VA is the Telehealth & Rural Access Manager and has expertise in telehealth models and will be able to share lessons learned and best practices. As Medicaid Alignment is also a major component of the CHART Model, input from the Advisory Council member from HHSC MCS has provided and will continue to provide invaluable input on HHSC's proposed approach to achieve Medicaid Alignment. HHSC will continue to use the CHART Advisory Council to develop and refine the Transformation Plan each year. As was evident in the most recent Advisory Council meeting during the Transformation Plan activity, members generously contributed their knowledge to the Transformation Plan and provided meaningful feedback about the Strategic Priorities and Action Steps. Outside of the Advisory Council, HHSC has had initial meetings with the Episcopal Health Foundation (EHF) and is exploring potential opportunities to partner with EHF with the implementation of the CHART Model. HHSC has an existing partnership with EHF, which supports the Medicaid Managed Care Organization (MCO) SDOH Learning Collaborative.

HHSC CHART Model staff will continue to work with partners to identify resources and partnerships to leverage the implementation of the Transformation Plan as the CHART Model progresses.

- 3. Access to Care:** Based on your Needs Assessment, provide a summary of conditions or services that impact access to care (e.g., access to broadband/WIFI within the service area, availability of public transportation, secure locations to facilitate a telehealth interaction, provider accessibility outside of normal business hours, languages/outreach to migrant or immigrant populations, translation service availability, etc.) and how you intend to address these barriers.

Because Telehealth is an important element of the CHART Model, HHSC is leveraging its previous work and expertise in telehealth for the CHART Model. In 2021, HHSC published its Assessment of Texas Medicaid Rural Teleservices, in which it provided an overview of the barriers to accessing healthcare services that rural residents often encounter in Texas regardless of their insurance coverage.

A primary barrier is distance—rural populations are more likely to travel long distances to access healthcare services. According to the Texas Organization of Rural & Community Hospitals (TORCH), 74 of Texas' 254 counties do not have a hospital, and some parts of Texas are more than 75 miles from the nearest hospital. This can be a significant burden in terms of travel time, cost and time away from the workplace.

Lack of reliable transportation can be another barrier to healthcare access for rural residents. In urban areas, public transit is generally an option for patients to get to medical appointments; however, these transportation services are often unavailable in rural areas. Rural communities often have more elderly residents with chronic conditions that require multiple visits to outpatient healthcare facilities. It can be challenging for them to make it to appointments without available public or private transportation.

Healthcare provider shortages are a third barrier to healthcare access in rural areas—a barrier that has become even harder to surmount during the current public health emergency (PHE). Across the nation, the Health Resources and Services Administration (HRSA) identifies Health

Professional Shortage Areas (HPSAs) based on a standard methodology that includes population to provider ratios, percent of the population living below the federal poverty level, travel time to the nearest source of care for residents of the area and other relevant metrics. Out of the 254 counties in Texas, 180 (71 percent) are classified as a rural county as defined by the Federal Office of Rural Health Policy. Furthermore, there are 31 rural census tracts in urban counties. In rural Texas, 189 (74 percent) counties are designated a primary care Health Professional Shortage Area (HPSA), 186 counties (73 percent) are designated as a Mental Health HPSA, and 119 counties (47 percent) are designated as a Medically Underserved Area/Population.

In addition, 27 rural Texas hospitals have closed (permanently or temporarily) since the beginning of 2010. When hospitals close, rural communities lose access not only to inpatient and emergency care, but to preventive and specialty services as well, as local physicians may relocate out of the impacted region. Experts believe the rural hospital closures stem from a difficult mix of demographic, social, and economic pressures. These underlying trends include high poverty and lower rates of private insurance in rural communities, lower average incomes and loss of population. They have been further exacerbated by shifts in healthcare consumption caused by COVID-19. HHSC, Medicaid Managed Care Organizations (MCOs) and Participant Hospitals will work collaboratively to ensure Medicaid alternative payment arrangements do not abruptly disrupt a hospital's financial viability.

Finally, residents in rural areas where there may be little anonymity may face social stigma and privacy concerns. Rural residents can have concerns about seeking care for mental health, substance abuse, sexual health, pregnancy, or even common chronic illnesses due to unease or privacy concerns. Patients may have healthcare providers or others working in healthcare facilities in their personal social networks or may have apprehensions that friends, family members or co-workers may notice them using services for health conditions that are typically not openly discussed, such as counseling or HIV testing services.

HHSC plans to address these barriers through the distribution of a portion of the cooperative agreement funding for telemedicine equipment and resources. HHSC plans continue to collaborate with the Advisory Council, Participant Hospitals and stakeholders in the revised Community to identify opportunities to address barriers inhibiting access to care and improve the monitoring and prevention of chronic conditions through the implementation of required telemedicine projects in the revised Community.

Expanding the availability of telehealth services is a key strategy for addressing rural healthcare access issues and improving the prevention and monitoring of chronic conditions because these services can reduce travel and provide more timely care in remote, rural areas. Improving patients' access to care and monitoring of chronic conditions can reduce unplanned hospital admissions/readmissions and nonemergent use of the emergency department. Community stakeholders recognize that non-health related problems may contribute to the exacerbation of chronic conditions when the non-health related problems prevent access to health care.

Many rural Texas communities are losing providers and having difficulty recruiting replacements, which makes telehealth services an appealing way to augment limited provider resources. Patients do not have to find childcare, transportation or parking. Providers have found that it can decrease patient no-show rates. Increased telehealth services may also give providers a better capability to assess a patient’s living environment and how it contributes to a patient’s health outcomes.

In September 2020, HHSC surveyed Texas rural hospitals and Rural Health Clinics (RHCs) to assess their participation in teleservices both prior to, and during, the COVID-19 Public Health Emergency, as well as barriers to their participation in these services. The most significant barriers reported by rural hospitals and RHCs regarding participation in teleservices generally involve issues related to provider reimbursement and patients’ lack of broadband and other technology.<sup>1</sup> In June 2022, the Texas Broadband Development Office published the Texas Broadband Plan, which highlighted critical areas of concern from 12 Texas communities in the recent Texas Broadband Listening Tour, including: slow data speeds, unreliable access, cost and coordination. The Texas Broadband Development Office plans to accomplish the following by early 2023: establish a broadband-focused grant program; Publish a broadband availability map and improve coordination and communication across stakeholders.<sup>2</sup>

4. **Population Health:** Summarize your Community population health profile, including population health statistics and a description of the Social Determinants of Health (SDOH)<sup>3</sup> that most impact the Community. Please specify which and how SDOH are addressed by your Strategic Priorities. Information on population health statistics can be found in the CHART Dashboard. In HHSC’s revised Community, the five most prevalent diseases for Medicare beneficiaries are: Diabetes (25.8 percent), Vascular Disease (15.9 percent), Heart Arrhythmia (13.9 percent), Congestive Heart Failure (13.9 percent), and COPD (13.2 percent). All five of these diseases have a higher prevalence in the Community than the statewide average. Some lifestyle habits, identified as behavioral risk factors, might increase the prevalence of certain diseases like cardiovascular disease, diabetes, cancer and chronic respiratory disease. Risk factors include obesity, smoking, physical inactivity and risky alcohol consumption according to the Centers for Disease Control and Prevention (CDC). The CDC reports that being overweight and obesity are direct consequences of physical inactivity and an unhealthy diet and have been responsible for 2.8 million deaths annually. Per 2022 data from CountyHealthRankings.org, the percentage of smokers in all Texas rural counties is equal to or near the Statewide average of 16 percent. Obesity rates in all rural Texas counties are higher than the state average of 30 percent. Additionally, all rural Texas counties have higher physical inactivity rates than the Statewide average of 24 percent.

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<sup>1</sup> <https://www.hhs.texas.gov/sites/default/files/documents/laws-regulations/policies-rules/Waivers/medicaid-1115-waiver/assessment-texas-medicaid-rural-telehealth.pdf>.

<sup>2</sup> <https://comptroller.texas.gov/programs/broadband/plan.php>.

