Centers for Medicare & Medicaid Services
Open Door Forum: Rural Health
Moderator: Jill Darling
September 15, 2020
2:00 p.m. ET

Coordinator: Welcome and thank you for standing by. All lines are in a listen-only mode until the question and answer sessions. At that time, please press star one and record your name as prompted. Today's conference is being recorded. If you have any objections, you may disconnect at this time.

I would now like to turn today's meeting over to Jill Darling. Thank you, you may begin.

Jill Darling: Great. Thank you, (Carolyn). Good morning and good afternoon, everyone. I'm Jill Darling in the CMS Office of Communications and welcome to today's Rural Health Open Door Forum.

As always, we greatly appreciate your patience in getting folks in on the line. Sometimes we're waiting for more speakers, but we greatly appreciate your patience, as we have a really great agenda today.

So before I hand the call off to John Hammarlund, I have one brief announcement.

This Open Door Forum is open to everyone, but if you are a member of the press, you may listen in, but please refrain from asking questions during the Q&A portion of the call. If you have any inquiries, please contact CMS at press@cms.hhs.gov.

And so now, I'll hand the call off to John Hammarlund.

John Hammarlund: Thanks so much, Jill. Well, hello, everybody. We're delighted you're joining this Rural Health Open Door Forum call. This is John Hammarlund from CMS, the Seattle office, and I hope your September has started off well. We have a very robust agenda for you today, and I know you're going to be very interested. In fact, we have quite a few people who have called in. So we're delighted to have Sally Caine Leathers who is from our CMMI Office, the Innovation Center, to talk about CHART which I know is of great interest to you.

We also are really delighted to have Jean Moody-Williams from CMS' CCSQ Office to talk about the most recent interim final comment rule that we published on the COVID-19 flexibilities. I know that's also of interest to you. And we're going to start off with a brief announcement from Darci Graves, from our Office of Minority Health, about a really neat rural crosswalk that she and some colleagues have developed that I think there's going to be useful to you.

We also have on the call today many of the regional rural health coordinators, and they're often times your first point of contact when you have an issue. We hope that there are - I know that they are there to serve you. We hope that you find them to be very useful to you in helping to sort of, sometimes mind your way through the bureaucracy of CMS. So we're delighted to have the 10 regional rural coordinators on today's call.

So with that, I'm going to hand it back to Jill so we can launch right into the agenda. Thanks again for joining us today.

Jill Darling: Great. Thanks, John. Just like John said, I'll hand it off to Sally Caine Leathers who will go over the CHART model.

John Hammarlund: I think we're going to do Darci first, if we can.

Jill Darling: Oh, I'm so sorry. You're right, and we did talk about that. My apologies, Darci Graves, who will speak on the Rural Crosswalk.

Darci Graves: Yes. No, not a problem. Good morning and good afternoon, everyone. I just want to, before we get to the really meaty parts of today's agenda and I know that's probably why the majority of you called in. I did want to let you all know about a resource that we released at the end of August, give or take, and it's something that we're calling a Rural Crosswalk to CMS Flexibilities to Fight COVID-19.

It's intended to assist all providers in accessing information on key provisions CMS has issued and/or carried out during the public health emergency. We know there is a ton of information that the agency has been putting out, so we tried to create this crosswalk that allows you to look at topics such as telehealth and other virtual services, and see how those waivers and flexibilities apply across facility types. So rural health clinics, (FQHCs), critical access hospitals, more traditional hospitals as well as skilled nursing facilities.

This document brings together all of the key information that CMS has released to date, so none of the information in the Crosswalk is new. It just helps by putting everything into a single location, hopefully easing provider burden in digesting the information that we put out and with the goal of empowering all of you to make the best decisions for their organization as swiftly as possible.

So, and this Crosswalk is being updated as CMS releases new flexibilities. So it is a living document. You can find it a couple of places on our CMS

website. It's in the current emergency section where we're losing a lot of the COVID information, but as well as - it's also on our Rural Health Page, which is go.cms.gov/ruralhealth. And then, all you have to do is look under Rural Health Resources.

So it's a - hopefully a helpful resource and we, if you have feedback, we'd love to hear it. But with that, I will turn it back to Jill so we can continue on with the agenda.

Jill Darling: Thank you, Darci, and apologies again. Next, we have Sally Caine Leathers who will go over the CHART model.

Sally Caine Leathers: Thanks, Jill. I am very excited to be presenting today. I'm happy to provide an overview of CHART and what we are offering under this model. And also to give you some news, hot off the presses that for one of our tracks within this model, we've released a Notice of Funding Opportunity within the last hour. We have lots of resources that I can direct you all too as we wrap up for future information about the model.

So, providing the overview on the model, we realize at CMS that there are unique health challenges facing rural beneficiaries and providers. We know that people living in rural areas have worse health outcomes, higher rates of preventable diseases than those living in rural areas - sorry, in urban areas. I say rural a lot, that's the first word that comes out over urban these days.

We also know they have less access to high quality care due to transportation issues, healthcare workforce shortages and financial insecurity of many rural healthcare providers. They often benefit less from the technological and care delivery innovations that are more prevalent in urban areas. Acknowledging that these challenges exists, the CHART model is coming to the public to

offer a voluntary model where we are testing whether aligned financial incentives, operational and regulatory flexibilities, as well as some robust technical support that we will provide, to see if that will help rural providers transform care on a broad scale to achieve a few key goals.

