Five Ways to Know if the CMS CHART Model's Community Transformation Track Is Right for You

Shanah Tirado
Manager

Allen Miller
Principal & CEO

In early August 2020, the Centers for Medicare and Medicaid Services (CMS) announced the Community Health Access and Rural Transformation (CHART) Model. This model aligns well with the overall momentum toward value-based payment from CMS, states, employers and health plans that has grown incrementally for several years. This particular program is targeted at reducing disparities and driving payment and delivery transformation in rural communities. The model contains two tracks – the ACO Transformation Track and the Community Transformation Track. While the ACO Transformation Track overlays advanced shared savings payments to the Medicare Shared Savings Program, the Community Transformation Track offers a completely new funding opportunity for community-wide transformation across multiple lines of business.

CMS intends to select up to 15 Lead Organizations for the Community Transformation Track. These Lead Organizations will need to drive a Transformation Plan that meets specific milestones and holds the community accountable. With a maximum of $5 million to disperse over a pre-implementation period and six performance periods, these organizations need to be able to leverage community infrastructure to drive results and efficiently target this funding to build community capacity and alignment. Successful applicants will be able to demonstrate an ability to achieve the goals of the program. Below are five questions applicants should consider.

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Are you a lead stakeholder in an existing collaborative or coalition?

This model places heavy emphasis on cross sector collaboration. Participation of the State Medicaid Agency (SMA), payer partners and hospital partners is a minimum requirement in addition to a multi-stakeholder community Advisory Council. Each stakeholder has defined obligations within the program to drive payment reform in both Medicare and Medicaid. While it is possible to establish a new coalition for the purposes of these programs, a strong collaborative foundation indicates an ability to coordinate and deliver on the ambitious program goals.

A variety of entities qualify to be a Lead Organization, including hospitals, independent practice associations (IPAs) and SMAs. Coalitions are uniquely placed to be Lead Organizations or key collaborators with Lead Organizations to efficiently harness the power, influence and resources of community stakeholders.

Do you have meaningful influence over a rural geography that covers 10,000+ Medicare FFS Beneficiary residents?

The program requires that the defined "Community" that the Lead Organization covers be a geography of rural counties or census tracts that includes the primary residences of at least 10,000 Medicare Fee-for-Service (FFS) beneficiaries. Beyond having beneficiaries living in the region, applicants should consider whether they are able to recruit the partner hospitals and community providers needed to serve these members to achieve the outcomes of the program. In addition to meeting this requirement, applicants must give consideration to Medicare Advantage penetration and the ability to coordinate with payers.

Does this region have similar needs and stakeholder alignment to benefit from a coherent community model?

While the model does provide up to $5 million dollars in funding, it also demands a great deal of transformation. To be most impactful, these dollars should be targeted at building needed capacity. The Transformation Plan that guides both goals and

spending can be most coherent when clearly aimed at defined community needs and a targeted approach. While some potential regional variation within Communities is expected, the complexity of successfully driving payment and delivery transformation increases as the regional needs profiles diverge and as the stakeholders needed to effect change expands. Similarly, the funds available to tackle specific issues and needs become diluted as the list of priority issues and needs grows. It is also helpful if these efforts are aligned with existing community initiatives whose funding and efforts can be amplified by this program.

Will hospitals in the region benefit from capitation of Medicare and Medicaid patients?

Although the program encourages efforts to align commercial payment models, its mandate is around Medicare and Medicaid capitation for participating hospitals. In order for delivery models to sustainably shift in response to payment models, a meaningful proportion of hospital revenues must be tied to models that align incentives. Hospitals with large public payer mix are most likely to benefit. The capitated model will offer a steady revenue stream alongside some critical waiver opportunities for critical access hospitals (CAH) that enable hospitals to stabilize their cash flow. In turn, they must drive quality improvement in metrics such as reduced avoidable readmission. These hospitals must also have commitment from leadership to drive the operational changes and investments required to materialize quality improvements.

Are you, in partnership with payers, able to execute on a physician engagement strategy that offers a clear value proposition?

Notably, the program places an emphasis on hospital participation. However, value-based payment and care delivery can only be successful with appropriate physician engagement and alignment. Lead Organizations and payer partners have the lever of physician compensation models to support this alignment. This, however, cannot be forced upon physician practices. Applicants must give consideration to the market dynamics to understand community provider willingness to participate and the terms of this participation. Features like the degree of practice consolidation, hospital physician employment rates, and the degree to which structural challenges like shortages and access issues can be mitigated to enable uptake of value-based payment models and incentives.

While these considerations are important for the Community Transformation Track, organizations across the country are contemplating similar considerations as the overall market continues to migrate toward value-based payment models, accelerated further by Covid-19. The CHART Model represents the latest in a series of programs that demonstrate a clear direction in Medicare and Medicaid policy. Whether the CHART Model, Medicare Direct Contracting, or other programs that seek to deploy advanced payment models, CMS has demonstrated a desire to increase capitated payments among providers, streamline and align quality measures, increase Medicare and Medicaid coordination, and embrace new delivery models – most notably, telehealth. Providers and community stakeholders must prepare to build the population health management capacity to successful meet the demands of these market trends.

For more information on system and payment transformation programs, the CMS Chart Model, and rural VBP Strategy, reach out to Shanah Tirado at stirado@copehealthsolutions.com or 213-369-7415 or Allen Miller at amiller@copehealthsolutions.com or 310-386-5812.