CHART Model: Operational Flexibilities Exercise

The Community Transformation Track of the Community Healthcare Access and Rural Transformation (CHART) Model consists of three core program elements designed to set up rural communities for success: funding to establish partnerships and technical support, operational flexibilities and value-based payment (VBP). The Centers for Medicare and Medicaid Services (CMS)' goals for the CHART Model are to improve access to care in rural areas, improve quality of care and health outcomes for rural beneficiaries, increase adoption of alternative payment models (APMs) among rural providers and improve rural provider financial sustainability. More detail is provided on the HHSC CHART website here.

The CHART Model offers three types of operational flexibilities to expand Lead Organization (HHSC)'s ability to implement health care delivery system redesign and promote Participant Hospitals' capacity to manage beneficiary care:

- Model Design Flexibilities
- Benefit Enhancements
- Beneficiary Engagement Incentives

While HHSC is responsible for requesting flexibilities and enhancements from CMS, HHSC seeks input from potential Participant Hospitals about which are needed to implement health care delivery redesign through the CHART Model. This exercise is meant to help potential Participant Hospitals determine which operational flexibilities are needed. Please work with appropriate hospital stakeholders and decision-makers to review the Model Design Flexibilities, Benefit Enhancements and Beneficiary Engagement Incentives listed in Table 1-3 on pages 2-9, and use the check box in the first column to confirm your interest or disinterest in each flexibility and write in examples that may be applicable to your hospital in the Hospital Notes column. Questions regarding this exercise or the CHART Model in general can be emailed to: HHSC_CHART@hhsc.state.tx.us.

Model Design Flexibilities

A Lead Organization, in collaboration with Participant Hospitals, may leverage any of the following Model design flexibilities as shown in Table 1 in designing and implementing their health care delivery system redesign strategy. Please note that these flexibilities are requested at the Community (State) level in the CHART Model. Tables 2 and 3 on subsequent pages are hospital-specific.

Table 1. Model Design Flexibilities (Community (State) Level)

Model Flexibility	Purpose of Flexibility	Example	Hospital Notes
☐Flexibility in Cooperative Funding Use	Lead Organizations may receive up to $5 million of cooperative agreement funding and may pass some of the funding directly to Participant Hospitals for investing in and successfully implementing health care delivery redesign efforts at the hospital-level.	In HHSC's application, it proposed to allocate up to $2.7 million of the cooperative agreement funding to Participant Hospitals to be used to purchase telemedicine equipment, training, software, and hire additional staff, if needed, to implement transformation goals.	
☐Flexibility for Service Line Adjustments (This flexibility may be added for future performance periods)	When Participant Hospitals shut down a service line, they will lose revenue from that service line while other Participant Hospitals may gain revenue from additional utilization. To the extent that Lead	Hospital A provides respiratory therapy for community members. Hospital A conducts a cost analysis and determines that it is not financially feasible to continue the service line of respiratory therapy. A voluntary budget-neutral agreement is	

	Organizations can construct voluntary budget-neutral agreements with multiple Participant Hospitals, CMMI will distribute payments for service line adjustments between hospitals.	developed and executed among a cohort of nearby CHART Model Participating Hospitals to provide respiratory therapy to their patients.	
☐Flexibility to Include or Exclude Outliers in the Medicare Capitated Payment Amount (CPA)	Participant Hospitals can elect whether to participate in an optional outlier policy if they would like to limit the impact of extraordinarily high cost claims on their CPA. 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'. This flexibility is offered annually and is done at the Community level, so all hospitals would participate if the flexibility were selected.	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 CMS considers 'high cost claims'. reduction efforts will influence outlier costs. However, Communities that use the Outlier Adjustment miss an opportunity to realize savings that come from better management of high-cost utilization	

	The outlier adjustment is applied at End-of-Year Reconciliation because outliers are not known in advance of the Performance Period. The End-of-Year Reconciliation Amount is then applied to future Performance Periods. In general, the Outlier expenditures are those above the 99th percentile (calculated for all aligned residents in the community).	during the Performance Period. The Outlier Adjustment is bi-directional. This means that if the Lead Org opts into the Outlier Adjustment and actual expenditures due to outliers are lower than the prospective calculation, then CMS would recoup the difference. If actual expenditures are higher for outliers than the prospective calculation, CMS would make the hospital whole. However, forgoing the Outlier Adjustment provides the opportunity to decrease expenditures for high-cost beneficiaries through transformation efforts, resulting in savings for the hospital. For additional information, see pages 36-40 of CHART Model Participation Community Track Financial Specifications (PDF).	

