



CHART Model: Managed Care Organization (MCO) 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. Medicaid Alternative Payment Models (APMs)

1. **Must APMs be structured initially as a capitated arrangement or at what point would it need to move to capitation?***

HHSC is seeking more clarification about what qualifies as a 'capitated payment' for the purposes of the CHART Model from the Centers for Medicare and Medicaid Services (CMS). HHSC plans to provide a framework for Medicaid Managed Care Organizations (MCOs) and Participant Hospitals to collaborate about APM(s) for the CHART Model.

The consensus that HHSC has gathered from each of the four MCOs is that moving rural hospitals to a capitated payment is risky. Therefore, our proposed approach in the Transformation Plan submitted to and later approved by CMS on July 15, 2022 was to facilitate an APM or APMs between Participant Hospitals and MCOs that do not abruptly shift to a fully capitated payment, but instead move rural hospitals further on the continuum of APMs as demonstrated by the [Health Care Payment Learning Action Network \(HCP LAN\) APM Framework](#). Implementation of new APMs specifically with rural hospitals will require system updates for a small number of providers, complex navigation of payment regulations, and establishing relationships and negotiations. It is unknown at this time which Medicaid managed care programs (STAR, STAR+PLUS, STAR Kids) and populations would be included into an APM arrangement. Potential quality measures will be aligned as much as possible with existing quality measures that rural hospitals currently report to reduce the administrative burden.

In the Transformation Plan, HHSC proposed a phased approach to achieve Medicaid Alignment. Phase One's goal would include HHSC identifying APMs in which rural hospitals may already be participating and to explore how to further promote APMs in rural areas by enhancing its generic requirement for MCOs to use value-based-payment arrangements including APMs. Phase Two would implement an out-patient prospective payment system (OPPS) methodology for out-patient services with the Enhanced Ambulatory Patient Group (EAPG). Because Texas' Medicaid program has established a prospective payment system for inpatient services by using the All-Patient Refined Diagnosis Related Groups (APR-DRG), HHSC is proposing to develop an OPPS model. This strategy allows HHSC to continue to promote ways to increase efficiencies under this cost contained reimbursement method that could be gradually expanded each performance period based on hospital and community input to meet the CHART Model Medicaid Participation Targets and address Community health goals.

Phase I (Performance Periods 1-3) Calendar years 2023 to 2025

- Medicaid APM planning and discussion among MCOs and hospitals – January to December 2023.
- Medicaid APM implementation begins in January 2024.
- HHSC plans to work collaboratively with Medicaid MCOs and Participant Hospitals to help facilitate an APM agreement(s) promoting CHART Model goal(s).
- HHSC is considering expanding reporting for CHART Model Participant Hospitals for the Hospital Quality-Based Payment Program.

Phase II (Performance Periods 4-6) Calendar years 2026 to 2028

- HHSC is considering implementing a statewide EAPG OPPS as proposed in its application to achieve alignment in Performance Periods 4-6.

2. Will HHSC increase capitation rates or pass funds through the MCO to the hospitals and allow the MCO to count it towards the Medicaid Participation Targets?

Unfortunately, there is no additional State funding for the CHART Model. The limited amount of Federal cooperative agreement funding is to be used as grants for Participant Hospitals to purchase Telemedicine equipment and potentially leverage the CHART Model's operational flexibility to provide certain beneficiary incentives.

3. Is HHSC contemplating a hospital 'capitated payment' for Medicaid as well or for a different model?*

No, HHSC does not plan to move Participant Hospitals immediately to capitation in Medicaid. Instead, HHSC plans to work with MCOs and Participant Hospitals to facilitate an APM. HHSC included this proposal in the Transformation Plan approved by CMS on July 15, 2022 and is seeking guidance on how the Performance Targets will be calculated and what will count as a 'capitated payment'. The framework HHSC and the MCOs have tentatively discussed does not include moving immediately to traditional capitation. Please see HHSC's proposed approach for Medicaid Alignment on pages 1-2 for more detail.

