# Community Health Access and Rural Transformation (CHART) Model

## Frequently Asked Questions

Version 9

**February 2022**

## Contents

# General Questions

## Model Overview

**What is the Community Health Access and Rural Transformation (CHART) Model?**

The Community Health Access and Rural Transformation (CHART) Model is a voluntary payment model designed to meet the unique needs of rural communities. The CHART Model will test whether aligned financial incentives, increased operational flexibility, and robust technical support promote rural health care providers' capacity to implement effective health care delivery system redesign on a broad scale. The Center for Medicare & Medicaid Innovation (CMMI) will evaluate the impact of the CHART Model on Medicare and Medicaid expenditures, access to care, quality of care, and health outcomes for rural residents.

Published October 2020

**What are the goals of the CHART Model?**

The CHART Model aims to improve health care quality and reduce Medicare and Medicaid expenditures within rural communities. The CHART Model will harness the drive, creativity, and local expertise of rural communities and leverage national resources to improve access to care, quality of care, and health outcomes for rural residents.

Published October 2020

**What are the track options under the CHART Model?**

The CHART Model includes one track: The Community Transformation Track.

Under the **Community Transformation Track**, award recipients (i.e., Lead Organizations) will receive cooperative agreement funding and a programmatic framework to assess the needs of their Community (as defined in the CHART Notice of Funding Opportunity (NOFO) *Section A.4.3.1. Community Definition*) and implement health care delivery system redesign. Hospitals participating in the Community Transformation Track Alternative Payment Model (APM) will receive capitated payments. Capitated payments provide hospitals with a stable revenue stream and incentivize reductions in fixed costs and avoidable utilization. Operational flexibilities will be available for participating hospitals to relieve regulatory burden, emphasize high-value services, and support providers in care management for their beneficiaries.

The ACO Transformation Track was removed from the CHART Model in February 2022.

Updated February 2022

**In January 2021, the Health Resources and Services Administration (HRSA) Federal Office of Rural Health Policy (FORHP) revised their definition of "rural," going into effect in Fiscal Year 2022. How does FORHP's new rural definition affect the CHART Model?**

Under FORHP's new definition of "rural," the current set of eligible counties and rural census tracts will remain eligible, and additional counties will gain eligibility for rural health grants. The Community Transformation Track Lead Organizations must use the Fiscal Year 2022 FORHP definition when defining their Communities. CMS will use the Fiscal Year 2022

FORHP definition when reviewing applications to determine if a Lead Organization's Community meets the definition of rural.

Additional information on the FORHP's definition of "rural" is available on the HSRA.gov website. A list of the counties that will gain eligibility for rural health grants through this change is available on the HRSA.gov website on Federal Office of Rural Health Policy (FORHP) Data Files.

Published March 2021

# CHART Community Transformation Track

## Application

**How do we apply for the CHART Community Transformation Track?**

Application materials are available at the Grants.gov website. Please note that CMS requires applications for all Notice of Funding Opportunity (NOFOs) to be submitted electronically through the Grants.gov website. Applicants will be able to download a copy of the application packet, complete it off-line, and then upload and submit the application via the Grants.gov website. Refer to CHART NOFO *Appendix II. Application and Submission* Information for additional requirements.

During the application period, the CHART Model will offer informational events (e.g. webinars and open-door forums) for applicants. CMS will gear these events towards increasing understanding of the CHART Model aims, plans, and conditions for participation. These events will provide an opportunity to introduce key concepts to applicants, engage individuals from across the applicant organization, and initiate action planning by applicants. Applicants are encouraged, but not required, to participate in these informational events.

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**How can organizations find information about interested applicants in their area, to coordinate applications or to participate in the CHART Community Transformation Track?**

While there is no official entity tracking potential applicants within each state, CMS recommends organizations contact their State Office of Rural Health (SORH) for information about applicants in the same community or region. The National Organization of State Offices of Rural Health (NOSORH) provides a state member list on the Members section of its website. In addition to the SORH, the State Medicaid Agency (SMA) may be tracking interested organizations and may be able to serve in a coordinating role.

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**How many cooperative agreements will CMS award for the CHART Community Transformation Track?**

CMS intends to award cooperative agreements of up to $5 million to up to 15 award recipients (i.e., Lead Organizations). Lead Organizations will participate in CHART for seven years (includes one Pre-Implementation Period and six Performance Periods). Cooperative

agreements will be awarded in consideration of (1) overall quality of the proposal and the ability to meet project goals; and (2) overall cost effectiveness of applicant's proposal. The amount of funding for each cooperative agreement award will depend on the individual Lead Organization's need as demonstrated in its responses to the CHART Notice of Funding Opportunity.

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**Can an organization submit more than one CHART Community Transformation Track application?**

Yes. An organization may submit more than one CHART Community Transformation Track application; however, CMS will award no more than one CHART Community Transformation Track cooperative agreement to a Lead Organization. The CHART NOFO *Section A.4.3 Lead Organization and the Community* describes specific programmatic eligibility requirements for Lead Organizations. Note: During application review, CMS will ensure that there is no overlap between Lead Organizations' defined Communities

Published March 2021

**What is the timeline for the CHART Community Transformation Track?**

*The Community Transformation Track Timeline*

| Activity | Timing | Duration |
|---|---|---|
| **Application Period** | September 15, 2020 – May 11, 2021 | 160 business days |
| **Application Evaluation** | May 12, 2021 – September 9, 2021 | |
| **Anticipated Notice of Award** | September 10, 2021 | |
| **Pre-Implementation Period** | October 1, 2021 – December 31, 2022 | 15 months |
| **Performance Period 1** | January 1, 2023 – December 31, 2023 | 1 year |
| **Performance Period 2** | January 1, 2024 – December 31, 2024 | 1 year |
| **Performance Period 3** | January 1, 2025 – December 31, 2025 | 1 year |
| **Performance Period 4** | January 1, 2026 – December 31, 2026 | 1 year |
| **Performance Period 5** | January 1, 2027 – December 31, 2027 | 1 year |
| **Performance Period 6** | January 1, 2028 – December 31, 2028 | 1 year |
| **Transition Period*** | January 1, 2029 – December 31, 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.***

Updated March 2021

**Why did CMS extend the application deadline for the Community Transformation Track?**

CMS received feedback from stakeholders that highlighted the challenges of preparing an application during the coronavirus disease 2019 (COVID-19) public health emergency. In

response, CMS extended the application deadline to allow interested applicants additional time to prepare their applications.

Updated March 2021

**Did CMS make changes to the CHART Notice of Funding Opportunity (NOFO) when the Community Transformation Track application deadline was extended?**

CMS did not change any Model requirements in the updated version of the NOFO posted to grants.gov on December 29, 2020. However, the timeline for the Community Transformation Track shifted to accommodate the lengthened application period. With this shift in timeline, the Community Transformation Track Pre-Implementation Period was modified from 17 months to 15 months. This modification will still allow Lead Organizations additional time to prepare for implementation because of the COVID-19 public health emergency. The table below summarizes the changes to the timeline in the updated NOFO.

| Activity | Previous Timing | New Timing |
|---|---|---|
| **Application Period** | September 15, 2020 – May 11, 2021<br>*100 business days* | September 15, 2020 – May 11, 2021<br>*160 business days* |
| **Application Evaluation** | March 17, 2021 – July 14, 2021 | May 12, 2021 – September 9, 2021 |
| **Anticipated Notice of Award** | July 15, 2021 | September 10, 2021 |
| **Pre-Implementation Period** | August 1, 2021 – December 31, 2022<br>*17 months* | October 1, 2021 – December 31, 2022<br>*15 months* |
| **Performance Period 1** | January 1, 2023 – December 31, 2023 | January 1, 2023 – December 31, 2023 |
| **Performance Period 2** | January 1, 2024 – December 31, 2024 | January 1, 2024 – December 31, 2024 |
| **Performance Period 3** | January 1, 2025 – December 31, 2025 | January 1, 2025 – December 31, 2025 |
| **Performance Period 4** | January 1, 2026 – December 31, 2026 | January 1, 2026 – December 31, 2026 |
| **Performance Period 5** | January 1, 2027 – December 31, 2027 | January 1, 2027 – December 31, 2027 |
| **Performance Period 6** | January 1, 2028 – December 31, 2028 | January 1, 2028 – December 31, 2028 |
| **Transition Period** | January 1, 2029 – December 31, 2030 | January 1, 2029 – December 31, 2030 |

Updated March 2021

**May we request a meeting with CMS to discuss our options as to how we can participate in CHART?**

During the application period, CMS is unable to meet separately with interested Community Transformation Track applicants. However, the CHART Model team will host public informational events (e.g. webinars and office hours). These events will aim to increase understanding of CHART Model components such as, but not limited to aims, eligibility, and conditions for participation.

The CHART Model team also continues to update information on the CHART Model website. If you are interested in receiving Model updates, including notifications when the website is updated with new information, please sign up for our listserv using the link on our website.

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**Will there be another application period for the CHART Community Transformation Track?**

At this time, CMS does not anticipate offering another application period for the CHART Community Transformation Track.

Published October 2020

**When is the Community Transformation Track general Letter of Intent (LOI) due?**

The general Letter of Intent (LOI) signaling intent to submit an application is due by April 13, 2021, 30 calendar days before applications are due on May 11, 2021.

The LOIs requested in the Project Narrative section of the actual CHART application are distinct from the general LOI that applicants are encouraged to submit within 30 days before the applications are due.

Updated March 2021

**We submitted a general Letter of Intent (LOI) before the deadline was extended to April 13, 2021, do we need to submit another LOI due to the new deadline?**

No. The general LOI is optional. If you submitted a general LOI prior to the deadline extension, you do not need to submit another LOI. You may update your general LOI with new information and resubmit it prior to the new deadline if desired, but it is not required.

Published March 2021

**Is there a minimum number of Participant Hospital Letters of Intent (LOIs) a Lead Organization must submit with its application for the Community Transformation Track?**

Yes, an application must include at least one LOI from a potential Participant Hospital (refer to CHART Notice of Funding Opportunity *Section E.1.2.2.3. Health Care Delivery System Redesign Concept* for additional details on documentation of Participant Hospital Interest). Applicants with a greater number of LOIs from potential Participant Hospitals, relative to the total number of potential Participant Hospitals within the Community, will receive preference during the application review process.

CMS would like to see applicants demonstrate their relationship with the Community through expressed interest from multiple potential Participant Hospitals. (Participant Hospitals, however, do not have to sign Participation Agreements until the end of the Pre-Implementation Period).