<sup>3</sup> Social Determinants of Health (SDOH) are the conditions in the environments where people are born, live, learn, work, play, worship, and age that affect a wide range of health, functioning, and quality-of-life outcomes and risks. Examples of SDOH include safe housing, transportation, and neighborhoods; racism, discrimination, and violence; education, job opportunities, and income; access to nutritious foods and physical activity opportunities; polluted air and water; language and literacy skills; etc. See: <https://health.gov/healthypeople/objectives-and-data/social-determinants-health>.

Between 2013 and 2018, a series of meetings, focus groups and community needs assessments were conducted and allowed Texas stakeholders to provide feedback about community health care-related needs, needs of specific populations, impact of geographies, proposed interventions, and health care challenges and opportunities. Stakeholders included: local health care providers, health care systems, government officials, hospital districts, community mental health centers, local health departments and others. Several similar and related health challenges in counties included in the Community as proposed in HHSC’s application were cited in these community assessments. They include these four community health challenges (hereafter referred to as Community health challenges): (1) lack of coordinated care, (2) uncoordinated care transitions resulting in unplanned hospital readmissions, (3) improved treatment and prevention of chronic conditions like diabetes (County Rankings for Diabetes Prevalence, 15 percent average), cardiovascular disease, and congestive heart failure, and (4) limited or no access to primary and specialty care.

Addressing Social Determinant(s) of Health (SDOH) and addressing health disparities are points of customization for Participant Hospitals to identify for themselves through the telemedicine project or another strategy if they choose. HHSC will require hospitals to address one or more of the Community health challenges (the improved treatment and prevention of chronic conditions is required) and identify a SDOH that impacts a health disparity and is related to the chosen Community health challenge(s).

As CHART Dashboard reflects HHSC’s Community as proposed in its application, HHSC will be able to provide more details on Community population health statistics as the CHART Dashboard is updated to reflect the revised Community and once Participant Hospitals are selected.

5. **Hospital Profile:** Provide a brief description of the hospitals that impact the Community population’s hospital cost of care. This may include hospitals that are located within the Community and hospitals outside of the Community that serve beneficiaries residing in the Community. Indicate each hospital’s provider type (i.e. Critical Access Hospital, acute care hospitals, etc.). This information can be found in the CHART Dashboard.

Thirty Critical Access Hospitals (CAH) and 23 Acute Care Hospitals have expressed interest in potentially participating. Forty of these 53 hospitals are the only rural hospital in their respective county. Nineteen of these hospitals either are part of a system or participate in some form of business arrangement with a management company.

In the revised Community (all Texas rural counties and census tracts), there are 163 hospitals. Eighty-eight of these hospitals are CAH. The remaining 75 hospitals are Acute Care Hospitals.

6. **Non-Hospital Provider Profile:** Provide a brief description of the Community’s non-hospital providers (e.g., primary care practices, Rural Health Clinics (RHCs), Federally Qualified Health Centers (FQHCs), pharmacies, specialty care providers, etc.). This information can be found in your Needs Assessment and the Area Deprivation Index (ADI) View in the Population Health Tab of the CHART Dashboard.

There are 72 Federally Qualified Health Centers (FQHCs) serving patients in Texas, operating more than 660 service delivery sites. There is currently one FQHC-Look-A-Like (LAL) in Texas. The FQHC LAL offers FQHC-like services but does not receive all the benefits of FQHC status. There



are approximately 330 Rural Health Clinics (RHCs) in Texas. Of the RHCs, 64 percent are provider-based. The CHART Dashboard reflects HHSC’s Community as proposed in its application. HHSC will be able to provide more details on the Non-Hospital Provider Profile as the CHART Dashboard is updated to reflect the revised Community.

7. **Anticipated Provider Changes in the Rural Landscape:** Provide any updates to trends in hospital closures, hospital consolidations (acquisitions), and hospital mergers since the time of application submission, and/or any planned changes within the Community that impact transformation activities. Please indicate whether any changes in closure, consolidation, and merger trends have increased or decreased over the past 5 years.

According to the Texas Organization of Rural & Community Hospitals (TORCH), there is a rural hospital closure crisis in Texas, as 27 rural hospitals have closed since 2010. Specifically in the revised Community, there have been ten rural hospital closures in the past five years (since 2017) including: Timberlands Hospital (closed 2017), East Texas Medical Center (ETMC) Trinity (closed 2017), Weimar Hospital (closed 2017), Stamford Healthcare System (closed 2018), Little River Rockdale and Little River Cameron (closed 2018), Chillicothe Hospital (closed 2019), and Hamlin Memorial Hospital (closed 2019), Texas General Hospital (closed 2019), and Central Texas Hospital of Bowie (closed 2020, after reopening in 2015 with a different owner). Of the ten hospital closures in the past five years, two of the hospitals reopened: Crocket Medical Center, previously Timberlands Hospital, and Van Zandt Regional Medical Center, previously Texas General Hospital.

8. **Certificates of Public Advantage:** Indicate any Certificates of Public Advantages (CoPAs) in the area (which allow certain providers to merge and form an ‘acceptable monopoly’ for the sake of preserving access in the area). Please indicate N/A if none.

There are eight counties in the revised Community with hospitals that can apply for Certificate of Public Advantage (COPA) based on the statutory applicability standards of Texas Health and Safety Code, Section 314A.002. These include Angelina, Bowie, Cherokee, Colorado, Taylor, Tom Green, Wichita and Wood counties. HHSC has issued two CoPAs to date: Hendrick Health System in Abilene (Taylor County) and Shannon Health System in San Angelo (Tom Green County). The agency has not received any more applications. The CoPA for Hendrick Health System involves two hospitals in Abilene. An additional hospital in the Hendrix Health System is Brownwood (Brown County) but is not an eligible county to apply for a CoPA. None of the current potential Participant Hospitals are affected by CoPAs.

9. **Participation in other CMS Innovation Models or other Programs:** As listed within your Needs Assessment, please name any community entity or health care facility within your Community that is participating in both CHART and any other CMS Models or Alternative Payment Models (APM) such as CMS Models<sup>4</sup>, Medicare Shared Savings Program<sup>5</sup>, etc.

Several providers in the revised Community are working with CMS to transform their local health care delivery system by participating in new payment and service delivery models in accordance with the requirements of sections 1115A of the Social Security Act. Providers in Maverick,

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<sup>4</sup> <https://innovation.cms.gov/>

<sup>5</sup> <https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/sharedsavingsprogram>

Wichita and Angelina Counties are participating in the Medicare Bundle Payment for Care Improvement Advanced Model (BPCI). A Brown County provider is participating in the Medicare Emergency Triage, Treat and Transport five-year payment model that is meant to bring greater flexibility to ambulance care teams to address emergency health care needs of Medicare fee-for-service (FFS) beneficiaries following a 911 call. Providers in Wichita and Kerr Counties are participating in the Advanced Payment (ACO) Model. Providers in Coryell, Chambers and Burnet Counties are participating in the Medicare Shared Savings Program. Please see Table 1 included below as reference, which includes more detail on providers in the revised Community that have advised that they are participating in CMS Models.

**Table 1: Providers in the Community participating in the CMS Models**

Model	Entity	Location	Model Details
BPCI Advanced	Fort Duncan Regional Medical Center (Potential Participant Hospital)	Maverick County	BPCI Advanced will operate under a total-cost-of-care concept, in which the total Medicare FFS spending on all items and services furnished to a BPCI Advanced Beneficiary during the Clinical Episode.
Medicare Emergency Triage, Treat, and Transport	Lifeguard Ambulance Service of Texas (not eligible for CHART Model participation)	Brown County	Under the model, CMS will pay participants to 1) transport to an alternative destination partner, such as a primary care office, urgent care clinic, or a community mental health center (CMHC), or 2) initiate and facilitate treatment in place with a qualified health care partner, either at the scene of the 911 emergency response or via telehealth.
BPCI Advanced	Hospitalist Medicine Physicians of Texas – Lufkin (not eligible for CHART Model participation)	Angelina County	BPCI Advanced will operate under a total-cost-of-care concept, in which the total Medicare FFS spending on all items and services furnished to a BPCI Advanced Beneficiary during the Clinical Episode.
BPCI Advanced	Healthcare, Ltd. (not eligible for CHART Model participation)	Angelina County	BPCI Advanced will operate under a total-cost-of-care concept, in which the total Medicare FFS spending on all items and services furnished to a BPCI Advanced Beneficiary during the Clinical Episode.
BPCI Initiative: Model 3	Encompass Home Health of East Texas (not eligible for CHART Model participation)	Angelina County	Post- Acute Care only - a retrospective bundled payment arrangement where expenditures were reconciled against a target price for an episode of care.
BPCI Advanced	Orthopedic Associates	Wichita County	BPCI Advanced will operate under a total-cost-of-care concept, in which the total Medicare FFS spending on all items and services furnished to a BPCI Advanced Beneficiary during the Clinical Episode.
Medicare Emergency Triage, Treat, and Transport	(not eligible for CHART Model participation)	Wichita County	Under the model, CMS will pay participants to 1) transport to an alternative destination partner, such as a primary care office, urgent care clinic, or a community mental health center (CMHC), or 2) initiate and facilitate treatment in place with a

