Community Health Access and Rural Transformation (CHART) Model: Frequently Asked Questions

December 2021

This document provides a summary of the questions and answers raised and shared by Lead Organizations as part of the December 14, 2021, CHART Model Office Hours Webinar.

Question 1: Is there a format for the Needs Assessment?
Yes, the Needs Assessment and Asset Mapping Template is available to CHART Model Lead Organizations on Box. The Lead Organization can download the template and share with Community Partners.

Question 2: Can cooperative agreement funding be used by Participant Hospitals to implement beneficiary engagement incentives, such as cost-sharing for Part B services or transportation?
Yes. There is no stipulation as to how much of the cooperative agreement funds can be allocated to those kinds of services. However, Section 2 (page 25) of the Financial Specifications document identifies the Area Deprivation Index adjustment that may be applied to these types of expenditures (i.e., education, transportation) if the Community qualifies under that adjustment. Funding plans for services can be specified in the Transformation Plan. The CMS Office of Acquisitions and Grants Management (OAGM) has discretion to request any additional information regarding proposed sub-recipients added to the Lead Organization’s Cooperative Agreement Award before issuing approval.

Question 3: Can telemedicine in schools be included in the Transformation Plan?
Yes, Communities may leverage regulatory flexibilities under the CHART Model to implement telehealth expansion. Funding plans for services can be specified in the Transformation Plan.

Question 4: What are the allowed waivers for Critical Access Hospitals (CAHs)?
The CAH 96-Hour Certification Rule (Section 1814[a][8] of the Act and 42 Code of Federal Regulations 424.15) or Conditions of Participation under the Medicare program may be included in the Transformation Plan for CAHs. If you have specific questions about Conditions of Participation for CAHs, please reach out to your Project Officer during the Transformation Planning process.

Question 5: Are there specific details regarding which Conditions of Participation will be waived?
Specific Conditions of Participation that can be waived will depend on the information the Lead Organization and Participant Hospitals provide to CMS. Lead Organizations and Participant Hospitals can work with their Project Officers to discuss options and present their proposals in the Transformation Plan.

Question 6: Are Community-based expenditures for non-Participant Hospitals included in the Capitated Payment Amount (CPA)?
Non-Participant Hospitals’ utilization for aligned residents is included in the Prospective Community
Benchmark to incent Lead Organizations to manage their populations’ total hospital costs of care.

Acute care hospitals, critical access hospitals, or any other hospitals not participating in the Community Transformation Track will continue to be paid using existing fee-for-service methodologies and are excluded from CPA payments.

**Question 7: What Part A and Part B services are included in the Capitated Payment Amount (CPA)?**
The CPA is based on Medicare hospital payments for services identified by facility claims with Type of Bill values. These include inpatient hospitalization covered under Part A and certain outpatient services covered under Part B that are billed on facility claims. Facility-based Part B services in the annual CPA calculation include emergency department services, observation stays, physical therapy, clinic visits, certain drugs, and outpatient surgery. For critical access hospitals, eligible hospital services include payments for swing bed services. Participant Hospitals will continue to submit claims as usual, and services included under the CPA will not be paid via individual claims. All other services provided by Participant Hospitals will continue to be reimbursable on a fee-for-service basis using the standard payment methodologies. For additional information, please refer to the Financial Specifications document.

**Question 8: How does the Capitated Payment Amount (CPA) methodology handle Coronavirus Disease 2019 (COVID-19)-related expenditures?**
CMS will perform a series of checks on Participant Hospital expenditures compared to the Prospective Community Benchmark and institute guardrails in uniquely volatile and unpredictable circumstances to protect both Participant Hospitals and CMS. Additionally, due to COVID-2019, CMS will not use claims data from 2020 to calculate the baseline. Instead, the baseline will be based on claims from 2018 to 2019. CMS will conduct a one-time baseline update once claims have stabilized to ensure volatile claims (e.g., related to an abnormal flu season or pandemic) are excluded and capture a realistic picture of beneficiary expenditures.

**Question 9: Who receives the Medicare discount factor funds?**
CMS receives first dollar savings through the Medicare discount factor. The remainder savings generated from transformation are kept by Participant Hospitals. The Community Transformation Track payment methodology is anchored on Medicare; non-Medicare payors can propose to adjust the methodology to suit their population profiles. For example, they may propose to not include a discount factor in Medicaid or commercial payor payments.

