



# CHART Model: Hospital Frequently Asked Questions (FAQ)

Please note that questions with an asterisk (\*) at the end have been added or updated in the September 2022 revision of this FAQ.

## A. General

### 1. What is the CHART Model?

The Community Health Access and Rural Transformation (CHART) Model is a funding opportunity from the Centers for Medicare and Medicaid Services (CMS). The CHART Model is a voluntary opportunity for rural communities to test health care transformation supported by payment reform.

There are two tracks for which organizations can apply for funding:

- Community Transformation Track – Provides award recipients with cooperative agreement funding and a programmatic framework to assess the needs of their Community and implement health care delivery system redesign. This track builds on lessons learned from the Maryland Total Cost of Care Model and Pennsylvania Rural Health Model.
- Accountable Care Organization (ACO) Transformation Track (Removed) – Provides upfront payments to rural ACOs that join the Medicare Shared Savings Program. This track builds on lessons learned from the ACO Investment Model (AIM). CMS has announced that it has removed the ACO Transformation Track from the CHART model. Please visit the [CMS web site](#) for more information.

### 2. What is the Community Transformation Track?

The Community Transformation Track of the CHART Model is based on the idea that with a predictable funding stream that hospitals will be able to reorient services to better meet the needs of their communities while also becoming more financially

stable. The CHART Community Transformation Track will combine community-wide transformation planning with payment changes to rural hospitals over 7 years. CMS will select up to 15 Lead Organizations to participate in the Community Transformation Track. Up to \$5 million in cooperative agreement funding is available for each Lead Organization participating in the CHART Community Transformation Track, in addition to a regular prospective payment in lieu of Medicare Fee-For-Service (FFS) payments for participating hospitals. The Community Transformation Track of the CHART Model will begin with a Pre-Implementation Period, during which a Lead Organization will collaborate with key participants and community stakeholders to develop a strategy to implement health care delivery system. In total, Lead Organizations will have six Performance Periods to implement their Transformation Plan.<sup>1</sup>

### **3. How do hospitals benefit from the CHART Model Community Transformation Track?**

The CHART Model Community Transformation Track will provide rural hospitals with three ways to transform their local health care system:

1. Participant Hospitals will receive regular, lump sum payments also called a “capitated payment amount (CPA)” in place of their Medicare Fee-For-Service (FFS) claims reimbursement for Eligible Hospital Services for the duration of the CHART Model funding opportunity.<sup>2</sup> The benefit to hospitals is the CPA payment stability and predictability, as well as the freedom to invest in new service lines and utilize regulatory flexibilities offered by the CHART Model initiative. For example, hospitals may have had to focus on providing higher-reimbursing specialty services over essential primary care and behavioral health capacity or maintaining inpatient beds to meet Medicare conditions of participation, even when it may not be what is needed in the community. The CHART CPA payment will be calculated by CMS, not HHSC.
2. Lead Organizations will receive cooperative agreement funding to implement its health care delivery system redesign strategy that is tailored to its Community’s needs. The funding may be used to establish partnerships with community stakeholders and procure technical support. Lead Organizations may also pass a portion of the funding directly to

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<sup>1</sup> A.4.2. Model Design and Funding Structure – [CHART Model Community Transformation Track Notice of Funding Opportunity](#) (Pages 14-17).

<sup>2</sup> A.4.5.2. Medicare FFS Payment Mechanism – [CHART Model Community Transformation Track Notice of Funding Opportunity](#) (Page 29).

Participant Hospitals for investing in and successfully implementing care delivery redesign efforts at the hospital-level.<sup>3</sup>

3. Lead Organizations, in collaboration with Participant Hospitals, will be able to leverage certain operational flexibilities available under the CHART Model to expand their ability to implement their health care delivery system redesign strategy. Operational flexibilities will include waivers of the Skilled Nursing Facility 3-day rule, telehealth [after the end of the current public health emergency (PHE) flexibilities], and care management home visits. Engagement of Medicare beneficiaries through transportation reimbursement, cost-sharing waivers and gift card rewards will be permitted. Lead Organizations are responsible for requesting operational flexibilities in their Transformation Plans in consultation with Participant Hospitals.

#### **4. What is the 'Community' for Texas, as determined by HHSC?\***

For purposes of the CHART Model, the "Community" is defined as one or more counties or census tracts (may be contiguous or non-contiguous), all of which must be classified as rural, as defined by the Federal Office of Rural Health Policy. At the time of application submission, the Lead Organization must have at least 10,000 Medicare Fee-For-Service (FFS) beneficiaries whose primary residence is within the region. Participating hospitals must be located within the Community or provide a significant amount of care for the residents of the Community (be responsible for at least 20 percent of Medicare expenditures for eligible hospital services provided to residents of the Community). For the purposes of the application, facilities need only to express interest in the CHART Model.<sup>4</sup>

In HHSC's application approved by CMS in September 2021, HHSC defined the Community as including 13 noncontiguous counties and census tracts, including: Angelina County, Brown County, Burnet County, Dawson County, DeWitt County, Haskell County, Maverick County, Mitchell County, Polk County, San Augustine County, Wichita County, Young County, census tracts 48187210100, 48187210200, 48187210300, 48187210400, 48187210504, 48187210508, 48187210801,

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<sup>3</sup> A.4.6. Operational Flexibilities under the Model – [CHART Model Community Transformation Track Notice of Funding Opportunity](#) (Pages 31-33).

<sup>4</sup> A.4.3.1. Community Definition – [CHART Model Community Transformation Track Notice of Funding Opportunity](#) (Page 19).

48187210901, and 48187210902 in Guadalupe County, and census tracts 48485013700 and 48485013800 in Wichita County.

Lead Organizations, like HHSC, can revise the Community once during the pre-implementation period. HHSC in its May 18th draft Transformation Plan, proposed a revision to the Community. CMS approved this update in HHSC's final Transformation Plan on July 15, 2022. The Community now includes all Texas rural counties and census tracts that meet rurality as defined by grant requirement in accordance with the Federal Office of Rural Health Policy's (FORHP) rural definition. More information on FORHP's rural designation can be found by visiting the [Health Resources & Services Administration website](#).

## **5. Will/can patients from neighboring counties be included in the CHART Model?\***

In HHSC's approved Transformation Plan, HHSC redefined the Community to include all Texas rural counties and census tracts that meet rurality as defined by CHART Model requirements that use the Federal Office of Rural Health Policy's (FORHP) rural definition. More information on FORHP's rural designation can be found by visiting the [Health Resources & Services Administration website](#).

## **6. What is HHSC's role in the CHART Model Community Transformation Track?\***

HHSC submitted its application for the CHART Model Community Transformation Track as the Lead Organization on behalf of the state. CMS notified HHSC on September 10, 2021, that it was awarded CHART Model funding as the Lead Organization. As a result, HHSC will coordinate efforts across a target community (as defined in the Notice of Funding Opportunity) to design and implement a health care transformation plan for its defined Community. HHSC will be responsible for driving health care delivery system redesign by leading the development and implementation of Transformation Plans as well as convening and engaging the Advisory Council.

HHSC submitted the first draft of the Transformation Plan to CMS on May 18, 2022. It was reviewed by the CHART Advisory Council, and the final version was submitted to and approved by CMS on July 15, 2022. The Transformation Plan is posted on the [HHSC CHART Model website here](#) and the associated workbook is posted [here](#). HHSC will work with the CHART Advisory Council and Participant Hospitals to update the Transformation Plan at least annually.

The Transformation Plan must focus on at least one of the following areas: (1) behavioral health, (2) substance use disorders, (3) chronic disease management

and prevention, or (4) maternal and infant health. CMS is specifically allowing transformation plans to include conversion of hospitals with inpatient units to freestanding emergency facilities, where appropriate for the community. Of these priorities, HHSC will focus on chronic disease management and prevention. To do this, HHSC envisions using a telemedicine project to achieve this goal. HHSC plans to have a framework from which participating hospitals can customize their role in the transformation plan by addressing a chronic condition and, if desired, to also address an additional Community health challenge that HHSC identified in its application:

1. lack of coordinated care,
2. uncoordinated care transitions resulting in unplanned hospital readmissions,
3. improved treatment and prevention of chronic conditions like diabetes, cardiovascular disease, and congestive heart failure, and
4. limited or no access to primary and specialty care.

