CHART Community Transformation Track – Q&A
Rural Health Value
Updated March 2, 2021

Introduction

The following questions were posed during virtual discussion or in the chat box during the following Rural Health Value "Let's Talk About CHART" webinars:

- Community Health Access and Rural Transformation (CHART) Model Community Transformation Track Overview– Session #1 on October 28, 2020.
- CHART Lead Organizations – Session #2 on November 18, 2020
- CHART Transformation Planning – Session #3 on December 14, 2020
- CHART Financial Model – Session #4 on February 4, 2021

The Rural Health Value team developed the answers presented here. Questions and answers are assigned to the following categories:

When possible, answers reference a specific section(s) of the CHART Notice of Funding Opportunity (NOFO). This document is provided as a resource to help support consideration of the CHART model in rural communities. It does not constitute formal guidance on the NOFO from the Center for Medicare & Medicaid Innovation (CMMI). Official guidance from CMMI, including a FAQ based on questions they have received, can be found on the CHART web page here: https://innovation.cms.gov/innovation-models/chart-model.

Note: Several sections of the CHART NOFO state that details may change at CMMI's sole discretion (CHART NOFO, pages 20, 25, 28, 113, 114.

Lead Organization

Q1. Can health systems/networks serve as the lead organization? *(October 2020)*

Yes, a health system may be eligible to be a Lead Organization (CHART NOFO, page 18). The "kinds of organizations" that can serve as a Lead Organization include the following (CHART Model FAQs, October 2020, p 6):

- For profit organizations other than small businesses,
- Nonprofits having a 501 (c)(3) status with the IRS, other than institutions of higher education,
- Nonprofits that do not have a 501(c)(3) status.

Q2. Would a QIO qualify (as a lead organization)? *(October 2020)*

Yes, see bullets in the previous answer for "kinds of organizations." Further, QIOs with a presence in the community will meet the specific eligibility requirements (CHART NOFO, page 18).

Q3. What if a state hasn't had experience in APMs or CMMI projects -- would they not be able to qualify as a Lead Organization? *(October 2020)*

CMS requires that Lead Organizations have experience 1) designing and implementing APMs and 2) engaging and maintaining provider participation (CHART NOFO, page 18):

- "Experience, either through direct management or through a partnership, in designing and implementing APMs"
- "Experience in engaging and maintaining provider participation in APMs or CMMI demonstration projects/models"

Designing and implementing systems and processes that healthcare organizations undergo to participate in an Alternative Payment Model (e.g. demonstration with CMMI), or alternatively, experience that is outside of CMS would meet the requirement. Note that the experience need not be specifically in Medicare APMs, meaning that experience with any APM, including commercial insurance or Medicaid, would meet the requirement. Further, the second requirement may be satisfied from experience with other CMMI demonstrations (not limited to APMs).

Q4. I would like to know what type of experience is needed with APMs or CMMI. *(October 2020)*

As indicated in the bullets in the previous answer, there are two categories of experience: 1) in designing and implementing APMs (could be a partner), and 2) engaging and maintaining provider participation. Again, note that the second requirement may be satisfied from experience with other CMMI demonstrations or APMs through commercial insurance or Medicaid.

Q5. Lead Organizations can request to receive less cooperative agreement funding in exchange for a lower discount factor for hospitals. Do you know how this may be determined? *(October 2020)*

CMMI offer three key flexibilities with respect to the discount (CHART NOFO, pages 22, 31, 117).

1. First, before the beginning of Performance Period 1, Lead Organizations may request to receive less cooperative agreement funding in exchange for a lower discount factor for their Participant Hospitals. CMS may allow additional opportunities for Lead Organizations to request less cooperative agreement funding in exchange for a lower discount on a case-by-case basis.
2. In addition, Lead Organizations will be able to negotiate participant-level discount factors with Participating Hospitals, subject to CMS approval, so long as the aggregate discount equals the final discount factor 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.

3. Lastly, Lead Organizations may receive up to $5 million of cooperative agreement funding, but may pass some of the funding directly to Participant Hospitals for investing in and successfully implementing care delivery redesign efforts at the hospital-level.

Q6. What is an example of a CMMI model? Are demonstration projects on the CMMI website? *(Added 11/18/2020)*

CMMI model example categories include Accountable Care, Primary Care Transformation, and Initiatives to Accelerate the Development and Testing of New Payment and Service Delivery Models (among others). See CMMI's complete model list here: https://innovation.cms.gov/innovation-models#views=models

Q7. I need a clear understanding about APMs. We meet all other criteria. Is there someone to contact? *(Added 11/18/2020)*

- For programmatic questions, please contact: Sally Caine Leathers at CHARTModel@cms.hhs.gov. For administrative or budget questions, please contact: Shamia Cunningham at CHARTModel@cms.hhs.gov (CHART NOFO, page 70).
- Please refer to upcoming CHART FAQs on the CHART website for additional information on APM experience.

