Community Health Access and Rural Transformation Model
Community Transformation Track Sample Payment Calculation

The CHART Model Community Transformation Track aims to **drive modernization of rural health delivery systems** by providing Communities upfront funding and predictable finances through a Capitated Payment Amount (CPA) and operational flexibilities through benefit enhancements and beneficiary engagement incentives. **This resource provides a sample CPA calculation for a fictional Participant Hospital, detailing how a fictional Lead Organization defined and transformed its fictional Community.** For further detail on these policies, please reference the Notice of Funding Opportunity (NOFO) and other materials on the CHART Model website: https://innovation.cms.gov/innovation-models/chart-model.

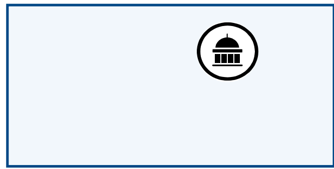
Overview of Capitated Payment Amount (CPA) Calculation

To calculate a Participant Hospital's CPA, CMS will first calculate a **Community prospective benchmark**, which aims to capture the hospital expenditures of Medicare Fee-For-Service (FFS) beneficiaries that reside in the defined Community, regardless of where they seek care. Then CMS will determine the **Participant Hospital's specific CPA,** which CMS will issue to each Participant Hospital in bi-weekly prospective payments in lieu of FFS payments for the assigned beneficiaries and eligible hospital services.

Community Prospective Benchmark			Participant Hospital CPA Calculation		
1	2	3	4	5	6
Determine baseline Community expenditures	Determine changes that occurred between the Baseline Period and up to the Performance Period	Adjust for changes to determine the Community's Prospective Benchmark	Determine each Participant Hospital's portion of the Community's expenditures	Determine each Participant Hospital's adjustments	Apply each Participant Hospital's adjustments

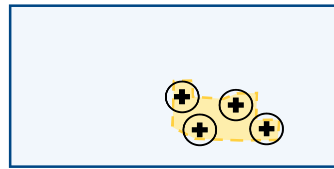
Sample Payment Calculation

The ***example*** *provided below is an* ***illustrative walk-through*** *of the process that CMS will use to calculate a Participant Hospital's CPA and does not represent a real model participant. Each CPA will vary based on specific characteristics of the Community and Participant Hospital and* ***will be provided to the prospective Participant Hospitals prior to signing the participation agreement****. Calculation steps have been simplified and numbers rounded for illustrative purposes (e.g., to the nearest million, nearest hundred-thousandth, etc.). As mentioned in the NOFO, this methodology is subject to change.*

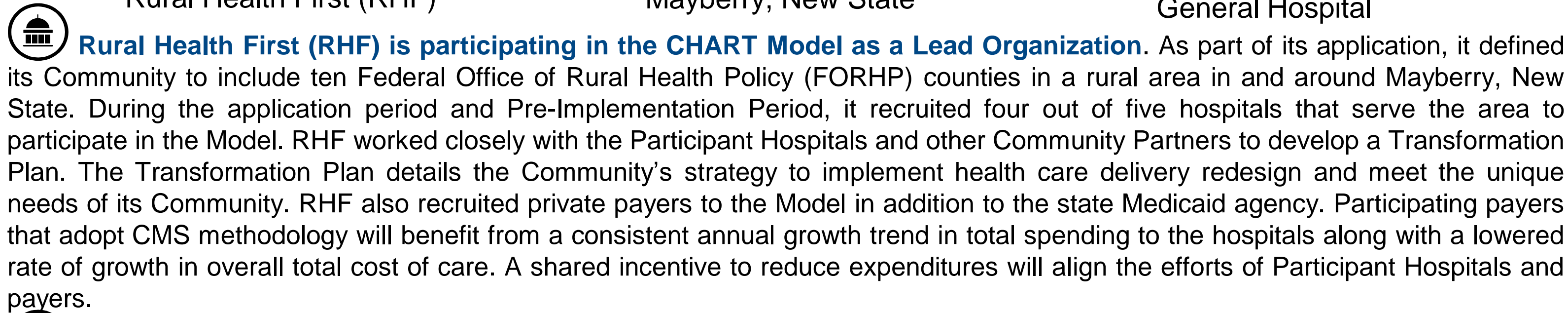


Lead Organization:
Rural Health First (RHF)