## **7. Has the Transformation Plan been completed, and can we get a copy?\***

HHSC submitted the first draft of the Transformation Plan to CMS on May 18, 2022. It was reviewed by the CHART Advisory Council, and the final version was submitted to and approved by CMS on July 15, 2022. The Transformation Plan is posted on the [HHSC CHART Model website](#). HHSC will work with the CHART Advisory Council and Participant Hospitals to update the Transformation Plan at least annually.

## **8. Can hospitals get a sample of the CHART Model Participation Agreement?\***

CMS released the final Participant Agreement in mid-September and HHSC distributed the agreement to potential Participant Hospitals. Hospitals will be required to sign the Participation Agreement by November 1, 2022 and HHSC will have until November 10, 2022 to sign the agreement.

## **9. How will outside clinical auditors be utilized in this program? (e.g., Recovery Audit Contractor (RAC))**

All CMS auditing that hospitals currently undergo will continue under the CHART model. Specially related to the CHART Model, CMS will evaluate the Model pursuant to section 1115A (b)(4) of the Act. Lead Organizations are required to provide data

and interact with the CMS Centers for Medicare and Medicaid Innovation (CMMI) and the CMMI independent evaluation contractor in accordance with 42 C.F.R. § 403.1110. Evaluation data may include, but is not limited to, individually identifiable health information that is needed to carry out CMMI's evaluation of the CHART Model, hosting and managing site visits, and making staff available for interviews (on site or telephonic). Hospitals are still required to submit claims and filing cost reports as they normally would under this model as well.

**10. Risk pools for some CHART Participant Hospitals will be very small. For instance, one hospital estimates only about 2,000 Medicare recipients in the county it serves. Are there any mitigation strategies possible, such as making early years upside risk only?**

The CHART Model Community Track is not an Advanced Alternative Payment Model (APM); and therefore, does not include upside risk as an option within the payment methodology. The CHART Model Community Track doesn't link quality and payment. Lead Organizations can apply for several model flexibilities such as adjusting the discount factor and passing cooperative agreement funding to Participant Hospitals.

**11. By Private Payers, do you mean Managed Care Organization(s) for Medicare and Medicaid only?\***

The term private payer for the CHART Model refers to a Commercial Payer who provides payment for clients that are non-Medicare/Medicaid beneficiaries.

**12. How will Participant Hospitals identify individual CHART population members, to heighten their direction of services, and will a risk profile of CHART beneficiaries be provided? What chronic diseases are most prevalent? Which proactive services should be established to improve health and lower spending?\***

Each CHART Lead Organization has access to the CHART Tableau Dashboard, which provides Community specifics relating to chronic disease prevalence, and cost of care, and flags action items that should be considered. CMS is still investigating if it can share individual beneficiary information in the CHART Model. CMS does not anticipate providing beneficiary/patient-level data to the Lead Organization or Participant Hospitals. The goal of CHART is to improve outcomes for rural beneficiaries, reduce health disparities and improve financials for rural hospitals. To support this goal, CMS envisions a CHART hospital report that will have hospital-specific data, which provide detail on CHART quality, financial and operational

alignment. This aligns with the approach for the Pennsylvania Rural Health Model (PARHM) and Maryland Total Cost of Care Models, in which hospitals do not receive individual beneficiary data. Hospital interventions are based on addressing hospital needs related to diagnoses, demographics, etc. (e.g., Diabetes, Congenital Heart Failure (CHF), Cancer, etc.) This in turn benefits Model beneficiaries. Also, something hospitals should remember is that the CHART Quality Measures are not CHART beneficiary specific. The final Medicare CPAs, however, will have a description of “how many lives” the CHART Model impacts for hospital reference.

#### **14. How will aggregate and individual data flow to the hospitals so progress can be tracked, and interventions planned and implemented?\***

CMS will track aggregate and hospital-specific data. CMS shares data with Lead Organizations via the CHART Tableau Dashboard. CMS anticipates the dashboard will be expanded as CHART moves into the implementation period. Updates may include tracking hospital progress on Transformation Plan goals, and Community aggregate quality metrics. CMS is currently considering the effectiveness of a similar CHART hospital dashboard or data report. CMS will release information to the Lead Organization when available.

#### **15. Will hospitals require their own data analytics staff to aggregate individual data flow so the hospitals progress can be tracked, interventions planned and implemented, or will CMS send sorted and actionable information?\***

Each Lead Organization has been provided access to a CHART Tableau Dashboard, which provides data on their requested Community “geographic area”. Dashboard data includes Medicare Outpatient/Inpatient hospital expenditures drilled down to Diagnosis-related Group (DRG)s, population health disease prevalence and quality metrics. CMS will support the Lead Organization with data analytics.

#### **16. How will hospitals collaborate and/or share the costs on best practices? Are there any best practices that will launch with the program to get wins out of the gate?\***

HHSC will lead hospital collaboration on best practices throughout the model. CMS will provide support as requested. One of HHSC’s Strategic Priorities in the Transformation Plan is to support hospital financial sustainability by providing technical assistance that will result in hospitals' ability to maximize the operational

flexibilities, beneficiary incentives and cooperation agreement funding. HHSC has also partnered with the Episcopal Health Foundation to provide technical assistance that could help hospitals “connect the dots” to realize the benefits and leverage CMS flexibilities to their greatest extent. This support would aid local hospital officials to ensure they maximize benefits and opportunities offered to the fullest extent for the benefit of the community. In 2024, HHSC also plans to work with hospitals to assess their operational, financial, and quality readiness to implement health care transformation, while maintaining financial solvency through the CHART Model, and identify the technical assistance needed to support them in the transformation process.

**17. As for the CHART attribution method, generally the Transformation programs are “an agreement to be measured on cost and quality of a defined population.” The defined population is not in the program but is the pool of beneficiaries from which the measurement of cost and quality is derived. Is this correct for CHART?\***

In the CHART Model, the defined population is the attributed beneficiaries that are included in the basis of the Community Benchmark and CPA calculations. It is important to note that CHART is not an Accountable Care Organization model, so the Community benchmark does not lead to calculated shared savings. CHART delivers capitated payments (derived from the Community benchmark) and focuses on Hospital Cost of Care. Each Participant Hospital reports on, and is measured by, the CHART quality measures for its entire Medicare population (and entire Medicaid population starting in 2024).

**18. Does the attribution method result in inclusion of all FFS Medicare patients treated by a Participant Hospital? Or are the attributed patients/beneficiaries a subset of all the Medicare patients seen/treated by the Participant Hospital?\***

With the assumption that “attribution method” means the criteria for which certain beneficiaries are included in the Medicare CPA, the answer to the questions are no, not all Medicare FFS beneficiaries a hospital served will be included in the CPA. Some beneficiaries may be excluded because they are included in other CMS models and some may not have met the residency requirements that CMS used in their calculation of the CPA. According to CMS, a Medicare Resident is excluded from the CHART Model Community Transformation Track if they are enrolled in Medicare Advantage, enrolled in Programs of All-Inclusive Care for the Elderly (PACE), or enrolled in any of the models below:

## **PAYMENT MODEL NAME**

- *Accountable Health Communities (AHC)*
- *ACO Investment Model (AIM)*
- *Comprehensive Care for Joint Replacement (CJR)*
- *Comprehensive ESRD Care (CEC)*
- *CPC+, non-SSP Participants*
- *Direct Contracting (DC)*
- *Frontier Community Health Integration Program (F-CHIP)*
- *IAH Practice Demonstration*
- *Intravenous Immune Globulin (IVIG) Demonstration*
- *Kidney Care Choices (KCC)*
- *Medicare Advantage Value-based Insurance Design (VBID)*
- *Medicare Care Choices Model (MCCM)*
- *Medicare Health Care Quality Demonstration – Meridian*
- *Medicare SSP*
- *MMCO Financial Alignment Demonstration (Duals)*
- *Next Generation ACO (NGACO)*
- *Oncology Care Model (OCM)*
- *Part D Enhanced Medication Therapy Management Model (Enhanced MTM)*
- *Primary Care First (PCF)*
- *Reduce Preventable Hospitalization Among Nursing Home Residents: Phase 2*
- *Transforming Clinical Practice Initiative (TCPI)*

### **19. If there are 310,000 eligible beneficiaries in rural Texas for the CHART model, how many total Traditional Medicare beneficiaries are in rural Texas?\***

In August 2022, the CHART Tableau Dashboard showed 685,050 'Total aligned Medicare FFS beneficiaries to Community', which is the total Traditional Medicare beneficiaries in rural Texas. The 310,000 eligible beneficiaries in rural Texas for the CHART model excludes beneficiaries enrolled in other payment programs and excludes beneficiaries served by rural hospitals that are not interested in participating in CHART. The CPA estimates connect the beneficiaries' assignment to the interested hospital, but also reflects uninterested hospitals CPAs as well. The additional beneficiaries are also attributed to nonparticipant hospitals in the calculation, but those hospitals will not be paid a CHART CPA.

