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

Rural Health Value

Session #4: Calculating a Capitated Payment Amount for CHART Participant Hospitals

February 4, 2021

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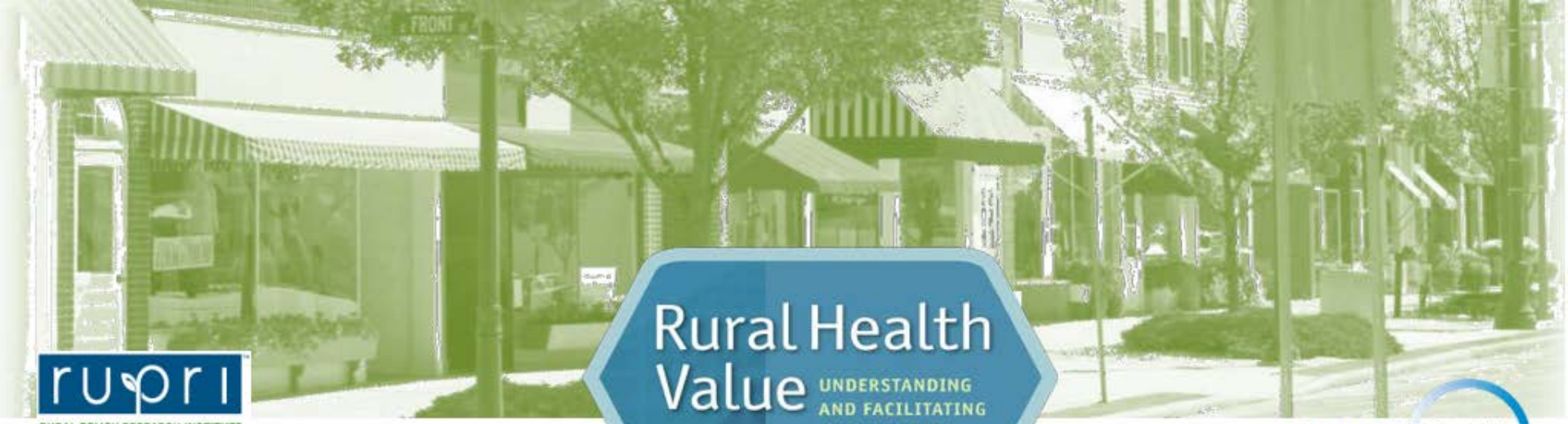

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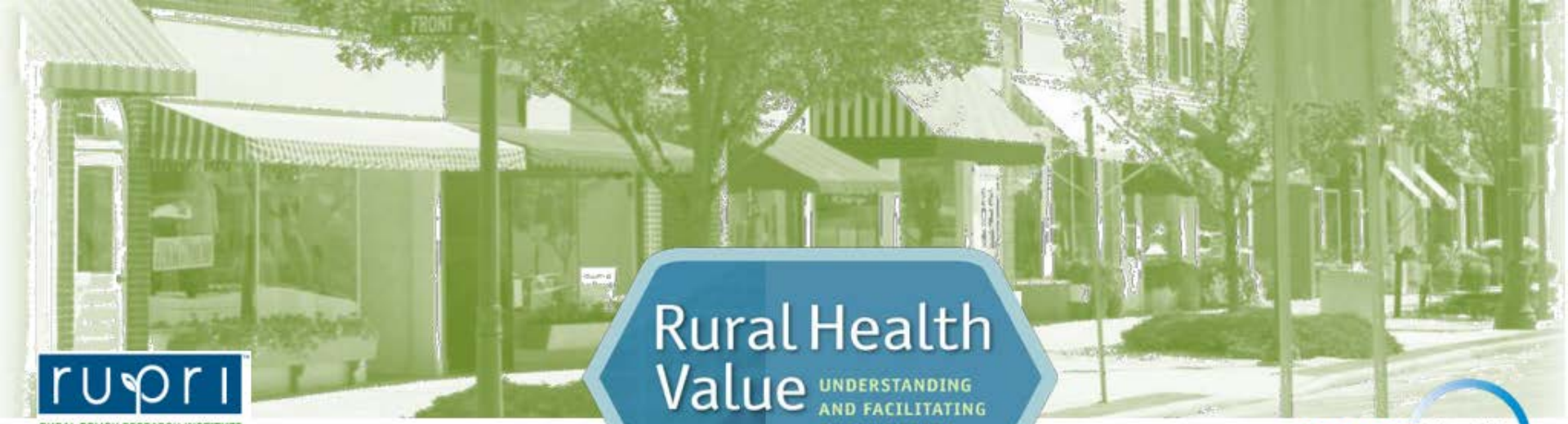
StratisHealth

Understanding and Facilitating Rural Health Transformation

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



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Let's Talk about CHART!