Model	Entity	Location	Model Details
			qualified health care partner, either at the scene of the 911 emergency response or via telehealth.
Advance Payment ACO Model	American Medical Response Ambulance Service	Wichita County	For physician-based and rural providers. Through the Advance Payment ACO Model, selected participants received upfront and monthly payments, which they could use to make important investments in their care coordination infrastructure.
Advance Payment ACO Model	Sid Peterson Memorial Hospital (Potential Participant Hospital)	Kerr County	The physician group participates in an Accountable Care Organization (ACO).
Medicare Shared Savings Program	Coryell Memorial Hospital (Potential Participant Hospital)	Coryell County	Participating in a Medicare Shared Savings Program through a vendor.
Medicare Shared Savings Program	Chambers County Public Hospital District No. 1	Chambers County	Participating in a Medicare Shared Savings Program through a vendor.
Medicare Shared Savings Program	Baylor Scott & White Marble Falls Medical Center	Burnet County	Part of Medicare Shared Savings Program through ACO at the system level.

### Participant Hospital Recruitment

1. List your potential Participant Hospitals and indicate which hospitals submitted a Letter of Intent as part of your CHART application.
  1. ELECTRA MEMORIAL HOSPITAL
  2. GRAHAM REGIONAL MEDICAL CENTER
  3. MEDICAL ARTS HOSPITAL
  4. MITCHELL COUNTY HOSPITAL DISTRICT
  5. CHI ST. LUKE'S HEALTH MEMORIAL LUFKIN
  6. HENDRICK MEDICAL CENTER BROWNWOOD
  7. HASKELL COUNTY HOSPITAL DISTRICT DBA HASKELL MEMORIAL HOSPITAL
  8. FORT DUNCAN REGIONAL MEDICAL CENTER
  9. ASCENSION SETON HIGHLAND LAKES
  10. CHI ST. LUKE'S HEALTH MEMORIAL LIVINGSTON HOSPITAL
  11. CHI ST. LUKE'S HEALTH MEMORIAL SAN AUGUSTINE HOSPITAL
  12. Titus regional medical center
  13. Muenster Memorial Hospital
  14. El Campo Memorial Hospital
  15. Uvalde Memorial Hospital
  16. Palo Pinto General Hospital
  17. Rolling Plains Memorial Hospital
  18. Stephens Memorial Hospital

19. CHI St. Joseph Health Burleson Hospital
20. CHI St. Joseph Health Grimes Hospital
21. CHI St. Joseph Health Madison Hospital
22. Coryell Memorial Hospital
23. Baylor Scott & White Marble Falls Medical Center
24. Val Verde Hospital Corporation
25. Somervell County Hospital District DBA Glen Rose Medical Center
26. Medina County Hospital District
27. Knox County Hospital District
28. Karnes County Hospital District dba Otto Kaiser Memorial Hospital
29. Sid Peterson Memorial Hospital
30. Chambers County Public Hospital District No. 1
31. Andrews County Hospital District
32. Ochiltree Hospital District
33. Scurry County Hospital District dba Cogdell Memorial Hospital
34. Jackson County Hospital District
35. Sweeny Hospital District
36. Hemphill County Hospital District
37. Preferred Hospital Leasing, Inc. dba Collingsworth General Hospital
38. Preferred Hospital Leasing Coleman, Inc. dba Coleman County Medical Center
39. Preferred Hospital Leasing Van Horn, Inc. dba Culberson Hospital
40. Preferred Hospital Leasing Junction, Inc. dba Kimble Hospital
41. Preferred Hospital Leasing Muleshoe, Inc. dba Muleshoe Area Medical Center
42. Preferred Hospital Leasing Hemphill, Inc. dba Sabine County Hospital
43. Preferred Hospital Leasing Eldorado, Inc. dba Schleicher County Medical Center
44. Preferred Hospital Leasing Shamrock, Inc. dba Shamrock General Hospital
45. Hamilton County Hospital District
46. Prime Healthcare Services - Pampa, LCC dba Pampa Regional Medical Center
47. Wilson County Memorial Hospital District
48. Scenic Mountain Medical Center
49. Rice Medical Center
50. Olney Hamilton Hospital
51. Ascension Seton Smithville
52. Ascension Seton Bastrop

- Hospitals in ALL CAPS are facilities that submitted a Letter of Intent (LOI).
- Removed Cuero Regional Hospital and Guadalupe Regional Medical Center withdrew from consideration and submitted LOIs. Also removed Wise health system that expressed interest and later withdrew from consideration.

2. Provide a summary of your Participant Hospital recruitment strategies for Performance Period 1 (CY 2023).

HHSC's hospital recruitment plan consists of three phases that each have an overarching goal:

Phase 1 (Oct. 2021 to May 2022) – Goal: Preparation to Participate. The purpose of this phase aims to have HHSC organize an infrastructure from which potential Participant Hospitals can access more detailed information about the CHART Model to begin their decision-making discussions with their leadership and Boards of Directors. This phase has included the following achievements to date:

- Promoting to stakeholders the information for participating in a CMS webinar on Dec. 14, 2021
- Drafting materials such as a stakeholder timeline, responsibilities of participation, fact sheets, financial methodology information and posting them on the HHSC web site.
- Promoting new CHART Model information on the HHSC web site to stakeholders
- Gaining access to the CHART Dashboard
- Interviewing and hiring HHSC CHART Model staff
- Sent an email to stakeholders requesting any eligible hospitals interested in participating in the CHART Model (even if they have submitted a Letter of Intent to HHSC) to complete a hospital interest survey to help HHSC determine if the Community will need to be amended.

Additional actions to be accomplished in this phase will include:

- Convening Advisory Council – Jan. to Feb. 2022
- Using the dashboard to identify potential new hospitals to recruit for the CHART Model – Jan. to Feb. 2022
- Submitting the Needs Assessment and Asset Mapping exercise to CMS – Feb. 2022
- Convening Advisory Council – Apr. to May 2022  
Submit a list of strongly interested hospitals to CMS to calculate an estimated Medicare CPA – Feb. to Mar. 2022

Phase 2 (June to Dec 2022) – Goal: Pursing Participation. The purpose of this phase is to ready hospitals and interested Medicaid MCOs to participate and make that commitment by November 1. Actions to be accomplished in this phase will include:

- Convening CHART Advisory Council – July to Aug. 2022
- Ensuring interested hospitals received their estimated Medicare CPA – May to Jun. 2022
- Draft the final version of the Transformation Plan – Due Jul. 29, 2022
- Secure commitments of participation from hospitals and Medicaid MCOs – Nov. 1, 2022

Phase 3 (Jan. 2023 to Dec. 2024) Implementation – Continue to recruit hospitals in the revised Community as funding and resources allow.

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## Section II –Strategy and Requested Flexibilities

The purpose of this section is for your Lead Organization to describe the elements of the Transformation Plan, including 1) Strategic Priorities, 2) Action Steps, and 3) measures of success. The Transformation Plan should be informed by the Needs Assessment. Be sure to reference the section below entitled *Health Equity and Access to Care* to ensure the health equity considerations are included in each Strategic Priority.

### List Strategic Priorities and Action Steps

List all Strategic Priorities and Action Steps in the “Transformation Activities” tab of the Transformation Plan Workbook. See the “Instructions” tab of the Transformation Plan Workbook for more information.