### **20. Can providers be given access to the Dashboard?\***

CMS understands the value for providers accessing data and the benefits to care. At this time, CMS is considering options for how hospitals participating in CHART will

receive hospital-specific data, similar to what is on the Lead Organization Tableau dashboard.

## **21. How is CMS going to calculate the Capitated Payment Amount for Rural Emergency Hospitals (REHs)?\***

The CPA calculation for REHs will be modeled after the CPA calculation for CAHs. CMS included additional information about REH inclusion in the CPA calculation in its September 2022 update of the [Financial Specifications](#) document.

## **B. Eligibility/Participation**

### **1. Does my hospital qualify to participate in the CHART Model?**

Each Participant Hospital must be (1) an acute care hospital (defined as a “subsection (d) hospital” in section 1886(d)(1)(B) of the Act) or (2) critical access hospital (CAH) that either:

1. Is physically located within the Community and receives at least 20 percent of its Medicare Fee-For-Service (FFS) revenue from Eligible Hospital Services provided to residents of the Community; or
2. 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.

All other types of health care facilities (e.g., Rural Health Clinics (RHCs)) are ineligible to be Participant Hospitals. If a hospital system has multiple inpatient campuses and outpatient locations, each inpatient campus and outpatient location will be considered a distinct Participant Hospital as long as it meets the eligibility criteria in this section.<sup>5</sup>

### **2. Is the Letter of Intent a binding agreement and/or guarantee CHART Model funding?**

A letter of intent (LOI) submitted by a potential participant hospital to HHSC for its application to CMS does not guarantee participation in CHART because of the factors identified below. The LOIs are non-binding and do not obligate the hospital to participate in the CHART Model. Moreover, there is a required pre-

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<sup>5</sup> A.4.4.2 Participant Hospitals, [CHART Model Community Transformation Track Notice of Funding Opportunity](#) (Pages 24-25).

implementation period for additional recruitment of participant hospitals that will allow all eligible rural hospitals to express interest in participating. To participate in the CHART Model, potential Participant Hospitals must sign Participation Agreements with CMS by November 1, 2022.<sup>6</sup>

### **3. Could a Critical Access Hospital (CAH) lose its CAH status simply by participating in the CHART Model Community Transformation Track?**

No. Participant Hospitals will be able to retain their hospital or CAH status because CMS intends to waive certain Medicare provisions for the purposes of testing the CHART Model. CMS also plans to waive 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 Medicare enrollment and certification, Medicare hospital quality reporting, and payment receipt under the capitated payment arrangement. Any such waivers under the Community Transformation Track will be available for the full Performance Period of the Model.<sup>7</sup>

### **4. In the CHART Community Transformation Track, can Participant Hospitals opt-out of the Model during the Pre-implementation Period or the Performance Period?**

Yes. During the Pre-implementation Period, a hospital may work with a Lead Organization in developing a Transformation Plan for its Community as specified in CHART Notice of Funding Opportunity (NOFO) Section A.4.3.2. Transformation Plan. However, a hospital and/or Critical Access Hospitals (CAHs) may choose not to sign a CMS Participation Agreement to participate in the Model ahead of the start of the Performance Period. A hospital and/or Critical Access Hospital (CAH) may sign a CMS Participation Agreement to participate in the Model ("Participant Hospital") ahead of the start of Performance Period 1. Pursuant to the CMS Participation Agreement, a Participant Hospital is expected to participate for the full duration of the CHART Model. HHSC is working with CMS to identify the process for hospitals if they decide they would like to 'opt-out' of the Model during the Pre-implementation or Performance Period.

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<sup>6</sup> [Community Health Access and Rural Transformation \(CHART\) Model Frequently Asked Questions](#) (Page 7). Version 9. February 2022

<sup>7</sup> [Community Health Access and Rural Transformation \(CHART\) Model Frequently Asked Questions](#) (Page 28). Version 9. February 2022.

A Participant Hospital will have up to two years to transition back to Fee-For-Service (FFS) reimbursement from the effective date of either (1) Model track termination or non-continuation, or (2) termination of the Participant Hospital's Participation Agreement. During this transition period, a Participant Hospital may continue to operate under a capitated payment arrangement until fully transitioned. See [CHART NOFO](#) Section A.4.4.2. Participant Hospitals for additional information.

## **5. If HHSC receives interest from more than 14 hospitals, could the CHART Model support all hospitals?**

Yes, it is possible that more than 14 hospitals could participate in the CHART Model. HHSC has estimated that based on the amount of cooperative agreement grant funding it received from CMS that up to 14 Participant Hospitals would be awarded approximately \$109,000 in grant funds for the purchase of telemedicine equipment, software and training to fulfill a CHART Model requirement of implementing a telemedicine project. If a hospital has sufficient telemedicine equipment to implement a telemedicine project that would meet the requirements of the CHART Model, then the hospital could participate in the CHART Model. The hospital would receive the Medicare CPA, certain Model operational flexibilities, participate in a Medicaid alternative payment model, but would NOT receive the cooperative agreement grant funds allocated by HHSC.<sup>8</sup>

## **6. What Social Determinants Health (SDOH) will HHSC be focused on addressing through the CHART Model?**

HHSC would work with each participating hospital to select social determinants of health (SDOH) that are relevant for each hospital and its stakeholders.<sup>9</sup>

## **7. Which performance measures is the Texas considering most closely?\***

CMS is requiring Participant Hospitals report on the first three measures below and requires Lead Organizations select another domain on which Participant Hospitals will report. HHSC proposed the selection of the Prevention Quality Domain in its draft Transformation Plan submitted to CMS on May 18, 2022, and these selections

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<sup>8</sup> E.1.2.1.2. Community Selection Rationale, (1) Community Geographic Parameters and Community Selection Rationale (Pages 10-12). [HHSC CHART Model Community Transformation Track Application](#).

<sup>9</sup> E.1.2.2.3. Health Care Delivery System Redesign Concept, (1) Health Care Delivery System Redesign Concept Summary (Pages 43-49). [HHSC CHART Model Community Transformation Track Application](#).

remained in the final Transformation submitted and were approved on July 15, 2022.<sup>9</sup> Please see the CHART Quality Measures table below for additional information.

### CHART Model Quality Measures

Quality and Population Health Domain	Full Measure Title	Short Name	NQF ID	Steward	Type	Data Source
<b>Chronic Conditions (Required)</b>	Prevention Quality Chronic Composite (Inpatient avoidable chronic disease admissions)	PQI 92	N/A	Agency for Health Care Research and Quality	Outcome	Claims
<b>Care Coordination (Required)</b>	Plan All-Caused Readmission	HEDIS PCR	NQF 1768	National Committee for Quality Assurance	Outcome	Claims
<b>Patient Experience and Engagement (Required)</b>	Hospital Consumer Assessment of Health Care Providers and Systems	HCAH PS	NQF 0166	CMS	Outcome	Hospital Compare Reporting
<b>Prevention Quality Domain</b>						
<b>Prevention</b>	Preventive Care and Screening: Tobacco Use: Screening and Cessation Intervention	N/A	NQF 0028	National Committee for Quality Assurance	Process	Claims
<b>Prevention</b>	Breast Cancer Screening	HEDIS BCS	NQF 2372	National Committee for Quality Assurance	Process	Claims
<b>Prevention</b>	Adults' Access to Preventive/Ambulatory Care Visits	HEDIS AAP	N/A	National Committee for Quality Assurance	Process	Claims

Quality and Population Health Domain	Full Measure Title	Short Name	NQF ID	Steward	Type	Data Source
Prevention	Child and Adolescent Well-Care Visits***	HEDIS WCV-CH	NQF 1516	National Committee for Quality Assurance	Process	Claims

**8. In reference to the Quality Strategy and the listed source as 'claims data'. Will this performance analysis and reporting be managed by the HHSC CHART Model Team/CMS using the claims data or are participating hospitals expected to obtain, analyze and report this data?**

CMS will provide quarterly hospital-specific reports on key performance indicators to all Participant Hospitals. CMS and the Lead Organization will both conduct monitoring activities to assess progress toward Transformation Plan activities and guard against unintended consequences.