Q8. Our Medicaid is planning on being the Lead Organization, but our only experience with APMs is PACE and a statewide PCMH program. Would that meet the APM requirement? *(Updated January 2020)*

See Q3, Q4, and Q7 above.

Q9. Is there a set amount or formula to calculate how much the Lead Organization must share with the SMA? *(Added 11/18/2020)*

If the SMA is not the Lead Organization, the SMA must be a named subrecipient of CHART cooperative agreement funding (CHART NOFO, page 59). The NOFO does not detail a formula for SMA subrecipient funding calculation.

Q10. Can the Participant Hospital also be the Lead Organization? (*Added 12/14/2020)*

Yes, a Participant Hospital can also be the Lead Organization, so long as the Lead Organization/Participant Hospital meet the requirements for both Lead Organizations and Participant Hospitals (CMMI CHART FAQ, V5. page 14).

Eligibility

Q1. Please define "Community" in the instance that a hospital serves both a rural and non-rural population. (*Updated January 2021*)

Each CHART Community Transformation Track Community must meet the following criteria:

- Encompass either (a) a single county or census tract or (b) a set of contiguous or noncontiguous counties or census tracts. Each county or census tract must be classified as rural, as defined by the Federal Office of Rural Health Policy's list of eligible counties and census tracts used for its grant programs (https://data.hrsa.gov/tools/rural-health.
- At the time of application submission, include a minimum of 10,000 Medicare FFS beneficiaries whose primary residence is within the Community.

For each CHART Community, certain hospitals are eligible. Each Participant Hospital, identified by its CMS Certification Number (CCN), must be an acute care hospital (defined as a "subsection (d) hospital" in section 1886(d)(1)(B) of the Act) or CAH that either:

- Is physically located within the Community and receives at least 20% of its Medicare FFS revenue from Eligible Hospital Services provided to residents of the Community; or
- Is physically located inside or outside of the Community and is responsible for at least 20% of Medicare expenditures for Eligible Hospital Services provided to residents of the Community (CHART NOFO, page 24).
- If a hospital does not meet one of the two aforementioned criteria, a Lead Organization may request that CMS review whether a potential Participant Hospital is eligible based on the Community's care redesign strategy, as specified in its Transformation Plan and CHART Quality Measures selected. CMS may, in its sole discretion, accept or reject the Lead Organization's request for the potential Participant Hospital to participate in CHART. (**Clarification added, January 2021 CHART FAQ**)

Q2. CAH must also meet the FORHP rural definition as well? This is important to know in order to choose the right Participant Hospital in our system. *(October 2020)*

Please see above for Participant Hospital eligibility criteria. In the event that 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 separately meets the eligibility criteria (CHART NOFO, page 24).

Q3. Does rural need to meet HRSA's definition of rural? The September 2020 Rural Action Plan states it should meet the OMB definition. Can you clarify for participating hospital? *(October 2020)*

Please see above for Participant Hospital eligibility criteria and also see the CHART FAQs at https://innovation.cms.gov/media/document/chart-model-faqs for additional information. The Rural Health Information Hub, Am I Rural? - Tool can be a useful tool to identify if specific locations fit the Federal Office of Rural Health Policy's list of eligible counties and census tracts used for its grant programs.

Lead Organizations will be responsible for defining the parameters of their Community, for the purposes of the CHART Model. Each Community must meet the following criteria:

1. Encompass either (a) a single county or census tract or (b) a set of contiguous or non-contiguous counties or census tracts. Each county or census tract must be classified as rural, as defined by the Federal Office of Rural Health Policy's list of eligible counties and census tracts used for its grant programs https://data.hrsa.gov/tools/rural-health).
2. At the time of application submission, include a minimum of 10,000 Medicare FFS beneficiaries whose primary residence is within the Community.

Q4. Are certified Rural Health Centers (RHCs) eligible for the CHART program? *(October 2020)*

RHCs are not eligible to participate as a Participant Hospital, but see sections in the CHART NOFO about the Transformation Plan component as to which provider and supplier types across the community may be included. CMS will be encouraging a Transformation Plan that spans across and outside of the hospitals and CAHs to incorporate other provider and supplier types in plans being pursued.

RHCs may also participate in the CHART program through the Advisory Councils. The Advisory Council must include a representative from at least three distinct entities from the following list (CHART NOFO, page 23).

1. A primary care provider, such as a Federally Qualified Health Center (FQHC), Rural Health Clinic (RHC), or physician group practice
2. A health care provider of substance use disorder treatment and/or mental health services
3. An additional Participant Hospital
4. The State Office of Rural Health
5. An additional Aligned Payer
6. A community stakeholder group, such as a rural patient advocacy group, Area Agency on Aging, or faith- and community-based organizations
7. A long-term care facility (e.g. nursing home), home health provider, or hospice provider
8. An Indian Health Service (IHS) or Tribal health provider or Federally recognized Tribe or Tribal organization
9. The U.S. Department of Veteran's Affairs (VA)

Q5. What happens if a Participant Hospital declines to execute the participation agreement after the negotiation of the CPA? (*Updated January 2021*)

CMMI has indicated that they will provide the CPA prior to requiring a signed agreement. Furthermore, a Participant Hospital may withdraw from the CHART Model by providing written notice. The Participant Hospital will then have up to two years to transition back to its previous payment system.