Note: Lead Organizations may recruit additional Participant Hospitals as necessary during the Performance Periods.

Published December 2020

**What if a Participant Hospital signs a Letter of Intent (LOI) for the application to the CHART Community Transformation Track, but cannot agree to terms in negotiating the actual contract?**

An LOI from a potential Participant Hospital in the submitted application is not a legally binding contract and does not require the hospital or CMS to enter into a Participation Agreement. Participant Hospitals must sign Participation Agreements with CMS before Performance Period 1 begins.

Published December 2020

**Is the Applicant's Letter of Intent (LOI) for the CHART Community Transformation Track binding?**

No. There are three types of LOI for the CHART Community Transformation Track, including the optional general LOI to apply (see CHART Notice of Funding Opportunity (NOFO) *Section C.3 Letter Of Intent*), the required Participant Hospital LOI (see CHART NOFO *Section E.1.2.2.3 Health Care Delivery System Redesign Concept*), and the required Advisory Council LOI (see CHART NOFO *Section E.1.2.2.2. Advisory Council*). None of these LOIs are legally binding.

*General LOI:* CMS highly recommends that interested applicants submit an LOI. You may email an LOI to the following address: CHARTModel@cms.hhs.gov. LOIs should include (1) an expression of interest, (2) a brief description of the interested organization, (3) a preliminary list of the rural counties or census tracts that may define the Community, and (4) contact information, including the organization's street address and a contact person's name, position, email, and phone number. The general LOI to apply for the CHART Community Transformation Track is optional. Submitting an LOI does not mean an applicant is required to submit a full application.

*Participant Hospital LOI:* Each application must include at least one LOI from a potential Participant Hospital. Each potential Participant Hospital's LOI must include:

- Hospital type (acute care hospital (defined as a "subsection (d) hospital" in section 1886(d)(1)(B) of the Act) or Critical Access Hospital (CAH);
- Its annual Fee-For-Service (FFS) Medicare revenue for each of the past five years (2014 to 2019);
- The number of Medicare FFS beneficiaries from the Community served by the Participant Hospital in each of the past five years;
- Whether the potential Participant Hospital's physical location is in the Community or outside of the Community; and
- Attestation that the potential Participant Hospital meets the eligibility criteria and is willing to perform required activities, as described in the CHART NOFO *Section, A.4.4.2 Participant Hospitals*.

Applicants with a greater number of LOIs from potential Participant Hospitals, relative to the total number of potential Participant Hospitals within the Community, will be given preference during the application review process.

Published January 2021

**CMS requires that Lead Organizations in the CHART Community Transformation Track have experience "designing and implementing Alternative Payment Models (APMs)." What does this mean?**

Lead Organization experience in "designing and implementing APMs" need not be specifically in Medicare APMs, meaning that experience designing and implementing any APM, including commercial insurance or Medicaid, would meet the requirement. Experience with other CMS models or demonstrations (not limited to APMs) can also be included. CMS also requires experience in engaging and maintaining provider participation in APMs or CMS demonstration projects or models. As stated in the CHART Notice of Funding Opportunity *Section A.4.3. Lead Organization and the Community*, applicants must describe their experience with the following:

- "Experience, either through direct management or through a partnership, in designing and implementing APMs."
- "Experience in engaging and maintaining provider participation in APMs or CMS demonstration projects/models."

Published December 2020

**Is there an opportunity for applicants to the CHART Community Transformation Track to focus on transformation in a single area (e.g., chronic disease or behavioral health)?**

Yes, the Transformation Plan requirements specified in the CHART Notice of Funding Opportunity (NOFO) provide an opportunity for applicants to focus on a specific area for transformation and improvement. Transformation Plans must focus on chronic conditions or target population health disparities present in the defined Community. Specifically, Transformation Plans must address at least one of the following: behavioral health treatment, substance use disorder treatment, chronic disease management and prevention, or maternal and infant health. In addition to selecting one of these areas, Transformation Plans must include strategies to expand the use of telehealth and other technology to support care delivery improvement. See CHART NOFO *Section A.4.3.2. Transformation Plan* for more information on requirements.

Published December 2020

**What should a CHART Community Transformation Track applicant include in their sustainability plan?**

The CHART Notice of Funding Opportunity (NOFO) *Section E.1.2.3 Sustainability Plan* describes the sustainability plan requirements. The applicant should:

- Identify which elements of their health care delivery system redesign strategies could be sustained if the Model was not extended and describe how they would sustain those program elements.

- If applicable, describe whether they have secured any supplemental sources of funding, are in the process of securing supplemental funding, or have any plans to explore supplemental funding sources (see CHART NOFO, *Appendix VIII. Additional Resources for Applicants: Literature and Funding Opportunities*). NOTE: securing supplemental funding is **not** a program requirement.

Also see CHART NOFO, *Appendix V. Review and Selection Process* for additional selection and review process information.

Published January 2021

**Do we need to include specific information in the CHART Community Transformation Track application cover letter or cover page?**

No. The CHART Notice of Funding Opportunity (NOFO) does not include specific requirements for what information must be included in the application cover letter. However, the cover letter or cover page must be formatted in accordance with the CHART NOFO *Section D.2. Content and Form of Application Submission,* which states that each application must include all contents of the application package, in the order indicated, and conform to formatting specifications.

Published March 2021

**Does the Business Assessment of Applicant Organization questionnaire in Appendix III of the CHART Notice of Funding Opportunity (NOFO) count towards the Project Narrative page limit?**

No. The Business Assessment of Applicant Organization questionnaire in Appendix III is separate from the Project Narrative, which has a limit of 60 pages, double-spaced. The Business Assessment of Applicant Organization may be single-spaced and has a limit of 10 pages.

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**Does the CHART Community Transformation Track Notice of Funding Opportunity (NOFO) Budget Narrative need to be single-spaced?**

No. CMS recognizes that the NOFO posted on 9/15/20 contained conflicting language regarding the spacing requirement for the Budget Narrative. In the updated NOFO posted on grants.gov, CMS clarified that it will accept single-spaced or double-spaced as long as the 10-page limit specified in the CHART NOFO *Section D.2 Content and Form of Application Submission* is met.

Updated March 2021

**In the CHART Community Transformation Track, will "Year 1" of the Budget Narrative be the 15-month Pre-Implementation Period followed by 12-month Budget Periods in "Years 2-7"?**

Yes. The First Budget Period, "Year 1," is a 15-month Pre-Implementation Period despite its 15-month length. The following Budget Periods, Years 2-7 will be 12-month periods. You should detail each Budget Period in the Budget Narrative.

As such, the Form SF-424A completed for the First Budget Period will be for 15-months and can be itemized in the first column on the SF-424A. Each year following the First Budget

Period will be in 12-month increments and should go in separate columns on the SF-424A. In addition, applicants must provide the entire budget breakdown in the Budget Narrative.

Published March 2021

**In the CHART Community Transformation Track application, how do we accurately complete the SF-424A budget forms?**

The application should include two SF-424A's documents:

- First SF-424A: Year 1 in column 1, Year 2 in column 2, Year 3 in column 3, Year 4 column 4.
- Second SF-424A: Year 5 in column 1, Year 6 in column 2, Year 7 in column 3.

Applicants should reference CHART Notice of Funding Opportunity (NOFO) *Section G.2. Administrative/Budget Questions* and *Appendix I. Guidance for Preparing a Budget Request and Narrative-Section B.*

Published March 2021

**In the CHART Community Transformation Track, can a Lead Organization request a 12-month no-cost extension at the end of year 7?**

Yes. A Lead Organization can request a 12-month no-cost extension at the end of year 7, subject to CMS approval. If the extension is approved, up to one additional year will be added to the cooperative agreement.

Published March 2021

**What should we do if we experience technical issues when trying to submit a CHART Community Transformation Track application in grants.gov?**

CMS requires all Community Transformation Track Notice of Funding Opportunity (NOFO) **applications to be submitted electronically via** www.grants.gov. If you experience technical issues when submitting your application, please contact Grants.gov Applicant Support by emailing support@grants.gov or calling 1-800-518-4726. Grants.gov Applicant Support is available 24/7 (except federal holidays). Be sure to include supporting details when you email or call. At that time, Applicant Support will issue you a ticket number to track your inquiry.

**Please Note**: The CHART Community Transformation Track NOFO application deadline is **May 11, 2021 at 3:00 p.m. Eastern Time.**

Published April 2021

## Eligibility

**What are the eligibility criteria for the award recipient (referred to as the "Lead Organization") in the CHART Community Transformation Track?**

CMS will award cooperative agreement funding for the Community Transformation Track of the CHART Model to a single entity, referred to as a Lead Organization. The Lead Organization will be responsible for driving health care delivery system redesign by leading the development and implementation of Transformation Plans as well as convening and engaging the Advisory Council. Lead Organizations will also be responsible for ensuring compliance with Model requirements and with any requests from CMS for additional data or other supplemental information. A potential Lead Organization must submit, as part of its application, documentation that demonstrates it meets each of the following requirements for selection:

1. A presence in the Community one year prior to the publication date of the CHART Notice of Funding Opportunity (NOFO). Examples of "presence" include advocating for (e.g. a representative organization), providing services to, or otherwise serving beneficiaries within the Community). While a physical presence in the Community is not required, a relationship with the Community is required.
2. Expertise in rural health issues, in particular specific diseases, health disparities, barriers to accessing care, policy, and other key factors that significantly influence health outcomes, particularly those prevalent in the Community.
3. Experience, either through direct management or through a partnership, in designing and implementing APMs.
4. Received and successfully managed one or several health-related grant(s) or cooperative agreement(s) totaling at least $500,000 over the last three years.
5. Experience in each of the following areas:
    a. Engaging and maintaining provider participation in APMs or CMS demonstration projects/models.
    b. Establishing, modifying as needed, and maintaining agreements between health care providers.
    c. Conducting outreach, developing, and managing relationships with diverse health care-related stakeholders.

Any organization that does not meet all of the criteria listed above is ineligible to serve as a Lead Organization. Examples of entities eligible to serve as Lead Organizations include, but are not limited to, State Medicaid Agencies (SMAs), State Offices of Rural Health (SORHs), local public health departments, Independent Practice Associations (IPAs), and Academic Medical Centers (AMCs).

