Community Health Access and Rural Transformation (CHART) Model

Payment Webinar: Community Transformation Track

The Centers for Medicare & Medicaid Services (CMS) Innovation Center

January 21, 2021

Today's Speakers

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Agenda

This webinar will cover the following key topics of the CHART Model Community Transformation Track and include time for questions and answers:

1. CHART Model Overview
2. Key Concepts and Policies
3. Community Transformation Track Capitated Payments
    - Calculate Participant Hospital's Payment for Performance Period 1
    - Performance Period 1 and Reconciliation
    - Calculate Participant Hospital's Payment for Performance Period 2
4. Q&A
5. Resources and Closing

CHART Model Overview

The CMS Innovation Center

The CMS Innovation Center Statute:

> The purpose of the [Center] is to test innovative payment and service delivery models to reduce program expenditures…while preserving or enhancing the quality of care furnished to individuals under such titles.

The Innovation Center was established by section 1115A of the Social Security Act (the "Act") (as added by section 3021 of the Affordable Care Act).

The CMS Innovation Center

If a model meets **one of the three below criteria** and other statutory prerequisites, the statute allows the Secretary to **expand the duration and scope of a model** through rulemaking.

Scenarios for success from the statute

Scenario One	Scenario Two	Scenario Three
⬆ Quality improves	➡ Quality neutral	⬆ Quality improves
➡ Cost neutral	⬇ Cost reduced	⬇ Cost reduced
		Best Case

CHART Model Review

The **CHART Model** is a voluntary model that will test whether **aligned financial incentives, operational & regulatory flexibilities, and robust technical support** will help rural providers **transform care** on a broad scale.

The CHART Model consists of two tracks for rural communities to implement Alternative Payment Models (APMs) to improve access to high quality care and reduce costs:

Community Transformation Track

Communities receive upfront funding, predictable finances through a capitated payment amount, and operational flexibilities through benefit enhancements and beneficiary engagement incentives.

Today's focus

ACO Transformation Track

Rural Accountable Care Organizations (ACOs) receive advance shared savings payments to participate in the Medicare Shared Savings Program (Shared Savings Program).

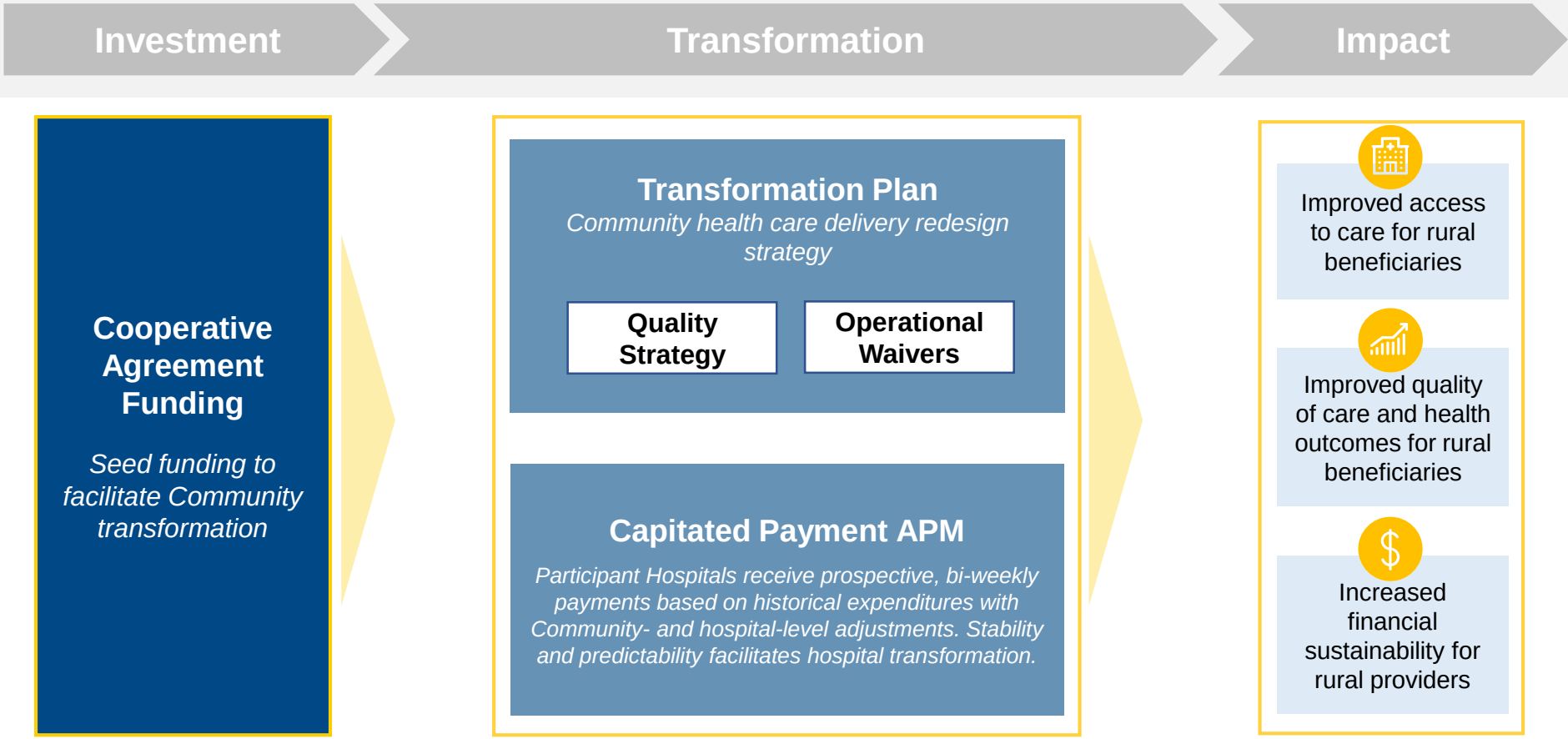
Model Goals:

- Improve access to care in rural areas
- Improve quality of care and health outcomes for rural beneficiaries
- Increase adoption of APMs among rural providers
- Improve rural provider financial sustainability

ACO Transformation Track: Request for Applications Upcoming Spring 2021 – Anticipate Awarding Up to 20 ACOs

Community Transformation Track

The CHART Model Community Transformation Track aims to catalyze modernization of rural health delivery systems through upfront funding, operational flexibilities, and APMs.



Application Timeline

CMS anticipates selecting up to 15 Award Recipients (Lead Organizations) for the Community Transformation Track.

Milestone	Date*
Community Transformation Track	
NOFO / Application portal opens†	September 15, 2020
Application deadline	March 16, 2021
LO/Awardee selection	July 2021
Pre-implementation period	August 2021 – December 2022
Performance periods	January 2023 – December 2028

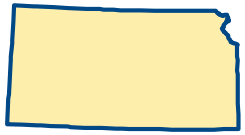
The NOFO is available now on the CHART Model website:

innovation.cms.gov/innovation-models/chart-model

*Dates are subject to change. Please sign up for our listserv to receive announcements.
†NOFO stands for Notice of Funding Opportunity.

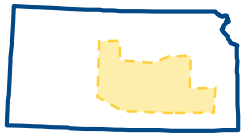
Key Entities

Within the Community, there are several key entities that will collaborate to implement transformation at the community level and form the Advisory Council.



State-Level Entities

- State Medicaid Agencies $



Community-Level Entities

- Lead Organizations $
- Community Partners
- Advisory Councils

Individual Entities

- Participant Hospitals $
- Aligned Payers

$

Lead Organizations will receive upfront cooperative agreement funding. State Medicaid Agencies are a sub-recipient of the Cooperative Agreement Award.

$

Participant Hospitals will sign participant agreements with CMS, at which point CMS will issue payments on a biweekly cadence throughout the Performance Period.

Community and Lead Organization Eligibility

For the Community Transformation Track, CMS anticipates selecting up to 15 Award Recipients (**Lead Organizations**) who will coordinate with Participant Hospitals.

Lead Organization Eligibility Requirements

Each Lead Organization must delineate the boundaries of its "Community," which **must meet the following criteria**:

- Encompass **either**
  - ❑ a single county or census tract **or**
  - ❑ a set of contiguous or non-contiguous counties or census tracts. Each county or census tract must be classified as rural, as defined by the Federal Office of Rural Health Policy's grant program eligibility criterion. (https://data.hrsa.gov/tools/rural-health)
- Include **at least** 10,000 Medicare Fee-for-Service (FFS) beneficiaries with a primary residence located within the Community.

Examples of entities eligible to apply to be a Lead Organization **include but are not limited to**:

State Medicaid Agencies	Local Public Health Departments	Independent Practice Associations
State Offices of Rural Health	Academic Medical Centers	Health Systems

CHART Model Participant Hospital Eligibility

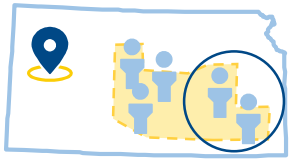
For the Community Transformation Track, Lead Organizations will recruit and partner with Participant Hospitals based on the below eligibility requirements.

Participant Hospital Eligibility

To participate in the Track, a Participant Hospital must be an acute care hospital or Critical Access Hospital that meets **at least one of the below requirements**:

1 **Located within the Community** and **receives at least 20%** of its eligible Medicare FFS revenue from services provided to residents of the Community.

2 Regardless of facility location, provides services to residents of the Community that in **aggregate account for at least 20%** of the eligible Medicare FFS expenditures of the Community.



3 If a hospital does not meet one of the two criteria above, a **Lead Organization may request that CMS review whether a potential Participant Hospital is eligible** based on the Community's care redesign strategy, as specified in its Transformation Plan and CHART Quality Measures selected**.** CMS may, in its sole discretion, accept or reject the Lead Organization's request for the potential Participant Hospital to participate in CHART.

Note, these organizations that are not eligible to participate as a Participant Hospital:

Federally Qualified Health Centers	Rural Health Clinics	Stand-alone skilled nursing facilities
Facilities providing dialysis services exclusively	Stand-alone ambulatory surgery centers	Organizations that provide home health services exclusively

Note: Section 125 of the Consolidated Appropriations Act of 2021 (Pub. L. 116–260) established "rural emergency hospital" as a new provider type under the Medicare program, effective 2023. CMS is in the process of implementing these provisions in accordance with Section 125. CMS is determining how to address rural emergency hospitals in the CHART Model's Community Transformation Track as more information becomes available.