### Summarizing the Transformation Plan

Summarize how the proposed Strategic Priorities within the Transformation Plan together address the following:

- Improve or maintain access to care in the rural community;
- Improve or maintain health equity in the rural community;
- Improve or maintain the cost of care in the rural community;
- Improve or maintain quality of care in the rural community, particularly within the population health domains outlined in the CHART Quality Strategy (see Measuring Success section below); and
- Anything else you would like to share.

Since hospitals have not yet signed Participation Agreements with CMS, HHSC’s approach is to focus on short, medium, and long-term strategic priorities in the first Transformation Plan that are needed to establish a foundation from which additional medium- and long-term strategies could be accomplished. In subsequent Transformation Plans, HHSC plans to work collaboratively with Participant Hospitals to develop additional medium- to long-term priorities that align with an approach to address Community Health Challenges (CHC) that are common to rural Texas as identified in the HHSC application. 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. HHSC and its CHART Model community partners will address one or more of the CHCs in the model implementation. Implementing the Strategic Priorities as outlined below will help lay the groundwork for Participant Hospitals and Medicaid MCOs in Texas to achieve health care delivery system redesign appropriate for their communities.

The first Strategic Priority is to improve chronic disease management and its prevention, as well as improve access to certain health care services, through the implementation of a locally designed telemedicine project at each Participant Hospital that fits its population's needs. HHSC envisions a framework from which Participant Hospitals can customize their role in the Transformation Plan by selecting one or more of the CHCs (improving chronic disease management and its prevention is required) to address through a telemedicine project(s) that fits the needs of their community. Each

telemedicine project will be required to address at least one CHC and at least one Social Determinant of Health (SDOH), identify a telemedicine delivery model and rationale for its use, and identify how health disparities among populations impacted by the selected Community health challenge(s) will be addressed in their community. This approach allows hospitals and their stakeholders to determine which telemedicine models, health disparities and SDOH are most appropriate and relevant to their geographic area. By allowing for certain aspects of the CHART Model to be customized by hospitals, the approach promotes ownership of the selected goals and ensures the strategies are relevant and meaningful to the community where they will be implemented.

The second Strategic Priority is for HHSC to promote adoption of Alternative Payment Models (APMs) by rural hospital providers by facilitating APM agreements between Medicaid managed care organizations (MCOs) and Participant Hospitals. APM adoption among rural hospitals in Texas is limited. Because about 95 percent of Medicaid beneficiaries in Texas receive services through managed care, HHSC plans to work with its contracted MCOs to achieve Medicaid Alignment. HHSC plans to facilitate an agreement with participating Medicaid MCOs and Participant Hospitals on Medicaid APMs. HHSC plans to achieve CHART Model Medicaid Alignment by enhancing its generic requirement for MCOs to use value-based-payment arrangements including APMs. HHSC already has implemented contract requirements for Medicaid MCOs to achieve certain levels of APM contracts with their providers. HHSC uses the Health Care Payment Learning and Action Network (HCP LAN) APM Framework to help guide this effort. This framework provides a menu of payment models from which MCOs can choose to develop APM contracts with their providers to meet incremental overall and risk based APM targets. HHSC collects the MCO reports on their APMs annually. HHSC plans to develop a CHART Medicaid APM facilitation exercise and host meetings through Performance Period 1 with Medicaid MCOs and Participant Hospitals to help facilitate Medicaid APM negotiations in Calendar Year (CY) 2023. This exercise would include a framework for the APM, including guidance regarding its payment structure, target populations and reporting potential quality measure data.

The third Strategic Priority is to support hospital financial sustainability by providing technical assistance that will result in hospitals' ability to maximize the operational flexibilities, beneficiary incentives and cooperation agreement funding in the CHART Model to achieve the goal of maintaining cost of care in the Community. Healthcare transformation cannot take root without a financially sustainable plan. Providing supports to hospitals so they can leverage all the CHART Model benefits is critical to ensuring financial solvency is maintained and that the healthcare transformation changes are sustainable. In meetings during the pre-implementation phase, potential Participant Hospitals requested assistance with identifying opportunities to transform health care while participating in the CHART Model. HHSC plans to identify appropriate resources to assess hospitals' readiness and provide technical assistance to address these gaps.

The fourth Strategic Priority is to advance awareness of strategies to report data to address health disparities and SDOH through collaborative learning opportunities with Participant Hospitals and Medicaid MCOs. Awareness of successful strategies to report data to address SDOH and health disparities may be limited among rural providers in Texas. HHSC is currently a partner in the MCO SDOH Learning Collaborative that explores the advancement of SDOH in Texas Medicaid.

In 2020, HHSC assessed social factors impacting healthcare quality in Texas Medicaid. Based on the results of the assessment, socioeconomic, environmental, and behavioral factors are correlated with key health care quality measures in Texas Medicaid, and the impact of SDOH is relevant across Medicaid managed care populations. Leveraging this existing learning collaborative, HHSC aims to bring attention to collaborative learning opportunities for Participant Hospitals and MCOs that will enable each to identify and implement strategies that would result in improved data collection and assist each with addressing SDOH and health disparities in their respective communities.

Implementing these Strategic Priorities will support Participant Hospitals in transforming healthcare delivery while maintaining financial stability. The distribution of funds for telemedicine equipment and resources will support hospitals' telemedicine projects to improve chronic condition monitoring/prevention, maintain access to care, and focus on unaddressed SDOH and health disparities. The facilitation of an agreement between Medicaid MCOs and Participant Hospitals for APMs will further support these goals by advancing hospitals' experience with innovative payment models.

Efforts to identify and provide technical assistance aim to ensure hospitals' ability to maximize the operational flexibilities, beneficiary incentives and cooperation agreement funding so that hospitals have the financial support to transform care delivery.

Improving the awareness of successful strategies to identify and address health disparities and SDOH in Medicaid managed care through collaborative learning opportunities with Participant Hospitals and MCOs can bolster efforts to improve the quality of healthcare delivery through reporting data and collaborating with community partners to address certain unmet needs that may contribute to certain health conditions and result in poor health outcomes.

Describe any state legislative or regulatory requirements that impact deployment of transformation activities (e.g., scope of practice limitation on who can provide telehealth services, if a nurse practitioner can practice independently, etc.).

The Texas Legislature authorized certain telehealth/remote delivery flexibilities approved for the COVID-19 Public Health Emergency to remain permanent via House Bill (HB) 4(87 Texas Legislature, 2021). HHSC anticipates these flexibilities may assist the Medicaid providers in using telehealth technologies. At a high-level, they include:

- Allow audio-only delivery of the following behavioral health service:
  - Screening, brief intervention and referral to treatment.
- Allow audio-visual delivery of the following behavioral health services:
  - Screening, brief intervention and referral to treatment.
  - Substance use multidimensional assessment.
  - Substance use disorder (SUD) counseling.
- Allow telehealth for clients of all ages for physical therapy, occupational therapy, and speech therapy, as clinically appropriate based on practice and policy requirements.
- Allow Community Living Assistance & Support Services (CLASS) therapies to be delivered via telehealth in the home for: occupational therapy; physical therapy; and speech therapy, as clinically appropriate based on practice and policy requirements.
- Allow telemedicine and telehealth services for Healthy Texas Women (HTW) and HTW Plus.



- Allow billable activities for supported employment assistance remotely through telehealth and telephonic-only in CLASS, Deaf Blind and Multiple Disabilities (DBMD), Home & Community-based Services (HCS), and Texas Home Living (TxHmL) programs.

In alignment with HB 4 (87th Legislative Session, 2021), HHSC has developed draft policy changes to allow covered services via telemedicine, telehealth and audio-only delivery if clinically appropriate and cost effective. These policies have been posted for public comment. To learn more about the implementation of HB 4 and the analysis framework, [visit the Medicaid and CHIP Services Teleservices webpage](#).<sup>6</sup>

### Health Equity and Access to Care

Consider the impact that each Strategic Priority will have on health equity<sup>7</sup> and underserved<sup>8</sup> populations within your Community. When possible, reference the relevant Strategic Priorities and Action Steps that support the response below. For additional resources, the CMS Office of Minority Health offers [Health Equity Technical Assistance](#) and other information to support equity efforts.

