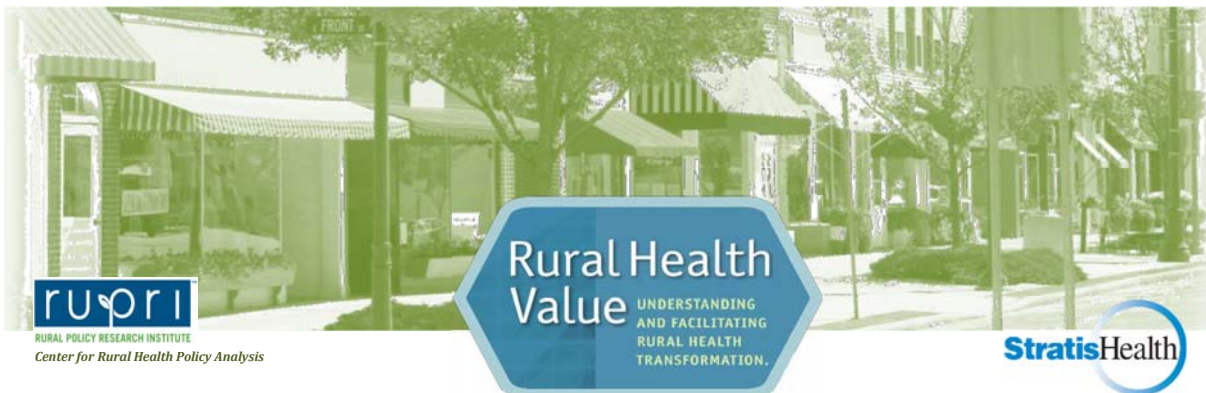


Community Health Access and Rural Transformation (CHART) Model Community Transformation Track

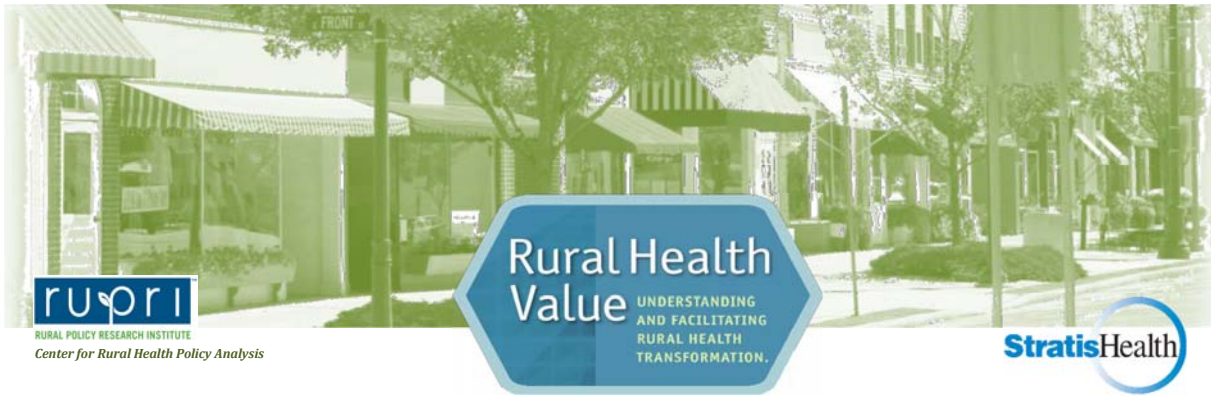
Rural Health Value
**Session #2 for
Prospective Applicants
and Stakeholders**

November 18, 2020



Rural Health Value

- Understanding and Facilitating Rural Health Transformation
 - To build and distribute an actionable knowledge base through research, practice, and collaboration that helps create high performance rural health systems.
- Led by the University of Iowa RUPRI Center for Health Policy Analysis and Stratis Health
- Funded by the Federal Office of Rural Health Policy



Rural Health Value

Let's Talk about CHART!

- Series of pre-application sessions for those considering applying or being part of CHART
- Slides, Q&A document, and registration available on the RHV website:
 - <https://ruralhealthvalue.public-health.uiowa.edu/InD/CHART/index.php>

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Today's CHART Session

Purpose	Overview	Discussion
Purpose: Focus on the Lead Organization role for those planning and preparing for a CHART Community Transformation Track application	Overview of requirements to serve as a Lead Organization and discussion regarding pre-application activities that should be underway as part of the pre-application process	What it takes to serve as a Lead Organization Key planning and readiness activities What partners are needed and strategies for engagement



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Model Overview and Lead Organization

Keith Mueller



CHART: Brief Overview

- Community Health Access and Rural Transformation (CHART)
- *Community*: Engagement of broad community (beyond health care organizations)
- *Health Access*: Address priority health needs of the residents of the community (drivers of morbidity and mortality)