Community Transformation

The CHART model focuses on transformation for a defined population in a rural community rather than transformation at the individual hospital level.

Transformation Plans drive regional care improvements

Community benchmarks create geographic cooperation and accountability

Incentives to work with non-hospital-based providers and **community partners**

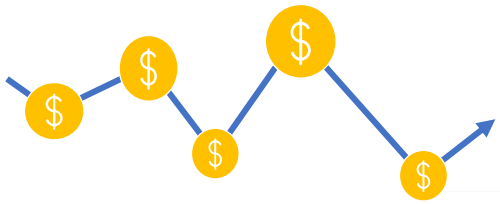
Key Concepts and Policies

Current and Future State

CMS will replace Participant Hospitals' Fee for Service (FFS) claim reimbursement with bi-weekly payments that equal the annual capitated payment amount (CPA) over the course of the first Performance Period.

Current State

FFS claims reimbursement



Future State

Bi-weekly payments provide a predictable funding stream to help with organizational budgeting

Represents single performance period

Known Issues

- Incentive for volume over value
- Lack of revenue predictability
- Risk of hospital closure in low-volume periods

Benefits

- Financial predictability, stable revenue, and opportunity to generate and keep savings
- Flexibility to innovate care and focus on quality
- Opportunities to drive population health

Capitated Payment Amount

The CHART Capitated Payment Amount (CPA) combines concepts from a global budget and from an ACO into a single hospital payment methodology.

Prospective Payment System Hospitals

The Capitated Payment Amount (CPA) for all Participant Hospitals is calculated based on Medicare FFS revenue using historical expenditures for Eligible Hospital Services. This will include any special designation status that hospitals currently have (e.g. Medicare Dependent Hospital).

Critical Access Hospitals

The Capitated Payment Amount (CPA) for all Participant Hospitals is calculated based on Medicare FFS revenue using historical expenditures for Eligible Hospital Services. **A CAH's prospective payment will be based on 101% of reasonable costs from historical eligible expenditures and trended forward**. CAHs prospective payments will replace interim payments on a reasonable cost basis through FFS claims for the eligible expenditures included in the CPA in future Performance Periods.

Hospitals' services that are not eligible for the CPA will continue to be reimbursed through FFS and standard CAH cost reporting.

Multi-Payer Financial Alignment

Multi-payer alignment ensures that Participant Hospitals receive predictable payments for larger portions of their revenue and thereby allowing differently insured beneficiaries to benefit from care transformation.

Medicaid Alignment:
Mandatory by Performance Period 2

Other Payer Alignment:
Encouraged but not mandatory

Each aligned payer:

- Must use a similar financial methodology as CMS uses for the Community Transformation Track APM.
- Is strongly encouraged to issue a prospective payment that follows a pre-specified cadence.
- Must describe how its financial methodology contributes to the goals of the Community's Transformation Plan.
- Must describe how its financial methodology will contribute to improvements on the Community's selected CHART quality measures.
- Is responsible for calculating its non-Medicare FFS CPA for each Participant Hospital.

CMS will provide more information on payer alignment during the Pre-Implementation Period, as payer alignment is not a requirement of the NOFO Application.
See NOFO or Medicaid Participation Factsheet on CHART Model website for details on Medicaid Alignment.

Quality Strategy

Participant Hospitals will continue to participate in, and have their CPAs adjusted, based on their performance in national CMS quality programs. CMS will not further adjust Participant Hospitals' CPAs based on their performance on CHART-specific quality measures.

CHART's Quality Framework Aims to:

Align financial incentives with quality improvement goals

Emphasize patient choice and engagement

Strengthen beneficiaries' access to and coordination of care

Facilitate redesign of health care delivery systems aligned with Communities' needs

Address health disparities that may exist in rural communities, including among different demographic groups

CHART Lead Organizations will partner with Participant Hospitals to:

Select relevant measures to drive quality improvement

Develop and execute Community's Transformation Plan that align with Community and Model goals