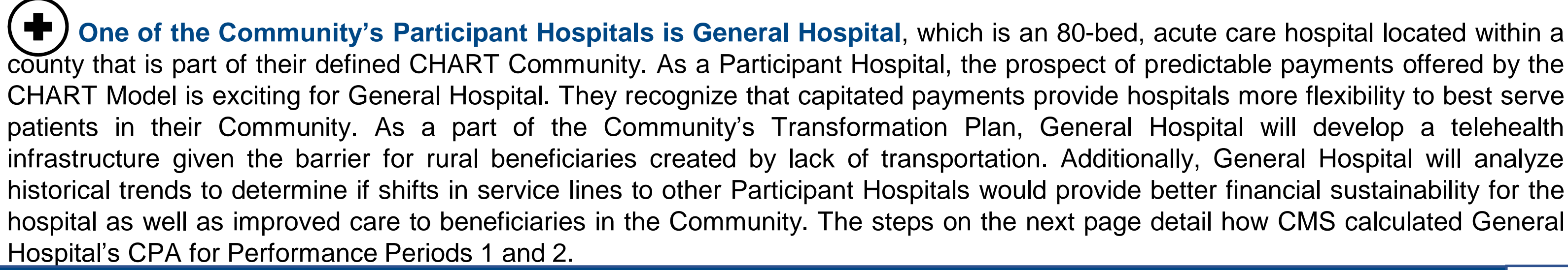
Community:
Mayberry, New State



Participant Hospital:
General Hospital



Rural Health First (RHF) is participating in the CHART Model as a Lead Organization. As part of its application, it defined its Community to include ten Federal Office of Rural Health Policy (FORHP) counties in a rural area in and around Mayberry, New State. During the application period and Pre-Implementation Period, it recruited four out of five hospitals that serve the area to participate in the Model. RHF worked closely with the Participant Hospitals and other Community Partners to develop a Transformation Plan. The Transformation Plan details the Community's strategy to implement health care delivery redesign and meet the unique needs of its Community. RHF also recruited private payers to the Model in addition to the state Medicaid agency. Participating payers that adopt CMS methodology will benefit from a consistent annual growth trend in total spending to the hospitals along with a lowered rate of growth in overall total cost of care. A shared incentive to reduce expenditures will align the efforts of Participant Hospitals and payers.

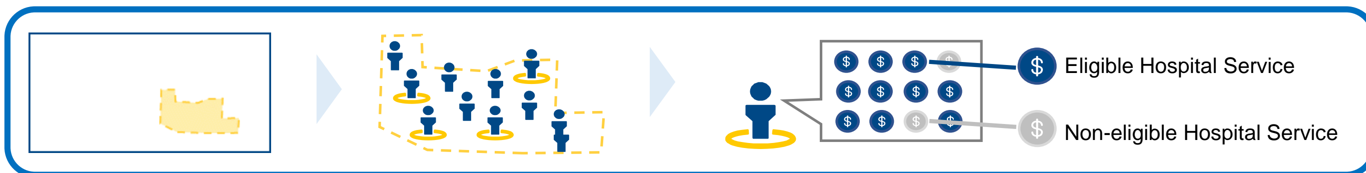


One of the Community's Participant Hospitals is General Hospital, which is an 80-bed, acute care hospital located within a county that is part of their defined CHART Community. As a Participant Hospital, the prospect of predictable payments offered by the CHART Model is exciting for General Hospital. They recognize that capitated payments provide hospitals more flexibility to best serve patients in their Community. As a part of the Community's Transformation Plan, General Hospital will develop a telehealth infrastructure given the barrier for rural beneficiaries created by lack of transportation. Additionally, General Hospital will analyze historical trends to determine if shifts in service lines to other Participant Hospitals would provide better financial sustainability for the hospital as well as improved care to beneficiaries in the Community. The steps on the next page detail how CMS calculated General Hospital's CPA for Performance Periods 1 and 2.

