CHART Community Transformation Track – Q&A
Rural Health Value
November 18, 2020

Introduction

The following questions were posed during virtual discussion or in the chat box during the Rural Health Value webinar titled "Community Health Access and Rural Transformation (CHART) Model Community Transformation Track – Session #1" on October 28, 2020.

The Rural Health Value team developed the answers presented here. Questions and answers are assigned to four categories. When possible, answers reference a specific section(s) of the CHART Notice of Funding Opportunity (NOFO). This document is provided as a resource to help support consideration of the CHART model in rural communities. It does not constitute formal guidance on the NOFO from the Center for Medicare & Medicaid Innovation (CMMI). Official guidance from CMMI, including a FAQ based on questions they have received, can be found on the CHART web page here: https://innovation.cms.gov/innovation-models/chart-model.

Note: Several sections of the CHART NOFO state that details may change at CMMI's sole discretion (CHART NOFO, pages 20, 24, 27, 109, 110).

Lead Organization

Q1. Can health systems/networks serve as the lead organization?

Yes, a health system may be eligible to be a Lead Organization (CHART NOFO, page 18). The "kinds of organizations" that can serve as a Lead Organization include the following (CHART Model FAQs, October 2020, p 6):

- For profit organizations other than small businesses,
- Nonprofits having a 501 (c)(3) status with the IRS, other than institutions of higher education,
- Nonprofits that do not have a 501(c)(3) status.

Q2. Would a QIO qualify (as a lead organization)?

Yes, see bullets in the previous answer for "kinds of organizations." Further, QIOs with a presence in the community will meet the specific eligibility requirements (CHART NOFO, page 18).

Q3. What if a state hasn't had experience in APMs or CMMI projects -- would they not be able to qualify as a Lead Organization?

CMS requires that Lead Organizations have experience 1) designing and implementing APMs and 2) engaging and maintaining provider participation (CHART NOFO, page 18):

- “Experience, either through direct management or through a partnership, in designing and implementing APMs”
- “Experience in engaging and maintaining provider participation in APMs or CMMI demonstration projects/models”

Designing and implementing systems and processes that healthcare organizations undergo to participate in an Alternative Payment Model (e.g. demonstration with CMMI), or alternatively, experience that is outside of CMS would meet the requirement. Note that the experience need not be specifically in Medicare APMs, meaning that experience with any APM, including commercial insurance or Medicaid, would meet the requirement. Further, the second requirement may be satisfied from experience with other CMMI demonstrations (not limited to APMs).

Q4. I would like to know what type of experience is needed with APMs or CMMI.

As indicated in the bullets in the previous answer, there are two categories of experience: 1) in designing and implementing APMs (could be a partner), and 2) engaging and maintaining provider participation. Again, note that the second requirement may be satisfied from experience with other CMMI demonstrations or APMs through commercial insurance or Medicaid.

Q5. Lead organizations can request to receive less cooperative agreement funding in exchange for a lower discount factor for hospitals. Do you know how this may be determined?

CMMI offer three key flexibilities with respect to the discount (CHART NOFO, pages 22, 31, 113).

- First, before the beginning of Performance Period 1, Lead Organizations may request to receive less cooperative agreement funding in exchange for a lower discount factor for their Participant Hospitals. CMS may allow additional opportunities for Lead Organizations to request less cooperative agreement funding in exchange for a lower discount on a case-by-case basis.
- In addition, Lead Organizations will be able to negotiate participant-level discount factors with Participating Hospitals, subject to CMS approval, so long as the aggregate discount equals the final 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, but may pass some of the funding directly to Participant Hospitals for investing in and successfully implementing care delivery redesign efforts at the hospital-level.

Eligibility

Q1. Please define "community" in the instance that a hospital serves both a rural and non-rural population.

Each CHART Community Transformation Track Community must meet the following criteria:

- Encompass either (a) a single county or census tract or (b) a set of contiguous or noncontiguous 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 (https://data.hrsa.gov/tools/rural-health.
- At the time of application submission, include a minimum of 10,000 Medicare FFS beneficiaries whose primary residence is within the Community.

For each CHART Community, certain hospitals are eligible. 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 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 (CHART NOFO, page 24).