4. If capitation is intended to be the Model, there are numerous approaches that could be employed, including full capitation and models excluding certain services or outliers. Has any approach yet been determined?

The approach has not been determined nor dictated by CMS. HHSC is seeking guidance on how the Performance Targets will be calculated and what counts as a 'capitated payment'. The framework HHSC and the MCOs have tentatively discussed does not include moving immediately to traditional capitation. Please see HHSC's proposed approach for Medicaid Alignment on pages 1-2 for more detail.

5. The CHART Notice of Funding Opportunity (NOFO) describes a bi-weekly payment to hospitals for Medicare, would CMS/HHSC require a similar payment schedule for Medicaid?*

The CHART Model does involve a Participant Hospital receiving a bi-weekly capitated payment amount for Eligible Services in lieu of the hospital's Medicare Fee-For-Service income for certain beneficiaries (within the 'Community' as defined by HHSC). In HHSC's Transformation Plan approved by CMS on July 15, 2022, HHSC included all rural counties and census tracts in Texas in the 'Community'. HHSC is seeking guidance on how the Performance Targets will be calculated and what counts as a 'capitated payment'. The framework HHSC and the MCOs have tentatively discussed does not include moving immediately to traditional capitation. Please see HHSC's proposed approach for Medicaid Alignment on pages 1-2 for more detail.

6. How will MCO rates be contemplated outside of community rating, if there is not consistent participation by all MCOs in a hospital's Service Delivery Area (SDA)?

HHSC does not expect the CHART Model to impact capitation rates to MCOs. HHSC is considering opportunities to promote APMs in rural areas in MCO APM contracting requirements and plans to work with MCOs and Participant Hospitals in Calendar Year 2023 to refine the Medicaid APM(s). Please see HHSC's proposed approach for Medicaid Alignment on pages 1-2 for more detail.

7. How will Comprehensive Hospital Increase Reimbursement Program (CHIRP) be addressed as part of this Model for applicable hospitals? Will the add on be carved into or out of the 'capitated payment'?

CHIRP is a separate program, and its payments should continue outside of the CHART Model. HHSC encourages MCOs or Participant Hospitals to provide any information on potential conflicts or issues between both programs.

8. How are Medicaid eligibility changes handled, including retroactive changes?

HHSC does not plan to direct MCOs on how to handle eligibility changes, including retroactive changes, within their APM agreements with Participant Hospitals. HHSC plans to work with MCOs and Participant Hospitals in Calendar Year 2023 to refine the Medicaid APM(s) and will request MCOs and Participant Hospitals submit considerations in developing a framework through that process. Please see HHSC's proposed approach for Medicaid Alignment on pages 1-2 for more detail.

9. Medicaid Members may change MCO month to month - how are material shifts in membership handled?

HHSC does not plan to direct MCOs on how to handle material shifts in membership in their APM arrangements with Participant Hospitals. HHSC plans to work with MCOs and Participant Hospitals in Calendar Year 2023 to refine the Medicaid APM(s) and will request MCOs and Participant Hospitals submit considerations in developing a framework through that process. Please see HHSC's proposed approach for Medicaid Alignment on pages 1-2 for more detail.

10. Will MCOs participating in the CHART Model be engaged in the setting of the capitated hospital rates?

HHSC does not plan to intervene in the development of APMs between MCOs and Participant Hospitals in Medicaid. HHSC plans to work with MCOs and Participant Hospitals in Calendar Year 2023 to refine the Medicaid APM(s). HHSC does not plan to direct MCOs on the specifics of their APM agreements with Participant Hospitals. Please see HHSC’s proposed approach for Medicaid Alignment on pages 1-2 for more detail.

11. How will HHSC account for differences in baseline between CMS Medicare CPA calculation and HHSC’s chosen payment methodology?

HHSC does not plan to intervene in the development of APMs between MCOs and Participant Hospitals in Medicaid, and therefore would not be involved in the details of the APM methodology. HHSC plans to work with MCOs and Participant Hospitals in Calendar Year 2023 to refine an approach for the Medicaid APM(s). Please see HHSC’s proposed approach for Medicaid Alignment on pages 1-2 for more detail.