Community Prospective Benchmark Calculation

Step 1: Determine baseline Community expenditures. In the Community listed in the RHF application, there are 40,000 residents. CMS reviews residency and Medicare eligibility, and determines that 40% (16,000) of all residents are eligible FFS beneficiaries. CMS accounts for seasonal fluctuations in population size by assessing beneficiary counties on a month-by-month basis.

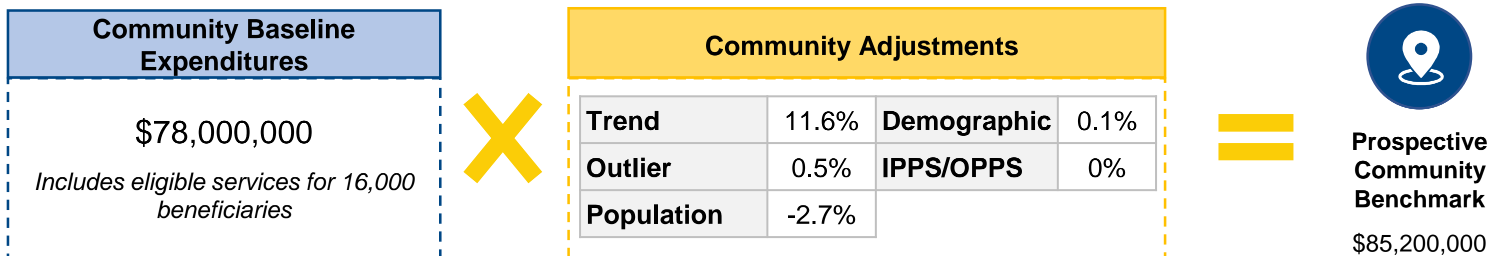
CMS determines that the total eligible hospital expenditures during the baseline period (Calendar Year 2018 and 2019) for the 16,000 beneficiaries, including Part A and facility-based Part B services, and Swing Bed services provided by Critical Access Hospitals, is $78,000,000 annually. That breaks down to an average annual beneficiary cost of approximately $4,900.



Step 2: Determine changes that occurred between the baseline period and Performance Period. CMS conducts several adjustments (listed below) to determine the Community's baseline adjustment discount.

- **Trend** – CMS applies a Community-specific trend on a per-beneficiary basis to ensure that the Community is compared only to its own historical performance. At the start of Performance Period 1 in January 2023, RHF's Community trend is 11.6% (annual rate of 2.78% from 2020 to 2023 such that 1.0278^4 – 1= 11.6%). Note: Given the COVID-19 Public Health Emergency (PHE), CMS has shifted the baseline period for this adjustment to a time period further in the past, thereby creating a four-year trend. After this one-time baseline is implemented, the trend will incorporate more recent data in the future once a new post-PHE baseline is established.
- **Outlier** – During the Pre-Implementation Period, CMS may allow Communities and their respective Participant Hospitals the option to receive an outlier adjustment. The purpose of the adjustment is to protect Participant Hospitals from unexpected catastrophically expensive utilization or high-cost claims not accounted for in RHF's Community benchmark or its Participant Hospitals' prospective CPAs. RHF accepts the option to receive an outlier adjustment so that it is not accountable for such utilization or claims. That adjustment is 0.5% to account for changes after the baseline period.
- **Population Size** – CMS accounts for further differences in the count of beneficiaries assigned to RHF's Community between the baseline years and the Performance Period. There was a decrease in the Medicare FFS population size of RHF's Community of 435 assigned beneficiaries leading to a population size adjustment of -2.7%.
- **Demographic** – The demographic adjustment accounts for changes in the profile of the Community population. RHF's average Community age increased between the baseline and the Performance Period. CMS adjusts the benchmark upward by 0.1%.
- **Updates to Medicare Policy (IPPS/OPPS)** – CMS regularly reviews and adjusts IPPS and OPPS FFS payment systems to account for changes in clinical practice, technology, and policy. Based on these changes CMS will adjust hospital payments at its discretion. There was no update to the IPPS and OPPS FFS payment systems between the baseline and Performance Period. RHF receives no adjustment from CMS.