Q2. CAH must also meet the FORHP rural definition as well? This is important to know in order to choose the right participating hospital in our system.

Please see above for Participant Hospital eligibility criteria. 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 (CHART NOFO, page 24).

Q3. Does rural need to meet HRSA's definition of rural? The September 2020 Rural Action Plan states it should meet the OMB definition. Can you clarify for participating hospital?

Please see above for Participant Hospital eligibility criteria and also see the CHART FAQs at https://innovation.cms.gov/media/document/chart-model-faqs for additional information. The Rural Health Information Hub, Am I Rural? - Tool can be a useful tool to identify if specific locations fit the Federal Office of Rural Health Policy's list of eligible counties and census tracts used for its grant programs.

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 https://data.hrsa.gov/tools/rural-health).
2. At the time of application submission, include a minimum of 10,000 Medicare FFS beneficiaries whose primary residence is within the Community.

Q4. Are certified Rural Health Centers (RHCs) eligible for the CHART program?

RHCs are not eligible to participate as a participant hospital, but see sections in the CHART NOFO about the Transformation Plan component as to which provider and supplier types across the community may be included. CMS will be encouraging a Transformation Plan that spans across and outside of the hospitals and CAHs to incorporate other provider and supplier types in plans being pursued.

RHCs may also participate in the CHART program through the Advisory Councils. The Advisory Council must include a representative from at least three distinct entities from the following list (CHART NOFO, page 23).

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)

Q5. What happens if a participant hospital declines to execute the participation agreement after the negotiation of the CPA?

The CHART NOFO does not provide information on this.

Q6. If a hospital is already working with an ACO, does it disqualify them from working in this program?

A three-part answer:

- Subject to CMS approval, Participant Hospitals may simultaneously participate in the Community Transformation Track and other Medicare value-based programs, models or demonstrations. 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 (CHART NOFO, page 24).
- CMS will not allow the same entity to be both an award recipient (the Lead Organization) in the Community Transformation Track and an ACO participating in the ACO Transformation Track (CHART NOFO, page 40).

- Maryland, Vermont, and Pennsylvania are currently testing state-wide, multi-payer Models. 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 (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 (CHART NOFO, page 41).

Q7. What if part of the community is deemed not rural from the 2020 census?

Please see Community definition in Q1 and Q3 above. The CHART NOFO does not offer guidance regarding potential changes in rural/urban classification of participating organizations.

Q8. Has there been any talk of allowing hospitals that have closed to reopen and participate in this model?

Each CHART Participant Hospital or CAH is identified by its CMS Certification Number (CCN). If a hospital or 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 would submit a Form CMS-855 application to their Medicare Administrative Contractor (MAC) to enroll in the Medicare program. A survey would occur to confirm compliance with the Medicare Conditions of Participation prior to a CCN being issued. For additional information on hospital/CAH certification, see State Operations Manual Chapter 2.
https://www.cms.gov/Regulations-and-uidance/Guidance/Manuals/downloads/som107c02.pdf.
Once a CCN has been issued, the hospital or CAH may be eligible to participate in CHART as long as they meet the CHART eligibility criteria (see Q7).

Q9. Do the attributed lives have to be geographically connected? Can one hospital in the east side of the state partner with one hospital on the west side of the state to have enough beneficiaries?

The Community does not need to be geographically contiguous. See the Community definition in Q1 and Q3 above. CMS will ensure that there is not overlap between Lead Organizations' defined Communities. If a Lead Organization's Community spans more than one state, the Lead Organization must secure participation from the SMA in both states.

Payment Model and Quality

Note: The Capitated Payment Amount (CPA) financial methodology is included in the NOFO for informational purposes only and may change at CMMI's sole discretion (CHART NOFO, page 110).

Q1. How will current reimbursement models be impacted by the capitated payment reimbursement mechanism? (i.e. CAH, RHC)?

There are two prospective payment adjustments made to the baseline revenue prior to the start of each performance period. For CAHs, the unit price adjustment consists of the change in the interim payment between the cost report that the CAH submitted for the baseline year and the cost report for the most recently available, adjudicated cost report (CHART NOFO, page 113). Physician services (e.g., RHC-based physician services) are not Eligible Hospital Services for the CPA (CHART NOFO, page 28). 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 CAH. All other types of health care facilities are ineligible to be Participant Hospitals, and thus ineligible for the CPA (CHART NOFO, page 24). RHC reimbursement will not be impacted.

