**CMS Innovation Center CHART Model – Framework for Maine’s Participation**

The following elements are proposed as a framework for Maine’s participation in the Community Transformation Track of the CMS Innovation Center’s Community Health Access and Rural Transformation (CHART) model:

* **Goals for Maine application/participation in CHART Community Transformation Track**
* Align with CMS goals:
	+ Improve access to care in rural areas
	+ Improve quality of care & health outcomes
	+ Increase adoption of alternative payment models
	+ Improve financial sustainability of rural providers
* Reflect needs of Maine rural communities, per DHHS Rural Health Listening Sessions:
	+ Support systems that provide adequate primary care, specialty care, behavioral health (mental health and substance use disorder) treatment, and prevention services
	+ Identify & address social health needs
	+ Ensure access to adequate after-hours emergency care, EMS services
	+ Coordinate care across settings
	+ Provide care in home and/or as close to home as possible
* **Guiding Principles**
* Identify clear vision for transforming health and health care and decreasing disparities within the participating/selected community
* Commit to implementing multi-payer, value-based payment models (VBP) that extend beyond hospital payment and shift savings from avoidable costs to address social health needs, support gaps in community-based care, and build on existing state and federal VBP programs (e.g. CMS Primary Care First /MaineCare Health Homes, Behavioral Health Homes, Opioid Health Homes, Accountable Communities)
* Be community-focused, reflecting community needs, and working with community organizations to incorporate community assets and implement community-based solutions
* Utilize key elements for improving of rural health care:
* Primary care-based
* Expanded use of telehealth and telemonitoring services for primary care, specialty care services, behavioral health, and home-based care
* New workforce models that support care in and/or close to home– e.g. (Community Health Workers, Community Paramedicine)
* Regional models for specialty/ tertiary care services
* Utilize evidence-based and/or promising local practices for interventions (e.g. NDPP, falls prevention, Community Health Workers, home visits), or scaling these interventions with additional payment and administrative flexibilities
* **Clinical Focus Areas**
* Chronic disease management, with focus on high-prevalence conditions – e.g. CVD, CHF, COPD, diabetes, dementia, with particular focus on serious illness care and palliative care
* Behavioral health conditions, including both mental health and substance use disorders
* Maternity and perinatal care