Q6. If a hospital is already working with an ACO, does it disqualify them from working in this program? *(October 2020)*

A three-part answer:

- Subject to CMS approval, Participant Hospitals may simultaneously participate in the Community Transformation Track and other Medicare value-based programs, models or demonstrations. If a Participant Hospital participates in a Medicare program, demonstration

or model, CMS may, in its sole discretion, make adjustments to the Participant Hospital's Capitated Payment Amount (CPA) to avoid duplicative accounting of, and payment or penalties for, amounts received by the Participant Hospital under such Medicare program, demonstration, or model (CHART NOFO, page 25).

- CMS will not allow the same entity to be both an award recipient (the Lead Organization) in the Community Transformation Track and an ACO participating in the ACO Transformation Track (CHART NOFO, page 41).
- Maryland, Vermont, and Pennsylvania are currently testing state-wide, multi-payer Models. The Maryland Total Cost of Care Model, the Vermont All-Payer ACO Model, and the Pennsylvania Rural Health Model, respectively. CHART will not accept applications that propose implementation within these states, unless the performance period of the applicable state-based Model has ended, is anticipated to end prior to the start of CHART's Performance Period 1 (2022), or CMS and the state amend the applicable state agreement or CMS Participation Agreement, as necessary, to permit Lead Organizations in the relevant state to apply and to permit rural hospitals located within the state to participate in the CHART Model (CHART NOFO, page 41).

Q7. What if part of the Community is deemed not rural from the 2020 census? *(October 2020)*

Please see Community definition in Q1 and Q3 above. The CHART NOFO does not offer guidance regarding potential changes in rural/urban classification of participating organizations.

Q8. Has there been any talk of allowing hospitals that have closed to reopen and participate in this model? *(October 2020)*

Each CHART Participant Hospital or CAH is identified by its CMS Certification Number (CCN). If a hospital or CAH closes, the CCN is terminated, meaning the hospital/CAH is no longer participating in the Medicare program at that point. If a closed hospital or CAH would like to reopen, the facility would submit a Form CMS-855 application to their Medicare Administrative Contractor (MAC) to enroll in the Medicare program. A survey would occur to confirm compliance with the Medicare Conditions of Participation prior to a CCN being issued. For additional information on hospital/CAH certification, see State Operations Manual Chapter 2. https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/som107c02.pdf . Once a CCN has been issued, the hospital or CAH may be eligible to participate in CHART as long as they meet the CHART eligibility criteria (see Q1).

Q9. Do the attributed lives have to be geographically connected? Can one hospital in the east side of the state partner with one hospital on the west side of the state to have enough beneficiaries? *(October 2020)*

The Community does not need to be geographically contiguous. See the Community definition in Q1 and Q3 above. CMS will ensure that there is no overlap between Lead Organizations' defined Communities. If a Lead Organization's Community spans more than one state, the Lead Organization must secure participation from the SMA in both states.

Q10. For Participating Hospitals, the key terms in NOFO identifies it as a hospital that provides inpatient medical care and other related services for surgery, acute medical condition, or injuries. These services must be provided to rural areas. The rural action plan identifies rural according to the OMB definition and not HRSA definition. Is this an accurate reflection? *(Added 11/18/2020)*

CHART will use the HRSA-defined rural counties and Census tracts. See HRSA tool here: https://data.hrsa.gov/tools/rural-health.

Q11. Does the Participant Hospital need to be physically located in the rural area or must service the rural areas? *(Added 11/18/2020)*

A Participant Hospital does not need to be physically located in the Community defined in the application. However, if the hospital is physically located outside of the Community, then the hospital must be responsible for at least 20% of Medicare expenditures for Eligible Hospital Services provided to residents of the Community (CHART NOFO, page 24).

Payment Model and Quality

Note: The Capitated Payment Amount (CPA) financial methodology is included in the NOFO for informational purposes only and may change at CMMI's sole discretion (CHART NOFO, page 114).

Q1. How will current reimbursement models be impacted by the capitated payment reimbursement mechanism? (i.e. CAH, RHC)? (*Updated January 2021*)

Current CAH cost-based reimbursement for Eligible Hospital Services will be replaced by the CPA. For CAHs, a unit price adjustment represents the change in the interim payment between the cost report that the CAH submitted for the baseline year and the cost report for the most recently available, adjudicated cost report (CHART NOFO, page 116). Physician services (e.g., RHC-based physician services) are not Eligible Hospital Services for the CPA (CHART NOFO, page 28). Each Participant Hospital, identified by its CMS Certification Number (CCN), must be an acute care hospital (defined as a "subsection (d) hospital" in section 1886(d)(1)(B)of the Act) or CAH. All other types of health care facilities are ineligible to be Participant Hospitals, and thus ineligible for the CPA (CHART NOFO, page 24). RHC reimbursement will not be impacted.