Q2. How are patients attributed?

The CPA is based on historic hospital revenue for included services (CHART NOFO, pages 27 and 111). The population adjustment to the CPA captures differences in population size, demographics such as age, and shifts in the Eligible Hospital Services between hospitals. The population demographic will be defined as a change in the demographic-only HCC Risk Score. The shift in Eligible Hospital Services adjustment will be defined as a change in the distribution of services between hospitals (CHART NOFO, pages 112, 113). Population change adjustments will be presumably based on the Community-defined geographic area.

Q3. Will non-participating rural hospitals in the leading organization be at risk with its current supplemental payments?

Although the NOFO does not address this question specifically, a CPA would not be applied to non-participating hospitals. The CPA financial methodology only applies to Participant acute care hospitals and CAHs (CHART NOFO, pages 110-115). A Participant Hospital is one that is either

- physically located with the Community and receives at least 20 percent of its Medicare FFS revenue from Eligible Hospital Services provided to residents or the community; or
- physically located inside or outside of the Community and is responsible for at least 20 percent of Medicare expenditures for Eligible Hospital Services provided to residents of the Community (CHART NOFO, page 24).

Q4. If a health system is the leading organization and has 2 participating hospitals in its system, but not all of its hospitals, will the reimbursement model of the non-existing hospitals be at risk?

Please see Question 3 above.

Q5. Do the payments include SNF/Home Health or just IP/OP?

Skilled Nursing Facility (SNF) level services provided by a hospital or CAH with swing beds are included in the CPA. SNF services provided by a non-hospital or non-CAH facility are not included in the CPA. Home health services provided by either an acute care hospital or a CAH are also not included in the CPA (CHART NOFO, page 28).

Q6. What is the methodology used to determine global payment rates?

The CPA is determined and adjusted in five steps:

(1) Determine baseline revenue using historical expenditures for eligible hospital services.
(2) Apply prospective payments.
(3) Apply a discount.
(4) Apply mid-year adjustments to CPAs.
(5) Apply end-of-year adjustments to CPAs (CHART NOFO, pages 110-115).

Q7. How will the capitated payment, specifically the discount rate, work?

In order for payers to realize savings, a percentage discount – or reduction – will be applied to the CPA (CHART NOFO, page 113). The specific discount factor for a Community is determined by its total Medicare FFS revenue under the capitated payment arrangement at the Community-level (CHART NOFO, page 11). The discount factor will increase over the duration of the CHART Model. The discount factor is greater if the total Medicare FFS revenue in the Community under a capitated payment arrangement is lower; i.e., smaller participant hospital(s) will experience a greater discount in their CPA (CHART NOFO, page 114).

Q8. Will the results of COVID-19 be taken into consideration in the average of the prior 3 years of the starting in the program? Or will it go into the average understanding that hospitals experienced extraordinary costs associated with the pandemic?

The NOFO does not mention adjustments based on COVID pandemic impacts on historic participant hospital costs. Each Participant Hospital's baseline CPA will be determined using the simple average of the hospital expenditures from the two calendar years starting three years prior to the first period the Participant Hospital joins up to one year prior to the hospital's performance year; e.g., CYs 2019-2020 for Performance Period 1 schedule to occur in 2022. The CPA is adjusted each year based on prior year fee-for-service Medicare expenditures. For subsequent years (after the baseline year) that a Participant Hospital participates in CHART, the Participant Hospital's baseline revenue will be equal to the CPA for the prior Performance Period (CHART NOFO, page 111). CMMI has identified several flexibilities for current models related to the impact of COVID:
https://innovation.cms.gov/innovation-models/covid-19-flexibilities

Q9. Do the adjustments address situations where the patient is transferred to a higher level of care?

The baseline CPA is determined using the simple average of hospital expenditures (for included services) for two prior years (CHART NOFO, page 111). Therefore, prior transfer patterns would be included in the baseline CPA. New transfer patterns would be included in the population adjustment; i.e., the shift in Eligible Hospital Service, defined as a change in the distribution of service between hospitals (CHART NOFO, page 113).