Benefit Enhancements

Participant Hospitals may request through their Lead Organizations for CMS to waive any of the following Medicare provisions for the purpose of testing the CHART Model. Participant Hospitals should review the waivers as shown in Table 2 to determine which, if any, may be helpful to implement their health care delivery redesign strategy and in the design of the hospital's telemedicine project.

Table 2. Benefit Enhancements (Hospital-Specific)

Waiver	Purpose of Waiver	Example	Hospital Notes
☐SNF 3-Day Rule Waiver (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.	A beneficiary who is in the hospital for fewer than three days or directly from a physician's office is admitted to a Skilled Nursing Facility.	
☐Telehealth Expansion (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	A beneficiary who is diabetic and enrolled in Chronic Care Management is monitored from their home.	

	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 (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.	A beneficiary with complex healthcare needs is visited at home by a community pharmacist to provide care management, health coaching and medication optimization services in close collaboration with their primary care provider.	
☐Waiver of certain Medicare Hospital and/or CAH Conditions of	Waivers of Medicare CoPs could allow Participant Hospitals to make certain changes to their facility structure and	A Participating Hospital's Conditions of Participation for life safety code and physical environment are waived which	

Participation (CoPs)	maintain their hospital or CAH status for the purpose of Medicare enrollment and certification, Medicare hospital quality reporting, and in order to receive payments under the capitated payment arrangement.	allows for patient care to be provided in an alternate care setting, such as an aligned beneficiary's home.	
☐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.	A beneficiary who is needing critical medical services that may have lengths of stay greater than 96 hours would be able to stay in the community at the hospital and receive those needed medical services.	

Beneficiary Engagement Incentives

Participant Hospitals may request through their Lead Organizations from CMS to use any of the following beneficiary engagement incentives as shown in Table 3 to use in conjunction with their CHART Model telemedicine project and/or another activity related to their health care redesign strategy. Cooperative agreement funding allocated from HHSC may be used to implement these incentives.

Table 3. Beneficiary Engagement Incentives (Hospital-Specific)

Beneficiary Engagement Incentive	Purpose of Incentive	Example	Hospital Notes
☐Cost Sharing for Part B Services	As a beneficiary engagement incentive, Participant Hospitals will be allowed to reduce or waive the applicable co-insurance on the Medicare allowed amount (estimated at approximately $10 per visit). 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	A beneficiary has a copay for their Chronic Care Management visits. The aligned beneficiary is unable to pay the co-pay so the Participant Hospital uses CHART Model funding from HHSC to reduce or waive the co-pay amount.	

	and disease progression; and ● Patients with recent hospitalizations or ED visits.		
☐Transportation	This will allow Participant Hospitals to offer free or discounted transportation services (to include a ride sharing service and a Participant Hospital's own contracted automobile) for beneficiaries requiring face to face care with a Participant Hospital and to connect beneficiaries with follow up services, including trips to: ● A pharmacy or courier service for medication; ● An external specialist's office; ● Elective procedures; and ● Health care providers for	A beneficiary is unable to pick up their prescription due to transportation challenges. The hospital owns a multiuse vehicle. The Participant Hospital uses CHART Model funding from HHSC all or part of the cost to ensure patient receives needed medicine.	

	other health-related services and activities.		
☐Gift Card Reward for Chronic Disease Management Programs	This would allow Participant Hospitals to provide gift cards to eligible aligned beneficiaries for incentivizing participation and adherence in a chronic disease management program.	To incentivize attendance for aligned beneficiaries at Chronic Disease Management Program appointments, the Participant Hospital uses CHART Model funding from HHSC to provide a gift card to the local merchants that can enhance chronic disease management.	

Contact: Questions regarding CHART Model can be emailed to: HHSC_CHART@hhsc.state.tx.us

Website: https://www.hhs.texas.gov/providers/medicaid-supplemental-payment-directed-payment-programs/rural-hospital-grant-facilitation/chart-model-community-transformation-track-texas