**9. Will the HHSC be applying for operational flexibilities on behalf of all Participant Hospitals? If so, which ones are being considered?**

Yes, HHSC will request the operational flexibilities on behalf of the Participant Hospitals. Participant Hospitals may request through their Lead Organizations for CMS to waive certain Medicare provisions for testing the CHART Model. Participant Hospitals should review these options to determine which, if any, may be helpful to implement their health care delivery redesign strategy and facilitate the hospital's chosen telemedicine project.

HHSC's approach is to request all hospital-specific Medicare Program and Payment Policy Waivers and Beneficiary Engagement Incentives and then work with hospitals individually to select appropriate operational flexibilities. HHSC has also selected to exclude Outliers in the Medicare CPA as a Model Design Flexibility, which is an optional outlier policy to limit the impact of extraordinarily high-cost claims on the hospitals Medicare CPA. This outlier adjustment will apply to all Participant Hospitals. Please click [here](#) for more information.

## **10. Where can I find more detailed information about the financial aspects of the CHART Model Community Transformation Track?**

More information about the Community Transformation Track payment calculation can be found in the following resources:

- [CMS Community Transformation Track Payment Policies \(PDF\)](#)
- [CHART Model Financial Specifications-Community Transformation Track – revised 2022](#)
- [CMS Community Transformation Track Sample Payment Calculation \(PDF\)](#)
- [CMS Community Transformation Track Payment Overview Webinar](#)
- [CMS CHART Model Frequently Asked Questions \(PDF\)](#)

## **11. What Condition of Participations (CoPs) can be waived?**

Due to the potential large number of CoP(s), CMS suggests that HHSC draft a proposal with justification for how waiving a certain CoP(s) will further Transformation Plan activities and improve care. Participant Hospitals interested in CoP waivers, should contact HHSC about requesting this operational flexibility. Please be able to identify potential unintended consequences and risks.

## **C. Medicare Capitated Payment Amount (CPA)**

### **1. What is the discount factor's role in the Medicare Capitated Payment Amount (CPA)?**

The Discount Factor refers to the small percentage discount (reduction) applied to the Medicare Capitated Payment Amount (CPA) for payers (managed care organizations) to realize savings. The specific discount factor for a Community is determined by its total Medicare Fee-for-Service (FFS) revenue under the capitated payment arrangement at the Community-level. It is expected that Participant Hospitals can achieve savings, despite the presence of a discount, through reductions in potentially avoidable utilization. Acknowledging the financial instability of many rural hospitals and the time it may take for Transformation Plans to result in reduced potentially avoidable utilization, the discounts will start at 0.5 percent and increase slowly.

Each Participant Hospital will have a 0.5 percent discount applied in Performance Period 1 and 1.0 percent discount applied in Performance Period 2. Starting in Performance Period 3, CMS will apply lower discounts to CPAs in Communities with

higher total revenue under a capitated payment arrangement. This variance provides an incentive for Communities to recruit more hospitals to participate in the CHART Model by Performance Period 3 and increases the likelihood that it will yield savings that meet or exceed the amount of the cooperative agreement funding. The discount will increase throughout the rest of the Performance Periods based on Eligible Hospital Revenue, with a maximum discount of up to 3 percent in Performance Periods 4 through 6. Please see pages 32-33 of the [CHART Model, Financial Specifications – Community Transformation Track – revised September 2022](#) for more detail.

Lead Organizations, like HHSC, 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 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.<sup>10</sup> Please see [CHART Model Financial Specifications-Community Transformation Track – revised September 2022](#) for more detail.

## **2. How will CMS incorporate the Medicare Advantage Program into the Capitated Payment Amount (CPA)?**

Only Traditional Medicare (Fee-For-Service (FFS)) will be included in the Medicare CPA calculation. The CHART Model will not impact the Medicare Advantage Program. Medicare beneficiaries enrolled in Medicare Advantage or Programs of All-Inclusive Care for the Elderly (PACE) are excluded from the Medicare Capitated Payment Amount (CPA). Please see page 15 of the its September 2022 update of the [Financial Specifications](#) for more detail. HHSC is planning to achieve Medicaid Alignment through managed care in Texas and is continuing to collaborate with Medicaid Managed Care Organizations and CMS on refining this approach.

## **3. Will CMS communicate to a CHART Community Transformation Track Participant Hospital its estimated Capitated Payment Amount (CPA) for Performance Period 1 prior to the Participant Hospital having to execute a Participation Agreement?\***

Yes. CMS calculated, and HHSC distributed, an estimated Medicare Capitated Payment Amount (CPA) for potential Participant Hospitals in June 2022. CMS will

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<sup>10</sup> Appendix XI, CPA Financial Methodology, [CHART Model Community Transformation Track Notice of Funding Opportunity](#) (Pages 121-126).

prepare, and HHSC will distribute, a final Medicare CPA for potential Participant Hospitals in early October. Potential Participant Hospitals were provided with the Participation Agreement in September 2022 and will have until November 1, 2022 to sign the agreement and submit it to HHSC.

#### **4. Has the CHART Model been implemented in other areas, and if so, what are the successes/experience?**

The CHART Model has not been implemented yet. A similar model, the Pennsylvania Rural Health Model has been implemented. More information about it can be found at: <https://innovation.cms.gov/innovation-models/pa-rural-health-model>.

#### **5. What is required of hospitals between now and receiving the final Medicare Capitated Payment Amount (CPA) amount from CMS?\***

If you are interested in receiving additional information about the CHART Model in Texas, please [sign up for email updates](#).

The interest form is now closed for rural hospitals to identify their interest in possible participation in the CHART Model for Calendar Year 2023. If your hospital submitted a Letter of Intent and/or interest form, you should:

1. Continue discussions with your hospital leadership board/team about how your hospital will comply with the CHART Model Community Transformation Track requirements. (e.g., Telemedicine project, Social Determinants of Health).
2. Review and complete identified steps in the [CHART Model Participation Checklist](#), including reviewing important resources and documents, such as the [CHART Model Participation Community Track Financial Specifications – revised September 2022](#), and [Operational Flexibilities Exercise](#).
3. Review your estimated Medicare Capitated Payment Amount (CPA), the FFS vs. CHART Analysis, and the Participation Agreement.
4. Prepare to review your final Medicare CPA, attend the joint meeting with CMS and HHSC to discuss questions and updates on October 18, 2022, and sign and submit to HHSC the Participation Agreement by November 1, 2022.
5. Notify HHSC ([HHSC\\_CHART@hhsc.state.tx.us](mailto:HHSC_CHART@hhsc.state.tx.us)) immediately if your hospital reaches a decision NOT to participate in the CHART Model Community Transformation Track.

## **6. How will the Medicare Capitated Payment Amount (CPA) be calculated?**

CMS will replace Medicare Fee-For-Service (FFS) claims reimbursement for Participant Hospitals with regular, lump sum payments that equal the annual CPA over the course of the Performance Period. Participant Hospitals must continue to submit FFS claims, but CMS will treat claims for Eligible Hospital Services as zero-pay. Continued claims submission is necessary to provide utilization data to inform many of the adjustments outlined in the CPA financial methodology, as well as for program monitoring and quality measurement.

Please review the CMS handout about its calculation:

<https://www.hhs.texas.gov/sites/default/files/documents/doing-business-with-hhs/provider-portal/medicaid-supp-pay/rural-hosp-grant/chart-model-payment-policies-texas.pdf>

## **7. What services will be included in/excluded from the Capitated Payment Amount (CPA)?**

CMS will calculate the Capitated Payment Amount (CPA) for each Participant Hospital located in the Community as follows:

1. Determine baseline Medicare Fee-For-Service (FFS) revenue using historical expenditures for Eligible Hospital Services.
2. Apply prospective adjustments to baseline revenue.
3. Apply a discount to the adjusted baseline revenue to yield the introductory CPA.
4. Apply mid-year adjustments to the introductory CPA to yield the mid-year CPA.
5. Apply end-of-year adjustments to the mid-year CPA to yield the final CPA.

Medicare Fee-For-Service (FFS) expenditures associated with the following Service Inclusion Criteria are classified as Eligible Hospital Services:

- Inpatient hospital or inpatient Critical Access Hospital (CAH) services, including but not limited to physical therapy and certain drugs and biologicals;
- Outpatient hospital or outpatient CAH services, including but not limited to clinic, emergency department (ED) and observation services, X-rays and other radiology services billed by the Participant Hospital, and certain drugs and biologicals; and
- Swing bed services rendered by CAHs.