### Equity Strategy

1. Describe how you will ensure that health equity is included in each Strategic Priority within the Transformation Plan.

Through the implementation of the Texas CHART Model, HHSC plans to allow for hospitals to customize how they plan to fulfill certain CHART Model participation requirements. This approach allows hospitals and their stakeholders to determine which health disparities and Social Determinant(s) of Health (SDOH(s)) that may contribute to health disparities are most appropriate and relevant to their geographic area. By allowing for certain aspects of the CHART Model to be customized by hospitals, the approach promotes ownership of the selected goals and ensures the strategies to address health disparities are relevant and meaningful to the community where they will be implemented. Once Participant Hospitals sign the CMS participation agreement, HHSC will require participating hospitals to submit a telemedicine project proposal that identifies: (1) how cooperative agreement funding will be used, (2) (SDOH(s)) to be addressed, (3) health disparities to be addressed, and an overall vision for how care will be transformed in their area. The proposal will also include a section for hospitals to describe how success will be measured for each of the components of the telemedicine project, including addressing SDOH and health disparities. Success at the statewide level will be measured in the short-term (CY 2023) by the percentage of Participant Hospitals that have submitted proposals for teleservices and began implementation.

2. Indicate what health disparities you will seek to reduce or eliminate in their Community? What data are you using to identify health disparities and/or priority populations.

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<sup>6</sup> [Medicaid and CHIP Teleservices | Texas Health and Human Services](#).

<sup>7</sup> *Health equity* means the attainment of the highest level of health for all people, where everyone has a fair and just opportunity to attain their optimal health regardless of race, ethnicity, disability, sexual orientation, gender identity, socioeconomic status, geography, preferred language, or other factors that affect access to care and health outcomes.

<sup>8</sup> *Underserved* refers to populations sharing a particular characteristic, as well as geographic communities that have been systematically denied a full opportunity to participate in aspects of economic, social, and civic. Examples include information regarding racial and ethnic minorities, people with disabilities, sexual and gender minorities, individuals with limited English proficiency, and rural populations.

This information will be determined by individual participating hospitals. HHSC plans to allow hospitals flexibility regarding the health disparities they will seek to reduce or eliminate in the areas of the Community that they serve. This approach allows hospitals and their stakeholders to determine which health disparities and Social Determinant(s) of Health (SDOH(s)) that may contribute to health disparities are most appropriate and relevant to their geographic area. By allowing this customization, this approach promotes ownership of the selected goals and ensures the strategies to address health disparities are relevant and meaningful to the community where they will be implemented. To support hospitals in this process, HHSC plans to provide a list of potential SDOH domains from which hospitals may choose to address in the Telemedicine Project Proposal. HHSC CHART Model staff also plan to collaborate with HHSC Medicaid and CHIP Services staff and the Texas Department of State Health Services to identify current data collection and leverage collaborative efforts, such as the MCO SDOH Learning Collaborative. The MCO SDOH explores the advancement of SDOH in Texas Medicaid and of which HHSC is already partner. HHSC aims for the collaboration to identify available data and supports for Participant Hospitals and to improve data collection among Participant Hospitals so that they can use data to address SDOH and health disparities. Based on the results of HHSC's 2020 Assessment of Social Factors impacting Health Care Quality in Texas Medicaid, socioeconomic, environmental, and behavioral factors are correlated with key health care quality measures in Texas Medicaid, and the impact of SDOH is relevant across Medicaid managed care populations. HHSC also plans to establish at least two meetings annually between Participant Hospitals, Medicaid MCOs, and relevant Community partners to discuss strategies to identify and address SDOH and health disparities. Collaborative learning opportunities for Participant Hospitals and MCOs will enable Participant Hospitals to identify and implement strategies in Medicaid to report data and address SDOH and health disparities in their respective communities. Because it is unknown at this time which hospitals will be participating, HHSC is unable to provide additional information on hospital-specific initiatives at this time but expects to update CMS in Calendar Year 2023. HHSC plans to support hospitals in identifying how to target their efforts related to addressing SDOH and health disparities.

3. Indicate what barriers to care you have identified, particularly for beneficiaries residing in areas of highest need? Information on Area Deprivation Index and parts of the Community with higher socio-economic disadvantage can be found in the Population Health tab of the CHART Dashboard.

All the counties in HHSC's revised Community have an Area Deprivation Index (ADI) National Rank higher than the national average. Some zip codes, such as 79548 and 79547, have ADIs as high as 98. This information will be dependent on the hospitals that participate, and the health disparities they identify to address. Because it is unknown at this time which hospitals will be participating, HHSC is unable to provide additional information at this time but expects to update CMS in Calendar Year 2023.

4. Describe how you intend to work with Participant Hospitals or other Community Partners to promote health equity and address health disparities in the Community. What specific actions will you and your partners pursue to advance Strategic Priorities related to health equity?

In addition to reviewing hospitals’ telemedicine project proposals, HHSC may engage consulting services to assist hospitals to prepare their facility to implement their proposal and ensure the readiness of their quality measure reporting systems, as well as identify any other gaps that may inhibit their readiness to participate in the CHART Model.

- Describe how you will monitor whether each proposed Strategic Priority within the Transformation Plan maintains and/or improves health equity in the Community. Monitoring methods will be influenced by the equity challenges participating hospitals identify. HHSC’s approach to allow hospitals and their stakeholders to determine which health disparities and Social Determinant(s) of Health (SDOH(s)) that may contribute to health disparities are most appropriate and relevant to their geographic area will promote ownership of the selected goals and ensures the strategies to address health disparities are relevant and meaningful to the community where they will be implemented. Because it is unknown at this time which hospitals will be participating and the challenges to be selected, HHSC is unable to provide additional information at this time but will update CMS in Calendar Year (CY) 2023. However, HHSC envisions that a hospital may focus on a population (or a subset of it) that is disproportionately affected by a certain chronic condition and identify if there is a role telemedicine could play to affect the population’s outcomes in a positive way. As a first step in measuring and monitoring progress, HHSC will ensure health disparity identification and measurement are included in the Telemedicine Project proposal. Hospitals will be asked to describe how success will be measured for each of its components, including addressing SDOH and health disparities. HHSC will work with Participant Hospitals to identify appropriate monitoring domains and methods relevant across all Participant Hospitals in CY 2023.

## Measuring Success

### Quality Measures

The CHART Model quality measures are listed below. Of note, the CHART Dashboard shows your Lead Organization’s baseline performance on each of the required and optional quality measures. The Dashboard also identifies areas for improvement or differences amongst counties and census tracts in a Community to help inform transformation activities. Please refer to the *CHART Community Transformation Track Program Terms and Conditions, Section 17 (Quality Strategy)*, for addition information on requirements.

### CHART Quality Measures

Quality and Population Health Domain	Full Measure Title	Shortened Name	NQF ID	Steward	Type	Data Source
<b>Chronic Conditions (Required)</b>	Prevention Quality Chronic Composite (Inpatient avoidable chronic disease admissions)	PQI 92	N/A	Agency for Health Care Research and Quality	Outcome	Claims

Quality and Population Health Domain	Full Measure Title	Shortened Name	NQF ID	Steward	Type	Data Source
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
<b>Substance Use Quality Domain</b>						
Substance Use	Pharmacotherapy for Opioid Use Disorder	HEDIS POD	NQF 3400, 3175	National Committee for Quality Assurance	Outcome	Claims
Substance Use	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
Substance Use	Use of Opioids at High Dosage in Persons without Cancer	N/A	NQF 2940	Pharmacy Quality Alliance	Process	Claims
<b>Maternal Health Quality Domain</b>						
Maternal Health	Prenatal and Postpartum Care	PPC-AD	NQF 1517**	National Committee for Quality Assurance	Process	Claims
Maternal Health	Prenatal and Postpartum Care: Timeliness of Prenatal Care	PPC-CH	NQF 1517**	National Committee for Quality Assurance	Process	Claims
Maternal Health	Contraceptive Care - Postpartum	N/A	NQF 2902	US Office of Population Affairs	Process	Claims
<b>Prevention Quality Domain</b>						
Prevention	Preventive Care and Screening: Tobacco Use: Screening and Cessation Intervention	N/A	NQF 0028	National Committee for Quality Assurance	Process	Claims

Quality and Population Health Domain	Full Measure Title	Shortened Name	NQF ID	Steward	Type	Data Source
Prevention	Breast Cancer Screening	HEDIS BCS	NQF 2372	National Committee for Quality Assurance	Process	Claims
Prevention	Adults' Access to Preventive/Ambulatory Care Visits	HEDIS AAP	N/A	National Committee for Quality Assurance	Process	Claims
Prevention	Child and Adolescent Well-Care Visits***	HEDIS WCV-CH	NQF 1516	National Committee for Quality Assurance	Process	Claims

\*HEDIS POD includes a combined rate from two NQF-endorsed measures.

