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

The **Community Health Access and Rural Transformation** (**CHART) Model** is a voluntary model that tests whether **aligned financial incentives, operational & regulatory flexibilities, and robust technical support** helps rural providers **transform care** on a broad scale. Within the CHART Model Community Transformation Track, Lead Organizations partner with Participant Hospitals to **drive modernization of rural health delivery systems.** Participant Hospitals receive predictable payments through a Capitated Payment Amount (CPA) and operational flexibilities through benefit enhancements and beneficiary engagement incentives.

How are Participant Hospitals paid in the CHART Model Community Transformation Track?

Capitated Payment Amount (CPA)

Through the Participant Hospital's participation in the CHART Model and their partnership with the Texas Health and Human Services Commission, CMS will replace a significant portion of the **Participant Hospitals'** Fee-for-Service (FFS) claim reimbursement with bi-monthly 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)) 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 Participant Hospitals in transforming rural healthcare delivery?

Transparency

CMS will calculate and share a prospective Participant Hospital's estimated CPA with the hospital during the Pre-Implementation Period, giving each prospective hospital *full awareness of their expected CPA* prior to signing a CMS Participation Agreement. Payments may be reconciled based on updated population size and demographic characteristics.

Flexibilities to Innovate Care

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

Financial Predictability

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

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. Participant Hospitals can reach out to their Lead Organization for more information on resources.

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.

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 will avoid COVID-19-impacted years.

2 Baseline Update
Once claims data has stabilized after the PHE, CMS will conduct a one-time Baseline update, using the stable claims data.

3 Guardrails
CMS may adjust the Community Benchmark accordingly to protect Participant Hospitals from unexpected volatility outside of their control.

CMS will follow the process below to **calculate each Participant Hospital's Capitated Payment Amount (CPA)**.

How will CMS Calculate a Participant Hospital's CPA 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 (the hospital's Base CPA) based on the hospital's share of unadjusted baseline Community expenditures.

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

Baseline Community Expenditures

Prospective Community Benchmark

Baseline Community Expenditures | Adjustment

| Hospital A | Hospital B | Hospital C | Hospital D |

Participant Hospital B's CPA

Base CPA | Adj.
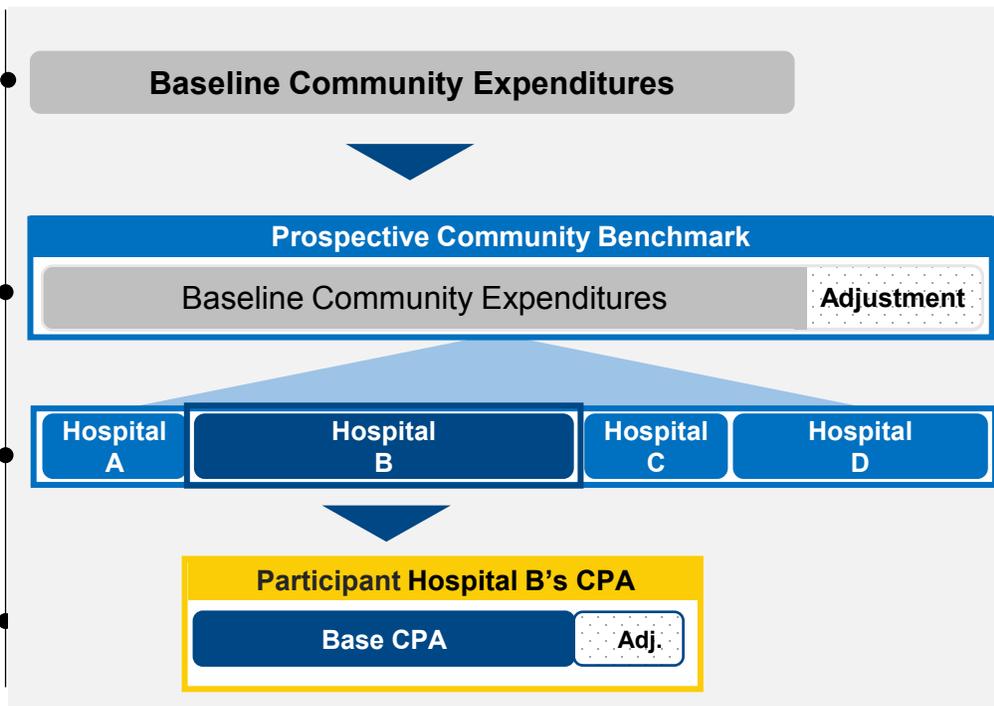
What Adjustments Will CMS Apply to Calculate the Participant Hospital CPA for Performance Period 1?

