CHART Community Transformation Track Operational Flexibilities

The CHART Community Transformation Track offers certain operational flexibilities to expand Lead Organizations' ability to implement health care delivery system redesign and promote Participant Hospitals' capacity to manage their beneficiaries' care. While Lead Organizations are responsible for requesting them from the Centers for Medicare & Medicaid Services (CMS), HHSC will consult with the participating hospitals about which flexibilities and enhancements are needed to implement health care delivery redesign for hospitals participating in the CHART Model.[1]

Three types of operational flexibilities are offered, and each gives participating hospitals unique benefits that could facilitate redesigning health care delivery in their community:

- Model Design Flexibilities
- Benefit Enhancements
- Beneficiary Engagement Initiatives

Model Design Flexibilities

A Lead Organization, in collaboration with Participant Hospitals, may leverage any of the following Model flexibilities in designing and implementing their health care delivery system redesign strategy.

Model Flexibility	Purpose of Flexibility
Flexibility in Collaborative 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

[1] (A.4.6. Operational Flexibilities under the Model – CHART Model Community Transformation Track Notice of Funding Opportunity)

Model Flexibility	Purpose of Flexibility
	in and successfully implementing health care delivery redesign efforts at the hospital-level.[2]
Flexibility in Applying Discounts	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[3] 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.
Flexibility for Service Line Adjustments	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 Organizations are able to construct voluntary budget-neutral agreements with multiple Participant Hospitals, CMMI will distribute payments for service line adjustments between hospitals.
Flexibility to Include or Exclude Outliers in the CPA	Participant Hospitals have the ability to elect whether or not to participate in an optional outlier policy if they would like to limit the impact of extraordinarily high cost claims on their CPA. Participant Hospitals may elect not to participate in such an arrangement if they believe that their cost-reduction efforts will influence outlier costs.[4]
Flexibility in Care Transformation Strategy	Communities will be able to develop care transformation strategies that are customized to meet the needs of their beneficiaries, improve health outcomes, and maintain or improve access to care.

[2] 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.
[3] The discount factor refers to the small percentage discount applied to the capitated payment amount (CPA). The specific discount factor for a Community is determined by its total Medicare FFS revenue under the capitated payment arrangement at the Community-level (A.4.1. Key Terms – CHART Model Community Transformation Track Notice of Funding Opportunity)
[4] 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 CHART Model Frequently Asked Questions (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 these waivers 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.

Waiver	Purpose of Waiver
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.
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 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.
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 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.

Beneficiary Engagement Incentives

Participant Hospitals may request through their Lead Organizations from CMS to use any of the following beneficiary engagement incentives 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.

Beneficiary Engagement Incentive	Purpose of Incentive
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 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 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.