Questions and Answers from Rural Health Open Door Forum- September 15, 2020

1. If you could please speak to any TA assistant that CMS is going to offer to the lead organizations on the CHART model.
    a. This is Sally Caine Leathers. I'm the CHART model lead. And in regards to technical assistance that we'll be providing, we're going to plan on doing a few things. First of all, we always support our models like CMMI with a learning system, and that won't be any different here. So we're definitely planning on building out a robust learning system to bolster, specifically that transformation plan work that I referenced. Each lead organization and community that selected for this track, we'll be designing a transformation plan and we hope to be able to provide lots of guidance and resources, and forums for communities to discuss how to best assess, do a needs assessment, just to kick things off, and then how to best plan a strategy for healthcare in their community. We plan on bringing in experts as well as doing case studies. We've been partnering with the CDC as well as FORHP within HRSA. So we really plan on doing lots of robust learning system support. We also will likely be providing some helpful aggregate data to rural communities once they've been selected. We hope to be able to provide some data that will help them see some trends on the ground around certain demographics and health outcomes, and figure out what areas they may want to target. So those are two concrete examples that I can share right now, that we'll be offering through this track.
2. There were organizations that were not eligible to participate as a participant hospital. You seem to have described it more but just wanted to confirm that even though say an (RHC) wouldn't be able to be the standalone as a participant hospital, a participant hospital that owns an (RHC) could provide eligible services through that RHC, correct?
    a. I'm not quite sure I'm following the question with the participant hospital, why they wouldn't be able to participate under the eligible services. But it's - I will definitely refer you to - we lay out in way more details than we're able to offer during the webinar. In the NOFO, we have a section where we lay out the eligibility criteria for participant hospitals. And at a high level, the hospital that can participate in this track and receive that capitated payment are acute care hospitals, and that's going to be defined as subsection D hospitals, as well as critical access hospitals. And there are some criteria that we're associating with those two of causing acute care hospitals. One, they have to be physically located within the community and receive a certain percentage of their Medicare fee-for-service revenues from eligible hospital services, provided to residents in that community. Or they can be physically located inside or outside of the community, as long as they're responsible for at least 20 percent of Medicare expenditures for those eligible hospital services provided to the residents of the

community that the lead organization draws within their, however they define the community.

3. I was wondering if the - where CMS' stance on, in regards to the test requirements for COVID, for post-acute care providers receiving patients from the acute care setting. There's seems to be a huge, you know, the standard is not the same across the board, and a lot of the post-acute providers are overly aggressive beyond the CDC recommendation. And it's causing a lot of delays with transitions of care as well as over utilization of testing. So where is CMS have a stance or are going to provide support in this manner, to provide some calmness and standardization across the care continuum in this regard?
    a. We can work with CDC - CMS follows the CDC guidelines, and I think you have spoken to what those are. And, however, I will say that they are and do exceed, they can exceed the requirements, and they often do. So as long as they're not below what our standards that, they can exceed. And some I know are doing out of an abundance of caution as far as what's being required to play, for example, residents to be able to return to a nursing home or to be admitted to home health. But I would encourage that, those that are listening, to look at those guidelines, particularly in low incident community. There are studies that are coming out that really look at the usefulness of the data that you're going to find. Like I just said, when you get no testing, it impacts your positivity rate and that. So it might not be providing the data that you're trying to get. Yes, but we don't really restrict states from imposing a more rigorous guideline.
4. My question is for rural health clinics attached also to a hospital. So if I'm a provider in a rural health clinic and I do a COVID-19 testing, and it goes to the hospital, who then is responsible for the reporting and the documentation of that test, as far as the requirements for CMS? Is it the hospital or is it me as a rural health clinic provider, and then send it to the local health department or to the appropriate body that's collecting the information? That seems to be a gray area, some people do it one way, some people do another.
    a. As it stands now, laboratories are responsible for reporting the test results. But we understand that the laboratories may not have all the information so they may reach out to the providers in order to get that information in order to report.
5. My question is, under the CHART model, is the funding that's provided the $5 million, up to $5 million, is that in addition to the capitation that the hospitals would receive? Is that fully for planning and development of the transformation plan?
    a. That is correct. Yes, they are entirely separate. The cooperative agreement funding will go directly to the lead organization that has received the award, and they'll sign terms and conditions for that funding. And then, the participant hospitals that sign an agreement with CMS will be the ones that received the capitated payment arrangement.