Published October 2020

**What kinds of organizations are eligible to apply as a Lead Organization for the CHART Community Transformation Track?**

- City or township governments
- County governments
- Faith-based organizations
- For profit organizations other than small businesses

- Federally recognized Indian Tribes or Tribal organizations (as defined by the Indian Health Care Improvement Act)
- Tribal organizations (other than federally recognized Tribal governments)
- Nonprofits having a 501(c)(3) status with the IRS, other than institutions of higher education
- Nonprofits that do not a 501(c)(3) status with the IRS, other than institutions of higher education
- Private institutions of higher education (including academic medical centers)
- Public and State controlled institutions of higher education (including academic medical centers)
- Small businesses
- Special district governments
- State governments

Published October 2020

**What are the rurality requirements for the CHART Community Transformation Track and how do we know if we qualify as a rural Community?**

Lead Organizations will be responsible for defining the parameters of their Community, for the purposes of the CHART Model. Each Community must meet the following criteria:

1. Encompass either (a) a single county or census tract or (b) 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 list of eligible counties and census tracts used for its grant programs.
2. At the time of application submission, include a minimum of 10,000 Medicare FFS beneficiaries whose primary residence is within the Community.

Published October 2020

**May a Lead Organization's geographic area span more than one state?**

Yes. If a Lead Organization's Community spans more than one state, the Lead Organization must secure participation from the SMA in both states.

Lead Organizations in the CHART Community Transformation Track will be responsible for defining the parameters of their Community. Each Community must meet the following criteria:

1. Encompass either (a) a single county or census tract or (b) 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 list of eligible counties and census tracts used for its grant programs.
2. At the time of application submission, include a minimum of 10,000 Medicare FFS beneficiaries whose primary residence is within the Community.

Lead Organizations should use the best data available to them at the time of the application.

Published October 2020

**What are eligibility requirements for Participant Hospitals under the CHART Community Transformation Track?**

Lead Organizations will be expected to recruit Participant Hospitals for the Community Transformation Track APM. Each Participant Hospital, identified by its CMS Certification Number (CCN), must be an acute care hospital (defined as a "subsection (d) hospital" in section 1886(d)(1)(B) of the Act) or Critical Access Hospital (CAH) that either:

1. Is physically located within the Community and receives at least 20% of its Medicare FFS revenue from Eligible Hospital Services provided to residents of the Community; or
2. Is physically located inside or outside of the Community and is responsible for at least 20% of Medicare expenditures for Eligible Hospital Services provided to residents of the Community.
3. If a hospital does not meet one of the two aforementioned criteria, during the Pre-Implementation Period 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.

All other types of health care facilities are **ineligible** to be Participant Hospitals. In the event that a hospital system has multiple inpatient campuses and outpatient locations, each inpatient campus and outpatient location will be considered a distinct Participant Hospital as long as it separately meets the eligibility criteria in this section.

Updated March 2021

**How can an organization participate in the CHART Community Transformation Track if they do not act as the Lead Organization or Participant Hospital, and what type of role may they play?**

Recognizing that stakeholder engagement is key to effective reform, the Community Transformation Track of the CHART Model requires that Lead Organizations establish an Advisory Council.

The Advisory Council will represent the Community's perspective and collectively advise the Lead Organization as they carry out their required activities (described in the CHART Notice of Funding Opportunity (NOFO) *Table 2. Funded Activities for Lead Organizations*). A few key activities the Advisory Council will advise on include, but are not limited to, developing and updating Transformation Plans, hospital and payer recruitment, developing arrangements with payers governing APM alignment and data-sharing, monitoring the progress of the Model, and identifying any necessary changes.

Lead Organizations must convene Advisory Councils at least quarterly. Advisory Councils should encompass a variety of perspectives and reflect the Community's needs. While the

specific membership of the Advisory Council will differ by Community, it **must** include the following representatives:

1. The SMA (if the Lead Organization is not the SMA) even if the SMA is physically located outside of the Community.
2. At least one Participant Hospital (see CHART NOFO *Section A.4.4.2. Participant Hospitals* for definition).
3. At least one Aligned Payer (if the Lead Organization has recruited any commercial payers) (see CHART NOFO *Section A.4.5.3. Multi-payer Alignment* for definition).
4. At least one beneficiary or unpaid caregiver.

Furthermore, the Advisory Council must include a representative from at least three distinct entities from the following list:

1. A primary care provider, such as a Federally Qualified Health Center (FQHC), Rural Health Clinic (RHC), or physician group practice.
2. A health care provider of substance use disorder treatment and/or mental health services.
3. An additional Participant Hospital.
4. The State Office of Rural Health.
5. An additional Aligned Payer.
6. A community stakeholder group, such as a rural patient advocacy group, Area Agency on Aging, or faith- and community-based organizations.
7. A long-term care facility (e.g. nursing home), home health provider, or hospice provider.
8. An Indian Health Service (IHS) or Tribal health provider or Federally recognized Tribe or Tribal organization.
9. The U.S. Department of Veteran's Affairs (VA).

The Lead Organization may include additional representatives from organizations or governmental entities not included in the list above. To be eligible to serve on the Advisory Council an organization must provide health care services, or services that address health-related social needs, to Community residents.

Published October 2020

**What are the requirements for number, type, and location of beneficiaries in a defined Community for the CHART Community Transformation Track?**

Lead Organizations will be responsible for defining the parameters of their Community, for the purposes of the CHART Model. Each Community must meet the following criteria:

1. Encompass either (a) a single county or census tract or (b) 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 list of eligible counties and census tracts used for its grant programs.

2. At the time of application submission, include a minimum of 10,000 Medicare FFS beneficiaries whose primary residence is within the Community.

Published October 2020

**Where can applicants find information on beneficiary counts for a community?**

Applicants will be able to access publicly available data to help assess whether their community will meet the required criteria.

CMS provides a few data sources:

1. The geographic variation public use files provide data on Medicare Fee-For-Service beneficiaries based on residence (currently data up to 2018 is available), and
2. The Medicare enrollment dashboard provides similar, but more recent data (data up to August 2019 is available as of the publication of this FAQ). Additionally, State Offices of Rural Health (SORHs) or other relevant community organizations may have similar data available for public use.

Published October 2020

**Is a health system eligible to be a Lead Organization in the CHART Community Transformation Track?**

Yes, a health system may be eligible to be a Lead Organization. The Lead Organization will be responsible for driving health care delivery system redesign by leading the development and implementation of Transformation Plans, as well as convening and engaging the Advisory Council, recruiting Participant Hospitals, and engaging the local State Medicaid Agency. Lead Organizations will also be responsible for ensuring compliance with Model requirements and with any requests from CMS for additional data or other supplemental information. See the CHART Notice of Funding Opportunity *Section A.4.3. Lead Organization and the Community.*

Like all potential Lead Organization applicants, the health system must demonstrate that it meets each of the following requirements for selection:

1. A presence in the Community one year prior to the publication date of this Notice of Funding Opportunity. Examples of "presence" include advocating for (e.g., a representative organization), providing services to, or otherwise serving beneficiaries within the Community. While a physical presence in the Community is not required, a relationship with the Community is required.
2. Expertise in rural health issues, particularly specific diseases, health disparities, barriers to accessing care, policy, and other key factors that significantly influence health outcomes, with an emphasis on those prevalent in the Community.
3. Experience, either through direct management or through a partnership, in designing and implementing Alternative Payment Models (APMs).
4. Past receipt and successful management of one or several health-related grant(s) or cooperative agreement(s) totaling at least $500,000 over the last three years.
5. Experience in each of the following areas:

a. Engaging and maintaining provider participation in APMs or CMS demonstration projects/models.

b. Establishing, modifying (as needed), and maintaining agreements between health care providers.

c. Conducting outreach to and developing and managing relationships with diverse health care-related stakeholders.

Any organization that does not meet all of the criteria listed above is ineligible to serve as a Lead Organization. Examples of entities eligible to serve as Lead Organizations include, but are not limited to, State Medicaid Agencies (SMAs), State Offices of Rural Health (SORHs), local public health departments, Independent Practice Associations (IPAs), and Academic Medical Centers (AMCs).

Published December 2020

**Can the Lead Organization also be a Participant Hospital within the Community in the CHART Community Transformation Track?**

Yes, a Lead Organization may be eligible to also be a Participant Hospital within the Community, so long as the Lead Organization/Participant Hospital meet the requirements for both Lead Organizations and Participant Hospitals:

A Lead Organization must demonstrate that it meets each of the following requirements:

1. A presence in the Community one year prior to the publication date of the CHART Notice of Funding Opportunity. Examples of "presence" include advocating for (e.g., a representative organization), providing services to, or otherwise serving beneficiaries within the Community). While a physical presence in the Community is not required, a relationship with the Community is required.
2. Expertise in rural health issues, particularly specific diseases, health disparities, barriers to accessing care, policy, and other key factors that significantly influence health outcomes, with an emphasis on those prevalent in the Community.
3. Experience, either through direct management or through a partnership, in designing and implementing APMs.
4. Receipt and successful management of one or several health-related grant(s) or cooperative agreement(s) totaling at least $500,000 over the last three years.
5. Experience in each of the following areas:
    a. Engaging and maintaining provider participation in APMs or CMS demonstration projects/models.
    b. Establishing, modifying (as needed), and maintaining agreements between health care providers.
    c. Conducting outreach to and developing and managing relationships with diverse health care-related stakeholders.

If the Lead Organization is also a Participant Hospital, it must be an acute care hospital (defined as a "subsection (d) hospital" in section 1886(d)(1)(B) of the Act) or CAH that either:

1. Is physically located within the Community and receives at least 20% of its Medicare Fee-for-Service revenue from Eligible Hospital Services provided to residents of the Community; or
2. Is physically located inside or outside of the Community and is responsible for at least 20% of Medicare expenditures for Eligible Hospital Services provided to residents of the Community.
3. If a hospital does not meet one of the two aforementioned criteria, during the Pre-Implementation Period, 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.

Updated March 2021

**Are Critical Access Hospitals (CAHs) with Rural Health Clinics (RHCs) eligible to participate in the CHART Community Transformation Track as Participant Hospitals?**

Each Participant Hospital must be an acute care hospital (defined as a "subsection (d) hospital" in section 1886(d)(1)(B) of the Act) or CAH that meets one of two criteria:

1. It is physically located within the Community and receives at least 20% of its Medicare Fee-for-Service revenue from Eligible Hospital Services provided to residents of the Community; or
2. It is physically located inside or outside of the Community and is responsible for at least 20% of Medicare expenditures for Eligible Hospital Services provided to residents of the Community.
3. If a hospital does not meet one of the two aforementioned criteria, 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.