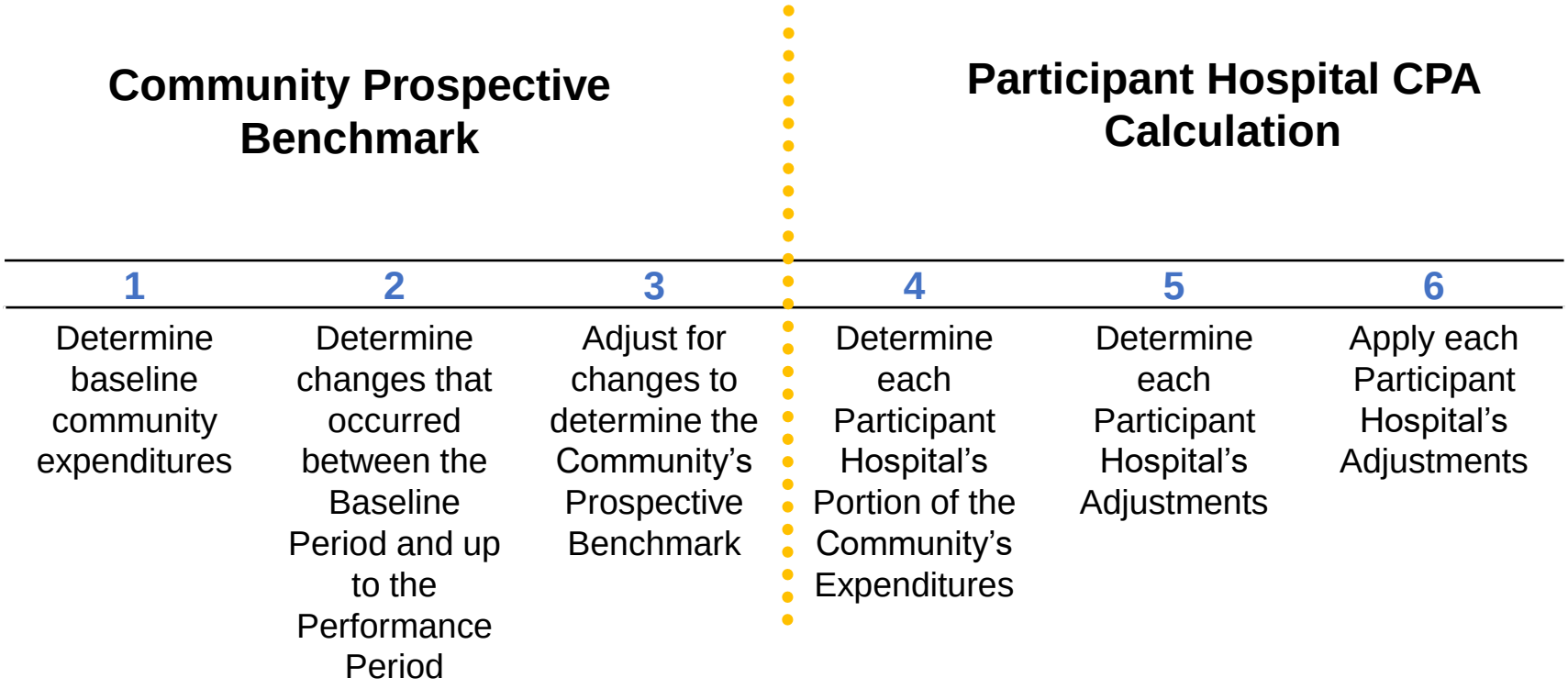
Identify strengths and opportunities for improvement to maximize progress and mitigate any unintended outcomes.

Community Transformation Track:

Calculate Participant Hospital's Payment for Performance Period 1

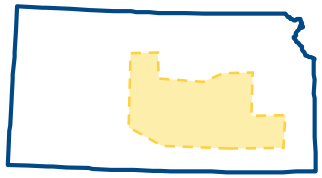
Overview of Capitated Payment Calculation

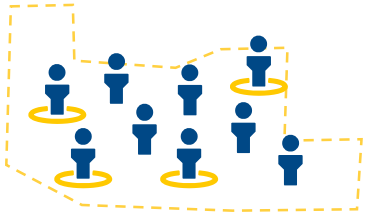
There are six overarching steps to calculate a Participant Hospital's Capitated Payment Amount (CPA).

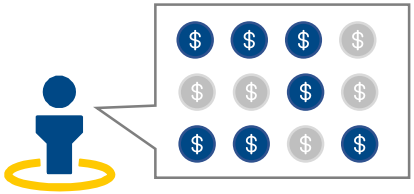


Step 1: Determine Baseline Community Expenditures

The calculation of the CPA begins with establishing relevant baseline Medicare FFS revenues for hospital expenditures incurred by assigned beneficiaries that live in the community:







Community Definition

- Defined by Lead Organization and approved by CMS
- May be updated once during Pre-Implementation Period

Beneficiary Assignment

Must meet criteria in the following areas:

- Residency Requirement
- Medicare Eligibility
- Service Utilization

Eligible Hospital Expenditures

- Inpatient and outpatient unadjusted expenditures: Hospital Part A and Facility Part B expenditures
- **The community baseline will exclude 2020 hospital expenditure data (due to Coronavirus Disease 2019)**

CMS uses these steps to offer financial predictability for Lead Organizations and Participant Hospitals. To promote transparency, CMS has provided more detail in the NOFO.

Step 2: Determine changes that occurred between the Baseline Period and up to the Performance Period

CMS will conduct the following types of adjustments to determine a baseline adjustment discount and ensure that the community benchmark depicts the beneficiaries that the community serves.

Trend

Apply a community-specific trend to forecast expected expenditures using historical expenditure data and behavior

Outlier

Exclude high-cost claims from the benchmark and in the Performance Period, if selected

Population

Account for differences in the population served between the baseline years and the Performance Period

Demographic

Adjust the benchmark based on changing populations & improve the accuracy of the benchmark calculation

IPPS/OPPS/CAH

Adjust the benchmark and CPA to account for any updates made to the IPPS and OPPS FFS payment systems as well as updated CAH policy

Step 3: Adjust for changes to determine the Community's Prospective Benchmark

Using the Community Baseline Expenditures from Step 1, apply the baseline adjustment discount determined in Step 2 to yield the Prospective Community benchmark for Performance Period 1.