The following services are NOT included in the Eligible Hospital Services:

- Physician services;
- Other professional services;
- Durable medical equipment that is billed separately from an included service;
- Hospice care;
- Home Health services;
- Swing bed services for non-CAH facilities;
- All other services furnished by the Participant Hospital not included in the Service Inclusion Criteria above;
- CAH Method II claims are excluded and will be paid as FFS; and
- All claims types other than inpatient (claim type=60) and outpatient (claim type=40) are effectively excluded.<sup>11</sup>

Please see the [CHART Model Financial Specifications-Community Transformation Track – revised September 2022](#) for more detail.

## **8. What is the 'Community Benchmark'?**

The Community Benchmark is a forecast of Community Expenditures for Eligible Hospital Services for Residents of the Community during the Performance Period as estimated by an Auto-Regressive Integrated Moving Average (ARIMA) model. In general, ARIMA models use time-series data from a specified lookback period to discern patterns in how the data changes over time. Time-series data is the same measurement at different points in time, which in this case is quarterly Community PBPM Expenditures. ARIMA models estimate parameters that describe these historical patterns and are used to forecast future values of the same data. Participant Hospitals are prospectively paid a share of the benchmark that corresponds to the share of services provided to the Community, known as the Capitated Payment Amount (CPA). For more detail, please see the September 2022 update of the [CHART Model Financial Specifications](#).

## **9. How does the CHART Model capture hospitals that are providing a higher level of care during a Performance Period than in the baseline period?**

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<sup>11</sup> A.4.5.1. Capitated Payment – [CHART Model Community Transformation Track Notice of Funding Opportunity](#) (Pages 28-30).

In terms of payment, CMS is instituting the following policies in the Community Transformation Track to address the changes brought about by the COVID-19 public health emergency:

Determining the Medicare Capitated Payment Amount (CPA):

For Performance Period 1:

CMS will use data from Quarter 1 through Quarter 4 in 2018 and Quarter 1 through Quarter 4 in 2019 to establish baseline Medicare Fee-for-Service (FFS) revenues for the sake of calculating the initial CPAs. This is designed to minimize non-representative data and quality concerns related to the COVID-19 public health emergency (e.g., decreased elective care and geographic variation); and

CMS will similarly use data prior to the COVID-19 public health emergency to develop the trend factor that is used to forecast expected Eligible Hospital Services expenditures during Performance Period 1.

For subsequent Performance Periods:

CMS will include a one-time update to baseline spending and to the community-specific trend factor once stable, predictable, and non-volatile expenditure data has been observed; and

CMS will update the trend factor that is used to forecast expected Eligible Hospital Services expenditures with data that indicates more stable, predictable, and non-volatile variation in national hospital expenditures.

For all Performance Periods:

At both mid-year and end-of-year checks on the CPAs throughout the Performance Period, CMS will assess variation in the CPA against a guardrail that will be used to protect against exogenous factors that might drive significant change to care utilization; and

Regular reviews of updates to Medicare payment policies will be included in the analysis used to develop CPAs as well, which will ensure that any payment changes instituted across Medicare will be incorporated accordingly into the CPAs for communities and Participant Hospitals.

While not specifically in response to the COVID-19 public health emergency, the CPA offered in the Model will also provide a significantly greater level of stability of payments to Participant Hospitals and is designed to stimulate transformation and resilience that should help in addressing any lingering effects of the current COVID-19 public health emergency and future public health emergencies. CMS will provide more information to Lead Organizations during the Pre-Implementation Period.

CMS will also consider on a case-by-case basis whether to apply adjustments for changes in CMS payment policies. For example, in response to Coronavirus disease

2019 CMS increased MS-DRG weights for inpatient stays with certain Coronavirus diagnoses. In the event of a similar payment policy change in the future, CMS could apply an adjustment to the Prospective or Final Community Benchmark or CPA. Any adjustment will be at sole discretion of CMS.

Please see the [CMS payment policies handout](#) and the [CHART Model Financial Specifications-Community Transformation Track – revised September 2022](#) for more detail.

## **10. What happens to hospital payments at the end of the end of the CHART Model Community Transformation Track? Does a Participant Hospital revert to its old payment structure?**

The CHART Model Notice of Funding Opportunity Section A.4.9. Model Timeline specifies the full anticipated timeline of the Model. After the end of the final Performance Period (Performance Period 6), a two-year transition period will commence. If the CHART Model is not expanded or extended, the Model will utilize the two-year transition period to gradually shift the capitated payments for the Participant Hospitals back to a Fee-for-Service reimbursement payment method.<sup>12</sup>

## **11. Is CMS including services provided by Rural Health Clinics (RHCs) in the Medicare Capitated Payment Amount (CPA)?**

The Medicare Capitated Payment Amount (CPA) financial methodology will include Medicare Fee-For-Service (FFS) expenditures for each Eligible Hospital Service (as defined in the CHART Notice of Funding Opportunity (NOFO) Section A.4.1. Key Terms). Eligible Hospital Services include the following health care services:

Inpatient hospital or inpatient Critical Access Hospital (CAH) services, including but not limited to physical therapy and certain drugs and biologicals.

Outpatient hospital or outpatient CAH services, including but not limited to clinic, emergency department (ED) and observation services, X-rays and other radiology services billed by the Participant Hospital, and certain drugs and biologicals.

Swing bed services rendered by CAHs.

CMS will provide a more detailed list of included services prior to potential Participant Hospitals signing their Participation Agreements.

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<sup>12</sup> A.4.9. Model Timeline. [CHART Community Track Transformation Notice of Funding Opportunity](#) (Page 39).

Services paid under the Medicare Physician Fee Schedule and other services noted in the CHART NOFO Section A.4.5.1 Capitated Payment are excluded from each Participant Hospital's Medicare Capitated Payment Amount (CPA).

The following facilities are excluded from participation in the Community Transformation Track: Federally Qualified Health Centers (FQHC), Rural Health Centers (RHC), facilities providing dialysis services exclusively, freestanding Ambulatory Surgery Centers, organizations that provide home health services exclusively, and freestanding Skilled Nursing Facilities. Claims submitted by these types of providers are excluded.

Please see the [CHART Model Financial Specifications-Community Transformation Track – revised September 2022](#) for more detail.

## **12. Will the roster of patients considered for the Medicare Capitated Payment Amount (CPA) be specific county residents, or will Medicare recipients in neighboring counties be part of the CHART Model?**

A beneficiary for consideration in the Medicare Capitated Payment Amount (CPA) under the CHART Model 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. In HHSC's Transformation Plan, the Community was revised to include all rural Texas counties and census tracts that meet the rurality definition as defined by the Federal Office of Rural Health Policy's (FORHP). More information on FORHP's rural designation can be found by visiting the [Health Resources & Services Administration website](#).

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).

HHSC has requested that CMS consider providing additional information to Participant Hospitals to help the hospital better predict their Medicare revenue while participating in the CHART Model of which beneficiary is one type of information.

In the figure 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.<sup>13</sup>

	Performance Period																	
	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec
Reside in United States	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Enrolled in Medicare Part A and/or Part B as Primary Payer	X	X	X	X	X	X	X	X	X	X	✓	✓	✓	✓	✓	✓	✓	✓
Alive	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Attributed to other CMS Models, Programs, and Demonstrations	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X
Residency in Community (per designated zip codes)	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓

### 13. Will Critical Access Hospitals (CAHs) participating in the CHART Community Transformation Track continue to receive payment at 101 percent of reasonable costs?