**Question 10: Why is the discount percentage expectation higher for low-cost regions/hospitals?**
CMS will apply a 0.5% discount off the trend in Performance Period 1 and 1% in Performance Period 2. The discount will increase throughout the rest of the Performance Periods based on eligible hospital revenue, with a maximum discount of 3% instead of 4% as previously indicated in the Notice of Funding Opportunity. This update was made to account for the financial obstacles many rural hospitals face, as well as for the time needed for transformation. The discount rate can be conceptualized as a haircut off the growth rate in that it does not outpace the growth of the Community. The discount rate is set very low in the first and second Performance Periods to allow Participant Hospitals to implement and ramp up their Transformation Plan strategies, reduce
utilization, and realize savings. The purpose is to incentivize hospitals to work together to improve the Community’s population health. There are also several discount factor flexibilities that can be found in the Financial Specifications document.

**Question 11: Is the Autoregressive Integrated Moving Average (ARIMA) a widely accepted tool?**

ARIMA is used in many forecasting applications, such as sales, prices, and health expenditures, and has been used successfully in other Innovation Center models. The CHART Model team, along with the Innovation Center’s head of Data Analytics, has conducted empirical testing on the difference between using the United States Per Capita Cost trends, fee-for-service price index adjustments, and ARIMA to determine the most accurate predictor of prices. ARIMA was found to be the most accurate at predicting benchmarks, which is important because CMS does not want to apply an inflated benchmark that later forces CMS to claw back payments. CMS wants this to be a predictable and stable funding source for Participant Hospitals. For example, in the Vermont Accountable Care Organizations Model, prospective payments are generally within five percent and benchmarks within two percent of actuals. The goal of the CHART Model’s use of ARIMA is to ensure that each Community is only compared to itself, not to a national or statewide benchmark.

**Question 12: How is resident defined for the capitated payment amount (CPA)? Specifically, how are beneficiary-months calculated?**

A beneficiary under the Community Transformation Track must be Medicare eligible; reside in the defined Community [for the previous six-month period when eligibility is assessed]; and not be attributed to other CMS models, programs, or demonstrations. Beneficiary residency and Medicare eligibility are assessed on a month-by-month basis, then combined to form a single monthly record for each beneficiary. These monthly records, defined as eligible months, are used to determine beneficiary alignment and subsequent financial calculations.

A beneficiary must have an address in the Community for more than half of the month to satisfy the residence requirement for that month. Beneficiaries are considered to have an address in the Community if the Common Medicare Environment record corresponds to the geography specified by the Community. The purpose of this requirement is to classify each month as either in or out of the Community and avoid partial months of residence. The calculation of the residence requirement will account for the number of days in each month, rather than use a fixed cutoff point (e.g., the 15th of the month).

In Figure I, below, Beneficiary D lives in the Community prior to the Performance Period, becomes eligible and enrolls in Medicare in May of the Performance Period. After six months, Beneficiary D meets the continuous eligibility requirement and becomes an Aligned Resident of the Community and contributes two Community Beneficiary Months during the Performance Period.

![Figure I: Alignment for Beneficiary D](image-url)
Question 13: Why was the outlier percentage calculated only on the top one percent rather than a set dollar amount?
The outlier adjustment compensates for the change in outliers. It also provides flexibilities on transformation strategies for the high-cost expenditures that add risk and pose prediction difficulties. In the CHART Model, outliers are beneficiaries with annual expenditures that exceed the 99th percentile of expenditures for eligible hospital services when calculated across all aligned residents in the Community who meet the inclusion criteria. The approach protects from very expensive procedures and beneficiaries who incur high expenditures due to complex medical conditions. The 99th percentile was selected instead of a fixed dollar threshold because it does not need to be updated over time and reflects the prices and distribution of services provided to residents of the Community. This allows CMS to focus on the unique characteristics of each Community.

Question 14: Can eligible Participant Hospitals participate in the CHART Model if they currently participate in the Medicare Shared Savings Program (MSSP)?
Yes, Participant Hospitals can participate in both the CHART Model Community Transformation Track and MSSP. CMS may adjust a Participant Hospital’s Capitated Payment Amount (CPA) to avoid duplicative accounting of, and payment or penalties for, amounts received by the Participant Hospital under MSSP or other Medicare programs, demonstrations, or models.