Community Baseline Expenditures

Baseline Medicare FFS revenues for all Community hospitals' eligible expenditures as calculated in Step 1

×

Baseline Adjustment

Adjustments to ensure that the community benchmark depicts the beneficiaries that the community serves as determined in Step 2

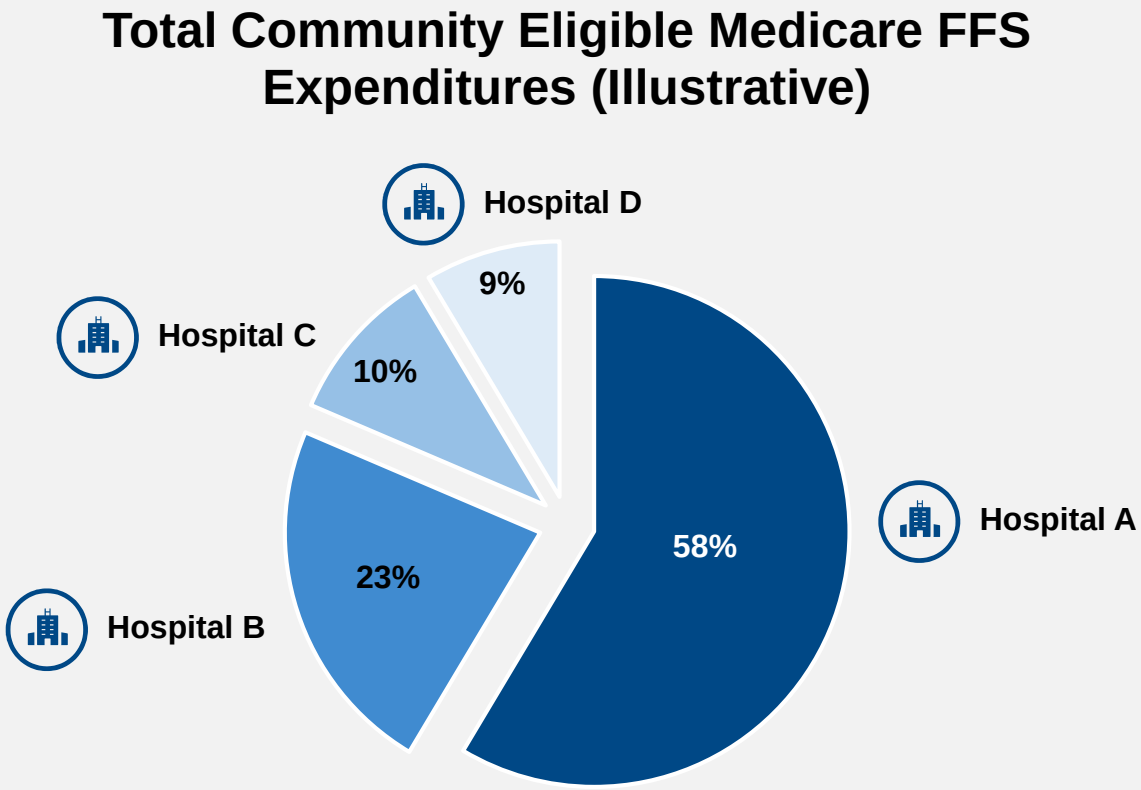
=

Prospective Community Benchmark

Establish the Predicted Expenditures for the Assigned Beneficiaries in the defined Community tied to the rural region tied to the Transformation Plan

Determining Hospitals' CPA

Participant hospitals will receive a CPA making up a portion of the total community eligible Medicare FFS.



Step 4: Determine each Participant Hospital's Portion of the Community's Expenditures

After determining total eligible hospital expenditures incurred by assigned beneficiaries residing in the Community, CMS will use the following calculation to determine each Participant Hospital's share:

Hospital Specific Share

Each Participant Hospital's CPA will be based on the portion of services that it provides to the community, as calculated by:

Hospital A's Base CPA = { Sum of IP/OP paid amounts to Hospital A for Assigned Beneficiaries / Unadjusted Community Expenditures from Step 1 } × **Prospective Community Benchmark (Step 3)**

Step 5: Determine each Participant Hospital's Adjustments

CMS will apply the following hospital specific adjustments to each Participant Hospital's base CPA:

Quality

Prospective Payment System (PPS) hospitals: CPAs will be prospectively adjusted to reflect performance in the national Medicare quality hospital programs

CAHs will not have a financial quality adjustment but will be required to report on the CHART-specific measures and participate in both the 1) the Medicare Beneficiary Quality Improvement Program and the 2) Quality Assurance and Performance Improvement Program.