Yes and no. The Capitated Payment Amount (CPA) for all Participant Hospitals for Performance Period 1 is calculated based on Medicare Fee-for-Service (FFS) revenue using historical expenditures for Eligible Hospital Services from the baseline period (e.g., 101 percent of reasonable costs from historical eligible expenditures for CAHs). CAHs that are Participant Hospitals will no longer receive interim payments on a reasonable cost basis for FFS claims for the eligible expenditures included in the CPA. CMS will instead incorporate the historical expenditures for Eligible Hospital Services (using the participating CAHs’ most recent cost reports) into the CPA. For inpatient and outpatient CAH services that are not Eligible Hospital Services, and therefore are not included in the CPA, CMS will continue to make payments to participating CAHs based on 101 percent of reasonable costs. As such, CAHs that are Participant Hospitals must continue to prepare and submit standard CAH cost reports. Throughout the Performance Period

<sup>13</sup> Question 12. CMS Community Health Access and Rural Transformation (CHART) Model: [Frequently Asked Questions](#) (Page 3). December 2021.

of the Model, CMS will make CPA adjustments to account for changes in the risk profile of patients that the participating CAH treats. However, CMS will not make an up or down CPA adjustment at final settlement based on what the CAH would have received under reasonable cost-based reimbursement for the Eligible Hospital Services that are included in the CPA. Furthermore, CMS is planning to use a community-specific trend to update the CPA for each Participant Hospital (for further information, see the CHART Notice of Funding Opportunity Section A.4.5.1. Capitated Payment). Like all Participant Hospitals, participating CAHs will receive their CPA amount prior to signing their Participation Agreements. Participating CAHs will be subject to the discount factor; however, Lead Organizations can adjust the discount for their Participant Hospitals accordingly. Please note that CMS will provide more information on payment operations and reconciliation during the Pre-Implementation Period, when Lead Organizations recruit Participant Hospitals.<sup>14</sup>

**14. Does the response in the CMS FAQ, "Will Critical Access Hospitals (CAHs) participating in the CHART Community Transformation Track continue to receive a payment at 101 percent reasonable costs?" (Included on pgs. 27-28 of [CMS FAQ](#)) regarding "Eligible Hospital Services" and "Eligible Expenses" reflect that attribution is the process that defines which patients will be included in the CHART payment and which will remain in standard FFS? \***

Yes.

**15. Will there be a true cost report settlement during the audit process so that a Critical Access Hospital (CAH) would receive payment for the difference between Medicare Costs as determined through the cost report and CPA made to the CAH in the Community Transformation Track?**

The Medicare Capitated Payment Amount (CPA) for all Participant Hospitals is calculated based on Medicare Fee-For-Service (FFS) revenue using historical expenditures for Eligible Hospital Services. CAHs calculation will be based on 101 percent of reasonable costs from historical eligible expenditures. CAHs will no longer receive interim payments on a reasonable cost basis through FFS claims for the eligible expenditures included in the CPA in future Performance Periods.

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<sup>14</sup> Community Health Access and Rural Transformation (CHART) Model [Frequently Asked Questions](#) (Page 27). Version 9. February 2022.

Hospitals' services that are not eligible for the CPA will continue to be reimbursed through FFS and standard CAH cost reporting.<sup>14</sup>

### **16. Is the Medicare Capitated Payment Amount (CPA) mid-year and end-of-year positively or negatively adjusted for Participant Hospitals in the Community Transformation Track?**

Yes. Mid-year and end-of-year population adjustments will correct (positively or negatively) for any differences between projected and observed shifts in Eligible Hospital Services, (e.g., in cases where the population size or ages increases or decreases) in the Medicare Capitated Payment Amount (CPA). Specifically, these positive or negative adjustments account for differences in the population served by the Participant Hospital between the baseline years and the Performance Period. It captures differences in population size, demographics such as age, and shifts in Eligible Hospital Services between hospitals. The population adjustment, by definition, is a change in beneficiary months for the defined Community. Beneficiaries are aligned if they are eligible and reside in the Community for the majority of the alignment period. The alignment period is the 12-month period beginning 18 months prior to the respective baseline or Performance Period.<sup>14</sup>

### **17. How will Participant Hospitals be reimbursed for non-residents of the Community receiving care in the Community Transformation Track?**

Hospitals will continue to be reimbursed for non-residents on a Fee-For-Service (FFS) Basis. Hospitals are reimbursed for Community residents by the Capitated Payment Amount (CPA).<sup>14</sup>

### **18. Will Critical Access Hospitals (CAHs) that are CHART Community Transformation Track Participant Hospitals receive a "market basket increase"?**

CAH's are paid 101 percent cost and market basket updates are applicable to other Fee-for-Service (FFS) payment systems. The Special Designation Hospital adjustment applicable to CAHs includes all revenue they would have received under FFS. CMS calculates a ratio between IPPS/OPPS and all the revenue received by the CAH for Aligned Residents of the Community. CMS tabulates the revenue from two sources – 1) interim payments made on claims and 2) settlement payments made on the cost report that are used to get to 101% of cost.

Because the Medicare CPA would otherwise be weighted heavily to IPPS/OPPS, this ratio allows the CAH CPA to be adjusted to what they would have received under

FFS. For example, if all the revenue received by the CAH to get to 101 percent of cost was 110 percent of what they would have been paid under IPPS/OPPS, then the CPA is adjusted up by 10 percent.

For more detail regarding the Medicare CPA methodology, please see the [CHART Model Financial Specifications-Community Transformation Track – revised September 2022](#).

### **19. Does the CHART Model include all patient types (Inpatient, Obstetrics, Outpatient, Surgery, clinic visits, home health visits, etc.)?**

The Medicare CPA is based on Medicare hospital payments for services identified by facility claims with Type of Bill (TOB) values listed in Exhibit 6 on page 17 of the September 2022 update of the [Financial Specifications](#). These include inpatient hospitalizations covered under Part A and certain outpatient services covered under Part B that are billed on facility claims. Facility-based Part B services included in the annual CPA calculation include services such as emergency department services, observation stays, physical therapy, clinic visits, certain drugs, and outpatient surgery. Additionally, for CAHs, Eligible Hospital Services include payments for swing bed services. All other services provided by the Participant Hospital will remain reimbursable on a FFS basis using the standard payment methodologies. Please see Page 17 in the September 2022 update of the [Financial Specifications](#) for more detail.

### **20. Are hospitals that participate in the CHART Model financially responsible for the care a beneficiary in their area receives at another hospital? For example, a beneficiary seeking treatment at MD Anderson for cancer treatment.**

The CHART hospital is not financially responsible for treatment a beneficiary seeks elsewhere. Therefore, a CHART hospital would not be responsible in the referenced example for reimbursing MD Anderson for cancer treatment for a beneficiary in their area.

The CHART Model CPA is a population-based capitated payment paid prospectively to Participant Hospitals. All care provided by Participant Hospitals that is included in CHART's Eligible Hospital Services is paid for by the CPA. Excluded services will continue to be paid on a Fee-For-Service (FFS) basis. The CHART Model is unique in that it is not an Accountable Care Organization (ACO) or global payment model

that holds the provider responsible via a capitated payment for ALL of the care a beneficiary receives.

In the case of a transfer of a Medicare FFS beneficiary in the Community to another hospital, CHART Model Eligible Hospital Services and any processing rules that impact Medicare's FFS payment for those services is included in the Community Total Paid amount and is therefore considered to be paid by the CPA. This is because Eligible Hospital Services, including processing rules around transfers, are included in the Community Total Paid amount that serves as the basis for the CPA. If either hospital is not a CHART Model participant, then their payment will not be impacted by the Model.

To clarify further, in the case of a transfer of a Medicare FFS beneficiary in the Community from one CHART Participant Hospital to another, payment for services provided by each hospital is assumed to have been covered through the CPA as a part of routine payments. In the case of a transfer of a Medicare FFS beneficiary in the Community from a CHART Participant Hospital to a non-Participant Hospital, payment for services provided at the non-Participant Hospital is on a FFS payment basis. The Participant Hospital does not have to pay the non-Participant Hospital for these services nor is the Participant Hospital's CPA adjusted downward to pay for these services.

The CHART Model CPA is meant to be a reliable, steady bi-monthly payment that is based on historical services to area beneficiaries. The predictability of the CHART Model CPA is meant to facilitate a hospital to transform its service delivery so that it is not income-driven but driven by needs of its community.

## **21. What about a transfer - maybe not necessarily a high claim like heart surgery? Do we pay the transferring hospital - if so, how is that negotiated?\***

The CHART Model CPA is a population-based capitated payment paid prospectively to Participant Hospitals on a twice-monthly basis – CPA is not based on episodes of care. All care provided by Participant Hospitals that is included in CHART's Eligible Hospital Services (see page 17-18, September 2022 update of the Financial Specifications) is paid for by the CPA. Excluded services (page 17, September 2022 update of the Financial Specifications) will continued to be paid on a Fee-For-Service (FFS) basis.

The example of transfers on page 20 of the September 2022 update of the Financial Specifications document is describing that processing rules that affect the paid

amount on Medicare claims (like denials, crossover claims or transfers) are included in the Community Total Paid amount. The Community Total Paid amount is the basis for CHART's PBPM calculations. CHART Model Eligible Hospital Services and any processing rules that impact Medicare's FFS payment for those services is included in the Community Total Paid amount and will therefore is considered paid by the CPA.