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

Community Health Access and Rural Transformation (CHART) Model

- The CHART Community Transformation Track
  - A hospital payment model (and more) that pays for inpatient and outpatient hospital services using a Capitated Payment Amount (CPA).
- Timeline
  - Applications due: March 16, 2021
  - Awardee selection: July 2021
  - Pre-Implementation Period: August 2021 – December 2022
  - Performance Periods: January 2023 – December 2028

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“Community”

- CHART requires organizing a “Community.”
- The Community must be comprised of county(ies) or Census tract(s) classified by FORHP as “rural”
  - Rural determination: https://data.hrsa.gov/tools/rural-health
  - May be single or a group (contiguous or non-contiguous)
  - Must include 10,000 fee-for-service Medicare beneficiaries, Medicare Advantage beneficiaries are not included

CHART NOFO, page 19

- Warning: this is not the traditional way we think of the word “community!”

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Lead Organization

- The organization that receives CMMI grant funding
- Requirements
  - Presence in Community for at least one year
  - Rural health expertise
  - Alternate payment models experience
  - Received grants totaling ≥ $500,000 in past 3 years
  - Provider agreements maintenance experience
  - Managing diverse stakeholder relationship experience

CHART NOFO, pages 18-19

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Participant Hospitals

- Physically located within the Community and receives at least 20% of its Original Medicare (FFS) revenue from Eligible Hospital Services provided to Community residents; or,
- Physically located inside or outside of the Community and responsible for at least 20% Original Medicare (FFS) expenditures for Eligible Hospital Services provided to Community residents.
- CMMI will review applications for exceptions.

CHART NOFO, page 24

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Disclaimer

"The CPA methodology is included in this NOFO for informational purposes and may change at CMMI's sole discretion…"

CHART NOFO, page 114

CMMI is always the final authority for the participant hospital financing methodology details presented in this webinar.

Contact CMMI at CHARTModel@cms.hhs.gov

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Six-step Methodology to Determine Participant Hospital CPA

- The process by which a Participant Hospital's CPA is calculated.
- CMMI will calculate each applicant hospital's CPA.
- CMMI will provide the CPA to the hospital for review prior to requiring a signed agreement.
- Two methodology phases
  - Community Prospective Benchmark (Steps 1-3)
  - Participant Hospital CPA Calculation (Steps 4-6)

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Step 1: Determine Community's Baseline Expenditures

- Define the "Community"
  - A FORHP-defined rural county or Census tract – or a collection of rural counties or Census tracts (need not be contiguous)
- Assign beneficiaries
  - Medicare eligible
  - Reside in community (evaluated monthly)
- Include inpatient/outpatient hospital expenditures (averaging 2018-2019, not 2020)
  - Physician services are not included
  - CAH Swing bed expenditures are included

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Step 2: Determine Changes between Community Baseline Expenditures and Prior Performance Period

- Apply trend in Original Medicare (FFS) expenditures
- Exclude outliers (>99th percentile) – optional
- Adjust for population change
- Adjust for demographic change
- Adjust for any PPS and CAH payment policy changes

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Step 3: Apply Adjustments from Step 2 to Determine the Community Benchmark

Community Baseline Expenditures from Step 1 **x** Baseline adjustments from Step 2 **=** Community Benchmark

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Step 4: Determine Each Participant Hospital's Portion of the Community Expenditure

$$\frac{\text{Sum IP/OP Hospital payments}}{\text{Community Baseline Expenditures from Step 1}} \times \text{Community Benchmark from Step 3} = \text{Hospital Base CPA}$$

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Step 5: Determine Each Hospital's Adjustments

- Apply quality adjustment
  - CMS quality payment adjustments for PPS continue.
  - CAHs are excluded from quality payment adjustment.
- Apply special designation status; e.g., CAH, SCH, MDH
- Apply Discount (a reduction to CPA) to reward larger Communities and attract payers.
  - CPA reduction increases from 0.5% to 4.0% for Communities with <$15 million Original Medicare (FFS) revenue.
  - Reduction increases over time for all but largest Communities.
  - Lead Organization may use grant dollars to offset Discount.

CHART NOFO, pages 117-118

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Step 6: Apply Each Participant Hospital Adjustments

Hospital Base CPA from Step 4 **x** Hospital Adjustments from Step 5 **=** Participant Hospital CPA (divided into bi-weekly payments)

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Important Notes 1

- CMMI will provide an applicant hospital its CPA before the hospital is required to sign an agreement.
- Historic baseline expenditures will be rebalanced only once after COVID volatility ends (model continues through 2028).
- Minimum Community size is 10,000 Original Medicare (FFS) beneficiaries (Medicare Advantage beneficiaries are not included).
- A Discount (a reduction in CPA) is added to encourage payer participation.
- The Discount (a reduction in CPA) is greater for smaller Communities to encourage configuration of larger Communities.

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Important Notes 2

- Financial penalties for quality continue for PPS hospitals, but financial quality penalties are not applied to CAHs.
- Population, demographic, and market shift adjustments are unknowns, but CMS will not recoup overpayments.
- CAH Swing Bed revenue is included in the CPA.
- Hospitals transferring services (i.e., planned service line shifts) will receive fixed costs for two years and hospitals accepting new services will receive variable costs for two years.
- A hospital may exit the model with advance notice. The hospital is allowed a two-year transition back to its previous payment system.

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Panel Discussion

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Questions

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