Special Designation

CMS will apply adjustments for:

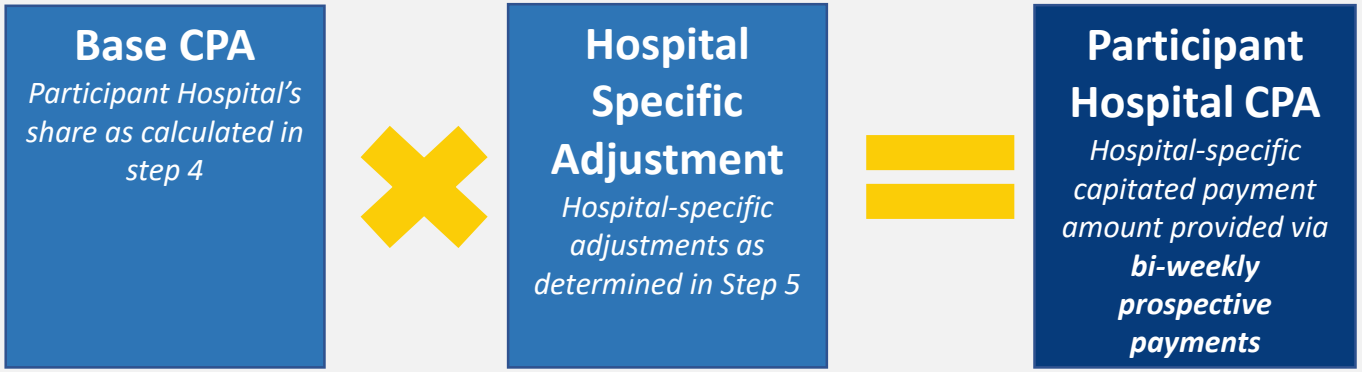
1. **Special status** hospitals (e.g., CAHs, SDH, MDH)
2. **Other** adjustment factors (e.g., bad debt, IME, LVA)

Discount

Apply a standard 0.5% discount during the first Performance Period

Step 6: Apply each Participant Hospital's Adjustments

Using the base CPA identified in Step 4, apply the adjustment factors determined in step 5 to yield each Participant Hospital's CPA for Performance Period 1.



Issuing Payments to Participant Hospitals

Payments to Participant Hospitals will be agreed to during the Pre-Implementation Period, with issuance commencing with the start of the Performance Period.

Pre-Implementation Period

Performance Period

CMS determines the Participant Hospital CPA using the previously described steps.

CMS shares CPA for each prospective hospital with the Lead Organization and prospective hospitals during the Pre-Implementation Period.

Prospective hospitals will review the CPA.

Prospective hospitals sign the Participant Agreement with CMS before the start of the Performance Period to directly receive their CPA

CMS issues payments to Participant Hospitals on a biweekly cadence throughout the Performance Period.

Through this process:

- ✓ **Lead Organizations** have useful details to help drive hospital recruitment and transformation plan creation.
- ✓ **Participant Hospitals** have full transparency on their expected CPA prior to signing a Participant Agreement, yielding a predictable funding flow.

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Community Transformation Track:

Performance Period 1 and Reconciliation

End-of Year Updates

Adjustments will be applied annually at the end of the Performance Period to ensure that hospital payments account for changing populations served. Prior to this, CMS will conduct a **mid-year check** to identify adjustments for the remainder of the Performance period.

Performance Period

Mid-Year Check

CMS will conduct a mid-year check to help identify necessary adjustments for the remainder for the Performance Period

End of Performance Period

End of Year Adjustment

Following the conclusion of the Performance Period, adjustments will be made with updates to the community benchmark and updates to hospital CPAs.

Updates to Community Benchmark

Constant	***Updated***
• Discount Factor	• Beneficiary Months
• Trend	• Demographics
	• Outliers

Updates to Hospital CPAs

Constant	***Updated***
• Discount Distribution	• Quality Adjustment Factor
• Special Designation	• Distribution in Services Adjustment

CMS will also assess the following:

- Utilization against established guardrail, which protects against exogenous factors (e.g., public health emergencies), is evaluated at mid-year reconciliation, and includes a regional adjustment
- Relevant IPPS/OPPS Updates

Change in Share of Beneficiary Expenditures

To incentivize community-level transformation, Participant Hospitals may choose to provide services that were not included in the baseline data. Participant Hospitals may request service line changes for the following reasons.

Service Line Type	Description
Service Line Addition	Participant Hospital adds a new service to invest in model goals or to satisfy an unmet community need.
Unplanned Shift in Services	Participant Hospitals request funding for the shift of a service from one hospital in the region (Participant Hospital or non-Participant Hospital) to another (Participant Hospital) due to unforeseen circumstance.
Strategic Planned Service Shift	Participant Hospitals request funding for a strategic shift of a service from one Participant Hospital to another for the purposes of optimizing how services are provided across the community to meet model goals.

The Community Transformation Track provides additional incentives to cover a hospital's fixed costs for providing services that are intentionally and strategically shifted to other hospitals in accordance with the Transformation Plan.