12. Can additional details be provided on what will be included/excluded from the payment methodology for further consideration?

HHSC plans to work with MCOs and Participant Hospitals in Calendar Year 2023 to refine the Medicaid APM(s). At this time, HHSC does not plan to direct MCOs on what will be included/excluded from APMs. This could be a topic for discussion and collaboration between MCOs and Participant Hospitals. Please see HHSC’s proposed approach for Medicaid Alignment on pages 1-2 for more detail.

13. Will Legislatively-appropriated, pass-through increases for rural hospitals be included as part of the capitation?

Any Legislatively-appropriated increases for rural hospitals should be maintained in any APM negotiated between MCOs and Participant Hospitals. Please see HHSC’s proposed approach for Medicaid Alignment on pages 1-2 for more detail.

14. How much leeway is HHSC planning to give MCOs in developing the APM model(s) for the CHART Model - or will HHSC implement a singular model across the state?

HHSC does not plan to implement a singular model across the state. HHSC plans to convene MCOs and Participant Hospitals in meetings through Calendar Year 2023 to facilitate the CHART Model APM(s). APM standardization could be a topic for discussion and collaboration between MCOs and Participant Hospitals. HHSC plans to provide a framework for Medicaid Managed Care Organizations (MCOs) and Participant Hospitals to collaborate about APM(s) for the CHART Model. Please see HHSC’s proposed approach for Medicaid Alignment on pages 1-2 for more detail.

15. Will there be the potential for the cohort to come together and develop one or two APMs?

HHSC plans to facilitate meetings between participating hospitals and MCOs through Calendar Year 2023 to facilitate CHART Model APM(s). APM standardization could be a topic for discussion and collaboration between MCOs and Participant Hospitals. Please see HHSC’s proposed approach for Medicaid Alignment on pages 1-2 for more detail.

16. For MCOs, what’s the date that you would need to hear commitment from MCOs?*

For planning purposes, HHSC would appreciate commitment by January 1, 2023. However, HHSC may continue to recruit MCOs through Calendar Year 2023.

B. Telemedicine

1. What is the MCO's role in the development of the hospitals’ Telemedicine services?

At this stage, HHSC does not envision a specific role for MCOs to play in the development of the Telehealth project. However, if an MCO has ideas about Telehealth services, we would encourage them to have discussions about it with the CHART Model Participant Hospitals in their service area.

2. Should the APM include requirements around Telehealth or will this be managed by HHSC?

This could be a topic for discussion and collaboration between MCOs and Participant Hospitals. The APM is not required to include Telehealth services.

C. Quality

1. What is MCO's role in developing quality measures (e.g., for Potentially Preventable Event (PPE) reduction, etc.)?

CMS will track reporting and performance on each of the CHART Model Quality Measures as part of its monitoring strategy. All CHART Model Participant Hospitals will report on three required and one other Quality and Population Health Domain. The required domains are chronic conditions, care coordination, patient experience and engagement and HHSC plans to select the Prevention domain. The measures and additional information about them can be found on the [HHSC web site](#). MCOs may also consider incorporating other performance metrics that align with the goals of the CHART Model in the development of APMs with Participant Hospitals, such as measures related to reducing PPEs related to the Hospital Quality-based Payment Program. HHSC plans to work with MCOs and Participant Hospitals through Calendar Year 2023 to facilitate APM(s). This could be a topic for discussion and collaboration between MCOs and Participant Hospitals.

2. Are quality measures and/or targets intended to be the same across all participating hospitals or contracts?*

Yes, all Participant Hospitals will be reporting on the same quality measures for the CHART Model. CMS will track reporting and performance on each of the CHART Model Quality Measures as part of its monitoring strategy. All CHART Model Participant Hospitals will report on three required and one other Quality and Population Health Domain. The required domains are chronic conditions, care coordination, patient experience and engagement and HHSC plans to select the Prevention domain. Please see the Table 1 below for more detail.