\*\*This measure is no longer endorsed by NQF.

\*\*\* 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.

### Quality Strategy

1. Indicate what Selected Quality Domain(s) listed in the CHART Quality Strategy will be pursued as part of your Transformation activities (behavioral health, maternal health, or prevention). Please also provide a brief rationale for why the domain(s) was selected.  
 HHSC is selecting the Prevention Quality Domain because its measures align with the Texas Medicaid population, which consists in large part of pregnant women, infants, children, and persons with disabilities. Supporting this decision is that many rural Texas hospitals do not offer maternal health services and, therefore, would not support a health domain with measures related to these services.
2. **OPTIONAL:** Provide your expected progress on the required quality measures and your Community's additional Selected Quality Domain in the Table below. Include expected progress following Performance Period 3 (CY2025) and performance targets for the entire course of the Model. Be specific and use language to describe a quantifiable target (e.g., "improve by", "reduce by", "maintain").

Domain	Measure	Mid-Performance Target (PP3)	Final Performance Target
<b>Chronic Conditions (Required)</b>	Prevention Quality Chronic Composite (Inpatient avoidable chronic disease admissions)		
<b>Care Coordination (Required)</b>	Plan All-Cause Readmission		

<b>Patient Experience and Engagement (Required)</b>	Hospital Consumer Assessment of Health Care Providers and Systems (HCAHPS)		
<i>(Insert Additional Domain)</i>	<i>(Add rows to include a Mid- and Final Performance Target for each measure in that domain)</i>		
<i>(Insert Additional Domain)</i>	<i>(Add rows to include a Mid- and Final Performance Target for each measure in that domain)</i>		
<i>(Insert Additional Domain)</i>	<i>(Add rows to include a Mid- and Final Performance Target for each measure in that domain)</i>		

n/a

3. Please share if you plan to set any additional measures or targets to assess progress for the Strategic Priorities and Action Steps identified in this Transformation Plan.

<b>Strategic Priority</b>	<b>Measure (Please include NQF or other identifier as applicable)</b>	<b>Data Source</b>	<b>Mid-Performance Target (PP3)</b>	<b>Final Performance Target</b>

n/a

### Assessing Strengths, Risks, and Planned Tactics

1. Describe the Lead Organization’s stakeholder engagement plan with your Advisory Council, Participant Hospitals, and other Community Partners, areas for action, anticipated outcomes, and timeline. Please note new versus existing relationships and which Participant Hospitals, stakeholders, and/or Aligned Payers have been engaged in defining your Strategic Priorities and Action Steps.

HHSC hosted its first meeting with the CHART Advisory Council (Council) on February 8, 2022 and presented and solicited feedback on the Strategic Priorities and Action Steps in the second Council meeting on April 29, 2022. HHSC also presented its proposal for achieving Medicaid Alignment and revising the Community in the Transformation Plan in the April 29, 2022 meeting. Council members also can review the draft Transformation Plan between May 18 and June 18, 2022. HHSC plans to continue to collaborate with the Council on the implementation of these Strategic Priorities and Action Steps through these quarterly meetings and regular communications.

The Council will also provide input into discussions about alternative payment models (APMs), including capitated arrangements identified in HHSC’s CHART Model application, as well as

suggest other alternative payment arrangements that would benefit the revised Community. The Council will help identify: strategies or resources related to telemedicine models, changes hospitals might need to make when rolling out new services, strategies for working with patients and caregivers with telemedicine/telehealth equipment, sustainability ideas for new and/or expanded services, ways to increase access to primary and specialty care, regional collaboration and ways to cultivate partnerships with university health science systems, quality improvement and sharing of best practices. To date, two members and one anticipated member have existing connections to HHSC that can provide valuable input to the planning an implementation of the CHART Model: John Henderson, CEO of the Texas Organization of Rural and Community Hospitals (TORCH), and Rebecca McCain, CEO of Electra Hospital (potential Participant Hospital). Through John and Rebecca’s participation on the Council, HHSC remains in close and constant contact with the concerns and ideas that are circulating among rural hospitals. Rebecca is an industry leader and executive of a CAH, while John’s organization, TORCH, represents almost all rural and community hospitals in the state. Both are members of the HHSC’s Rural Hospital Advisory Committee (RHAC). It is a newly formed subcommittee of the Hospital Payment Advisory Committee (HPAC) mandated by Senate Bill 1621, 86th Legislature, Regular Session, 2019, to advise HHSC of issues relating specifically to rural hospitals. HPAC functions as a sub-committee of the Medical Care Advisory Committee (MCAC) and advises it and the HHSC about hospital reimbursement methodologies for inpatient hospital prospective payment and on adjustments for disproportionate share hospitals. The HPAC committee advises to ensure reasonable, adequate and equitable payments to hospital providers and to address the essential role of rural hospitals. HPAC and RHAC have been avenues for HHSC staff to educate and inform stakeholders about the CHART Model and its implementation progress.

2. Describe your primary methods for engagement (e.g., ongoing meeting series; in-person convenings; etc.).

Primary methods for engagement include regular meetings and webinars with Participant Hospitals, quarterly CHART Model Advisory Council meetings, as well as frequent website updates, regular email communication through a subscription email service for the CHART Model. HHSC will also consider opportunities for in-person convenings as appropriate, including attendance and presentations at the Texas Organization of Rural and Community Hospital (TORCH) conferences. In April 2022, HHSC CHART Model staff attended the annual TORCH spring Conference and met individually with more than ten hospitals. HHSC CHART Model staff have secured an offer to present at TORCH’s September 2022 Conference.

3. Describe potential risks you foresee arising in pursuing each Strategic Priority (e.g., risks to Community residents, access to care, quality of care, financial sustainability of the Participant Hospitals).

Potential risks that may arise in the distribution funding for the purchase of telemedicine equipment and resources may include that Participant Hospitals are unable to optimize the use of this equipment and resources due to their lack of knowledge of and/or experience with telehealth. Outside of the Participant Hospital walls, broadband access may be an issue for patients and the patients will not use telehealth if they do not have a good connection. Potential risks that may arise in the facilitation of Medicaid APMs between MCOs and Participant Hospitals

include that the negotiated APMs may put the hospitals at risk financially, as many of them are already operating at the margin and potentially unable to bear the brunt of downside risk involved in APMs further along the APM continuum. Additionally, there is a risk that MCOs and hospitals may have difficulty negotiating contract amendments to include the CHART Model Medicaid APM framework. MCOs and hospitals have expressed concern that the other party would use this opportunity to open the contract and add other issues beyond the CHART Model. This could potentially lead to a stalemate and inhibit CHART’s Medicaid implementation. Potential risks in identifying gaps in operational, financial and quality readiness may include that available resources for technical assistance may not be sufficient to address these gaps for Participant Hospitals.

4. Provide risk mitigation strategies to ensure continued access to care, care quality, and financial sustainability for Participant Hospitals, including a description of your monitoring strategy. HHSC plans to work closely with the CHART Advisory Council and Participant Hospitals to identify and mitigate potential risks to ensuring continued access to care, care quality, and financial sustainability throughout the implementation of the CHART Model. The second Strategic Priority of HHSC facilitating APMs between Medicaid MCOs Participant Hospitals is meant to mitigate the risk of a stalemate occurring or negotiations getting sidetracked by other issues between these parties. The third Strategic Priority to identify the technical assistance needed for Participant Hospitals is intended to help identify and mitigate risks faced by Participant Hospitals due to the potential lack of operational, financial and quality readiness. Monitoring methods will be influenced by the risks identified by Participant Hospitals. Because it is unknown at this time which hospitals will be participating, HHSC is unable to provide additional information at this time but expect to update CMS in Calendar Year 2023.