Step 3: Adjust for changes to determine the Community's Prospective Benchmark.
Using RHF's annual baseline expenditures of $78 million, CMS applies each of the adjustment factors above, which yields RHF a Prospective Community Benchmark of approximately $85,200,000.



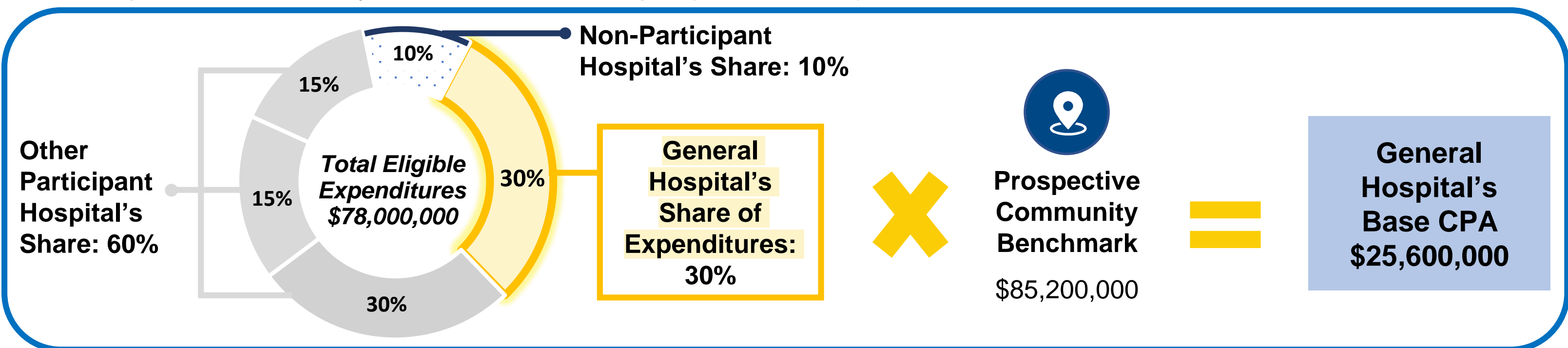
Trend	11.6%	Demographic	0.1%
Outlier	0.5%	IPPS/OPPS	0%
Population	-2.7%		

Now we will move on to determine General Hospital's CPA on the next page.

Participant Hospital CPA Calculation

Step 4: Determine each Participant Hospital's portion of Community expenditures.

There are five hospitals that serve assigned beneficiaries in the RHF Community. RHF has successfully recruited 4 Participant Hospitals; the fifth hospital has chosen not to participate. During the baseline period, CMS paid General Hospital an annual average of $23,000,000 for services provided to the Community's Medicare FFS beneficiaries. Thus, General Hospital was responsible for 30% of RHF's Community total expenditures of $78,000,000. To determine General Hospital's Base CPA, CMS multiplies the portion of Community expenditures provided by General Hospital (30%) by RHF's total Prospective Community Benchmark from Step 3 ($85,200,000).



Step 5: Determine each Participant Hospital's adjustments.