Specific to the question about negotiating payments between a transferring hospital and the hospital that is receiving a Medicare FFS patient: If either the transferring hospital and/or the receiving hospital is a model participant and the patient was provided an Eligible Hospital Service, then this care will be considered paid to the Participant Hospital by the CPA. This is because Eligible Hospital Services, including processing rules around transfers, are included in the Community Total Paid amount which serves as the basis for the CPA. If either hospital is not a model participant, their payment will not be impacted.

## **22. Will the CPA Calculation that CMS provides be just a dollar amount, or will it show the number of identified beneficiary months in the "Community"?**

The Prospective Medicare CPA calculation will provide information related to the 6-Step methodology, including beneficiary months. Additional information on the calculation of beneficiary months can be found in the September 2022 update of the [Financial Specifications](#) beginning on page 21.

## **23. How much will the hospitals be involved in, if any, in determining the mid-year and end-of-year calculations?**

Hospitals will not be involved in determining mid-year or end-of-year calculations. CMS will calculate all adjustments.

## **24. Will Medicare claims still be filed to capture the data – even though there won't be payment on them?**

Yes, hospitals participating in the CHART Model will submit all Medicare Claims using standard claims filing processes. For the CHART Model, the Medicare Administrative Contractor (MAC) will process the claims as No Pay Claims. All standard data elements that are found on Medicare claims are populated on these claims, including the paid amount field, which will display what the claim would have paid under Fee-For-Service (FFS).

## 25. What about CAH status and Medicare payments while participating in the CHART Model?

We wanted to add some additional clarification on CAH status. Participant hospitals will be able to retain their hospital or CAH status because CMS intends to waive certain Medicare provisions for the purposes of testing the CHART Model. CMS also plans to waive 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 Medicare enrollment and certification, Medicare hospital quality reporting, and payment receipt under the capitated payment arrangement. Any such waivers under the Community Transformation Track will be available for the full Performance Period of the Models (see [CHART Operational Flexibilities](#) for additional information).

The Medicare Capitated Payment Amount (CPA) for all Participant Hospitals for Performance Period 1 will be calculated based on Medicare Fee-for-Service (FFS) revenue using historical expenditures for Eligible Hospital Services from the baseline period (2018-2019) (e.g., 101 percent of reasonable costs from historical eligible expenditures for CAHs). While participating in the CHART Model, CAHs will no longer receive interim payments on a reasonable cost basis for FFS claims for the eligible expenditures included in the CPA. CMS will incorporate the historical expenditures for Eligible Hospital Services (using the participating CAHs' most recent cost reports) into the CPA. For inpatient and outpatient CAH services that are not Eligible Hospital Services, and therefore are not included in the CPA, CMS will continue to make payments to participating CAHs based on 101 percent of reasonable costs. As such, CAHs that are Participant Hospitals must continue to prepare and submit standard CAH cost reports.

Throughout the Performance Period of the Model, CMS will make CPA adjustments to account for changes in the risk profile of patients that the participating CAH treats. However, CMS will not make an up or down CPA adjustment at final settlement based on what the CAH would have received under reasonable cost-based reimbursement for the Eligible Hospital Services that are included in the CPA.

Adjustments for the **Medicare CPA** at the mid-year and end of-year may be positively or negatively adjusted for Participant Hospitals. Mid-year and end-of-year population adjustments will correct (positively or negatively) for any differences between projected and observed shifts in Eligible Hospital Services, (e.g., in cases where the population size or ages increases or decreases).

Specifically, these positive or negative adjustments account for differences in the population served by the Participant Hospital between the baseline years and the Performance Period. **(In other words, differences in the population served (e.g., resulting from COVID-19) at the hospital since 2018, the baseline year, and 2023, performance period 1, would be accounted for here.)**

These adjustments capture differences in population size, demographics such as age, and shifts in Eligible Hospital Services between hospitals. The population adjustment, by definition, is a change in beneficiary months for the defined Community. Beneficiaries are aligned if they are eligible and reside in the Community for most of the alignment period. The alignment period is the 12-month period beginning 18 months prior to the respective baseline or Performance Period.

CMS is planning to use a community-specific trend to update the CPA for each Participant Hospital (for further information, see the CHART Notice of Funding Opportunity Section A.4.5.1. Capitated Payment).

Like all Participant Hospitals, participating CAHs will receive their CPA amount prior to signing their Participation Agreements. Participating CAHs will be subject to the discount factor; however, Lead Organizations can adjust the discount for their Participant Hospitals accordingly. Please note that CMS will provide more information on payment operations and reconciliation during the Pre-Implementation Period, when Lead Organizations recruit Participant Hospitals.

The capitated payment amount in the Community Transformation Track is designed to establish the financial flexibility necessary for Participant Hospitals to engage in health care delivery system redesign activities that will be outlined in our Transformation Plan. In contrast to FFS incentives to grow volumes, this APM is meant to create an incentive to reduce potentially avoidable utilization, prevent readmissions, and reduce hospital lengths of stay as appropriate (section A.4.5, CHART Notice of Funding Opportunity, page 27).

## **26. How will CHART affect the hospital's cost reporting, Medicare bad debt that is reported to CMS? How would it affect uncompensated care? What would happen to the reporting of bad debt, uncompensated care, and charity care?**

Bad debt is excluded from the CHART Model Medicare CPA calculation and adjustment. Pass-through payments made by a Medicare Administrative Contractor (MAC) are outside of the claims processing systems and will continue as currently designed. Uncompensated care is included in the CHART Model CPA adjustment

calculation. Uncompensated Care is updated at the end of the year reconciliation due to change infrequently.

**27. What if a hospital’s scope of services increases such as adding a surgeon or dialysis services? How does that impact the CPA?**

As long as the services are Eligible Hospital Services (inpatient, hospital-based outpatient or CAH swing bed), this would increase the hospital’s share of services.

**28. Will patients who get hospital services outside the Community be accounted against the CPA?\***

No; in advance of each Performance Period, a Prospective Community Benchmark is calculated based on historical expenditures for Eligible Hospital Services for a defined rural Community that incorporates an adjustment for trend, demographics, and population size. Beneficiaries in the Community can receive services from both Participant Hospitals and Non-participant Hospitals. The Prospective Community Benchmark includes expenditures at both Participant Hospitals and Non-participant Hospitals; however, Non-participant Hospitals will be paid under their current structure. Also, in CHART, Lead Organizations are made aware of which services are leaving the Community. This allows collaboration with CHART Hospitals on developing strategies to reduce outmigration.

**29. Are hospital-based rural health clinic physician charges and Provider-Based Specialty charges included in the CPA rate?\***

Physician Services, other professional services such as, Durable Medical Equipment that is billed separately from an included service, hospice care and home health services, and swing bed services provided in non-CAH facilities are excluded from the CHART CPA calculation.

Type of Bill Service Inclusion Criteria:

- 11X Inpatient
- 12X Inpatient, Critical Access Hospital
- 13X, 14X, 85X Outpatient
- 18X Swing Bed (CAH only)<sup>12</sup>

The CHART Type of Bill Service Inclusion Criteria does not include 71x or 77x (TOB).

**60 - Billing Requirements for RHCs and FQHCs**  
(Rev. 3434, Issued: 12-31-15, Effective: 03-31-16, Implementation: 03-31-16)

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RHCs and FQHCs are institutional claims and are submitted to the MAC on TOB 71x and 77x. Generally, only those services that are included in the RHC and FQHC benefits are billed on these claims.

- The RHC and FQHC benefits are defined in Pub. 100-02, Medicare Benefit Policy Manual, Chapter 13 (<http://www.cms.hhs.gov/manuals/Downloads/bp102c13.pdf>.)

All professional services in the RHC and FQHC benefit are paid through the AIR system or the FQHC PPS payment for each patient encounter or visit. Technical services (or technical components of services with both professional and technical components) are not billed on RHC/FQHC claims.

For FQHCs with cost reporting periods beginning on or after October 1, 2014, all services are paid according to the FQHC PPS methodology. The visit rate includes: covered services provided by a FQHC practitioner and services and supplies furnished incident to the visit. For additional information on FQHC services, see the Medicare Policy Manual, Chapter 13.

### **30. How will the CHART Program affect cost-based accounting for Critical Access Hospitals?\***

In the CHART CPA calculation, Special Designation Hospitals (SDHs), like CAHs, receive a calculation adjustment that considers the current payment structure under which these hospitals are paid. Baseline data for these SDH hospitals include both interim payments made on claims and settlement data made via the cost report to ensure that the baseline correctly includes all relevant hospital revenue.