### Operational Flexibilities

The CHART Model offers certain operational flexibilities to expand Lead Organizations’ ability to implement health care delivery system redesign and promote Participant Hospitals’ capacity to manage beneficiary care. Lead Organizations can request other specialized waivers of Medicare payment and participation rules under CMMI’s authority at 1115A(d)(1) of the Social Security Act. Please refer to NOFO sections A.4.6. *Operational Flexibilities under the Model*; A.4.6.1. *Benefit Enhancements*, and A.4.6.2. *Beneficiary Engagement Incentives* for additional information.

Please fill out the “Operational Flexibilities” tab in the Transformation Plan Workbook to indicate which flexibilities your Lead Organization is interested in pursuing. Your Project Officer will follow up to request additional information, as needed, for the flexibilities in which you are interested.



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## Section III – Aligned Payers

### Medicaid Alignment

The Lead Organization (in conjunction with the SMA) should be making progress during the pre-implementation period to ensure timely implementation of Medicaid alignment. Please refer to the Community Transformation Track Program Terms and Conditions Section 14 (Implementing Necessary Changes to the Medicaid Program) and Section 15 (Medicaid Participation Targets) for additional information on requirements. Information from the “Medicaid Needs Assessment” portion of your CHART application may be applicable here.

1. Describe the current Medicaid alignment strategy, including target populations, potential quality measures, alternative payment methodology implementation, and plans to achieve scale during the Model.

Over time, Texas has transitioned most of its Medicaid population from fee-for-service (FFS) to managed care and is evolving its Medicaid and CHIP programs from paying for volume to paying for value. Because HHSC is charting a fundamental change in Medicaid away from paying for volume to paying for the value of healthcare services, its recent history has many examples of how this change is occurring. First, HHSC’s transformation aims to achieve better care for individuals, better health for populations and lower cost for the state. To this end, HHSC has implemented contract requirements for Medicaid managed care organizations (MCOs) to achieve minimum levels of alternative payment model (APM) agreements with providers and redesigned its medical and dental Pay-for-Quality (P4Q) programs. Although rural Texas hospitals and clinicians do participate in a variety of private-sector, state, and federal quality measurement and improvement efforts, many quality initiatives exclude some rural hospitals and clinicians from participation because they are paid differently than other providers or because of other measurement challenges. According to the National Quality Forum (2015), this exclusion may impact rural providers’ ability to identify and address opportunities for improvement in care, deny rural residents’ access to information on providers performance, and prevent rural providers from earning payment incentives that are open to non-rural providers.

Integrating rural healthcare providers into current HHSC and Medicaid MCO quality improvement programs requires more attention now given the myriad of federal and state efforts to advance healthcare payments from a volume-based system to one that is focused value and quality. To do this, HHSC proposes a phased approach to achieve Medicaid Alignment with the first phase focused on identifying existing opportunities for rural hospitals to participate in value-based arrangements. Specifically, for Performance Period 1 to 3 (Phase I), HHSC plans to achieve CHART Model Medicaid Alignment by enhancing its generic contract requirement for MCOs to use value-based-payment arrangements including Alternative Payment Models (APMs). Phase I’s goal would include HHSC exploring how to identify APMs for which rural hospitals may already be participating and to further promote APMs in rural areas through its generic requirement for Managed Care Organizations (MCOs) to use value-based-payment arrangements including APMs.

About 95 percent of Texas Medicaid and 100 percent of CHIP recipients are enrolled in an MCO; therefore, HHSC plans to work with its contracted MCOs to achieve Medicaid Alignment. Under

Texas Medicaid, MCOs operating in 13 service areas coordinate and ensure the delivery of necessary care for most persons with Medicaid. Within each service area, MCOs act with significant flexibility to innovate, but are required to establish adequate networks to deliver necessary primary, specialty, behavioral health, home health, pharmaceutical and facility-based care and to meet other contractual standards. HHSC contracts with 17 MCOs and three DMOs that manage networks of healthcare providers in their respective service areas.

Since 2012, HHSC has required that each Medicaid MCO and Dental Maintenance Organization (DMO) submit an annual report on its APM activities with their providers for HHSC information and planning purposes. HHSC instituted a significant change for Calendar Year (CY) 2018, when it added to the managed care contracts two types of APM targets that the MCOs and DMOs must meet every year. Starting with CY 2018, 25 percent of the MCO's and DMO's payments to providers must be APMs, increasing to 50 percent in 2021, for each MCO by program type (STAR, STAR+PLUS, STAR Health, STAR Kids and CHIP), and DMO by main program (Medicaid and CHIP), with certain exceptions. A portion of these APMs is required to include downside financial risk for providers, starting with 10 percent of MCO payments and 2 percent for DMO payments in 2018 and increasing to 25 percent and 10 percent, respectively, by 2021, with certain exceptions. Subsequently, the targets for CY 2021 have been extended to CY 2022. HHSC uses the nationally recognized Health Care Payment Learning and Action Network (HCP LAN) APM Framework to guide this effort and to align definitions. This framework describes a range of APM concepts, encompassing varying degrees of risk for providers. HHSC also requires MCOs and DMOs adequately resource their APM activities, by establishing and maintaining data sharing processes with providers, developing Provider Performance Reports, and dedicating resources to evaluating the impact of APMs on utilization, quality and cost.

Statewide all Medicaid inpatient claims by hospitals are considered APMs because of their participation in the Hospital Quality-Based Payment Program, which involves (dis)incentives related to performance on Potentially Preventable Readmissions and Complications. In 2018, the total expenses associated with these models was more than \$1.1 billion and nearly \$5 million of it was paid directly to providers as financial incentives. For Texas' Medicaid Rural Service Areas (MRSAs) there were 47 APMs in MRSA-Central SDA, 36 in MRSA-East Service Delivery Area (SDA), and 30 in MRSA-West SDA. These APMs accounted for \$2.6 billion in MRSA Central SDA, nearly \$1.6 billion in MRSA East SDA, and almost \$1.5 billion in MRSA West SDA.

To review opportunities to achieve Medicaid Alignment in managed care, HHSC CHART Model staff, HHSC Office of Value-Based Initiatives staff, and HHSC Medicaid and CHIP Services (MCS) staff met with four Medicaid MCOs (Amerigroup Health Plan, Superior Health Plan, United Healthcare Community Plan (UHC), and Community First Health Plans) that expressed interest in participating in the CHART Model. Each of the health plans has contracted providers within the revised Community.

In HHSC's initial discussion the MCO representatives expressed interest in supporting rural communities and provided insight on expanding APMs for rural hospitals. The MCOs reported that APMs in rural areas are currently limited, and providers are facing financial struggles. Rural

hospitals and Medicaid MCOs expressed concern regarding the assumption of additional financial risk. The discussions resulted in a consensus to recommend taking a conservative approach when moving any provider from FFS to an arrangement with increased financial risk.

HHSC's proposed approach will be to help facilitate an APM or APMs between Participant Hospitals and MCOs that do not abruptly shift to a fully capitated payment. HHSC's goal will be to move rural hospitals further on the continuum of APMs as demonstrated by the HCP LAN APM Framework. Implementation of new APMs specifically with rural hospitals will require system updates for a small number of providers, complex navigation of payment regulations, and establishing relationships and negotiations. It is unknown at this time which Medicaid programs (e.g., STAR, STAR+PLUS, STAR Kids) and populations would be included into an APM arrangement. Potential quality measures will be aligned as much as possible with existing quality measures that rural hospitals currently report to reduce the administrative burden.

For Phase II (Performance Periods 4-6), HHSC is considering implementing an out-patient prospective payment (OPPS) methodology for out-patient services with an Enhanced Ambulatory Patient Group (EAPG) methodology. Because Texas' Medicaid program has established a prospective payment system for inpatient services by using the All-Patient Refined Diagnosis Related Groups, HHSC is proposing to develop a statewide OPPS model.