Q2. How are patients attributed? (*Updated January 2021*)

The CPA is based on historic hospital revenue for Eligible Hospital Services (CHART NOFO, pages 28 and 114). The population adjustment to the CPA captures differences in population size, demographics such as age, and shifts in the Eligible Hospital Services between hospitals. The population demographic will be defined as a change in the demographic-only HCC Risk Score. The shift in Eligible Hospital Services adjustment will be defined as a change in the distribution of services between hospitals (CHART NOFO, page 116). Population change adjustments will be presumably based on the Community-defined geographic area.

Q3. Will non-participating rural hospitals in the leading organization be at risk with its current supplemental payments? *(Updated January 2021)*

Although the NOFO does not address this question specifically, a CPA would **not** be applied to non-participating hospitals. The CPA financial methodology only applies to Participant acute care hospitals and CAHs. A Participant Hospital is one that is either:

- physically located with the Community and receives at least 20 percent of its Medicare FFS revenue from Eligible Hospital Services provided to residents or the community; or
- 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 (CHART NOFO, page 24).
- If a hospital does not meet one of the two aforementioned criteria, a Lead Organization may request that CMS review whether a potential Participant Hospital is eligible based on the Community's care redesign strategy, as specified in its Transformation Plan and CHART Quality Measures selected. CMS may, in its sole discretion, accept or reject the Lead Organization's request for the potential Participant Hospital to participate in CHART. (Clarification added, January 2021 CHART FAQ)

Q4. **If a health system is the leading organization and has 2 Participant Hospitals in its system, but not all of its hospitals, will the reimbursement model of the non-existing hospitals be at risk?** ***(October 2020)*** Please see Question 3 above.

Q5. **Do the payments include SNF/Home Health or just IP/OP?** ***(October 2020)***
Skilled Nursing Facility (SNF) level services provided by a hospital or CAH with swing beds are included in the CPA. SNF services provided by a non-hospital or non-CAH facility are not included in the CPA. Home health services provided by either an acute care hospital or a CAH are also not included in the CPA (CHART NOFO, page 28).

Q6. **What is the methodology used to determine global payment rates?** ***(Updated January 2021)***
The CPA is determined and adjusted in six steps:

1. Determine Community's Baseline Expenditures
2. Determine Changes between Community Baseline Expenditures and Prior Performance Period
3. Apply Adjustments from Step 2 to Determine the Community Benchmark
4. Determine Each Participant Hospital's Portion of the Community Expenditure
5. Determine Each Hospital's Adjustments
6. Apply Each Participant Hospital Adjustments

(CHART NOFO, pages 114 – 119, CHART Model Community Transformation Track Payment Webinar, January 21, 2021)

Q7. **How will the capitated payment, specifically the discount rate, work?** ***(October 2020)***
In order for payers to realize savings, a percentage discount – or reduction – will be applied to the CPA (CHART NOFO, page 117). The specific discount factor for a Community is determined by its total Medicare FFS revenue under the capitated payment arrangement at the

Community-level (CHART NOFO, page 11). For all but the largest Communities, the discount factor will increase over the duration of the CHART Model. The discount factor is greater if the total Medicare FFS revenue in the Community under a capitated payment arrangement is lower; i.e., smaller Communities (size based on total Original Medicare revenue) will experience a greater discount in their CPA (CHART NOFO, page 116).

Q8. Will the results of COVID-19 be taken into consideration in the average of the prior 3 years of the starting in the program? Or will it go into the average understanding that hospitals experienced extraordinary costs associated with the pandemic? (*Updated January 2021)*
Due to the COVID pandemic, CMMI will exclude 2020 when determining the Baseline Community Expenditures. For the first performance year, CMMI will use the average of 2018 and 2019 expenditures. (CHART Model Community Transformation Track Payment Webinar, January 21, 2021).

Q9. Do the adjustments address situations where the patient is transferred to a higher level of care? *(October 2020)*
The baseline CPA is determined using the simple average of hospital expenditures (for included services) for two prior years (CHART NOFO, page 114). Therefore, prior transfer patterns would be included in the baseline CPA. New transfer patterns would be included in the population adjustment; i.e., the shift in Eligible Hospital Service, defined as a change in the distribution of service between hospitals (CHART NOFO, page 116).

Q10. How would a new payment model affect CAH designation? *(October 2020)*
CAHs are eligible to participate in CHART. CAH designation is granted by CMS when a hospital is enrolled in the Medicare program and converts to being a CAH provider type by complying with the CAH Conditions of Participation (CoPs) set forth at 42 CFR Part 485 Subpart F. See the Medicare State Operations Manual Chapter 2 for additional information regarding CAH designation. CMS plans to offer benefit enhancements to the CHART participants, which may include but are not limited to the Medicare waiving CoPs listed in the NOFO.