CMS determines the following hospital specific adjustments:

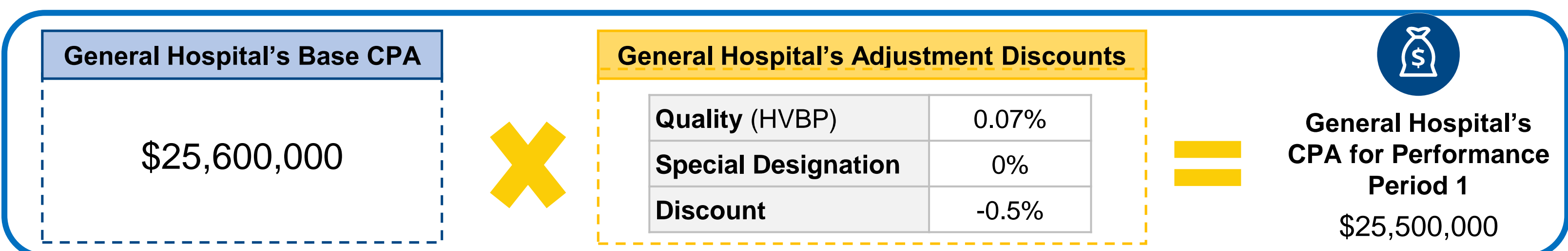
Quality – For Prospective Payment System (PPS) hospitals, CMS will prospectively adjust CPAs to reflect performance in the national Medicare quality hospital programs outside of the CHART Model, with no further CHART-specific quality adjustments. Critical Access Hospitals (CAHs) will not have a financial quality adjustment but will be required to report on the CHART-specific measures and participate in both the Medicare Beneficiary Quality Improvement Program and Quality Assurance and Performance Improvement Program. As a PPS hospital, General Hospital participates in the Hospital Value Based Purchasing Program (HVBP) and received a payment adjustment factor of +0.813%, which is applied to the same portion of the hospital's base CPA as in FFS (which equals a .07% reduction on the CPA). Similar calculations would be performed for the Hospital Readmission Reduction (HRRP) Program and Hospital Acquired Condition (HAC) Reduction Program.

Special Designation – To ensure the designations that Participant Hospitals received prior to the CHART Model are maintained in determining each hospital's prospective payment, CMS will adjust for both 1) special status hospitals (e.g., CAHs, MDH, SCH) and 2) other special designations (e.g., Bad debt, IME, LVA). General Hospital does not qualify for these designations, so in this example CMS will not apply a Special Designation adjustment.

Discount – The Lead Organization in each Community can negotiate discounts with its Participant Hospitals, so long as the aggregate Community discount matches the discount determined for the Model in a given year. The aggregate discount for Performance Period 1 is a 0.5% reduction off the trend and -1.0% for Performance Period 2. Beginning in Performance Period 3, each Community's discount will vary depending on the level of hospital participation in the Community. General Hospital receives the standard discount of 0.5% for the first Performance Period.

Step 6: Apply each Participant Hospital's adjustments

Using General Hospital's Base CPA of $25,600,000 million, CMS applied General Hospital's HVBP adjustment factor of +0.07% and the standard discount of -0.5%, which gave General Hospital a CPA of $25,500,000. This CPA is paid out in the bi-weekly amount of $980,000 in lieu of FFS payments for the duration of Performance Period 1. In this scenario, even with the discount, General Hospital's CPA will increase relative to the baseline period.



Adjustment	Value
Quality (HVBP)	0.07%
Special Designation	0%
Discount	-0.5%

Mid-Year Check and End of Year Adjustments

CMS assesses new data as it becomes available during the Performance Period to ensure prospective payments issued were as accurate as possible and to mitigate the risk of having to make significant financial adjustments at the end of the year. The **mid-year check** identifies if there are any material changes in RHF's defined Community since the annual CPA was set and issued. If there are, CMS will notify Participant Hospitals and consider updating the remaining annual prospective payments of the CPA. The **end of year check** similarly identifies changes and applies necessary adjustments to determine the Final Community Benchmark with reconciliation to follow. The items that are updated at the mid-year check and end-of year adjustments are listed below.