SDHs will be paid by multiplying the Base CPA by a payment adjustment factor that is the ratio between what the SDH is paid after settlement, and what the SDH would have paid under IPPS/OPPS. This adjustment is to ensure that SDHs continue to receive any payment differentials that would have been provided in Medicare FFS. For example, if an SDH was paid 103% of what it would have been paid under IPPS and OPPS, the CPA would be multiplied by 1.03.

### **31. Are Medicare Advantage and Medicare Shared Savings Program (MSSP) attributed patients included in the CPA?\***

No. A Medicare Resident is excluded from the CHART Community Transformation Track if they are enrolled in Medicare Advantage, or Programs of All-Inclusive Care for the Elderly (PACE) or enrolled in any of the models below:

- Accountable Health Communities (AHC)
- ACO Investment Model (AIM)
- Comprehensive Care for Joint Replacement (CJR)
- Comprehensive ESRD Care (CEC)
- CPC+, non-SSP Participants
- Direct Contracting (DC)
- Frontier Community Health Integration Program (F-CHIP)
- IAH Practice Demonstration
- Intravenous Immune Globulin (IVIG) Demonstration
- Kidney Care Choices (KCC)
- Medicare Advantage Value-based Insurance Design (VBID)
- Medicare Care Choices Model (MCCM)
- Medicare Health Care Quality Demonstration – Meridian
- Medicare SSP
- MMCO Financial Alignment Demonstration (Duals)
- Next Generation ACO (NGACO)
- Oncology Care Model (OCM)
- Part D Enhanced Medication Therapy Management Model (Enhanced MTM)
- Primary Care First (PCF)
- Reduce Preventable Hospitalization Among Nursing Home Residents: Phase 2
- Transforming Clinical Practice Initiative (TCPI)

### **32. If the CAH cost-based methodology was established to reimburse for the portion of the cost of services provided to care for Traditional Medicare beneficiaries and the CHART model capitated payment is a prepayment for the cost to cover services for the same Traditional Medicare beneficiaries, what will be the impact to the CAH cost report settlement for those patients?\***

CAHs still submit one cost report, and CMS will provide instruction on how to delineate the CHART claims from other claims, since CHART claims will not be reconciled back to 101% of the cost. CMS has provided cost report instructions for providers participating in other Centers for Medicare and Medicaid Innovation (CMMI) models in the past.

**33. Does the CAH lose cost-based reimbursement for the patient's lives covered under the CHART model capitated payments?\***

No, CAHs do not lose cost-based reimbursement in CHART.

**34. The deficit in the CPA vs current Medicare collections can only be reconciled by knowing the specific patients it will affect. When will Participant Hospitals be given the data to identify those patients?\***

CMS is still investigating if it can share individual beneficiary information. The goal of CHART is to improve outcomes for rural beneficiaries, reduce health disparities and improve financials for rural hospitals. The final Medicare CPA, however, will include "how many lives" the CHART Model impacts.

**35. What is the best way to compare the ratio of CHART beneficiaries to the individual hospital's total Traditional Medicare beneficiaries they serve?\***

CMS shared a "What If" comparison of what was paid to hospitals in Fee-For-Service versus what have been paid for eligible hospital services in the CHART Model for 2021 in mid-September and HHSC distributed to the hospitals. Hospitals should note that these numbers are perspectives based on historical claims and that CMS advises hospitals not attempt to conduct a similar retrospective review. The CPA calculation presents significant barriers to replicating and validating.

**36. Can you clarify the CAH cost report per diem calculation? The way I understand this, CHART days will NOT be considered traditional Medicare days and thus not included in the calculation of the CAH per diem. However, we will receive an adjustment to the Base CPA to account for that. Is that correct?\***

CAHs will continue to submit the interim claims cost report as they currently submit in traditional FFS. CAHs will not receive payment for the Per Diem CHART Eligible Hospital Services. As for CAH's excluded CHART services, the per diem amount/interim rate will be reimbursed as they otherwise would be or currently are. The CMS CHART Model Team will have a system in place with the Medicare Audit Contractors (MACs) that ensures that all CHART-eligible services are set to no-pay, thus a payment will not be rendered for the CHART-eligible services. The CPA will be reconciled outside the normal cost reporting process. CMS will provide additional

instruction and information to participating CAHs ahead of submitting any cost reports. For any reporting periods where the CAH is participating in CHART, CMS will provide instruction on how to delineate those CHART costs.

## **D. Medicaid Payment Changes**

### **1. What does “multi-payer alignment” mean for the CHART Model Community Transformation Track?**

Multi-payer alignment refers to non-Medicare payers’ adoption of the Community Transformation Track Alternative Payment Model’s (APM) financial, operational and quality processes to ensure that differently insured persons who reside in the CHART Model Community benefit from the transformation that occurs. According to the Notice of Funding Opportunity, the goal of multi-payer alignment in the Community Transformation Track is to increase Participant Hospitals’ total revenue from Eligible Hospital Services such that care transformation becomes a more rational business decision. Each Lead Organization must secure multi-payer alignment with the State Medicaid Agency by the beginning of Performance Period 2 (January 1, 2024). While multi-payer alignment from commercial payers is not required, it is recommended.<sup>15</sup>

### **2. How will Medicaid payments work?**

State Medicaid Agencies (SMA), HHSC, will propose how they intend to incorporate Medicaid-specific adjustments into their payment methodologies for CMS’s review and approval. HHSC will provide more detail on its plan for Medicaid payments in its draft and final Transformation Plan. Specifically, HHSC will explain how it proposes the Community will meet the CMS-required 'Medicaid Participation Targets', which are as follows. By January 1, 2024 (Quarter 2 of Budget Period 3) and for each subsequent Budget Period, the SMA and Recipient (if the SMA is not the Recipient), must demonstrate that Medicaid is an Aligned Payer to the Community Transformation Track APM’s financial, operational and quality processes (see Table 4 on the following page from the [CHART NOFO](#)).

#### ***Table 4. Payer Alignment Characteristics***

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<sup>15</sup> A.4.5.3. Multi-payer Alignment – [CHART Model Community Transformation Track Notice of Funding Opportunity](#) (Pages 29-31).

Characteristic	Description
<b>Financial alignment</b>	The Aligned Payer uses a similar financial methodology as CMMI uses for the Community Transformation Track APM. To implement financial alignment, an Aligned Payer may need to build IT infrastructure or change internal policies (e.g., Medicaid agencies may need to apply for state plan amendments or 1115(a) waivers).
<b>Operational alignment</b>	The Aligned Payer offers changes to health care provider contracts or benefits in compliance with existing law to support care transformation. For example, the Aligned Payer may offer benefit enhancements matching those available in Medicare Fee-For-Service (FFS), or allow Participant Hospitals to make similar changes permitted under a potential Medicare waiver of hospital Conditions of Participation (CoPs).
<b>Quality alignment</b>	The Aligned Payer uses the same set of quality measures to adjust payments or track performance.

Medicaid alignment may be achieved through the alignment of Medicaid Fee-For-Service (FFS), Medicaid managed care plans, or both for revenue from Eligible Hospital Services.

- i. For Calendar Year (CY) 2024, fifty percent (50 percent) of the aggregate eligible Medicaid revenue for Participant Hospitals must be under a CMS-approved Capitated Payment Amount.
- ii. For CY 2025, sixty percent (60 percent) of the aggregate eligible Medicaid revenue for Participant Hospitals must be under a CMS-approved Capitated Payment Amount.
- iii. For CY 2026—2028, seventy-five percent (75 percent) of the aggregate eligible Medicaid revenue for Participant Hospitals must be under a CMS-approved Capitated Payment Amount.

**3. Who do I contact if I am interested in participating in the CHART Model Community Transformation Track as an “Aligned Payer”?\***

HHSC continues to seek health care payers (e.g., Medicaid managed care organizations (MCO) and commercial payers) that are interested in partnering with HHSC in the Community Transformation Track. HHSC would like to ensure that all interested hospitals that can participate in the CHART Model have a Medicaid MCO with which they can partner.

To participate in the CHART Model, Medicaid MCOs and commercial payers must be operating in HHSC’s chosen Community. In HHSC’s Transformation Plan, HHSC revised the CHART Model Community to include all rural Texas counties and census tracts that meet the rurality definition as defined by the Federal Office of Rural

Health Policy's (FORHP). More information on FORHP's rural designation can be found by visiting the [Health Resources & Services Administration website](#).

If you are a health care payer interested in participating in the Community Transformation Track as an aligned payer, you can contact HHSC at [HHSC\\_Chart@hhsc.state.tx.us](mailto:HHSC_Chart@hhsc.state.tx.us) to express your interest.