Q11. How does this work with existing Medicaid managed care arrangements for pmpm (per member per month) payments? *(October 2020)*
A Medicaid Needs Assessment is required for the CHART application (CHART NOFO, pages 103-104). The Medicaid Needs Assessment inquiries about how different Medicaid payment models can be leveraged to meet CHART's financial alignment requirement (CHART NOFO, page 104). CHART requires that Medicaid payment (Medicaid FFS, Medicaid managed care plans, or both) progressively aligns with CHART's CPA methodology. The required percent of each Participant Hospital's Medicaid revenue under a CPA arrangement is 0 percent during Performance Period 1 and increases to 75% in performance periods 4 through 6 (CHART NOFO, page 30).

Q12. Would the CPA payment be similar to the PIP (Periodic Interim Payment)? *(October 2020)*

CHART provides biweekly payments to the Participant Hospital based on the CPA (CMS Office Hour Session webinar, October 27, 2020, slide 13). A unit price adjustment is applied to the CPA at mid-year and year-end. The unit price adjustment for CAHs consists of the change in the interim payment between the cost report that the CAH submitted for the baseline years and the most recently available, adjudicated cost report (CHART NOFO, page 116).

Q13. Was rationale given as to why the discount rate is smaller for larger organizations? *(October 2020)*

A discount is applied to the CPA in order for the payers to realize savings (CHART NOFO, page 117). The greater discount applied to smaller Participant Hospital(s) (as measured by total FFS revenue in the community under a CPA arrangement) serves as an incentive to recruit more hospitals to participate in CHART by Performance Period 3 (CHART NOFO, page 117 and 118).

Q14. Would the filing of a cost report still be required? *(October 2020)*

Yes. The unit price adjustment is determined by the change in the interim payment rate between the cost report that the CAH submitted for the baseline years and most recently available, adjudicated cost report (CHART NOFO, page 116).

Q15. How will the quality payment adjustment be calculated?

CMMI released updated information about the structure of the quality adjustment in the January 2021 FAQ (pages 25 – 26):

"As stated in the CHART Notice of Funding Opportunity (NOFO), Participant Hospitals will continue reporting on core measures in Medicaid, quality measures in Medicare, and other existing CMS quality programs. After further discussion and review, CMS has decided to forego a CHART-specific quality adjustment in favor of a pay-for-reporting program given concerns that adding additional financial risk on top of current Medicare hospital quality programs or additional hospital cost of care risk to be borne by critical access hospitals would significantly reduce hospital participation. Further, additional research illuminated concerns with measure selection, feasibility and reliability concerning rural sample size and benchmarking needed to implement a robust pay-for-performance program. Therefore, the proposed approach is to align with current national hospital quality programs as described by hospital type below:

- *Acute care hospitals*: Prospective Payment System (PPS) hospitals will have their CPA adjusted to reflect their performance in the national Medicare hospital quality programs, including the Hospital Value-Based Purchasing (Hospital VBP) Program, the Hospital-Acquired Condition Reduction Program (HACRP), Hospitals Inpatient Quality Reporting Program (Hospital IQR), Hospital Outpatient Quality Reporting Program (Hospital OQR), Promoting Interoperability Programs, and the Hospital Readmissions Reduction Program (HRRP)). Therefore, the CPAs for PPS Participant Hospitals will be adjusted to reflect their performance on the current national Medicare quality programs by using the performance adjustment factors to update the CPA annually.

- *Critical Access Hospitals*: The CPAs for Critical Access Hospital (CAH) Participant Hospitals will not be subject to a financial quality adjustment, as they are not required to participate in many Medicare hospital quality programs. CHART will recommend that CAHs align their CHART Quality Measures to fulfill the mandatory Quality Assurance and Performance Improvement (QAPI) program requirements (regulation §485.641, to be implemented by March 30, 2021). Additionally, CHART will require that CAHs report to the Medicare Beneficiary Quality Improvement Project (MBQIP) and meet their minimum reporting requirements, which aligns with many of the CMS hospital quality programs."

Q16. Will HCAHPS be evaluated by participant hospitals or for the group as a whole? If several low-volume hospitals band together, there may not be sufficient HCAHPS responses if evaluated on a facility by facility basis. *(October 2020)*

The Lead Organization and the Participant Hospitals will be required to report on the same six quality measures, including HCAHPS (CHART NOFO, pages 36-37). The NOFO does not address a threshold number of HCAHPS surveys completed for reporting.

Q17. Do the CPA discounts and Quality discounts apply at the same level to the Medicaid cap (i.e. if the cap discount is 1% and quality is 2%, is the Medicaid cap discount also 1% and 2%)? *(Added 11/18/2020)*

The NOFO does not outline Medicaid payment requirements other than to require a percentage of each Participant Hospital's Medicaid revenue must be under a Capitated Payment Arrangement. The percentage mandates increase from 0 percent in Performance Period 1 and 75 percent in Performance Period 6 (NOFO, page 31).