Community Benchmark Adjustments

Updated Each Year to Calculate Final Benchmark

Population	0%	**Demographic**	+ 0.3%
Outlier	0%		

Hospital-Specific CPA Adjustments

Updated Each Year to Calculate Final CPA

Change in Beneficiary Expenditures	+ 10% (share increased from 30% to 33%)
Quality	+ 0.0%

End of Year Adjustments

Prospective Community Benchmark

$85,200,000

As a % change to final Community Benchmark

Population	0%	**Demographic**	+0.3%
Outlier	0%		

Final Performance Period 1 Community Benchmark

$85,500,000

Setting the CPA for Performance Period 2

After determining the final Performance Period 1 benchmark, CMS uses the same data to set the Prospective Community Benchmark for Performance Period 2. At this time, CMS adjusts the RHF Community's final Community Benchmark to reflect 1) any reconciliation from Performance Period 1 and 2) the new trend factor. This yields a **new prospective Community benchmark of $87,900,000**.

Next, CMS determines General Hospital's specific share of the Performance Period 2 Prospective Community Benchmark. This calculation yields a **Performance Period 2 CPA of $31,300,000**.

General Hospital reviews the new prospective payment prior to the start of Performance Period 2. CMS Updates Prospective Payment Amounts.

Final Performance Period 1 Community Benchmark

$85,500,000

Includes latest beneficiary months, outlier, demographic adjustment, & updates to Medicare policy.

PP2 Trend 2.5%

Community Reconciliation for Performance Period 1

Trend	0
Outlier	0
Demographic	+300,000
IPPS/OPPS	0
Total	**$300,000**

Performance Period 2 Prospective Community Benchmark

$87,900,000

General Hospital's Performance Period 2 Base CPA

$29,000,000

($87,900,000 x 33% expenditure share)

General Hospital's Adjustment

Quality (e.g., HVBP)	.07%
Special Designation	0%
Discount	-1.0%
Total	**$28,700,000**

Hospital Reconciliation for Performance Period 1

Performance Period 1 Prospective Benchmark	$85.2M
Change in Beneficiary Expenditures	* 3%
Total	**$2.6M**

General Hospital's Performance Period 2 CPA

$31,300,000

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Hospital Perspective and Benefits

The CPA allows General Hospital to have stable revenue to provide services to their Medicare population through biweekly payments. As part of the RHF Community, General Hospital and other Community Partners can collaboratively implement their collective Transformation Plan. In the Transformation Plan, the Community utilized waivers, benefit enhancements, and other flexibilities to focus and redesign health care to best meet the needs of their specific Community. In doing so, General Hospital was able to lower overall utilization, reducing their expenditures and allowing them to realize cost savings all retained by General Hospital.

General Hospital Transformation Initiatives

Telehealth Infrastructure

Noting that lack of transportation is a major barrier to care for rural patients, General Hospital collaborated with RHF and used some of the CPA to develop a telehealth infrastructure so that patients were able to gain access to specialists rather than make long commutes for those appointments. This infrastructure involved both live-video telehealth and remote patient monitoring technology, enabling General Hospital to deploy telehealth strategies in chronic disease management, care transitions, and direct-to-consumer (DTC) telehealth within their Community.

Shift in Service Line

Rather than waiting for Fee-for-Service (FFS) payments tied to point of care, General Hospital was able to use historical knowledge and trends to predict what patients needed and to create a plan to address those needs. A trend of declining volume in General Hospital's oncology services could have proven financially unviable. As a part of the Transformation Plan, General Hospital elected to shift its oncology services to another hospital with a larger and higher quality program. To aid in the transition of operations to the receiving hospital, General Hospital received fixed costs for two years under the CHART.

General Hospital's Performance Period 1 CPA	−	General Hospital's Actual Costs	=	Realized Savings
$25,500,000		*This number is internal to a specific hospital and is expected to decrease with meaningful transformation.*		Dependent on transformation efforts

Performance Period 1 CPA Biweekly Payments

In this scenario, even with the discount, General Hospital's CPA in Performance Period 1 and 2 will **increase to account for Community trends**.

Participant Hospitals will also be able to keep the savings that are generated through transformation.