All other types of rural health care facilities are ineligible to be Participant Hospitals and, thus, receive a CPA. Each Participant Hospital must sign a Participation Agreement with CMS.

RHCs are not eligible to participate as a Participant Hospital, but CMS encourages Transformation Plans that extend outside Participant Hospitals and across the Community to incorporate other provider and supplier types in the health care delivery system redesign strategy. Furthermore, RHCs may participate in the Community Transformation Track through the Advisory Councils (for additional information regarding Advisory Councils refer to the CHART Notice of Funding Opportunity *Section A.4.4.1. Advisory Council*).

Updated March 2021

**What if my hospital does not meet either of the two CHART Community Transformation Track eligibility criteria listed in the CHART Notice of Funding Opportunity Section A.4.4.2 Participant Hospitals?**

If a hospital does not meet one of the two Participant Hospital eligibility criteria**,** 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 selected CHART Quality Measures, which is submitted during the Pre-Implementation Period. CMS may, in its sole discretion, accept or reject the Lead Organization's request for the potential Participant Hospital to participate in CHART. CMS will make this decision prior to the hospital signing a CMS Participation Agreement before the start of Performance Period 1. CMS will consider both 1) the Participant Hospital's participation in the Lead Organization's development and implementation of the Transformation Plan and 2) the Participant Hospital's impact on the Community's eligible hospital expenditures when considering the Lead Organization's request.

Published January 2021

**Is there any flexibility in the years a Lead Organization has managed grants (i.e., experience over the last three years) in order to be eligible for the CHART Community Transformation Track?**

No. In addition, as stated in the CHART Notice of Funding Opportunity (NOFO) *Section A.4.3 Lead Organization and the Community*, a potential Lead Organization must submit, as part of its application, documentation that demonstrates it meets each of the following requirements for selection:

- A presence in the Community one year prior to the publication date of this NOFO. Examples of "presence" include advocating for (e.g. a representative organization), providing services to, or otherwise serving beneficiaries within the Community). While a physical presence in the Community is not required, a relationship with the Community is required.
- Expertise in rural health issues, in particular specific diseases, health disparities, barriers to accessing care, policy, and other key factors that significantly influence health outcomes, particularly those prevalent in the Community.
- Experience, either through direct management or through a partnership, in designing and implementing Alternative Payment Models (APMs).
- Received and successfully managed one or several health-related grant(s) or cooperative agreement(s) totaling at least $500,000 over the last three years.
- Experience in each of the following areas:
    - Engaging and maintaining provider participation in APMs or CMS demonstration projects/models.
    - Establishing, modifying as needed, and maintaining agreements between health care providers.
    - Conducting outreach, developing, and managing relationships with diverse health care-related stakeholders.

Any organization that does not meet all of the criteria listed above is ineligible to serve as a Lead Organization. Examples of entities eligible to serve as Lead Organizations, subject to meeting the above-mentioned criteria, include, but are not limited to, State Medicaid Agencies (SMAs), State Offices of Rural Health (SORHs), local public health departments, Independent Practice Associations (IPAs), and Academic Medical Centers (AMCs).

Published January 2021

**Would a hospital that recently closed be able to reopen and participate in the CHART Community Transformation Track?**

In the CHART Community Transformation Track, a Participant Hospital is identified by its CMS Certification Number (CCN). If a hospital or Critical Access Hospital (CAH) closes, the CCN is terminated, meaning the hospital/CAH is no longer participating in the Medicare program at that point. If a closed hospital or CAH would like to reopen, the facility must re-enroll in the Medicare program. Once a CCN has been issued by CMS, the hospital or CAH may be eligible to participate in CHART as long as it meets all other Participant Hospital eligibility criteria.

Published January 2021

**If an applicant is not awarded a cooperative agreement by CMS, could the potential hospitals identified in its application participate in the CHART Community Transformation Track with a different Lead Organization?**

Yes. A Lead Organization may recruit potential Participant Hospitals that were originally identified by an applicant that was not ultimately awarded so long as the Participant Hospitals meet the eligibility requirements specified in the NOFO (see number (2) Documentation of Participant Hospital Interest in CHART Notice of Funding Opportunity *Section E.1.2.2.3. Health Care Delivery System Redesign Concept* and *Section A.4.4.2 Participant Hospitals*).

If an organization does not act as the Lead Organization or a Participant Hospital, a representative from that organization may also be able to serve on the Advisory Council if the organization meets the eligibility criteria as stated in the CHART Notice of Funding Opportunity *Section A.4.4.1 Advisory Council*.

Published January 2021

**Are Indian Health Services (IHS) and Tribal facilities eligible to participate in the CHART Community Transformation Track as Participant Hospitals?**

As specified in the CHART Notice of Funding Opportunity (NOFO), each Participant Hospital, identified by its CMS Certification Number (CCN), must be an acute care hospital (defined as a "subsection (d) hospital" in section 1886(d)(1)(B) of the Act) or Critical Access Hospital (CAH) that either:

- Is physically located within the Community and receives at least 20% of its Medicare FFS revenue from Eligible Hospital Services provided to residents of the Community; or

- Is physically located inside or outside of the Community and is responsible for at least 20% of Medicare expenditures for Eligible Hospital Services provided to residents of the Community.
- If a hospital does not meet one of the two aforementioned criteria, during the Pre-Implementation Period, 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.

Therefore, IHS and Tribal facilities that are either acute care hospitals or CAHs are eligible to participate as a Participant Hospital. Furthermore, IHS or Tribal facilities may participate in the Community Transformation Track as members of the Advisory Council (see CHART NOFO *Section A.4.4.1. Advisory Council*) or as contributors to the Community's Transformation Plan.

Published January 2021

**How is a Community defined for the CHART Community Transformation Track?**

Each hospital must meet the below requirements:

- Located within the Community and receives at least 20% of its eligible Medicare Fee-For-Service (FFS) revenue from services provided to residents of the Community
- 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
- If a hospital does not meet one of the two aforementioned criteria, during the Pre-Implementation Period, 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.

During application and approval:

- Lead Organizations' definition of their Community is subject to CMS review and approval. During application review, CMS will ensure that there is no overlap between Lead Organizations' defined Communities.

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.

Updated March 2021

**Can CMS provide information on how rural emergency hospitals may affect CHART Community Transformation Track participation?**

CMS is aware that 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.

Published March 2021

**Will the beneficiary count in the CHART Community Transformation Track be affected if beneficiaries are attributed to an Accountable Care Organization (ACO)?**

Medicare Fee-For-Service (FFS) beneficiaries that are attributed to an ACO will still count toward the required 10,000 Medicare beneficiaries in the Lead Organization's defined Community. In the CHART Community Transformation Track, Medicare beneficiaries are aligned based on residence and Medicare eligibility. Participant Hospitals will continue to submit FFS claims, and CMS will treat claims for Eligible Hospital Services as zero-pay. The continued submission of FFS claims enables tracking of Medicare FFS spending for ACOs.

Published March 2021

**Is a Lead Organization still able to participate in the Community Transformation Track if it has not secured any participation agreements from Participant Hospitals by the end of the Pre-Implementation Period?**

No. At least one Participant Hospital is required to sign a Participation Agreement prior to the beginning of Performance Period 1 for the Lead Organization to remain in the Model, as value-based payment is one of the CHART Model's three core program elements designed to position rural communities for success.

The Lead Organization should use the Pre-Implementation Period to recruit Participant Hospitals and partner with them and other community stakeholders to develop a health care delivery system redesign strategy.

Published March 2021

**How does CMS consider rural designation statuses such as Sole Community Hospital in the calculation of the Capitated Payment Amount (CPA) for the CHART Community Transformation Track?**

CMS will include adjustments to the CPA for a Participant Hospital with a special designation (e.g. Medicare Dependent Hospital, Sole Community Hospital, Critical Access Hospital) to ensure that the designations received by each Participant Hospital prior to participation in the CHART Community Transformation Track are maintained in determining each hospital's prospective payment amounts.

For more additional information about how a hospital's special designation status is factored in to the CPA, please refer to the CHART January 21, 2021 payment webinar slides and recording which can be found on the CHART Model website.

Published March 2021

## Program Overlap

**Can there be geographic overlap between Lead Organization Communities in the CHART Community Transformation Track?**

A Lead Organization's definition of their Community is subject to CMS review and approval. During application review, CMS will ensure that there is not overlap between Lead Organizations' defined Communities.

Published October 2020

**Can organizations, providers, and/or hospitals participate in the CHART Community Transformation Track and other CMS Models or Medicare programs simultaneously?**

Yes, Participant Hospitals may simultaneously participate in the Community Transformation Track and other Medicare value-based programs, models, demonstrations, or the Medicare Shared Savings Program, subject to CMS approval. If a Participant Hospital participates in a Medicare program, demonstration or model, CMS may, in its sole discretion, make adjustments to the Participant Hospital's Capitated Payment Amount (CPA) to avoid duplicative accounting of, and payment or penalties for, amounts received by the Participant Hospital under such Medicare program, demonstration, or model.

Maryland, Vermont, and Pennsylvania are currently testing state-wide, multi-payer Models, known as the Maryland Total Cost of Care Model, the Vermont All-Payer ACO Model, and the Pennsylvania Rural Health Model, respectively. CHART will not accept applications that propose implementation within these states, unless the performance period of the applicable state-based Model has ended, is anticipated to end prior to the start of CHART's Performance Period 1 (CY 2022), or CMS and the state amend the applicable state agreement or CMS Participation Agreement, as necessary, to permit Lead Organizations in the relevant state to apply and to permit rural hospitals located within the state to participate in the CHART Model.

Updated February 2022

**Will CMS allow overlap between the CHART Community Transformation Track and other Medicare programs, models, or demonstrations, such as the Shared Savings Program or a direct contracting model?**

Generally, a Lead Organization in the Community Transformation Track may participate in another Medicare program, model, or demonstration, including the Shared Savings Program or a direct contracting model. However, CMS will not accept applications that overlap with state-based models (e.g., the Maryland Total Cost of Care Model, the Vermont All-Payer ACO Model, and the Pennsylvania Rural Health Model). CMS may permit performance in these states if the applicable state-based model has ended, if the state-based model is anticipated to end prior to the start of CHART's Performance Period 1, or if CMS and the state amend the applicable state agreement or CMS Participation Agreement, as necessary, to permit such participation.