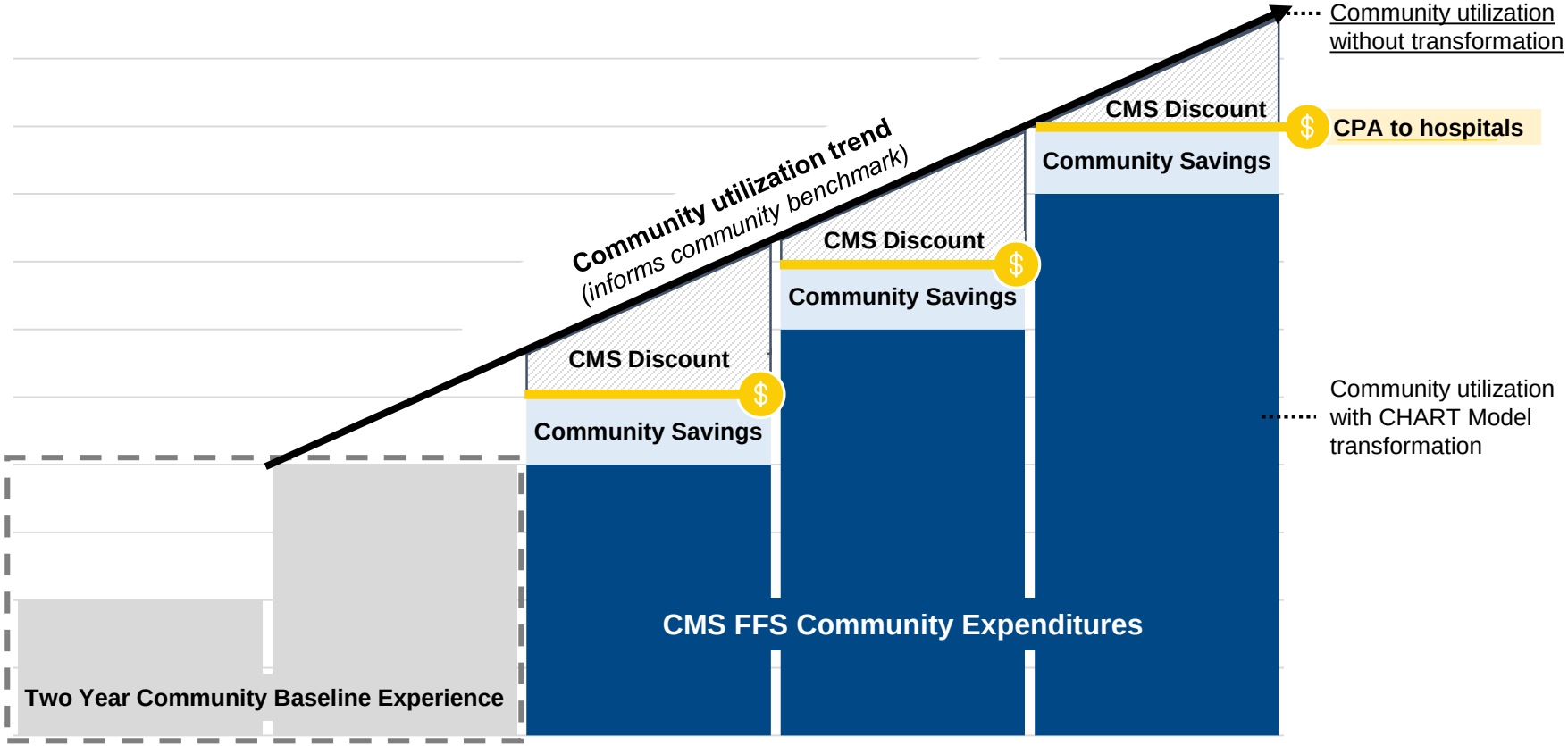
Reconciliation

CMS anticipates that mid-year checks and end-of year adjustments will help mitigate risk of overpayment or underpayment. Below are CMS policies for reconciling discrepancies that do exist.

Chapter	Adjustment	CMS Policy
Community Benchmark	Trend Population Size Demographic Risk	*Final benchmark below projected benchmark:* **CMS will not recoup the monies paid out for changes in the same performance period.** CMS will update the benchmark with the new data to reflect the most accurate figures for the future Performance Period. *Final benchmark above projected benchmark:* **CMS will true up the monies from both the past performance period** and increase the benchmark accordingly going forward to reflect the most up-to-date trend.
	Outlier Adjustment	**CMS will bi-directionally reconcile** for variation above and below the projected benchmark.
	IPPS/OPPS & CAH policy updates	This will be reviewed on a **case-by-case basis**.
Hospital-Specific CPA	Quality Adjustment	**CMS will bi-directionally reconcile** for variation above and below the projected benchmark, as this is intended to coincide with the national quality programs and the incentives they create.
	Change in Share Beneficiary Expenditures	**CMS will bi-directionally reconcile** for variation above and below the projected benchmark, as these variations in payment to one Participant Hospital could impact payments to another Participant Hospital.

Performance & Savings

Over the lifecycle of the CHART Model, the CPA will increase as it accounts for community trends as a community transforms.