Question 15: Are Medicare Shared Savings Program (MSSP) beneficiaries included in the CHART Model?
MSSP beneficiaries are excluded from the Community Transformation Track geographic attribution, and consequently from the Capitated Payment Amount (CPA) methodology.

Question 16: Will there be any mask or vaccine mandates under the CHART Model?
Currently, the CHART Model does not have or plan to issue mask or vaccine mandates for CHART Model participants. However, the CHART Model will follow any federal or CMS-specific policies issued for hospitals participating in CMS programs, demonstrations, or models.

Question 17: Have the rural hospital partners (Participant Hospitals) in this grant been chosen?
CHART Lead Organizations were selected in a competitive application process. Participant Hospitals have not yet been selected. The CHART Model is designed to be a Community-level effort. CMS encourages broad participation across various stakeholders in the Community. Interested hospitals should contact their respective Lead Organizations to get involved.

Question 18: Are rural health centers eligible to be Participant Hospitals?
No, eligible Participant Hospitals are acute care hospitals and critical access hospitals. However, CMS encourages Lead Organizations to engage non-hospital-based providers, as transforming rural healthcare delivery requires community effort.

Acute care hospitals and critical access hospitals must meet at least one of these three criteria to participate:

1. The hospital is physically located within the defined Community and receives at least 20 percent of its Medicare fee-for-service revenue from the eligible hospital services provided to residents of the Community;
2. The hospital is 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;

3. The hospital does not meet the above two criteria but aligns with the goals of the Transformation Plan based on the proposed care redesign strategy.

**Question 19:** Does the CHART Model incentivize Participant Hospitals to coordinate with non-hospital providers?

One of the main requirements for a Lead Organization in the CHART Model is to assemble an Advisory Council to ensure that health care delivery system redesign strategies reflect the Community’s needs and goals. Participant Hospitals will want to work with primary and tertiary care providers to promote care outside of the hospital. As hospital utilization decreases, the hospital can keep the savings earned from the capitated payment. Through stakeholder engagement activities, CMS learned that a change in hospital payment methodology is required to bring about transformation in rural areas as hospital costs are a large part of total cost of care.

**Question 20:** Can prospective Participant Hospitals gain access to the Connect site?

Currently, Connect access is limited to Lead Organizations. Lead Organizations can provide interested hospitals with CHART Model information available on Connect as appropriate.

**Question 21:** The capitated payment amount (CPA) focuses on Medicare. How would Medicaid payments such as upper payment limit, supplemental payments and disproportionate share hospital payments be included?

State Medicaid Agencies will propose how they intend to incorporate those Medicaid-specific adjustments into their payment methodologies for CMS review and approval.
Community Health Access and Rural Transformation (CHART) Model: Frequently Asked Questions

November 2021

This document provides a summary of the questions raised by Lead Organizations and answers provided by the Model team during the month of November 2021.

**Question 1: If a Lead Organization does not have Participant Hospitals enrolled, can it convene its Advisory Council and other members to begin work on the Transformation Plan?**

Yes. Lead Organizations have letters of intent (LOIs) from potential Participant Hospitals, so there are documented relationships and conversations underway. The official list of Participant Hospitals is to be included in the final submission of the Transformation Plan, so collaboration is appropriate and necessary. The Centers for Medicare & Medicaid Services (CMS) encourages Lead Organizations to reengage with the hospitals that have submitted LOIs and engage any other hospitals that may be interested.

**Question 2: When completing the Needs Assessment, is it acceptable to use the proposed Community in the application?**

It is acceptable to use the proposed Community in the Needs Assessment and initial Transformation Plan. All Lead Organizations can update their defined Communities once. Community updates are subject to CMS’ review and approval to ensure that the updates align with CHART Model goals. The proposed updates must be made prior to submitting the final Transformation Plan during the Pre-Implementation Period.

**Question 3: Are there final dates for making requests related to flexibilities/benefit enhancements/beneficiary engagement incentives?**

As stated in the CHART Model Notice of Funding Opportunity (NOFO), CMS provides Participant Hospitals (through their Lead Organizations) the opportunity to select certain benefit enhancements and beneficiary engagement incentives. These selections, at a minimum, should be included in the final Transformation Plan, as well as communicated to the Project Officer as early as possible during the Transformation Plan development process. For information on how to request Medicare flexibilities, see the Transformation Plan Instructions in the Model Participation folder on Connect. Lead Organizations and their Project Officers would collaborate to ensure alignment around the requested flexibilities.