Q10. How would a new payment model affect CAH designation?

CAHs are eligible to participate in CHART. CAH designation is granted by CMS when a hospital is enrolled in the Medicare program and converts to being a CAH provider type by complying with the CAH Conditions of Participation (CoPs) set forth at 42 CFR Part 485 Subpart F. See the Medicare State Operations Manual Chapter 2 for additional information regarding CAH designation. CMS plans to offer benefit enhancements to the CHART participants, which may include but are not limited to the Medicare waiving CoPs listed in the NOFO.

Q11. How does this work with existing Medicaid managed care arrangements for pmpm (per member per month) payments?

A Medicaid Needs Assessment is required for the CHART application (CHART NOFO, page 100). The Medicaid Needs Assessment inquiries about how different Medicaid payment models can be leveraged to meet CHART's financial alignment requirement (CHART NOFO, page 100). CHART requires that Medicaid payment (Medicaid FFS, Medicaid managed care plans, or both) progressively aligns with CHART's CPA methodology. The required percent of each Participant Hospital's Medicaid revenue under a CPA arrangement is 0 percent during Performance Period 1 and increases to 75% in performance periods 4 through 6 (CHART NOFO, page 30).

Q12. Would the CPA payment be similar to the PIP (Periodic Interim Payment)?

CHART provides biweekly payments to the Participant Hospital based on the CPA (CMS Office Hour Session webinar, October 27, 2020, slide 13). A unit price adjustment is applied to the CPA at mid-year and year-end. The unit price adjustment for CAHs consists of the change in the interim payment between the cost report that the CAH submitted for the baseline years and the most recently available, adjudicated cost report (CHART NOFO, page 113).

Q13. Was rationale given as to why the discount rate is smaller for larger organizations?

A discount is applied to the CPA in order for the payers to realize savings (CHART NOFO, page 113). The greater discount applied to smaller Participant Hospital(s) (as measured by total FFS revenue in the community under a CPA arrangement) serves as an incentive to recruit more hospitals to participate in CHART by Performance Period 3 (CHART NOFO, page 113 and 114).

Q14. Would the filing of a cost report still be required?

Yes. The unit price adjustment is determined by the change in the interim payment rate between the cost report that the CAH submitted for the baseline years and most recently available, adjudicated cost report (CHART NOFO, page 113).

Q15. Will HCAHPS be evaluated by participant hospitals or for the group as a whole? If several low-volume hospitals band together, there may not be sufficient HCAHPS responses if evaluated on a facility by facility basis.

The Lead Organization and the Participant Hospitals will be required to report on the same six quality measures, including HCAHPS (CHART NOFO, page 35). The NOFO does not address a threshold number of HCAHPS surveys completed for reporting. However, the CHART Quality Strategy (CHART NOFO, page 35-37) will impact up to 2 percent of the CPA (i.e., a CPA reduction of up to 2 percent) and will be applied at the Community level to incent all Participating Hospitals within the Community to collaborate (CHART NOFO, page 112).

Q16. To clarify - are there only potential disincentives/penalties for not meeting quality metrics? Isn't there a potential for an enhancement due to quality performance?

Please see question #15 above.

Partnering/Redesign, Potential Impacts, Other

Q1. How will CHART help engage Federally Qualified Health Centers (FQHCs) that may typically not be interested in working with hospitals?

FQHCs, along with primary care providers, RHCs or physician group practices are identified as potential Advisory Council members (CHART NOFO, page 23). Collaborative Governance and Care Coordination with Community Safety Net Providers (which includes FQHCs) is also listed as a potential example of health care delivery system redesign (CHART NOFO, page 99).

Those interested in stronger collaboration with safety net providers are encouraged to review this resource from the Federal Office of Rural Health Policy: Guide for Rural Health Care Collaboration and Coordination (2019). The Guide describes how rural hospitals, community health centers, local public health departments, and other rural stakeholders can work together to assess and address their rural communities' health needs.

Q2. Is it feasible to have a patient transfer system from rural to tertiary hospital similar to the EMS trauma system?