Community Transformation Track:

Calculate Capitated Payment for Performance Period 2

Setting the CPA for Performance Period 2

After the end-of-year adjustments have been made, the CPA will be determined by the following process:

1. **Calculate Prospective Benchmark using the latest Community Adjustment** from end-of year adjustments in Performance Period 1.
2. **Calculate Hospital specific share of the updated Performance Period 2 Community benchmark,** incorporating data from the hospital-specific end of year adjustments from Performance Period 1.
3. **Calculate and issue new prospective payments,** which will be reviewed by Participant Hospitals prior to the start of Performance Period 2.

Open Q&A

CHART Model Open Q&A

Open Q&A

Please **submit questions via the Q&A button** to the bottom of your screen.

Specific questions about your organization can be submitted to CHARTmodel@cms.hhs.gov

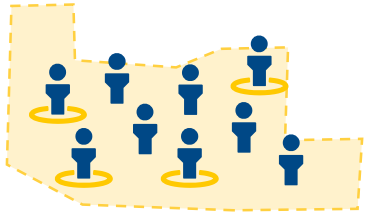
Not all questions submitted to the Q&A will be addressed during this time. Please look out for an updated FAQ document on the CHART Model website, which will be informed by questions submitted during today's session and questions sent to the CHART mailbox.

Frequently Asked Questions and Answers

Question and Answer

How will Participant Hospitals be reimbursed for non-residents of the Community receiving care?

Hospitals will continue to be reimbursed for non-residents on a Fee For Service Basis.



Hospitals are reimbursed for **residents** by the CPA.

Hospitals are reimbursed for **non-residents** through FFS.

Questions and Answers

How is a **Community** defined for the CHART Model?

Criteria	Each Community must meet the criteria noted previously (see slide 11).
Application & Approval	Lead Organizations' definition of their Community is subject to CMMI review and approval. During application review, CMMI will ensure that there is **no overlap between Lead Organizations' defined Communities**.
Updating Community Boundaries	Lead Organizations can update their Community boundaries **once during the Pre-Implementation Period,** if the following conditions are met: ○ Must maintain its 10,000 minimum-aligned FFS beneficiary requirement. ○ The amount of change is limited to a threshold. ○ CMS must review and approve all changes to the zip-codes updates and new Community definition.

Question and Answer

What are the criteria to determine **eligible beneficiaries** related to residence/service utilization and Medicare eligibility?

Beneficiary eligibility related to residence/service utilization and Medicare eligibility is assessed on a **month-by-month basis**, then combined to form a single monthly record for each beneficiary used for beneficiary attribution and subsequent financial calculations.

Residency Requirement

Beneficiaries are aligned to the Community if the monthly Resident eligibility records created in the previous two steps satisfy the following rules:

1. Beneficiaries are eligible and reside in the Community **for the majority of the alignment period** (12-month period beginning 18 months prior to the respective baseline or PP)
2. The **beneficiary must not move out of the Community** before or during the respective baseline or performance period.

Medicare Eligibility

- **Inclusion criteria:** Enrolled in Medicare Parts A or Part B, Medicare is designated primary payer, United States residency, and must be living.
- **Exclusion Criteria:** Enrolled in Medicare Advantage or Programs of All-Inclusive Care for the Elderly (PACE), Must not be enrolled in any of the Alternative Payment Models (APMs) listed in the Overlaps policy.

Service Utilization

- **Utilizers and non-utilizers** of hospital services that reside within the Community
- Calculated as a **per-beneficiary per month rate**, with non-utilizers contributing member months to the calculation

Question and Answer

What hospital expenditures are included and excluded for the sake of determining **baseline community expenditures**?

Beneficiary eligibility related to residence/service utilization and Medicare eligibility is assessed on a **month-by-month basis**, then combined to form a single monthly record for each beneficiary used for beneficiary attribution and subsequent financial calculations.

Inclusion Criteria

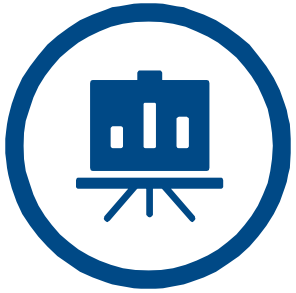
- **Part A** services include inpatient hospitalizations and swing bed services provided by Critical Access Hospitals.
- **Part B** services include: ED services, outpatient surgery, observation stays, physical therapy, occupational therapy, speech therapy, clinic visits, dialysis, imaging services, lab services, and certain drugs.
- Included services are billed on UB-04 facility claim forms and are identified by type of bill codes corresponding to inpatient and outpatient hospitals,
- Payments made on claims **can include additional reimbursement activities** such as medical education or for bad debt expense.

Exclusion Criteria

The service inclusion criteria effectively exclude services include but are not limited to:

- Physician services
- Other professional services
- Durable medical equipment
- Hospice
- Home health services
- Skilled Nursing Facility services

Audience Poll



What topics related to Payment under the Community Transformation Track would you like to learn more about?

a) Model Eligibility
b) Community Definition
c) CAH Policies
d) Multi-payer Financial Alignment
e) Performance Period 1 Participant Hospital Payment Calculation
f) Reconciliation Process
g) Performance Period 2 Participant Hospital Payment Calculation

Additional Resources

Resources and Contact Info

For more information about the CHART Model and to stay up to date on upcoming model events:

Visit

https://innovation.cms.gov/innovation-models/chart-model

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