CHART: Brief Overview

- *Rural*: Federal Office of Rural Health Policy list of counties and census tracts; in any combination
- *Transformation*: Changes to delivery system based on community needs; achieved by implementing a plan developed by lead Organization in collaboration with Advisory Council, Participant Hospital, and State Medicaid Agency



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Overview: Key Participants in the Model

- Lead Organization
- State Medicaid Agencies (could be Lead Organization)
- Participating Hospitals
- Other payers
- Members of Advisory Council



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Overview: Key Elements of the Model

- Organizing community entities
- Developing transformation plans
- Changing hospital payment to capitated payment for eligible hospital services



Overview: Timeline

The Community Transformation Track Timeline

Activity	Timing	Duration
Application Period	September 15, 2020 – February 16, 2021	100 business days
Application Evaluation	Spring 2021	
Anticipated Notice of Award	June 16, 2021	
Pre-Implementation Period	July 1, 2021 – June 30, 2022	1 year
Performance Period 1	July 1, 2022 – June 30, 2023	1 year
Performance Period 2	July 1, 2023 – June 30, 2024	1 year
Performance Period 3	July 1, 2024 – June 30, 2025	1 year
Performance Period 4	July 1, 2025 – June 30, 2026	1 year
Performance Period 5	July 1, 2026 – June 30, 2027	1 year
Performance Period 6	July 1, 2027 – June 30, 2028	1 year
Transition Period*	July 1, 2028 – June 30, 2030	2 years

*Transition Period back to FFS reimbursement in the absence of expansion or extension of CHART

NOTE: The Model timeline may be subject to change.





The Applicant: Lead Organization



Eligibility requirements



Capabilities



Lead Organization Eligibility Requirements



Must meet all of the following



Presence in the Community for at least the prior year: minimum is relationship with the community (not necessarily physical presence)



Expertise in rural *health issues* – health conditions, barriers to access, policy and other factors that influence outcomes



Experience in designing and implementing alternative payment models (APMs): direct management or through partnership



Lead Organization Eligibility Requirements

- Received and managed one or more health-related grants or cooperative agreements totaling at least \$500,000 over last three years
- Experience in:
 - Maintaining provider participation in APMs or CMMI demonstration projects/models
 - Establishing and maintaining agreements between health care providers
 - Conducting outreach and managing relationships with diverse health care-related stakeholders



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Lead Organization Capabilities

- Define the community
- Ability to develop transformation plan for the community, with participating hospitals and State Medicaid Agency (SMA) – means having relationships with them in advance
- If not the SMA, ability (skill and resources) to enter into a Memorandum of Understanding with the SMA, who will be a subrecipient of cooperative agreement funding



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Lead Organization Capabilities

- Enrolling participating hospitals – at least one prior to the application, reaching the minimum 10,000 *fee-for-service* beneficiaries most likely requires more
- Form and convene the Advisory Council
- Capacity to manage this project over a seven-year period



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Who Might be Lead Organizations?

- Direct examples: SMAs, State Offices of Rural Health, local public health departments, Independent Practice Associations, Academic Medical Centers
- From FAQs version 1 (October 2020): nonprofits with 501(c)(3) status, other government entities, small businesses, Indian Tribes or Tribal organizations, faith-based organizations





Questions

- Can a health system serve as a Lead Organization? How about Quality Improvement Organization?
- What if a state hasn't had experience in APMs or CMMI projects -- would they not be able to qualify as a Lead Organization? What type of APM experience is needed?
- Lead organizations can request to receive less cooperative agreement funding in exchange for a lower discount factor for hospitals. Do you know how this may be determined?



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Data on Characteristics of Proposed Community (1 of 2)

Suggested Resources

1. Medicare Geographic Variation - Public Use File
https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/Medicare-Geographic-Variation/GV_PUF
2. Medicare Enrollment Dashboard
<https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/CMSProgramStatistics/Dashboard>



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Data on Characteristics of Proposed Community (2 of 2)

Additional Resources

1. 2010 Census Tract Reference Maps
<https://www.census.gov/geographies/reference-maps/2010/geo/2010-census-tract-maps.html>
2. CMS Cost Report data
<https://www.cms.gov/Research-Statistics-Data-and-Systems/Downloadable-Public-Use-Files/Cost-Reports>
3. MMCO Statistical & Analytic Reports
<https://www.cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination-Office/Analytics>