Please see a high-level timeline of planned activities to achieve Medicaid Alignment below:

Phase I (Performance Periods 1-3) Calendar Years (CYs) 2023 to 2025

- Medicaid APM planning and discussion among MCOs and Participant Hospitals – January to December 2023.
- Medicaid APM implementation begins in January 2024.
- HHSC plans to work collaboratively with Medicaid MCOs and Participant Hospitals to help facilitate an APM agreement(s) promoting CHART goal(s).
- HHSC is considering expanding reporting for CHART Participant Hospitals for the Hospital Quality-Based Payment Program.

Phase II (Performance Periods 4-6) CYs 2026 to 2028

- HHSC is considering implementing a statewide Enhanced Ambulatory Patient Group (EAPG) APM as proposed in its application to achieve alignment in Performance Periods 4-6.

**2. Provide a summary of the progress made to date towards securing Medicaid alignment.**

HHSC requested more detail regarding Medicaid Alignment requirements. HHSC has contacted CMS' Center for Medicaid & CHIP Services (CMCS), but, to date, has not received any response. Below is an estimated timeline and overview of HHSC's current and planned actions to achieve Medicaid Alignment.

To identify and implement any changes to the State's Medicaid Authorities necessary to implement the Community Transformation Track requirements and satisfy Payer Alignment requirements for meeting the Medicaid Participation Targets beginning in Calendar Year (CY) 2024, HHSC CHART Model staff collaborated with staff from HHSC Medicaid and CHIP Services

(MCS) to develop the following updated draft\* timeline for next steps to achieve Medicaid Alignment in the CHART Model.

Due to close to 95 percent of Medicaid clients in Texas receiving services through managed care, HHSC plans to achieve Medicaid Alignment in managed care by enhancing its generic managed care contracting strategies to promote Alternative Payment Models (APMs) in rural areas for Performance Period 1 to 3. As of June 2022, HHSC has successfully recruited four Medicaid MCOs, including Community First Health Plans, Superior Health Plan, United Healthcare Community Plan (UHC) and Amerigroup Health Plan. Once the list of Participant Hospitals for Texas is finalized, and these hospitals have signed Participation Agreements with CMS, HHSC's recruitment plans will include approaching all Medicaid MCOs in the service areas of all Participant Hospitals. HHSC also plans to develop a CHART Medicaid APM Exercise to help facilitate APM negotiations between Medicaid MCOs and Participant Hospitals in the CHART Model. This exercise would include a framework for the APM, including guidance regarding its payment structure, target populations and reporting potential quality measure data. HHSC plans to implement Enhanced Ambulatory Patient Group (EAPG) APM proposed in HHSC's CHART application to achieve alignment in Performance Periods 4-6.

- February 2022 – Initiated internal HHSC discussions to begin identifying and designing required changes to the Texas Medicaid program to achieve Medicaid Alignment.
- March 2022 – Requested contact at Center for Medicaid and CHIP Services (CMCS) to refine and finalize the concepts detailed in HHSC's application and identify necessary changes to the Texas Medicaid program to collaboratively achieve Medicaid Alignment.
- March 2022 – Continued internal HHSC discussions to identify opportunities to achieve Medicaid Alignment by leveraging HHSC's requirements for MCOs to engage in APMs with their providers, achieve certain targets for these APM arrangements, and report on these APMs to HHSC annually. HHSC is considering how to further promote APMs in rural areas through these requirements.
- March 2022 - Met with three Medicaid MCOs (including Community First Health Plans, United Healthcare Community Plan (UHC) and Superior Health Plan) operating in services areas within the Community as proposed in HHSC's application to collaborate on opportunities to achieve Medicaid Alignment through managed care. Discussion topics included the MCOs level of interest in participating in the CHART Model, whether MCOs currently engage in or are planning to implement APMs with rural hospitals, the feasibility of implementing APMs to achieve Medicaid Alignment in CY 2024, and whether there are special considerations for APMs with rural hospitals. The MCOs expressed interest in working with CHART Participant Hospitals to engage in APMs and advised engaging in APMs that gradually move these hospitals along the continuum of the Health Care Payment Learning Action Network's APM Framework in lieu of moving directly to capitated arrangements.
- April 2022 – Continued internal HHSC discussions and discussions with MCOs to identify opportunities to achieve Medicaid Alignment through managed care. Sought feedback

from CHART Advisory Council and interested hospitals on the proposed approach to achieve Medicaid Alignment. Met with Amerigroup Health Plan representatives and secured their participation in the CHART Model in late April.

- May - July 2022 – Refine approach to achieve Medicaid Alignment as needed and in draft and final Transformation Plan.
- August 1, 2022 – Deadline to obtain CMS approval of the Transformation Plan, including the approach to achieve Medicaid Alignment.
- September – October 2022 – Collaborate with MCOs to develop a CHART Medicaid APM Exercise to facilitate APM development between MCOs and Participant Hospitals.
- November – December 2022 – Collaborate with Participant Hospitals to refine CHART Medicaid APM Exercise to help facilitate APM development between MCOs and Participant Hospitals.
- January – December 2023 - Establish a series of regular meetings between Participant Hospitals and Medicaid MCOs to discuss phase 1 implementation of the Medicaid APM(s).
- September 1, 2023 – Deadline to implement proposed approach to achieve Medicaid Alignment in 2024 and incorporate into MCO contracts.
- January 1, 2024 – Deadline to obtain final CMS approval for any necessary changes under Medicaid authorities to achieve Medicaid Alignment in 2024.

\*Please note that this is a high-level timeline drafted with information currently available to HHSC CHART Model staff. This timeline is tentative and subject to change as more detailed information is identified through internal HHSC discussions and those with CMS. HHSC CHART Model staff are also still determining the timelines of Medicaid managed care contract changes and if other Medicaid authorities (e.g., Medicaid waiver(s), Medicaid demonstration(s) and/or modifications under 42 CFR Part 438) may need to be changed.

3. Identify which of the following mechanisms the state plans to use to secure Medicaid alignment and how each authority will be leveraged: State Plan Amendment, 1115(a) Waiver, amendments to managed care contracts, etc.

For Performance Periods 1 to 3, HHSC is proposing to use managed care contracting strategies to promote Alternative Payment Models (APMs) in rural areas. As previously discussed, HHSC is planning to help facilitate collaboration between Managed Care Organizations (MCOs) and Participant Hospitals to negotiate APMs in Calendar Year 2023. HHSC is also considering opportunities to promote APMs in rural areas by adjusting APM requirements for MCOs (e.g., giving MCOs credit for engaging in APMs specifically in rural areas).

For Performance Periods 4 to 6, HHSC plans to implement Enhanced Ambulatory Patient Group (EAPG) APM proposed in HHSC’s CHART application to achieve alignment. As this is a statewide initiative, HHSC CHART Model staff will continue to collaborate with appropriate HHSC staff

responsible for its implementation and provide updates in future Transformation Plans on the mechanisms necessary for implementation.

4. Indicate whether the SMA plans to propose any modifications to the Financial Specifications used to determine Capitated Payment Amounts. If able, please describe potential modification proposals. Indicate “N/A” if this hasn’t yet been determined.

HHSC’s approach of promoting Alternative Payment Models (APMs) through managed care contracting strategies will allow MCOs and Participant Hospitals flexibility to negotiate APMs appropriate for their Medicaid clients and service areas. To facilitate agreement between MCOs and Participant Hospitals, HHSC plans to host a series of meetings and a framework from which Medicaid MCOs and Participant Hospitals can collaborate to develop a CHART Medicaid APM. HHSC also plans to develop an exercise to facilitate APM negotiations that will occur in Calendar Year (CY) 2023. HHSC continues to contact and work in collaboration with CMCS on Phase 1 implementation of the Medicaid APM(s) through a series of meetings in CY 2023.

### Aligned Payers

1. Describe your private payer recruitment efforts to date.

HHSC distributed information about the CHART Model via email subscription services, emails and the HHSC web site to identify potential Aligned Payers interested in participating in the CHART Model.

2. Indicate if any private payers have already been recruited and expressed interest in participating in CHART.

HHSC has not approached any private Aligned Payers to date.

3. Name of interested payer(s):

n/a

4. Number and type of members by lines of business (e.g., Medicaid managed care, Medicare Advantage, employer-sponsored, etc.) served in the Community:

n/a

5. If applicable, describe the payers you are targeting in recruitment efforts during Performance Period 1.

n/a