Published December 2020

**Can the CHART Community Transformation Track be used as a vehicle to implement innovative service delivery models in rural communities, such as Mobile Integrated Healthcare?**

Yes. Lead Organizations will be able to leverage technical support and input from Community Partners to design and implement Transformation Plans that are both tailored to the Community's needs and informed by best practices. If, for example, a Lead Organization and its Community Partners would like to focus on Mobile Integrated Healthcare as part of its Transformation Plan they may do so subject to CMS approval. For additional information, see the CHART Notice of Funding Opportunity *Section A.4.3.2. Transformation Plan*.

Published January 2021

## Operational Flexibilities

**What are the benefit enhancements allowed in the CHART Community Transformation Track?**

CMS plans to offer benefit enhancements, which may include but are not limited to the Medicare waivers described in the table below.

| Waiver | Purpose of waiver |
|---|---|
| Skilled Nursing Facility (SNF) 3-Day Rule Waiver<br>(Section 1861(i) of the Act) | This would waive the rule requiring a three-day stay in a Participant Hospital with swing-bed for approval of Medicare post-hospital extended care services prior to admission to a SNF. |
| Telehealth Expansion<br>(Section 1834(m) of the Act) | This would expand allowable originating sites to include a beneficiary's place of residence for certain synchronous and asynchronous telehealth services. Services would be related to wellness visits, evaluation & monitoring, and analyzing patient images. Additionally, health care providers would be permitted to engage in telehealth services with individuals who are not established patients. |
| Care Management Home Visits<br>(Section 1835(a)(2)(A) of the Act) | This would allow Participant Hospitals to offer home visits to beneficiaries proactively and in advance of any potential hospitalization, and would waive the homebound requirement for receiving such services. |
| Waiver of certain Medicare Hospital and/or CAH Conditions of Participation (CoPs) | Waivers of Medicare CoPs could allow Participant Hospitals to make certain changes to their facility structure, and maintain their hospital or CAH status for the purpose of Medicare enrollment and certification, Medicare hospital quality reporting, and in |

| Waiver | Purpose of waiver |
|---|---|
| | order to receive payments under the capitated payment arrangement. |
| CAH 96 Hour Certification Rule (Section 1814(a)(8) of the Act and 42 C.F.R. §424.15). | This would waive the condition of payment for inpatient CAH services that a physician must certify that a patient is expected to be discharged or transferred within 96 hours of being admitted into a CAH. |

Published October 2020

**Will the CHART Model telehealth benefit enhancement apply to telehealth services furnished after the current Public Health Emergency has expired?**

Yes. Under the telehealth benefit enhancement for the CHART Model, CMS waives the geographic location requirement for furnishing originating site services under Medicare and makes available certain synchronous and asynchronous telehealth services. Participants will have access to this benefit enhancement during the Performance Period and Transition Period of the Model, subject to CMS approval.

Published December 2020

**How much flexibility will CMS allow CHART Community Transformation Track Lead Organizations on the final structure of their Transformation Plan?**

Each Lead Organization will be allowed to customize the care redesign approach to best meet the needs of the Medicare Fee-For-Service beneficiaries that reside in its defined Community. The CHART Community Transformation Track offers several financial and operational flexibilities as CMS recognizes that a one-size-fits-all approach may not be best for rural communities. The CHART Notice of Funding Opportunity (NOFO) *Section A.4.6 Operational Flexibilities Table 6* outlines flexibilities pertaining to funding and care transformation strategies.

Published March 2021

**If a CHART Community Transformation Track Lead Organization's Community covers non-contiguous counties, will CMS require multiple Transformation Plans?**

No. CMS envisions that each Lead Organization will develop a single Transformation Plan for the Community – whether it is contiguous or non-continuous counties or census tracts - and update it annually. The Lead Organization's single Transformation Plan must include the Community's health care delivery redesign strategy that incorporates the Lead Organization, state Medicaid agency, and all Participant Hospitals. CMS will provide Lead Organizations a final list of Transformation Plan requirements during the Pre-Implementation Period, which will specify how a Lead Organization should discuss its specific care delivery system redesigns for distinct Participant Hospitals and/or geographic areas. Additional information on Transformation Plan requirements is available in the CHART Notice of Funding Opportunity *Appendix X. Transformation Plan Requirements.*

Published March 2021

**Is Medicare beneficiary cost-sharing altered by the Capitated Payment Amount (CPA) Alternative Payment Model in the CHART Community Transformation Track?**

No. Medicare beneficiary cost-sharing is not altered by the CPA Alternative Payment Model in the CHART Community Transformation Track.

Relatedly, this track offers a cost-sharing beneficiary engagement incentive, where a Participant Hospital will be allowed to reduce or waive the applicable co-insurance on the Medicare allowed amount for Part B services if certain conditions are met including the Participant Hospital covering the expense. Examples of potential criteria for waiving cost sharing could include:

- Financial need;
- Patients with high disease burden that would benefit from more frequent visits to avoid hospitalization and disease progression; and
- Patients with recent hospitalizations or emergency department (ED) visits.

Published March 2021

## Payment, Adjustments, and Repayment

**How are capitated payments amounts (CPA) calculated for Participant Hospitals in the CHART Community Transformation Track?**

The CPA financial methodology is included in the CHART Notice of Funding Opportunity (NOFO) for informational purposes only and may change at CMS's sole discretion. The final CPA financial methodology will be detailed further in a time and manner to be specified by CMS (see CHART NOFO *Appendix XI. CPA Financial Methodology* for full methodology).

Published October 2020

**What flexibilities does the CHART Community Transformation Track offer to decrease the amount of the discount applied to the Capitated Payment Amount (CPA) for Participant Hospitals?**

As specified in the CHART Notice of Funding Opportunity (NOFO) *Appendix XI. CPA Financial Methodology Step 3. Apply a Discount* and in *Table 6: Model Design Flexibilities*, a Community's total Medicare Fee-for-Service (FFS) revenue determines the specific overall discount factor for a Community, as specified in CHART NOFO *Appendix XI*. CPA Financial Methodology. However, we offer three key flexibilities with respect to the discount as addressed in the CHART NOFO in *Table 6: Model Design Flexibilities*:

First, prior to the beginning of Performance Period 1, Lead Organizations may request to lower their cooperative agreement funding in exchange for a lower discount factor for their Participant Hospitals. CMS may allow additional opportunities in subsequent performance years for Lead Organizations to request less cooperative agreement funding in exchange for a lower discount on a case-by-case basis.

Second, Lead Organizations will be able to negotiate participant-level discount factors with individual Participating Hospitals, subject to CMS approval, so long as

the aggregate discount equals the Community-level discount factor for the total revenue in the Community. This will allow Participant Hospitals and Lead Organizations to optimize participant-level discount factors to hospitals of different sizes to help recruit and retain Participant Hospitals.

Lastly, Lead Organizations may receive up to $5 million of cooperative agreement funding, and may pass some of the funding directly to Participant Hospitals to invest in implementation of the Transformation Plan at the hospital-level.

Published December 2020

**Does the Capitated Payment Amount (CPA) include an estimation for outliers for Participant Hospitals in the CHART Community Transformation Track?**

During the Pre-Implementation Period, CMS may allow Participant Hospitals to receive an outlier adjustment. This adjustment would protect Participant Hospitals from unexpected, catastrophically expensive utilization not accounted for in their prospective CPAs. Communities that opt to include the outlier adjustment in their payments will not be accountable for beneficiary claims for eligible hospitals services that are considered 'high cost claims' (CMS will winsorize claims values above the 99 percentile). Participant Hospitals may elect not to participate in such an arrangement if they believe that their cost-reduction efforts will influence outlier costs.

Published December 2020

**Will CMS communicate to a CHART Community Transformation Track Participant Hospital (both Prospective Payment Systems (PPS) hospitals and Critical Access Hospitals (CAH)) its Capitated Payment Amount (CPA) for Performance Period 1 prior to the Participant Hospital having to execute a Participation Agreement?**

Yes. After awarding Lead Organizations, the Pre-Implementation Period will commence. Lead Organizations will recruit Participant Hospitals during this time. CMS will calculate the CPAs that Participant Hospitals will receive starting in Performance Period 1 before the end of the Pre-Implementation Period. CMS will provide each Participant Hospital time to review its projected CPA prior to signing its Participation Agreement and the beginning of Performance Period 1.

Published December 2020

**Will the methodology for determining the Capitated Payment Amount (CPA) for Participant Hospitals in the Community Transformation Track include Inpatient and Outpatient services?**

Yes. The CPA financial methodology will include Medicare Fee-for-Service expenditures for each Eligible Hospital Service (as defined in the CHART Notice of Funding Opportunity (NOFO) *Section A.4.1. Key Terms*). Eligible Hospital Services include the following health care services:

- Inpatient hospital or inpatient Critical Access Hospital (CAH) services, including but not limited to physical therapy and certain drugs and biologicals.
- Outpatient hospital or outpatient CAH services, including but not limited to clinic, emergency department (ED) and observation services, X-rays and other radiology services billed by the Participant Hospital, and certain drugs and biologicals.

- Swing bed services rendered by CAHs.

CMS will provide a more detailed list of included services prior to potential Participant Hospitals signing their Participation Agreements.

Services paid under the Medicare Physician Fee Schedule and other services noted in the CHART NOFO *Section A.4.5.1 Capitated Payment* are excluded from each Participant Hospital's CPA.

Published December 2020

**Regarding adjustments for the Capitated Payment Amount (CPA), are the mid-year and end-of-year positively or negatively adjusted for Participant Hospitals in the Community Transformation Track?**

Yes. Mid-year and end-of-year population adjustments will correct (positively or negatively) for any differences between projected and observed shifts in Eligible Hospital Services, (e.g., in cases where the population size or ages increases or decreases). Specifically, these positive or negative adjustments account for differences in the population served by the Participant Hospital between the baseline years and the Performance Period. It captures differences in population size, demographics such as age, and shifts in Eligible Hospital Services between hospitals. The population adjustment, by definition, is a change in beneficiary months for the defined Community. Beneficiaries are aligned if they are eligible and reside in the Community for the majority of the alignment period. The alignment period is the 12-month period beginning 18 months prior to the respective baseline or Performance Period.

Published December 2020

**Will Critical Access Hospitals (CAHs) participating in the CHART Community Transformation Track continue to receive payment at 101 percent of reasonable costs?**

Yes and no. The Capitated Payment Amount (CPA) for all Participant Hospitals for Performance Period 1 is calculated based on Medicare Fee-for-Service (FFS) revenue using historical expenditures for Eligible Hospital Services from the baseline period (e.g., 101 percent of reasonable costs from historical eligible expenditures for CAHs). CAHs that are Participant Hospitals will no longer receive interim payments on a reasonable cost basis for FFS claims for the eligible expenditures included in the CPA. CMS will instead incorporate the historical expenditures for Eligible Hospital Services (using the participating CAHs' most recent cost reports) into the CPA.