MCOs may also consider incorporating other performance metrics that align with the goals of the CHART Model in the development of APMs with Participant Hospitals, such as measures related to reducing PPEs related to the Hospital Quality-based Payment Program. HHSC plans to work with MCOs and Participant Hospitals through Calendar Year 2023 to facilitate APM(s). This could be a topic for discussion and collaboration between MCOs and Participant Hospitals.

Table 1. CHART Model Quality Measures

Quality and Population Health Domain	Full Measure Title	Short Name	NQF ID	Steward	Type	Data Source
Chronic Conditions (Required)	Prevention Quality Chronic Composite (Inpatient avoidable chronic disease admissions)	PQI 92	N/A	Agency for Health Care Research and Quality	Outcome	Claims
Care Coordination (Required)	Plan All-Caused Readmission	HEDIS PCR	NQF 1768	National Committee for Quality Assurance	Outcome	Claims
Patient Experience and Engagement (Required)	Hospital Consumer Assessment of Health Care Providers and Systems	HCAH PS	NQF 0166	CMS	Outcome	Hospital Compare Reporting
Prevention Quality Domain						
Prevention	Preventive Care and Screening: Tobacco Use: Screening and Cessation Intervention	N/A	NQF 0028	National Committee for Quality Assurance	Process	Claims
Prevention	Breast Cancer Screening	HEDIS BCS	NQF 2372	National Committee for Quality Assurance	Process	Claims
Prevention	Adults' Access to Preventive/Ambulatory Care Visits	HEDIS AAP	N/A	National Committee for Quality Assurance	Process	Claims
Prevention	Child and Adolescent Well-Care Visits***	HEDIS WCV-CH	NQF 1516	National Committee for Quality Assurance	Process	Claims

**The Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life (W34-CH) and Adolescent Well-Care Visits (AWC-CH) measures were modified by the measure steward into a combined measure that includes rates for Ages 3 to 11, 12 to 17, 18 to 21, and a total rate. The NQF number refers to the endorsement of the W34-CH measure.*

3. Will there be any downside financial risk for MCOs participating in the CHART Model?

It is currently unknown. We have not received any guidance from CMS that requires downside financial risk for a Payer. However, we are seeking more clarification about what qualifies as a 'capitated payment'.

4. Can we align Critical Access Hospital (CAH) reporting requirements with quality measures in this program? These hospitals have a ton of reporting around quality for CAH "qualification."

Per the [CHART Model Notice of Funding Opportunity \(NOFO\)](#) (page 38), the CHART Model is exploring alignment between its Quality Strategy and the voluntary Federal Office of Rural Health Policy (FORHP) Medicare Beneficiary Quality Improvement Program (MBQIP). Additionally, "CAH participation in CHART's Quality Strategy shall align with the mandatory Quality Assessment and Performance Improvement Program (regulation §485.641, effective March 30, 2021)." HHSC encourages MCOs and Participant Hospitals to propose opportunities to improve this alignment.

Waivers of certain Medicare Conditions of Participation (COPs) could allow Participant Hospitals to make certain changes to Medicare hospital quality reporting while participating in the CHART Model. HHSC plans to work with Participant Hospitals to request appropriate flexibilities from CMS. Please see HHSC's [Operational Flexibilities Fact Sheet](#) for more information.

For the CHART Model, CMS will track reporting and performance on each of the CHART Model Quality Measures as part of its monitoring strategy. Please see Table 1 on pages 8 and 9 for more detail. MCOs may also consider incorporating other performance metrics that align with the goals of the CHART Model in the development of APMs with Participant Hospitals, such as measures related to reducing PPEs related to the [Hospital Quality-Based Payment Program](#). HHSC plans to work with MCOs and Participant Hospitals through Calendar Year 2023 to facilitate APM(s). This could be a topic for discussion and collaboration between MCOs and Participant Hospitals.

D. Medicaid Participation Targets

1. Can MCOs count existing Alternative Payment Model (APM) arrangements towards the Medicaid Participation Targets for the CHART Model?