Q18. The NOFO says that CHART's measures target quality at both the Community and Participant Hospital levels, and a majority of the measures are claims-based. Does every participant Hospital need to report on the three required measures and measures chosen from the list of measures Lead Organizations may choose from? *(Updated January 2021)*

Lead Organizations and Participant Hospitals within their community will be required to report on the same six quality measures for the duration of the model (NOFO, page 35). The quality measures outlined on pages 36 – 37 of the CHART NOFO include both measures that are calculated based on claims data, and measures that would be reported by hospitals. It is not clear if the claims-based measures will be calculated at a hospital level, or at the 'Community' level (or both). CMMI has clarified that participating hospitals will be required to report data for selected measures that are not calculated via claims (i.e. HCAHPs). (CHART FAQ January 2021, page 32)

Q19. How will CHART affect the payments made by secondary/supplemental/replacement Medicare plans? *(Added 12/14/2020)*

The Medicare CPA will be based on Original Medicare fee-for-service payments only (CHART NOFO, page 28). Medicare Advantage plan payments are not included in the CPA. Similarly,

Medicare Supplement plan payments will likely not be included in the CPA.

Q20. Is this, or how can we make this financially viable for CAHs that are financially successful now? *(Added 12/14/2020)*

Since "the CPA financial methodology is included in the NOFO for informational purposes only and may change at CMMI's sole discretion" (CHART NOFO pages 28 and 114), and because the financial situation at each CAH is unique, we cannot determine the financial impact of the CHART model on individual hospital finances at this time.

Q21. How will CHART participation impact quality reporting for CMS quality programs? What about the Medicare Beneficiary Quality Improvement Program (MBQIP) for CAHs? (*Updated based on January 2021 CHART FAQ)*

Participant Hospitals will continue reporting on core measures in Medicaid, quality measures in Medicare, and other existing CMS Quality Programs (CHART NOFO, page 37).

- *Acute care hospitals*: Prospective Payment System (PPS) hospitals will have their Capitated Payment Amounts (CPAs) adjusted to reflect their performance in the national Medicare hospital quality programs, including the Hospital Value-Based Purchasing (Hospital VBP) Program, the Hospital-Acquired Condition Reduction Program (HACRP), Hospitals Inpatient Quality Reporting Program (Hospital IQR), Hospital Outpatient Quality Reporting Program (Hospital OQR), Promoting Interoperability Programs, and the Hospital Readmissions Reduction Program (HRRP)).
- *Critical Access Hospitals*: The CPAs for Critical Access Hospital (CAH) Participant Hospitals will not be subject to a financial quality adjustment, as they are not required to participate in many Medicare hospital quality programs. CHART will recommend that CAHs align their CHART Quality Measures to fulfill the mandatory Quality Assurance and Performance Improvement (QAPI) program requirements (regulation §485.641, to be implemented by March 30, 2021). Additionally, CHART will require that CAHs report to the Medicare Beneficiary Quality Improvement Project (MBQIP) and meet their minimum reporting requirements, which aligns with many of the CMS hospital quality programs.

Q22. How will 'snow birds' be accounted for in the assignment of beneficiaries to the Community? (*Added February 2021*)

The CHART Model payment webinar held by CMS on January 21, 2021, slide 41 lists the following:

The CHART Capitated Payment Amount Methodology assigns Medicare Fee-For-Service (FFS) beneficiaries to the Community based on the following residency logic:

1. Beneficiaries are Medicare FFS-eligible (as defined below and on slide 41 in the webinar) and reside in the Community for the majority of the alignment period (12-month period beginning 18-months prior to the respective baseline or Performance Period).
2. The beneficiary must not move out of the Community before or during the respective baseline or Performance Period.

Medicare FFS eligibility is defined as follows:

- **Inclusion criteria:** Enrolled in Medicare Parts A or Part B, Medicare is designated primary payer, United States residency, and must be living.
- **Exclusion Criteria:** Enrolled in Medicare Advantage or Programs of All-Inclusive Care for the Elderly (PACE); must not be enrolled in any of the Alternative Payment Models (APMs) listed in the Community Track overlaps policy.

Based on the criteria listed above, CMS will assess eligibility on a month-by-month basis, which will then be combined to form a single monthly record for each beneficiary used for beneficiary attribution and subsequent financial calculations.

Partnering/Redesign, Potential Impacts, Other

Q1. How will CHART help engage Federally Qualified Health Centers (FQHCs) that may typically not be interested in working with hospitals? *(October 2020)*

FQHCs, along with primary care providers, RHCs or physician group practices are identified as potential Advisory Council members (CHART NOFO, page 23). Collaborative Governance and Care Coordination with Community Safety Net Providers (which includes FQHCs) is also listed as a potential example of health care delivery system redesign (CHART NOFO, page 102).

Those interested in stronger collaboration with safety net providers are encouraged to review this resource from the Federal Office of Rural Health Policy: Guide for Rural Health Care Collaboration and Coordination (2019). The Guide describes how rural hospitals, community health centers, local public health departments, and other rural stakeholders can work together to assess and address their rural communities' health needs.