For inpatient and outpatient CAH services that are not Eligible Hospital Services, and therefore are not included in the CPA, CMS will continue to make payments to participating CAHs based on 101 percent of reasonable costs. As such, CAHs that are Participant Hospitals must continue to prepare and submit standard CAH cost reports.

Throughout the Performance Period of the Model, CMS will make CPA adjustments to account for changes in the risk profile of patients that the participating CAH treats. However, CMS will not make an up or down CPA adjustment at final settlement based on what the CAH would have received under reasonable cost-based reimbursement for the Eligible Hospital Services that are included in the CPA. Furthermore, CMS is planning to use

a community-specific trend to update the CPA for each Participant Hospital (for further information see the CHART Notice of Funding Opportunity *Section A.4.5.1.Capitated Payment*).

Like all Participant Hospitals, participating CAHs will receive their CPA amount prior to signing their Participation Agreements. Participating CAHs will be subject to the discount factor; however, Lead Organizations can adjust the discount for their Participant Hospitals accordingly.

*Please note that CMS will provide more information on payment operations and reconciliation during the Pre-Implementation Period, when Lead Organizations recruit Participant Hospitals.*

Published December 2020

**Could a Critical Access Hospital (CAH) lose its CAH status simply by participating in the CHART Community Transformation Track?**

No. Participant Hospitals will be able to retain their hospital or CAH status because CMS intends to waive certain Medicare provisions for the purposes of testing the CHART Model. CMS also plans to waive certain Medicare Hospital and/or CAH Conditions of Participation (CoPs). Waivers of Medicare CoPs could allow Participant Hospitals to make certain changes to their facility structure, and maintain their hospital or CAH status for the purpose of Medicare enrollment and certification, Medicare hospital quality reporting, and payment receipt under the capitated payment arrangement. Any such waivers under the Community Transformation Track will be available for the full Performance Period of the Model.

Published December 2020

**What happens at the end of the end of the CHART Model Community Transformation Track? Does a Participant Hospital revert to its old payment structure?**

The CHART Notice of Funding Opportunity *Section A.4.9.Model Timeline* specifies the full-anticipated timeline of the Model. After the end of the final Performance Period (Performance Period 6), a two-year transition period will commence. If the CHART Model is not expanded or extended, the Model will utilize the two-year transition period to gradually shift the capitated payments for the Participant Hospitals back to a Fee-for-Service reimbursement payment method.

Published December 2020

**In the CHART Community Transformation Track, are the Participant Hospital Capitated Payment Amounts (CPAs) considered block grants?**

No, the CHART Community Transformation Track Participant Hospitals' CPAs are not considered block grants. CMS will replace Fee-For-Service claims reimbursement for Participant Hospitals with regular, lump sum payments that amount to the calculated annual CPA over the course of the Performance Period.

Published January 2021

**How do the Transformation Plans work in coordination with the Capitated Payment Amount (CPA) in the Community Transformation Track?**

CMS envisions the cooperative agreement laying the ground-work on which to implement the Transformation Plan and the Capitated Payment Alternative Payment Model (APM). These two items work simultaneously to facilitate Community-level "Transformation" towards a sustainable health care delivery system over time, thereby achieving the track's goals of improving access to care in rural areas, quality of care and health outcomes for rural beneficiaries, and rural provider financial sustainability.

The Transformation Plan and the Capitated Payment APM are a symbiotic pair for transformation. Specifically, in the Transformation Plan, Lead Organizations and their Community partners will detail strategies for how the predictable capitated payments allow Participant Hospitals to transform care delivery to, for example, increase access to primary and specialty care, advance telehealth care offerings, or improve population health efforts based on community needs.

Published January 2021

**Will there be a true cost report settlement during audit so that a Critical Access Hospital (CAH) would receive payment for the difference between Medicare Costs as determined through the cost report and Capitated Payment Amount (CPA) made to the CAH in the Community Transformation Track?**

The Capitated Payment Amount (CPA) for all Participant Hospitals is calculated based on Medicare Fee-For-Service (FFS) revenue using historical expenditures for Eligible Hospital Services. CAHs calculation will be based on 101% of reasonable costs from historical eligible expenditures. CAHs will no longer receive 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.

Published January 2021

**What specific quality programs will the CHART Model adjust for in the Community Transformation Track?**

As stated in the CHART Notice of Funding Opportunity (NOFO), Participant Hospitals will continue reporting on core measures in Medicaid, quality measures in Medicare, and other existing CMS quality programs. After further discussion and review, CMS has decided to forego a CHART-specific quality adjustment in favor of a pay-for-reporting program given concerns that adding additional financial risk on top of current Medicare hospital quality programs or additional hospital cost of care risk to be borne by critical access hospitals would significantly reduce hospital participation. Further, additional research illuminated concerns with measure selection, feasibility and reliability concerning rural sample size and benchmarking needed to implement a robust pay-for-performance program. Therefore, the proposed approach is to align with current national hospital quality programs as described by hospital type below:

- **Acute care hospitals**: Prospective Payment System (PPS) hospitals will have their Capitated Payment Amounts (CPAs) adjusted to reflect their performance in the national Medicare hospital quality programs, including the Hospital Value-Based

Purchasing (Hospital VBP) Program, the Hospital-Acquired Condition Reduction Program (HACRP), Hospitals Inpatient Quality Reporting Program (Hospital IQR), Hospital Outpatient Quality Reporting Program (Hospital OQR), Promoting Interoperability Programs, and the Hospital Readmissions Reduction Program (HRRP)). Therefore, the CPAs for PPS Participant Hospitals will be adjusted to reflect their performance on the current national Medicare quality programs by using the performance adjustment factors to update the CPA annually.

- **Critical Access Hospitals**: The CPAs for Critical Access Hospital (CAH) Participant Hospitals will not be subject to a financial quality adjustment, as they are not required to participate in many Medicare hospital quality programs. CHART will recommend that CAHs align their CHART Quality Measures to fulfill the mandatory Quality Assurance and Performance Improvement (QAPI) program requirements (regulation §485.641, to be implemented by March 30, 2021). Additionally, CHART will require that CAHs report to the Medicare Beneficiary Quality Improvement Project (MBQIP) and meet their minimum reporting requirements, which aligns with many of the CMS hospital quality programs.

Published January 2021

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

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:

Example services that are not included in the Capitated Payment Amount are as follows:

- Physician services
- Other professional services
- Durable medical equipment
- Hospice
- Home health services

- Skilled Nursing Facility services

Published January 2021

**Why does the CHART Community Transformation Track Alternative Payment Model not include a total cost of care option for communities ready to take on that level of risk?**

Even though some rural areas might express interest in Total Cost of Care, transformation must start somewhere. In rural communities, hospitals costs are a large component of overall total cost of care.

CMS has found through other state-based models that operationalizing global budgets for hospital costs alone can be quite challenging for communities. However, the Community Transformation Track's design serves as a starting point for potential expansion later down the road (as evidenced by Maryland All Payer Model that is the in process of expanding beyond hospital expenditures most recently).

Published January 2021

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

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

- Hospitals are reimbursed for Community residents by the Capitated Payment Amount.
- Hospitals are reimbursed for non-Community residents through FFS.

Published January 2021

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

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 Performance Period)
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.

Published January 2021

**How will CMS consider and respond to the COVID-19 public health emergency in the CHART Community Transformation Track?**

In terms of payment, CMS is instituting the following policies in the Community Transformation Track to address the changes brought about by the COVID-19 public health emergency:

- Determining the Capitated Payment Amount (CPA):
  - For Performance Period 1:
    - CMS will use data from Quarter 1 through Quarter 4 in 2018 and Quarter 1 through Quarter 4 in 2019 to establish baseline Medicare Fee-for-Service (FFS) revenues for the sake of calculating the initial CPAs. This is designed to minimize non-representative data and quality concerns related to the COVID-19 public health emergency (e.g., decreased elective care and geographic variation); and
    - CMS will similarly use data prior to the COVID-19 public health emergency to develop the trend factor that is used to forecast expected Eligible Hospital Services expenditures during Performance Period 1.
  - For subsequent Performance Periods:
    - CMS will include a one-time update to baseline spending and to the community-specific trend factor once stable, predictable, and non-volatile expenditure data has been observed; and
    - CMS will update the trend factor that is used to forecast expected Eligible Hospital Services expenditures with data that indicates more stable, predictable, and non-volatile variation in national hospital expenditures.
  - For all Performance Periods:
    - At both mid-year and end-of-year checks on the CPAs throughout the Performance Period, CMS will assess variation in the CPA against a guardrail that will be used to protect against exogenous factors that might drive significant change to care utilization; and

- Regular reviews of updates to Medicare payment policies will be included in the analysis used to develop CPAs as well, which will ensure that any payment changes instituted across Medicare will be incorporated accordingly into the CPAs for communities and Participant Hospitals.

In terms of participation, CMS has extended the application period to provide Lead Organizations and their potential partners additional time to prepare and submit applications.

While not specifically in response to the COVID-19 public health emergency, the CPA offered in the Model will also provide a significantly greater level of stability of payments to Participant Hospitals and is designed to stimulate transformation and resilience that should help in addressing any lingering effects of the current COVID-19 public health emergency and future public health emergencies. CMS will provide more information to Lead Organizations during the Pre-Implementation Period.

Published March 2021

**How does the Community Transformation Track's Capitated Payment Amount (CPA) for Participant Hospitals compare to global budgets?**

The CHART Community Transformation Track's CPA is similar to global budgets in that it replaces payments for hospital inpatient and hospital-based outpatient services with prospective bi-weekly payments. Like a global budget, the CPA will be provided to Participant Hospitals prior to the start of the Performance Period. Participant Hospitals will have the opportunity to review the CPA prior to signing their participation agreement. This will ensure that bi-weekly payments received are predictable and transparent and will allow rural hospitals the opportunity to budget and plan for care transformation efforts throughout the year. However, the CPA is not truly global because it does not cover and replace all hospital services with a prospective payment; an example of an item that would remain reimbursed through Fee-For-Service would be services provided to non-resident beneficiaries.