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Panel Discussion



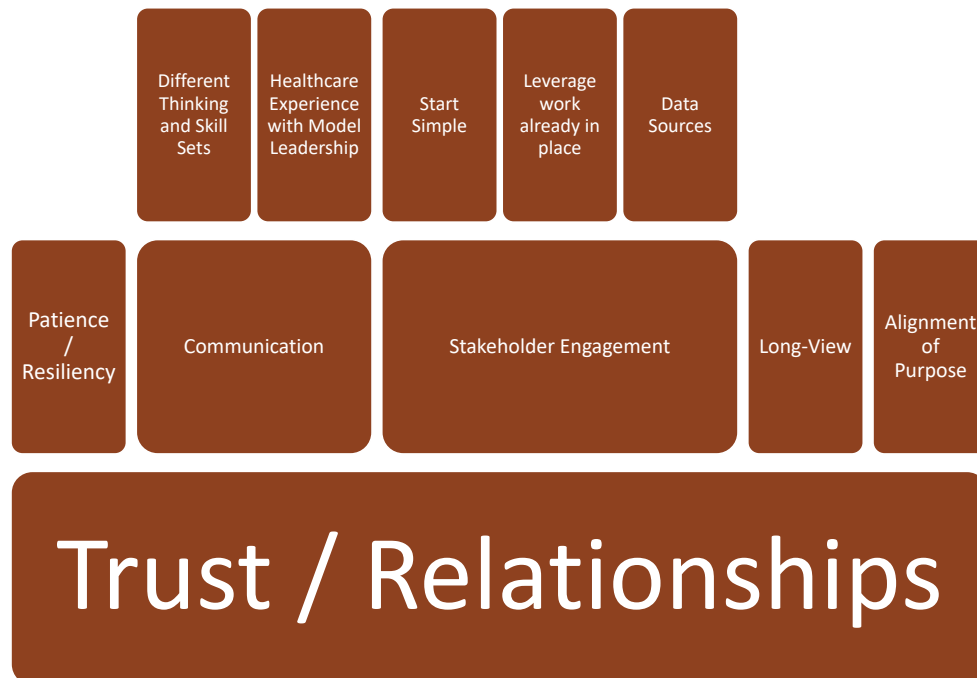
Panelists

- Janice Walters, Chief Operating Officer, PA Rural Health Model
- Jen Brockman, Vice President of Health Services, Iowa Healthcare Collaborative
- Cari Seddon, Director of Community Quality Initiatives, Iowa Healthcare Collaborative



A Federally Funded Program

A few insights on what is needed to make a program of this nature work:



Focus Areas to Support the Transformation of Health Care in Rural Communities

Technical Services and Capabilities Developed to Support PA Rural Communities



Jennifer Brockman,
MHA, BSN, RN
Vice President,
Health Services

Cari Seddon,
MA, RDN, LD, CDCES
Director, Community
Quality Initiatives



Primary Aims:

- + Align payers in value-based purchasing
- + Equip providers and communities for service delivery transformation
- + Improve clinical-community integration to address social determinant of health needs



Healthier
Communities



Better
Care



Smarter
Spending

Community and Clinical Care Initiatives (C3)

State and Local Clinical-Community Integrated Efforts

Governor's Healthcare Innovation and Visioning Roundtable

- + Engaged state leaders to identify and prioritize elements necessary for healthcare transformation
- + Healthy Communities Workgroup & Data Steering Workgroup

Steering Committee

- + Identified health strategies and provided leadership in care coordination and service integration
- + Ensured all relevant partners were included in decision-making
- + Aligned responsibilities for strategy development and implementation

Community Coalitions

- + Broad multi-sector partners represented
 - + Served as a source of communication and collaboration to drive project implementation
-

Data Analytics + Technical Assistance

Data Analytics

- + Live data dashboard displayed point in time metrics driving interventions

Technical Assistance (TA)

- + Educate, engage and execute
- + Resource distribution - conferences, virtual events, toolkits and practice modules
- + Peer mentoring and targeted TA for active participation
- + Promote successful and sustainable practices following the Accountable Communities for Health Model
- + Focus areas included needs assessments, strategic planning, process improvement and system alignment



Accountable Communities for Health (ACH)

- + ACH is a structured, cross-sectoral alliance of clinical and community stakeholders
- + Members are dedicated to improving health, safety and equity
- + An ACH creates a greater effectiveness towards population health transformation



Thank You

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Discussion



Upcoming Rural Health Value CHART Sessions

Monday, December 14,
1:00 Eastern

Focus on Transformation Planning

TBD,
January 2021*

Focus on financial modeling

*Note: A session that had been tentatively scheduled for November 30th will not be held. CMMI has since indicated that additional information about the financial model will be available in January.

Information from Rural Health Value CHART Webinars can be found at:
<https://ruralhealthvalue.public-health.uiowa.edu/InD/CHART/index.php>