Q2. Is it feasible to have a patient transfer system from rural to tertiary hospital similar to the EMS trauma system? *(October 2020)*

Possibly, if the proposed system aligns with CHART goals and community needs. As part of CHART, Lead Organizations will develop a Transformation Plan that is the description of their health care delivery system redesign strategy. Specifically, Transformation Plans must address at least one of the following: behavioral health treatment, substance use disorder treatment, chronic disease management and prevention, or maternal and infant health. CMMI also requires Transformation Plans to include strategies to expand the use of telehealth and other technology to support care delivery improvement (CHART NOFO, page 20). A variety of Medicare Program and Payment Policy Waivers may be available to support implementation of the Community Transformation Plan(s) (CHART NOFO, page 33). Potential examples of health care delivery system redesign are also listed in Appendix VII of the CHART NOFO.

Q3. Our state Medicaid agency has indicated they think CMMI will allow for some state specific flexibility - do you have any sense of this? *(October 2020)*

Involvement of the SMA is required in CHART. Lead Organizations and SMAs are encouraged to review the Medicaid Needs Assessment Questionnaire (CHART NOFO, pages 104-107), and the

Medicaid Pathway Guidance (CHART NOFO, pages 107-113) that outlines potential considerations for alignment through state plan amendments, alignment through managed care, and alignment through 1115 Demonstration Authority. The NOFO states that CMS welcomes states to engage with CMS as they plan an approach to the CHART Model that addresses unique state needs. CMS and states will work together to identify available authorities and submit the required applications and amendments as needed. CMS is available to provide technical assistance to states on how to meet federal transparency requirements as well as to preview states' draft 1115 proposals and public notice documentation to help ensure states successfully meet federal requirements (CHART NOFO, page 112).

Q4. Will CAHs lose CAH Designation if they move to this model? *(October 2020)*
CAH designation persists in the CHART Model and is referenced on multiple pages in the CHART NOFO.

Q5. Is there any conflict with the Flex or SHIP programs? *(October 2020)*
Awardees should work with Flex and SHIP projects officers for these specific questions (https://www.hrsa.gov/rural-health/rural-hospitals/region-map.html).

Q6. Can participating hospitals still participate in the Managed Care Incentive Program (run by the State Medicaid program)? *(October 2020)*
Involvement of the SMA is required for CHART. Participation in incentive programs developed and implemented by the SMA will need to be part of the consideration for alignment. See question 3 above for additional detail.

Q7. If the administration changes on November 3, will it have any impact on this program? *(October 2020)*
There is strong bi-partisan support for movement to value-based models.

Q8. Has anyone developed an analysis of the anticipated costs required to implement this program, and how that compares to the CMMI funding to cover same? *(October 2020)*
CMMI funding for CHART will be up to $5 million for up to 15 award recipients (total of up to $75 million). Award recipients will participate in CHART for seven years (includes one Pre-Implementation Period and six Performance Periods). The cost to implement CHART requirements is unknown.

Q9. It's apparent that CMS is pushing for a certain model of rural health care delivery (such as the use of discount rates to encourage organizations to work together). Is there any good example of what their preferred model looks like? *(October 2020)*
As part of CHART, Lead Organizations will develop a Transformation Plan that is the description of their health care delivery system redesign strategy. Specifically, Transformation Plans must address at least one of the following: behavioral health treatment, substance use disorder treatment, chronic disease management and prevention, or maternal and infant health. CMMI

also requires Transformation Plans to include strategies to expand the use of telehealth and other technology to support care delivery improvement (CHART NOFO, pages 19-20). A variety of Medicare Program and Payment Policy Waivers may be available to support implementation of the Community Transformation Plan(s) (CHART NOFO, page 33). Potential examples of health care delivery system redesign are also listed in Appendix VII of the CHART NOFO.

Q10. If this is successful, is there a pathway for continuation? ***(October 2020)***

Under CMMI Statute, if a model meets one of the three criteria below and other statutory prerequisites, the statue allows the Secretary to expand the duration and the scope of a model through rulemaking. Criteria/Scenarios for success include the following (Community Health Access and Rural Transformation (CHART) Model – Model Overview Webinar. CMMI. August 18, 2020).

- Quality improves and costs is neutral,
- Quality is neutral, and cost is reduced, or
- Quality improves and cost is reduced (best case)

Q11. What happens at the end of the planning year if you realize this is beyond our scope, capacity, or that the data analysis indicates that the "model" won't actually benefit our providers? ***(October 2020)***

The CHART NOFO is silent regarding the options for an awardee (Lead Organization) if during the Pre-implementation Period the awardee decides not to continue in the CHART Model or does not satisfactorily complete funded activities (CHART NOFO, pages 15, 20-21).

Q12. Is there any guidance for participant hospitals who opt to withdraw before the end of program? ***(Added 11/18/2020)***

The NOFO does not provide guidance on if a Participant Hospital withdraws before the end of the program.