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 may use adjustments including:

- **Trend:** Based on observed trends during baseline period that will avoid expenditure data impacted by COVID-19.
- **Demographics:** Based on changing population characteristics to improve the accuracy of the benchmark calculation.

- **Outliers (optional):** Adjust to protect Participant Hospitals from unexpected, catastrophically expensive utilization.
- **Population Size:** Adjust for differences in the Community's assigned Medicare FFS population between baseline years and the Performance Period.

- **Inpatient/Outpatient Prospective Payment System (IPPS/OPPS) / CAH:** IPPS and OPPS FFS payment systems adjustments 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 Base CPA as applicable:

- **Quality:** The Base CPA for 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 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 the time needed for transformation.

- **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.
- **Area Derivation Index (ADI):** The ADI is a positive-only adjustment for hospitals serving populations from communities with high levels of socioeconomic deprivation compared to the average national rural community.

- **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. Due to rural hospitals' obstacles in maintaining service lines, CMS may approve a Strategic Planned Service Line Shift to ensure that at least one Participant Hospital in the region maintains access to care for rural residents.

How will CMS Calculate a Participant Hospital's CPA following Performance Period 1?

CMS will conduct Mid-Year and End-of-Year assessments at the middle and end of each Performance Period to identify and apply any necessary adjustments to Participant Hospitals' payments due to changes in a Community's population size and demographic characteristics.

1

Mid-Year Assessment

CMS will conduct a Mid-Year assessment in **August of the Performance Period** to identify if there are necessary adjustments to payments that have already occurred during the Performance Period and to apply updates for future payments during the remainder of the Performance Period. Adjustments will be based on a Participant Hospital's distribution of services, quality, and IPPS/OPPS adjustments.

2

End-of-Year Adjustment

Following the **conclusion of Performance Period 1**, CMS will update:
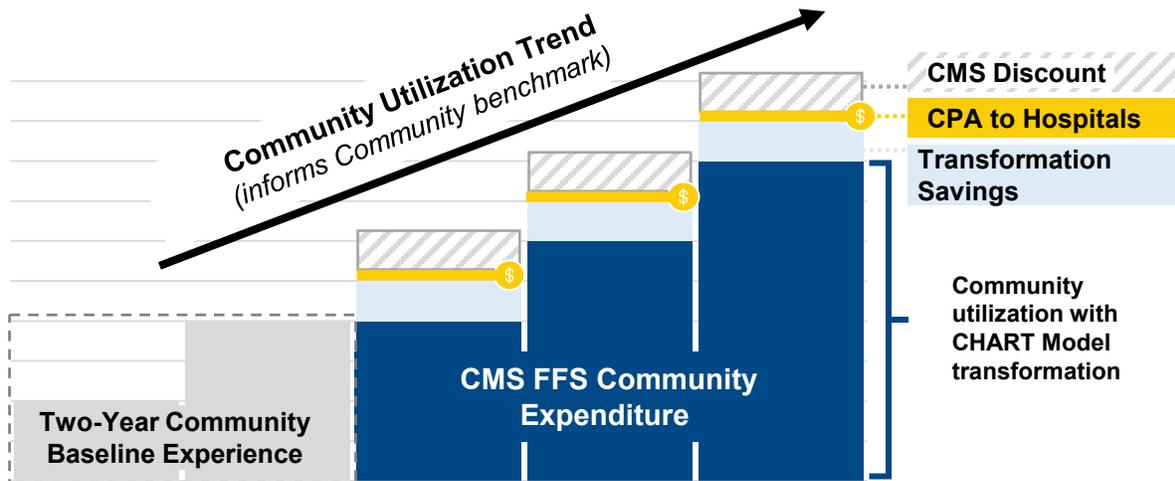- Community benchmark (to reflect changes in the **beneficiary population size and demographic characteristics**).
- Participant Hospital CPA (to reflect changes in the **distribution of services, IPPS/OPPS adjustments, and special status adjustments).**

After the Participant Hospital has reviewed the new payment, the new CPA will be issued.

How will a Participant Hospital's CPA 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.

Community Utilization Trend (informs Community benchmark)

CMS Discount
CPA to Hospitals
Transformation Savings

Community utilization with CHART Model transformation

CMS FFS Community Expenditure

Two-Year Community Baseline Experience

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 non-Medicare FFS beneficiaries to benefit from care transformation. **Medicaid alignment is required by Performance Period 2, and 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 cadence as CHART's Medicare prospective payments (i.e., bimonthly).