Published March 2021

**Will Capitated Payment Amounts (CPAs) for Critical Access Hospitals (CAHs) in the CHART Community Transformation Track include reimbursement for swing bed utilization?**

Yes. A CAH's expenditures for swing bed services will be included in its CPA calculation. See CHART Notice of Funding Opportunity *Section A.4.5.1. Capitated Payment* for more information on service inclusion criteria.

Published March 2021

**Does the bi-weekly Capitated Payment Amount (CPA) for a Participant Hospital in CHART Community Transformation Track include operational costs?**

Yes. A Participant Hospital's CPA is based on eligible historical Medicare Fee-for-Service (FFS) revenues for hospital expenditures, which already account for operational costs. The specific operational costs are dependent upon each Participant Hospital's established charges. There is an option for strategic shifts in services, which may affect operational costs. For example, a Lead Organization can coordinate with multiple Participant Hospitals

to transition services from one hospital to another in a way that benefits the entire Community. The hospital removing a service line in this collaborative transition of services within the Community will receive payment for fixed costs for two years to transition the service. The hospital adding the service line will receive payment for variable costs for two years as well, and receive full payment after the two-year period. Please refer to the CHART January 21, 2021 payment webinar slides and recording which can be found on the CHART Model website.

Published March 2021

**What period will CMS use in the CHART Community Transformation Track to determine the baseline Community and Participant Hospital expenditures?**

For Performance Period 1, which will begin on January 1, 2023, CMS will use Medicare Fee-for-Service expenditure data from 2018 and 2019 as the baseline.

Published March 2021

**In the CHART Community Transformation Track, if services are shifted from a Participant Hospital to a non-Participant Hospital, how would this affect the Capitated Payment Amount (CPA)?**

If services shift to non-Participant Hospitals, these shifts will be reflected in the updates to the beneficiary expenditures. For instance, if a Participant Hospital no longer provides a portion of the services they provided previously, its CPA will be adjusted downward to ensure an accurate reflection of services provided.

Published March 2021

**Is a Critical Access Hospital (CAH) that has elected CMS Method II billing for outpatient services eligible to be a CHART Community Transformation Track Participant Hospital?**

Yes, as long as it meets the eligibility requirements for a Participant Hospital as outlined in the CHART Notice of Funding Opportunity *Section A.4.4.2. Participant Hospitals.*

The professional services that would be billed under institutional claims in Method II billing would continue to be paid under the reasonable cost system and would not be part of the CAH's Capitated Payment Amount (CPA), since professional services fall outside of the Eligible Hospital Services.

To ensure that the CMS designations that Participant Hospitals received prior to the CHART Model are maintained in determining each hospital's prospective payments, CMS will adjust for 1) special status hospital status (CAH, Sole Community Hospital, Medicare Dependent Hospital, etc.) and 2) other adjustments (e.g. bad debt, indirect medical education, low volume adjustment). To preserve hospital specific adjustments, CMS will prospectively adjust the CPA by the same payment adjustment factor as determined in Fee-For-Service (FFS) and will apply the adjustment to the same portion of revenue as if the hospital was participating in FFS.

Published March 2021

**How will CMS identify 1) attributed beneficiaries and 2) which beneficiary claims are covered by the Capitated Payment Amount (CPA) versus which will continue to be reimbursed under**

**Fee-For-Service (FFS) for a Participant Hospital in the CHART Community Transformation Track?**

CMS will replace FFS claims reimbursement for Participant Hospitals with regular, lump sum payments that equal the annual CPA over the course of the Performance Period. This payment will replace reimbursement for aligned Medicare FFS beneficiaries whose primary residence is within the Community.

**Regarding Beneficiary Attribution**: CMS will assess residency on a month-by-month basis then combine to form a single monthly record for each beneficiary. Beneficiaries are aligned if they are eligible and reside in the Community for over half of the alignment period. The alignment period is the 12-month period beginning 18-months prior to the respective baseline or Performance Period. For beneficiaries who are not community members as defined for the purposes of the Model, reimbursement will continue to be provided on a FFS basis.

**Regarding Applicable Claims**: Although not a global budget per se, like many global budgets, the CHART Payment methodology covers hospital utilization for Part A and facility-based Part B services. Part A services primarily include inpatient hospitalizations. Swing bed services provided by Critical Access Hospitals are also included.

Participant Hospitals must continue to submit FFS claims, but CMS will treat claims for Eligible Hospital Services as zero-pay. Continued claims submission is necessary to provide utilization data to inform many of the adjustments outlined in the CPA financial methodology, as well as for program monitoring and quality measurement. More details are provided in the CHART January 21, 2021 payment webinar slides and recording which can be found on the CHART Model website.

Published March 2021

**Will Critical Access Hospitals (CAHs) that are CHART Community Transformation Track Participant Hospitals receive a market basket increase?**

Yes. Specifically, to preserve hospital specific adjustments such as the CAH market basket increase, CMS will prospectively adjust the Capitated Payment Amount by the same payment adjustment factor as determined in Fee-For-Service (FFS) and will apply the adjustment to the same portion of revenue as the hospital would have received in FFS.

Published March 2021

## Payer Participation

**What are state Medicaid agency (SMA) requirements for the CHART Community Transformation Track?**

SMA participation is required under the Community Transformation Track of the CHART Model. If the Lead Organization is not the SMA, it must partner with the SMA to implement the CHART Model. The SMA must participate in the Advisory Council and serve as an Aligned Payer (see the CHART Notice of Funding Opportunity (NOFO) *Section A.4.5.3. Multi-payer Alignment*). To ensure that the SMA has the capacity to carry out CHART's program requirements, the SMA must be a subrecipient of cooperative agreement funding. As a component of the Community Transformation Track application, SMAs must submit a

Memorandum of Understanding (MOU) with the potential Lead Organization (see CHART NOFO *Section E.1.2.2.3. Health Care Delivery System Redesign Concept* for MOU requirements).

Published October 2020

**How can organizations find contact information for their State Medicaid Agency (SMA)?**

CMS recommends applicants search for contact information on their SMA websites and/or contact the National Association of Medicaid Directors (NAMD) for information on their SMAs (http://medicaiddirectors.org/about/medicaid-directors/).

If a Lead Organization's Community spans more than one state, the Lead Organization must secure participation from the SMA in both states.

Published October 2020

**Will commercial payers participate in the CHART Community Transformation Track?**

Multi-payer alignment refers to non-Medicare payers' adoption of the Community Transformation Track Alternative Payment Models (APM) financial, operational, and quality processes to ensure that differently insured residents benefit from APM-driven care transformation. The goal of multi-payer alignment in CHART is to increase Participant Hospitals' total revenue from Eligible Hospital Services such that care transformation becomes a more rational business decision. By Performance Period 2, each Lead Organization must secure multi-payer alignment from the state Medicaid Agency (SMA), in accordance with this section. **Multi-payer alignment from commercial payers is recommended but not required.** Requiring multi-payer alignment beginning in Performance Period 2 allows Lead Organizations and Aligned Payers, to address legislative or regulatory barriers to payer participation, and build any IT infrastructure necessary to implement the APM.

Published October 2020

**Can you provide more detail on the requirements for the CHART Community Transformation Track multi-payer financial alignment?**

As detailed in the CHART Notice of Funding Opportunity (NOFO) *Section A.4.5.3. Multi-payer Alignment*, multi-payer alignment refers to non-Medicare payers' adoption of the Community Transformation Track Alternate Payment Model's (APM) financial, operational, and quality processes to ensure that differently insured beneficiaries that reside in each CHART Community benefit from APM-driven care transformation. Medicaid alignment is required by Performance Period 2, and CMS strongly encourages Communities to recruit private payers. Multi-payer alignment ensures that larger portions of a Participant Hospital's revenue is included in the capitated payment arrangement.

As specified in the CHART NOFO *Section A.4.5.3.1. Payer Alignment Characteristics*, each Aligned Payer may implement their capitated payment arrangement with Participant Hospitals differently based on their plan benefits and member populations. For example:

- Aligned Payers may need to modify the Capitated Payment Amount (CPA) financial methodology to account for smaller per-plan enrollment and/or more volatile year-over-year enrollment than Medicare Fee-For-Service (FFS).
- Aligned Payers may not need to align with the adjustments that rely on Critical Access Hospital (CAH) cost report data, since those are not relevant for other payers besides Medicare FFS.

CMS and awarded Lead Organizations will work together to explore CPA financial methodology modifications in order to facilitate design alignment. These modifications from the CPA financial methodology will be subject to CMS approval. Please see CHART NOFO Appendix XI. CPA Financial Methodology for more details and attend the payment webinar in early 2021 (following the event, webinar materials will be posted on the CHART Model website). Below we expand on CHART NOFO *Section A.4.5.3.1. Payer Alignment Characteristics*, by clarifying expectations for financial alignment.

- The Aligned Payer uses a similar financial methodology as CMS uses for the Community Transformation Track APM. To implement financial alignment, an Aligned Payer may need to build IT infrastructure or change internal policies (e.g. Medicaid agencies may need to apply for state plan amendments or 1115(a) waivers).
- The Aligned Payer is strongly encouraged to issue a prospective payment that follows a pre-specified cadence (semi-annually, monthly, or biweekly), though it does not have to be the same as CHART's Medicare Fee-For-Service (FFS) prospective payments (biweekly). This prospective payment is intended to provide rural hospitals with predictable funding in order to enhance access to care and achieve implementation of their Community's Transformation Plan. For Medicaid Managed Care inclusion, the CHART Lead Organization should collaborate with the state Medicaid agency and the Center for Medicaid & CHIP Services (CMCS) to develop a prospective payment strategy.
- The Aligned Payer must describe how its financial methodology contributes to the goals of the Community's Transformation Plan.
- The Aligned Payer must describe how its financial methodology will contribute to improvement on the Community's selected CHART quality measures.
- Medical assistance payments under Medicaid will remain subject to Medicaid upper payment limits and disproportionate share hospital limits.
- Each Aligned Payer will be 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 CHART NOFO Application.