Regardless of when a Participant Hospital signs a Participation Agreement, it will have up to two years to transition back to 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, Participant Hospitals may continue to operate under a capitated payment arrangement until fully transitioned. (CHART NOFO, page 24)

Q13. Specifically, how would CMS handle shifts to the community definition or transformation plan? ***(Updated January 2021)***

CMMI has noted that applicants should use HRSA's most current county and Census tract definitions. It is unclear how updated county and Census tract definitions will impact community definitions. Lead Organizations may update their Community geographic boundaries once during the pre implementation period. (CHART FAQ, January 2021, page 18)

Q14. How might shifts in the community definition or transformation plan impact the cooperative agreement funding? *(Added 11/18/2020)*

Award recipients must meet reporting and certification deadlines to be eligible throughout the initial 12-month budget period and to remain eligible for a non-competing continuation award for subsequent budget periods in multi-year projects. In addition, award recipients would need to demonstrate strong performance during the previous funding cycle(s) before additional year funding is awarded; or, in the case of awards where all funding is issued in the first year, to ensure continued access to funding. At any time in the award cycle, award recipients could receive decreased funding, or their award could be terminated if they fail to perform the requirements of the award (CHART NOFO, page 41).

Q15. How could this model help Critical Access Hospitals stay in business? *(11/18/2020)*

The CPA methodology presented in the NOFO is for informational purposes only and may change at CMMI's sole discretion (CHART NOFO, pages 28 and 114). That said, equal bi-weekly payments based on a predetermined CPA will even out the often unpredictable CAH revenue highs and lows. Experience with the Pennsylvania Rural Health Model suggests that revenue consistency eases CAH financial management challenges. However, under CHART, the CAH CPA is subject to a discount (for payers to realize savings). Furthermore, a CAH's CPA unit price adjustment consists of the change in the interim payment rate between the cost report that the CAH submitted for the baseline years and the most recently available, adjudicated cost report (CHART NOFO, page 116).

Q16. What is the role of health professions education in the CHART model, a critical element of workforce supply? *(Added 12/14/2020)*

Although there is potential that a health professions education focus could be included in a Community's Transformation Plan, the CHART NOFO does not identify any specific role or focus in this area.

Q17. Can the Rural Health Value team share a copy of the Hospital Data Profile they indicated was used to help support transformation planning with PA RHM hospitals? *(Added 12/14/2020)*

Yes, a template of the Rural Health Value developed hospital data profile is posted on the Rural Health Value website with the materials from the December 14, 2020 webinar, which focused on CHART Transformation Planning.

Application Process (*added 11/18/2020*)

Q1. What is the level of detail expected by CMMI in describing the recruitment of the Participant Hospitals? All you need is a letter of intent to apply, correct?

- Applicants must submit a description of the interest they have received from potential Participant Hospitals (e.g., facility name, facility type, estimated annual FFS Medicare revenue). Each application must include *at least one* LOI from a potential Participant Hospital. Each potential Participant Hospital's LOI must include:

a. Hospital type (acute care hospital (defined as a "subsection (d) hospital" in section 1886(d)(1)(B) of the Act) or CAH;
b. Its annual FFS Medicare revenue for each of the past five years (2014 to 2019);
c. The number of Medicare FFS beneficiaries from the Community served by the Participant Hospital in each of the past five years; and
d. Whether the potential Participant Hospital's physical location is in the Community or outside of the Community.
e. Attestation that the potential Participant Hospital meets the eligibility criteria and is willing to perform required activities, as described in section A.4.4.2 Participant Hospitals.

- NOTE: Applicants with a greater number of LOIs from potential Participant Hospitals, relative to the total number of potential Participant Hospitals within the Community, will be given preference during the application review process
- Applicants must submit a description of their Participant Hospital recruitment strategy for the Pre-Implementation Period. (CHART NOFO, page 56).

Q1. Clarification is needed on the budget narrative requirements – are the requirements for single spacing or double spacing (see pages 43 and 58)?

CMS recognizes that the NOFO posted on 9/15/20 contained conflicting language regarding the spacing requirement for the Budget Narrative. In the updated NOFO posted on 12/23/20, CMS clarified that it will accept single-spaced or double-spaced as long as the 10- page limit specified in the CHART NOFO Section D.2 Content and Form of Application Submission is met.(January 2021 CHART FAQ)

Q2. How "locked down" do we need to have the hospital participants prior to submitting an application vs. during the initial planning year?

- Please review answer to Question #1 under Application Process above.
- Lead Organizations' participation in the CHART Model will begin with a Pre-Implementation Period, during which they will regularly convene and collaborate with their Advisory Council, prepare Transformation Plans, and engage Aligned Payers and potential Participant Hospitals. During the Pre-Implementation Period, Lead Organizations will submit, and CMMI will review and approve, Transformation Plans and other requested documentation. During the final quarters of the Pre-Implementation Period, CMMI will conduct program integrity screenings of potential Participant Hospitals and generate respective CPAs. Lead Organizations must ensure relevant parties sign Participation Agreements before the end of the Pre-Implementation Period.