Community Health Access and Rural Transformation Model
Payment Policies for the Community Transformation Track

The **CHART Model** is a voluntary model that will test whether **aligned financial incentives, operational & regulatory flexibilities, and robust technical support** will help rural providers **transform care** on a broad scale. Within the CHART Model, the Community Transformation Track aims to **drive modernization of rural health delivery systems** by providing Lead Organizations with upfront funding and Participant Hospitals with predictable finances through a Capitated Payment Amount (CPA) and operational flexibilities through benefit enhancements and beneficiary engagement incentives.

What are the types of funding available in the CHART Model Community Transformation Track?

Cooperative Agreement Funding

Each **Lead Organization** will enter into a cooperative agreement with funding of up to $5 million to coordinate with Community Partners (e.g., Advisory Council members, Participant Hospitals, and the state Medicaid agency) and transform care. CMS will make up to $2 million available to each Lead Organization upon acceptance into the CHART Model, with the rest of the funding available as Communities progress through the Model. Funding is dependent on the Lead Organization meeting performance requirements.

Capitated Payment Amount (CPA)

CMS will replace a significant portion of the **Participant Hospitals'** Fee-for-Service (FFS) claim reimbursement with bi-weekly payments that equal the annual CPA over the course of each Performance Period. The CPA will be calculated based on Eligible Hospital Services (e.g., Part A and facility-based Part B services, and swing bed services provided by Critical Access Hospitals (CAH)) that are provided to eligible Medicare FFS beneficiaries. Hospital services that are not eligible will continue to be reimbursed through FFS and standard CAH cost-based reimbursement.

How does the CHART Model support rural healthcare delivery transformation?

Transparency

CMS will calculate and share a prospective hospital's estimated CPA with Lead Organizations and that prospective hospital during the Pre-Implementation Period, giving each prospective hospital *full awareness of their expected CPA* prior to signing a Participation Agreement.

Population Health Improvement

Participant Hospitals and Lead Organizations will be able to use Model resources and collaboration opportunities *to improve local health outcomes* in their Communities.

Flexibilities to Innovate Care

Operational and regulatory flexibilities allow Participant Hospitals to *redesign their health care delivery system* based on what their Community and hospital need e.g., SNF 3-Day Rule waiver, Telehealth expansion waiver, CAH 96-Hour Rule waiver

Technical Assistance & Shared Learning

Participant Hospitals will receive *support from CMS and be able to share lessons learned with each other* to tackle common issues and implement best practices.

Financial Predictability

With CMS support, Participant Hospitals will be able to *forecast their annual revenue under the Model and strategically make investments* to navigate fluctuations in demand and other Community-level changes.

Access to Care

Rural beneficiaries will experience *improved access* to care through Community-level transformation.

How will CMS account for the COVID-19 Public Health Emergency (PHE) in this Track?

1. **Historical Baseline**
Data used to develop a historical baseline and trend adjustment will avoid COVID-19-impacted years.

2. **Normalization of Data**
CMS will update baseline and trend data following the COVID-19 PHE to account for changes in expenditures.

3. **Guardrails**
Guardrails and Medicare payment policies will build in protections from future variation and changes due to COVID-19.

For more information and additional payment resources, please visit the CHART Model website:
https://innovation.cms.gov/innovation-models/chart-model

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CMS will follow the process below to **calculate each Participant Hospital's Capitated Payment Amount (CPA)**. Detailed information on this process can be found on the CHART Model website: https://innovation.cms.gov/innovation-models/chart-model.