Published January 2021

**In the CHART Community Transformation Track, will all Medicaid plans be required to participate in the capitated payments for Participant Hospitals?**

No. Medicaid alignment may be achieved through alignment of Medicaid Fee-For-Service (FFS), Medicaid managed care plans, or both. Lead Organizations, in collaboration with their state Medicaid agency (SMA), will be required to meet the Medicaid alignment targets in the table provided below. (See the CHART Notice of Funding Opportunity *Table 5. Medicaid Participation Targets* in *Section A.4.5.3.2. Medicaid Alignment*.)

| **Medicaid Alignment Target**<br>(% of each Participant Hospital's Medicaid revenue under a Capitated Payment Arrangement) |
|---|
| Performance Period 1 0% |
| Performance Period 2 50% |
| Performance Period 3 60% |
| Performance Period 4 75% |
| Performance Period 5 75% |
| Performance Period 6 75% |

Published January 2021

**Does a Lead Organization need to direct a certain amount of grant funding to the state Medicaid agency (SMA) in the CHART Community Transformation Track?**

No. There are no requirements in the Community Transformation Track about the amount of funding the Lead Organization must direct to the SMA via a subaward.

Per CHART's program requirements (see CHART Notice of Funding Opportunity *Section A.4.4.3. State Medicaid Agency*), the SMA must be a named subrecipient of CHART cooperative agreement funding. The budget must separate out funding that will be administered directly by the Lead Organization from funding that will be subcontracted to other partners. Though the Lead Organization and SMA must partner together to submit an application and implement this award, only one entity will be the Lead Organization. For more information on subrecipient and contractual relationships, please refer to HHS regulation 45 C.F.R. 75.351 Subrecipient and Contractor Determinations and 45 C.F.R. 75.352 Requirements for Pass-through Entities. Applicants must verify that they understand that they are required to avoid program duplication and ensure that award funds are not used to duplicate or supplant current federal, state, or local funding. Specifically, award funds cannot be used for the non-federal share of Medicaid payments.

Published January 2021

**What would you describe as the benefit for Medicaid and private payers to invest their resources in support of the Community Transformation Track?**

CMS recently released guidance for states on how to advance value-based care across their healthcare systems, with a particular emphasis on Medicaid populations. Our colleagues at

Center for Medicaid & CHIP Services (CMCS) are interested in advancing value based care for Medicaid beneficiaries, and CMS collaborated with CMCS in designing this Community Transformation Track, in which Medicaid participation is mandatory.

CMS understands that Alternative Payment Models (APMs) are difficult to administer. One design element CMS included is for State Medicaid Agencies to be sub-recipients of the Cooperative Agreement to ensure that they receive funding for their efforts. In addition to financial support, CMCS has played a critical role in our communications and intends to provide strong support to State Medicaid Agencies in standing up 1115 demonstration waivers and State Plan Amendments.

Private payer alignment is not mandatory but encouraged. The Pennsylvania Rural Health Model found that payers have demonstrated interest in alignment, and CHART's criteria for multi-payer alignment does offer flexibilities as appropriate for a payer's beneficiary population. Finally, CMS models are pilot programs, and therefore, usually cannot be all-encompassing from the beginning without any prior proof of concept. If CMS is able to demonstrate the feasibility of this Community Transformation Track at a smaller scale, then expansion can be considered in the future.

Published January 2021

**Why is the CHART Community Transformation Track multi-payer? Is CMS encouraging Lead Organizations to engage private payers?**

A broad multi-payer approach is needed to truly transform care and align financial incentives at the community level. The CHART Model strongly desires both public and private payer alignment to coordinate financial incentives for clinicians in rural regions. Within CMS, we have the ability to be unified and aligned within our own locus of control, which directly relates to Medicare and Medicaid. Medicare and Medicaid are significant payers in rural communities, and therefore we find that having both payers at the table is essential for rural hospitals. CMS has worked closely with the Center for Medicaid and CHIP Services (CMCS) when designing the Community Transformation Track to incorporate Medicaid participation in the CHART Model. Together, CMS recognizes that the requirement for Medicaid participation will take time and resources to implement. As a result, State Medicaid Agencies, as the Lead Organization or an Advisory Council member, are at the table from the beginning, the Pre-Implementation Period, and the implementation of Medicaid financial alignment is not required until Performance Period 2 (Year 3 of the Cooperative Agreement). Moreover, State Medicaid Agencies are required sub-recipients of the Cooperative Agreements. Throughout the Pre-Implementation Period, State Medicaid Agencies will work closely with CMCS to ensure that the state is able to successfully align to the CHART Model, and serve the rural Community to achieve the Track's goals of improving access to care in rural areas, quality of care and health outcomes for rural beneficiaries, and rural provider financial sustainability.

Published January 2021

**In the CHART Community Transformation Track, do the Capitated Payment Amounts (CPAs) replace Medicare Fee-For-Service (FFS) payments only, or does it also account for Medicaid beneficiaries and private payer members?**

The CPA replaces only Medicare FFS payment for Participant Hospitals. However, by Performance Period 2, Medicaid alignment is required and CMS strongly encourages communities to recruit private payers that will also align their payment strategy. Each Aligned Payer may implement their capitated payment arrangement with Participant Hospitals differently based on their plan benefits and member populations. Additionally, to implement financial alignment, an Aligned Payer may need to build out infrastructure or change internal policies. For example, the state Medicaid agency may need to apply for state plan amendments for 1115 waivers. For Medicaid managed care inclusion, the Lead Organization should collaborate with the state Medicaid agency and the Center for Medicaid and CHIP Services, which is ready to offer assistance, to develop a prospective payment strategy. See the CHART Notice of Funding Opportunity *Appendix IX. Medicaid Needs Assessment* for more information and guidance on Medicaid alignment.

Published March 2021

**Will the new payment methodology the state Medicaid agency designs to align with the CHART model lead to any changes in drawing down the federal Medicaid match?**

No. Any payment methodology a state Medicaid Agency develops to align with CHART will not change the federal Medicaid match since states will work closely with CMS/CMCS to ensure the new payment methodology meets Medicaid federal statutory and regulatory requirements in order to be eligible for federal financial participation.

Published March 2021

**What guidance can CMS provide to CHART Community Transformation Track Lead Organizations to help with private payer recruitment?**

CMS will provide resources to the Lead Organizations during the Pre-Implementation Period to assist with private payer recruitment. In addition, Lead Organizations are required to assemble an Advisory Council, which will advise on a few key activities including, but not limited to, payer recruitment and developing arrangements with payers governing Advanced Alternative Payment Model (APM) alignment and data sharing. At a minimum, Lead Organizations must have the state Medicaid agency (SMA) as an Aligned Payer. The SMA may be an additional resource for the Lead Organization to encourage private payer participation as they may have existing relationships with the local private payers.

Published March 2021

## Quality

**In the CHART Community Transformation Track, does each Participant Hospital have to report on all CHART quality measures or is the data going to be rolled up to the Community level for quality reporting to CMS?**

Yes, each Participant Hospital must report on all CHART quality measures. As stated in the NOFO, as a condition of participation, Lead Organizations and Participant Hospitals within their Community must report on the same six quality measures for the duration of the Model:

- CMS will determine the three required measures.

- The Lead Organization will select the remaining three measures from a list of options provided by CMS.

To be considered Aligned Payers, payers will need to report on the same six measures selected by their Lead Organization. Additional information on CHART quality measures can be found in the CHART Notice of Funding Opportunity *Section A.4.7. Quality Strategy*.

Published January 2021

**Does a CHART Community Transformation Track Lead Organization's Transformation Plan strategy need to align with each of the chosen quality measures?**

Yes. The Lead Organization's transformation strategies should align with the chosen quality measures. CMS will provide more guidance on Transformation Plans to Lead Organizations after awards are issued for the Community Transformation Track.

Published March 2021

## Award Information

**In the CHART Community Transformation Track, can Participant Hospitals opt-out of the Model during the Pre-implementation Period or the Performance Period?**

Yes. During the Pre-implementation Period, a hospital may work with a Lead Organization in developing a Transformation Plan for its Community as specified in CHART Notice of Funding Opportunity (NOFO) *Section A.4.3.2. Transformation Plan*. However, a hospital and/or Critical Access Hospitals (CAHs) may choose not to sign a CMS Participation Agreement to participate in the Model ahead of the start of the Performance Period.

A hospital and/or Critical Access Hospital (CAH) may sign a CMS Participation Agreement to participate in the Model ("Participant Hospital") ahead of the start of Performance Period 1. Pursuant to the CMS Participation Agreement, a Participant Hospital may withdraw from the Model at any time with advanced written notice to CMS.

A Participant Hospital will have up to two years to transition back to Fee-For-Service reimbursement from the effective date of either (1) Model track termination or non-continuation, or (2) termination of the Participant Hospital's Participation Agreement. During this transition period, a Participant Hospital may continue to operate under a capitated payment arrangement until fully transitioned. See CHART NOFO *Section A.4.4.2. Participant Hospitals* for additional information.

Published January 2021

**In the CHART Community Transformation Track, if there are cooperative agreement funds left over at the end of the budget period, are those funds lost?**

No. If funds remain during the designated Budget Period, the Lead Organization may submit a carryover request to CMS for review to allow the Lead Organization to use such funds in the subsequent budget period (See the CHART Notice of Funding Opportunity *Table 1. Funding Timeline and Prerequisites in Section A.4.2 Model Design and Funding Structure.)*

Published January 2021

**Will CMS release a list of the selected CHART Community Transformation Track Lead Organizations?**

Yes. CMS anticipates announcing Lead Organizations after selections have been made.

Published March 2021

**May Lead Organizations in the Community Transformation Track use cooperative agreement funds to assist Participant Hospitals in purchasing equipment and/or other materials needed to implement Transformation Plans?**

Purchasing equipment may be allowable if it supports the Transformation Plans; however, note that all equipment, staff, and other budgeted resources and expenses must be used exclusively for the projects identified in the applicant's original application, subsequently agreed upon by CMS, and may not be used for any prohibited uses. No funds under this award may be used for any of the activities/costs outlined in the CHART Notice of Funding Opportunity Section D.6. Cost Restrictions unless an exception is specifically authorized by statute.

Published April 2021

## CHART ACO Transformation Track

### Why was the ACO Transformation Track removed from the CHART Model?

CMS is developing an Agency-wide vision and strategy for accountable care, including opportunities to increase ACO adoption in rural areas. As part of this effort, CMS is examining lessons learned from the Innovation Center's ACO Investment Model (AIM) to inform future ACO policies, to advance health equity and to increase the number of beneficiaries in accountable care relationships in rural and other often underserved areas. Given these broader efforts underway, the CMS Innovation Center is removing the ACO Transformation Track from the CHART Model. CMS will keep engaging with beneficiaries, providers, local communities and other stakeholders to expand the availability of accountable care models and programs to Medicare beneficiaries in rural and underserved areas. CMS anticipates more information on new opportunities becoming available later this year.

Updated February 2022