Possibly, if the proposed system aligns with CHART goals and community needs. As part of CHART, Lead Organizations will develop a Transformation Plan that is the description of their health care delivery system redesign strategy. 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. CMMI also requires Transformation Plans to include strategies to expand the use of telehealth and other

technology to support care delivery improvement (CHART NOFO, page 19). A variety of Medicare Program and Payment Policy Waivers may be available to support implementation of the Community Transformation Plan(s) (CHART NOFO, page 32). Potential examples of health care delivery system redesign are also listed in Appendix VII of the CHART NOFO.

Q3. Our state Medicaid agency has indicated they think CMMI will allow for some state specific flexibility- do you have any sense of this?

Involvement of the SMA is required in CHART. Lead Organizations and SMAs are encouraged to review the Medicaid Needs Assessment Questionnaire (CHART NOFO, pages 100-104), and the Medicaid Pathway Guidance (CHART NOFO, pages 104-108) that outlines potential considerations for alignment through state plan amendments, alignment through managed care, and alignment through 1115 Demonstration Authority. The NOFO states that CMS welcomes states to engage with CMS as they plan an approach to the CHART Model that addresses unique state needs. CMS and states will work together to identify available authorities and submit the required applications and amendments as needed. CMS is available to provide technical assistance to states on how to meet federal transparency requirements as well as to preview states' draft 1115 proposals and public notice documentation to help ensure states successfully meet federal requirements (CHART NOFO, page 109).

Q4. Will CAHs lose CAH Designation if they move to this model?

CAH designation persists in the CHART Model and is referenced on multiple pages in the CHART NOFO.

Q5. Is there any conflict with the Flex or SHIP programs?

Awardees should work with Flex and SHIP projects officers for these specific questions (https://www.hrsa.gov/rural-health/rural-hospitals/region-map.html).

Q6. Can participating hospitals still participate in the Managed Care Incentive Program (run by the State Medicaid program)?

Involvement of the SMA is required for CHART. Participation in incentive programs developed and implemented by the SMA will need to be part of the consideration for alignment. See question 3 above for additional detail.

Q7. If the administration changes on November 3, will it have any impact on this program?

There is strong bi-partisan support for movement to value-based models.

Q8. Has anyone developed an analysis of the anticipated costs required to implement this program, and how that compares to the CMMI funding to cover same?

CMMI funding for CHART will be up to $5 million for up to 15 award recipients (total of up to $75 million). Award recipients will participate in CHART for seven years (includes one Pre-Implementation Period and six Performance Periods). The cost to implement CHART requirements is unknown.

Q9. It's apparent that CMS is pushing for a certain model of rural health care delivery (such as the use of discount rates to encourage organizations to work together). Is there any good example of what their preferred model looks like?

As part of CHART, Lead Organizations will develop a Transformation Plan that is the description of their health care delivery system redesign strategy. 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. CMMI also requires Transformation Plans to include strategies to expand the use of telehealth and other technology to support care delivery improvement (CHART NOFO, page 19). A variety of Medicare Program and Payment Policy Waivers may be available to support implementation of the Community Transformation Plan(s) (CHART NOFO, page 32). Potential examples of health care delivery system redesign are also listed in Appendix VII of the CHART NOFO.

Q10. If this is successful, is there a pathway for continuation?

Under CMMI Statute, if a model meets one of the three criteria below and other statutory prerequisites, the statue allows the Secretary to expand the duration and the scope of a model through rulemaking. Criteria/Scenarios for success include the following (Community Health Access and Rural Transformation (CHART) Model – Model Overview Webinar. CMMI. August 18, 2020).

- Quality improves and costs is neutral,
- Quality is neutral, and cost is reduced, or
- Quality improves and cost is reduced (best case)

Q11. What happens at the end of the planning year if you realize this is beyond our scope, capacity, or that the data analysis indicates that the "model" won't actually benefit our providers?

The CHART NOFO is silent regarding the options for an awardee (Lead Organization) if during the first year (Pre-implementation Period) the awardee decides not to continue in the CHART Model or does not satisfactorily complete funded activities (CHART NOFO, pages 15, 20-21).