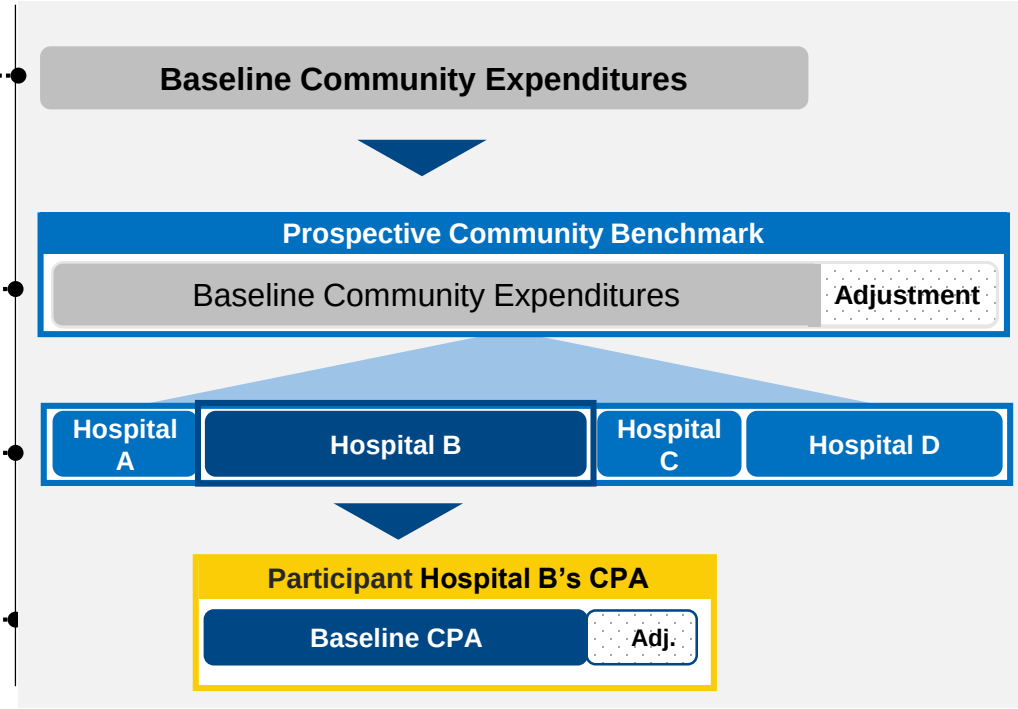
How will CMS Calculate Participant Hospital CPAs for Performance Period 1?

Determine baseline Community expenditures. The Lead Organization will define the Community within Model guidelines. CMS will identify eligible FFS beneficiaries and eligible hospital expenditures during the baseline period with the assignment methodology (i.e. residency, Medicare eligibility, and service utilization).

Apply Community adjustment factors (see below) to baseline Community expenditures to determine the prospective Community benchmark.

Determine each Participant Hospital's share of the prospective Community benchmark based on the hospital's share of unadjusted baseline Community expenditures.

Apply hospital-specific adjustments (see below) to each hospital's Baseline CPA to calculate Participant Hospital's CPA.



What Adjustments Will CMS Apply to Calculate the Participant Hospital CPA in Performance Period 1?

Baseline Community Expenditure Adjustment

To ensure that the prospective Community benchmark accounts for the beneficiaries that the Community serves and reflects changes that may have occurred between the years used for baseline data and the Performance Period, CMS will use adjustments including:

- **Trend:** Based on observed trends during baseline period that will avoid expenditure data impacted by COVID-19.
- **Demographic:** Based on changing populations to improve the accuracy of the benchmark calculation.
- **Outlier (optional):** Adjust to protect Participant Hospitals from unexpected, catastrophically expensive utilization.
- **Population Size:** Adjust for differences in Community's assigned Medicare FFS population between baseline year and Performance Period.
- **IPPS/OPPS/CAH:** IPPS and OPPS FFS payment systems adjustment and CAH policy changes to account for changes in clinical practice, technology, and policy.

Hospital Specific Adjustment

Similar to the Community baseline, CMS will also apply the following adjustments to each Participant Hospital's baseline CPA:

- **Quality:** Prospective Payment System Participant Hospitals will be adjusted to reflect performance in the national Medicare hospital quality programs.
- **Discount:** CMS will apply a 0.5% discount off the trend in Performance Period 1 as specified in the Notice of Funding Opportunity.
- **Special Designation:** CMS will prospectively adjust special status hospitals by the same payment adjustment factor and apply it to the same portion of revenue as if the hospital was participating in FFS.
- **Service Line Adjustments:** Participant Hospitals may choose to invest in service line changes that were not captured in the baseline data due to service line additions, unplanned shifts in service, or strategic planned shifts in service.

How will CMS Calculate Participant Hospitals' CPAs Following Performance Period 1?