**Question 4: If a Lead Organization includes a request for flexibilities in the final Transformation Plan, will the request be approved by January 1, 2023?**

If a Lead Organization requests benefit enhancements/beneficiary engagement incentives included in the NOFO, it should be able to implement them by January 2023 when hospital participation in the CHART Model begins. However, a request that pertains to waiving conditions of participation in Medicare may take longer to determine approval as a request would likely be unique to a Participant Hospital(s) based on existing flexibilities, state requirements, etc. CMS would do its part to establish an approval timeline once a request has been confirmed in a Lead Organization’s Transformation Plan.

**Question 5: Can Lead Organizations request flexibilities but not use them due to**
changes in Participant Hospital composition?
CMS will aim to work on flexibility requests submitted by Lead Organizations (on behalf of their Participant Hospitals). However, if a hospital, on whose behalf a flexibility request was made, does not participate in the CHART Model, CMS would not operationalize the request for that hospital. Flexibilities can also be removed or changed during the CHART Model’s duration as updates are made to the Transformation Plan.

Question 6: How should Lead Organizations incorporate the outlier policy into their Transformation Plans?
Lead Organizations will choose whether to elect the outlier policy as part of their Transformation Plan. If a Lead Organization chooses to elect the outlier policy, it is applied for every Participant Hospital in the Community. Lead Organizations that elect this policy as part of their Transformation Plan strategy must finalize the decision by the Transformation Plan deadline. CMS is providing this flexibility in acknowledgement of the priority of controlling costs for high-cost beneficiaries.

Question 7: Should Lead Organizations expect the Transformation Plan to be different for various patient populations (e.g., Medicare, Medicaid)? Is a three-pronged approach (based on payer type: Medicare, Medicaid, and commercial) or a global approach expected for the Transformation Plan?
CMS expects Lead Organizations to identify overarching themes that cut across the various patient populations in their Communities for their Transformation Plan goals, but understands that the action steps might be implemented differently across these patient populations. Lead Organizations’ review of disparities in their Communities will identify populations of focus and specify stakeholders’ (including payers’) responsibility in implementing action steps.

Question 8: Can Lead Organizations change their Communities during the Pre-Implementation period?
Yes, the Community update is a one-time opportunity available only during the Pre-Implementation Period. This ensures that the Performance Period initiates with the finalized Community. CMS recognizes that once Lead Organizations enter the transformation planning phase and have had the opportunity to talk with potential Participant Hospitals, Lead Organizations might want to bring in additional rural areas that are aligned with the hospitals’ service areas.

Question 9: To what degree should Lead Organizations expect to spend the money on operations (e.g., transportation services, care coordination services)?
There is no stipulation as to how much of the Cooperative Agreement funds can be allocated to those kinds of services. However, in Section 2 (page 25) of the Financial Specifications document identifies the Area Deprivation Index adjustment that may be applied to these types of expenditures if they qualify under that adjustment (i.e., education, transportation). Funding plans for services can also be specified in the Transformation Plan. CMS can conduct individual discussions on the funding mechanisms with each Lead Organization.

Question 10: Should a Lead Organization aim to have a smaller, concise Community or a larger Community based on the calculations being applied?
Lead Organizations should define Communities that they can assess and transform their health care delivery systems. CMS has and will continue to provide resources (e.g., CHART Model Dashboard) to aid Lead Organizations in their efforts to transform their Communities.

The CHART Model does not aim to be prescriptive in Community selection and gives Lead Organizations the opportunity to set population health goals and areas for improvement, then recruit providers and hospitals that impact those Communities’ outcomes and costs of care. However, Lead Organizations should note that the larger the Community (size is measured by the Participant Hospital’s Medicare fee-for-service revenue for Eligible Hospital Services), the more favorable the discount rate. This is to encourage the development of a strong coalition.
**Question 11:** If a hospital is recruited in Performance Period 4, will it need to follow the phase-in process with each payer (i.e., Medicare, Medicaid, or commercial), such as Medicare in Performance Period 1 and Medicaid in Performance Period 2, or will the hospital be set up with all payers at that time?

CMS requires state Medicaid programs to have a payment model set up for all Participant Hospitals by 2024. If a hospital joins the CHART Model after that point, it will immediately implement all payer types (foregoing the three-year ramp-up period). The ramp-up period is designed to accommodate CHART Model design and development of any updates that may be necessary under the state’s Medicaid authorities (e.g., state plan amendments, Section 1115(a) demonstration waivers).