HHSC expects that existing APMs may count and plans to use this approach in Performance Years 1 to 3 of the Model, if it will allow Participating Hospitals to meet their Medicaid Participation Targets as required by CMS. Please see HHSC's proposed approach for Medicaid Alignment on pages 1-2 for more detail.

2. Is there a Penalty for not achieving Medicaid Participation Targets for a Performance Period?

There is no financial penalty to a hospital or an MCO in the CHART Model related to Performance Period targets.

3. Is the measurement and/or penalty for Medicaid Participation Targets for each Performance Period relative to each hospital or Community Service Area?

HHSC has requested more detail on the calculation of the Medicaid Participation Targets. There is no financial penalty to a hospital or an MCO in the CHART Model related to Performance Period targets.

4. Is the Medicaid Participation Target relative to only one MCO's Medicaid members in the Community, or is it a combination of all Medicaid?*

HHSC expects the targets to be calculated based on aggregate eligible Medicaid revenue for all CHART Participant Hospitals in Texas and not per MCO or individual hospital. Per the [CMS Medicaid Alignment Fact Sheet](#), Medicaid Participation Targets are based on the percent of Participant Hospitals' eligible Medicaid revenue under a CMS-approved Capitated Payment Amount (CPA). HHSC is seeking guidance on how the Medicaid Participation Targets will be calculated and criteria for CPA approval.

5. What if there is only one MCO that participates in the Model or a particular service area in the CHART Model? How does this change calculations/impact the Model?

HHSC is aware of the potential implications of only one MCO participating in the model or a particular service area, as limited participation may affect a hospital's

ability to meet the Medicaid Participation Targets if the calculation of those targets does not take this situation into account. HHSC is seeking guidance on how the Medicaid Participation Targets will be calculated and to what Medicaid revenue the calculation of the targets may be limited.

6. Will an annual discount factor goal be applied by HHSC?

HHSC does not plan to include a discount factor or impact MCO capitation rates in its approach to achieve Medicaid Alignment.

7. How are the Medicaid Participation Targets calculated? Is it based on Total Hospital Medicaid Revenue by individual hospital if more than one hospital is in a Community Service Area or is it aggregated to all Participant Hospitals?*

HHSC expects the targets to be calculated based on aggregate eligible Medicaid revenue for all CHART Participant Hospitals in Texas and not per individual hospital or MCO. Per the [CMS Medicaid Alignment Fact Sheet](#), Medicaid Participation Targets are based on the percent of Participant Hospitals' eligible Medicaid revenue under a CMS-approved Capitated Payment Amount. HHSC is seeking guidance on how the Medicaid Participation Targets will be calculated and criteria for CPA approval.

8. Does the calculation for the Medicaid Participation Targets exclude Medicaid revenue for a Participant Hospital for Medicaid members living out of the Community Service Area that may receive treatment at a Participant Hospital?*

The CHART Model is technically limited to the 'Community' as defined by HHSC. In its Transformation Plan approved by CMS on July 15, 2022, HHSC included all rural counties and census tracts that meet the rurality definition as defined by the Federal Office of Rural Health Policy's (FORHP) in the 'Community'. The [CMS Medicaid Alignment Fact Sheet](#), does not limit the calculation of Medicaid Participation Targets to specific Medicaid revenue. HHSC is seeking guidance on how the Medicaid Participation Targets will be calculated and what counts as a 'capitated' payment.

9.If there are a minimal number of MCOs that participate in the Model, will the Medicaid Participation Targets of 50 percent and more be able to be met?*

HHSC is aware of the potential implications of only one MCO participating in the Model or a particular service area, as limited participation may affect the Community's ability to meet the Medicaid Participation Targets if the calculation of those targets does not take this situation into account. HHSC included its proposal to achieve Medicaid Alignment in the Transformation Plan approved by CMS on July 15, 2022 and is seeking guidance on how the Medicaid Participation Targets will be calculated. Please see HHSC's proposed approach for Medicaid Alignment on pages 1-2 for more detail.