CMS will conduct a mid-year check to identify if there are necessary adjustments for the remainder of the Performance Period. Following the end of the Performance Period, CMS will apply adjustments annually to ensure that hospital payments account for changing populations served moving forward.

Performance Period 1

Mid-Year Check

CMS will conduct a mid-year check to help identify necessary adjustments for the remainder of the Performance Period. If there are material changes in the population served, (e.g., increase in beneficiary months or a younger population), after the annual CPA was set and issued, CMS will notify Participant Hospitals and may update the remaining annual prospective payments.

Performance Period 2

End of Year Adjustment

Following the conclusion of Performance Period 1, CMS will update the Community benchmark (e.g., beneficiary months) and Participant Hospitals' CPAs (e.g., distribution in services adjustment).

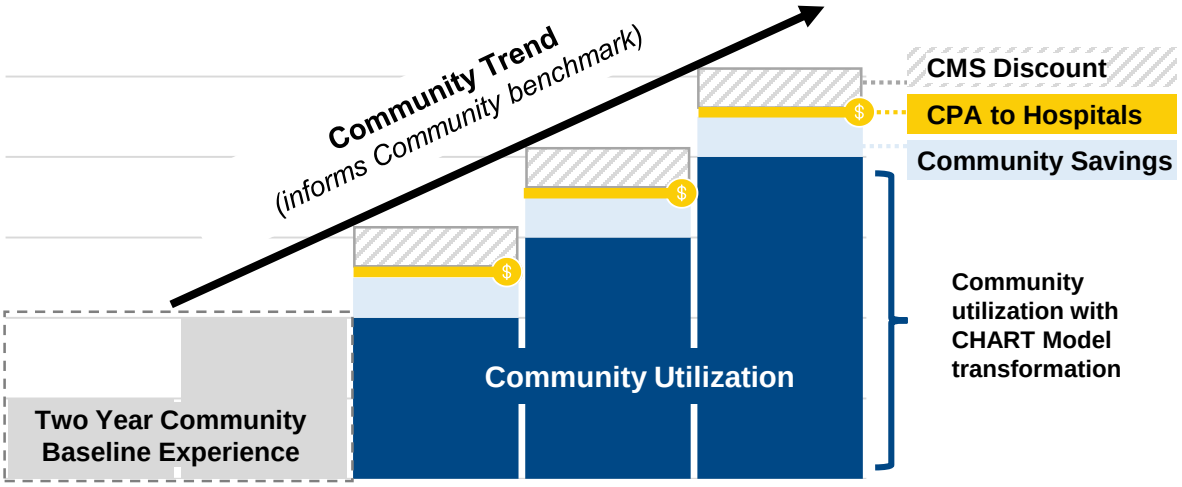
Setting CPA For Performance Period 2

CMS will use the latest Community adjustment (post-reconciliation) to calculate the prospective Community benchmark and the hospital specific share using the same community and hospital specific adjustments used prior. After the Participant Hospital has reviewed the new payment, the new CPA will be issued.

How do hospital CPAs adjust to reflect Community changes over time?

The CHART Model Community Transformation Track accounts for changes in the assigned beneficiary population's utilization over the course of the Model while rewarding transformation through shared savings.

A Participant Hospital's CPA will **adjust to account for Community trends**. Participant Hospitals will also be able to keep the savings that are generated through transformation.



How does multi-payer alignment factor into the CHART Model?

Multi-payer alignment ensures that Participant Hospitals receive predictable payments for larger portions of their revenue, allowing differently insured patients to benefit from care transformation. **By Performance Period 2, Medicaid alignment is required, but CMS strongly encourages Communities to recruit private payers into alignment with the Model.** Aligned payers are strongly encouraged to issue a prospective payment that follows a pre-specified cadence, though it does not have to be the same as CHART's Medicare prospective payments (biweekly).

Aligned payers can benefit from a consistent annual growth trend in total spending to Participant Hospitals along with a lowered rate of growth in overall total cost of care as Participant Hospitals' incentives to keep patients healthy align with payer incentives. For more information on multi-payer alignment, please see the Community Transformation Track Notice of Funding Opportunity.