The NOFO specifies that hospital recruitment is allowed until Performance Period 2; CMS will determine if recruitment efforts will continue after this time. Evaluation of the CHART Model will be considered in the decision to extend recruitment efforts past Performance Period 2. CMS will inform Lead Organizations when a decision is made.

**Question 12:** Can Lead Organizations designate cooperative agreement funding to their Participant Hospitals?

Yes. As stated in the NOFO, “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.” To carry this out, the Lead Organization must designate relevant Participant Hospital(s) as subrecipient(s) in its budget request for a given Budget Period for CMS to review and approve. If your Lead Organization is interested in doing so, please inform your Project Officer.
Community Health Access and Rural Transformation (CHART) Model: Frequently Asked Questions

October 2021

This document provides a summary of the questions raised by Lead Organizations and answers provided by the Model team during the month of October 2021.

**Question 1: Is there a limit on the number of Lead Organization personnel who are allowed to access the CHART Model Connect site?**

There is no limit on the number of users associated with each Lead Organization that can have access to Connect. You can request access from [this page](#) by clicking “New User Registration.”

**Question 2: When will more information be provided on the Capitated Payment Arrangement (CPA) for Participant Hospitals?**

The Innovation Center will release a Payment Package on November 5, 2021. The package will include the [CHART Model Financial Specifications - Community Transformation Track](#) which contains a detailed description of the financial methodology and operational payment features of the CHART Model Community Transformation Track. The Payment Package also includes a [Payment Methodology Fact Sheet](#), which provides a short, easily digestible summary of the financial methodology. This information may be shared with interested and/or potential Participant Hospitals. The payment fact sheet may be a particularly helpful tool when recruiting Participant Hospitals.

**Question 3: How can Lead Organizations update their Advisory Council members?**

Lead Organizations must inform their Project Officers of Advisory Council member composition changes and document these updates in the Quarterly Progress Reports submitted via [GrantSolutions](#).

**Question 4: How can Lead Organizations update key personnel originally listed in their applications?**

The only key personnel that need to be updated in GrantSolutions are the Authorizing Official Representative (AOR) and Project Director for the award. To make changes to these key personnel listed on the award, the award recipient would need to submit an amendment in GrantSolutions. Once logged into GrantSolutions, go to the “Manage Amendments” action, then submit an amendment request. More information on how to submit an amendment can be found in the Welcome Webinar slide deck (posted in the [Learning Events](#) folder on Connect).

**Question 5: How can Lead Organization support staff sign up to receive CHART Model communications?**

If individuals supporting the Lead Organization, other than the Authorizing Official Representative (AOR) and Project Director, would like to receive Model communications, please submit their names, roles, and email addresses to [CHARTModel@cms.hhs.gov](mailto:CHARTModel@cms.hhs.gov), stating that they would like to be added to the Lead Organization distribution list. Please include the Lead Organization’s state abbreviation in the email subject line.

**Question 6: How should the Lead Organization arrange the required meeting with the Center for Medicaid and Children’s Health Insurance Program Services (CMCS) by November 15, 2021, and who should attend this meeting?**
The Lead Organization is responsible for arranging a meeting with CMCS by November 15, 2021. The desired attendees for this meeting include Lead Organization personnel, state Medicaid agency (SMA) representatives, CMCS representatives (Ellen-Marie Whelan and the respective state lead), and the respective CHART Project Officer. Lead Organizations who do not know their state lead should reach out to the CMCS Central Office leads: EllenMarie.Whelan@cms.hhs.gov and Tannisse.Joyce@cms.hhs.gov.

CHART Project Officers will help each Lead Organization facilitate the meeting and reach the following objectives:

- Establish key SMA and CMCS connections with the Lead Organization.
- Ensure there is a shared understanding of the specific CHART Model goal to attain Medicaid financial alignment with the CPA alternative payment model.
- Set the stage for next steps needed to implement Medicaid financial alignment by January 2024.

Please note that this is an initial meeting; recurring meetings will be needed. Ideally, Lead Organization/SMA/CMCS meetings should occur outside of scheduled CHART Model Project Officer/Lead Organization biweekly meetings. SMA and/or CMCS representatives can be incorporated into the biweekly meetings if needed, but it is important to understand that these two meetings serve distinct purposes.