CHART aims to improve the access to care in rural areas, the quality of care and health outcomes for the rural beneficiaries, financial stability for rural healthcare providers, and increase the adoption of alternative payment models or APMs among rural providers, which promote value-based care over volume-based care where we know that patient volume in rural areas often doesn't support a fee-for-service payment structure.

The value-based payment models have accelerated nationally, but rural healthcare providers have been slow to adopt these models. The technical support and administrative infrastructure necessary to participate in an APM is often a barrier. CHART offers a framework to harness the drive, creativity and the local expertise of rural communities to address these rural health disparities. Focusing on the creativity element, we know that each rural community is unique and that a one-size-fits-all solution will not work. Therefore, CHART gives communities the opportunity to determine how best to meet their local healthcare needs.

During the design phase of CHART, which has been in the works for a long time, we're so happy to finally be releasing it and bring it to the public. During those conversations about the design, we took in some input from stakeholders. And we were able to boil the input down into three buckets of feedback, where the themes were funding, flexibility and time. So we have made sure that in this model that we're bringing to the public for rural health, that we have incorporated all three of those elements, because we found them crucial.

So, on the first funding item, both tracks that we're going to offer a CHART, provide seed funding, upfront funding and payment structures to help rural communities get a jumpstart on healthcare delivery improvement or redesign efforts. The second one on flexibility, we wanted to create a model that offered options for our participants. So we're going to have participation options with two separate tracks, with design elements that allow participants to use benefit enhancements and waivers to customize the value-based redesign efforts to truly fit their community's needs.

And third, on time, both application periods for each track - we realized that there are pressing priorities right now with the public health emergency for COVID-19, and we were going to be factoring that into the duration for how long the application stay open. And then also for the runtime of the actual tracks within CHART, we want to make sure that there's plenty of time to prepare for the implementation process, and then the run time so that we can actually see if the needle is going to be moving on any of the health outcomes that we'll be tracking under this model.

So that's an overview of some of the themes that we've made sure to incorporate into the design. And now, I'll walk through an overview of each track that we're offering.

The first one is called the Community Transformation Track. This track will support lead organizations in rural communities by providing upfront funding of up to $5 million to collaborate with their state Medicaid agency, community stakeholders, as well as participating hospitals to implement a healthcare delivery redesign strategy to achieve better health outcomes for their community. In this track, we're going to award up to 15 lead organizations that will represent the rural community. The State Medicaid agencies are eligible to serve as a lead organization.

Each lead organization will receive up to $5 million, and that's going to be in the form of a cooperative agreement funding. And, the Notice of Funding Opportunity that I mentioned at the front end, that was released today and you can find that on grants.gov, under the CHART model name, Community Health Access and Rural Transformation Model.

So, for the lead organizations that apply and are awarded, they will be responsible for forming an advisory council, which the state Medicaid agency must be represented, if it's not the lead organization. And they'll also be responsible for designing a transformation plan which is what I referenced earlier as the healthcare delivery redesign strategy, we're calling that the transformation plan for this track.

Our vision for this transformation plan is for it to be a truly collaborative effort across the entire community with that lead organization being the representative. They'll be pulling together that advisory council, which will have a diverse representation across the community, and it will bring in payers, hospitals, beneficiaries and unpaid caregivers. There's a diverse set of members that will be present at the table.

And for that care transformation plan that everyone put their heads together to design, they will ask what are the needs on the ground for your community, what are some improvements we can make, and for that to be not just at a hospital but at the community level - so that it incorporates not just hospitals within the community, but also non-hospital providers. If you check out the In the Notice of Funding Opportunity, NoFO, we lay out criteria for lead organizations, as well as for the advisory council, and that will give you a better idea of who will qualify to serve in those roles and expectations.

Another big element under this track is that participating hospitals will receive a stable predictable-capitated payment in place of their fee-for-service. The goal here is to have increased operational flexibilities and allow for that stable-capitated payment to provide an opportunity to reduce avoidable utilization. We're also going to be offering increased operational flexibility through the specific waivers and benefit enhancements that will be available underneath this track.

The last detail for this track I'd like to highlight is this track will be multipayer-oriented. We, of course, will be having Medicare included in that capitated payment. We're also going to be requiring Medicaid to be involved and come on board with this capitated payment over the course of the model. We are going to encourage that communities have commercial payer involvement as well so we have a stronger business case for the hospitals to have a larger amount of their revenue based on a capitated payment, rather than piecemeal with some capitated some fee-for-service.

So as I mentioned, the Notice the Funding Opportunity release today, the timeline for this track is, the clock has started now for the application period. It will be closing not until early next year, in February. We wanted to make sure that applicants have at least 100 business days to review the application, start having conversations about who they might want to partner with across their community, and think about what might be the best approach on the ground for their needs, to have those conversations during this application phase, and pull the details together before needing to submit the application.

This track, the way the timeline runs, we'll be closing the application in February. We aim to announce the selected awardees in the spring of 2021, and then we'll kick off this track with a yearlong pre-implementation period that will start approximately July 2021 and run for a full year. And that pre-

implementation year is to ensure that we have plenty of time for the selected communities to get all the players that need to be involved, get them at the table and come up with a comprehensive plan that they would like to pursue. After the pre-implementation year concludes, the model will - the track within this model - will run for six full performance years after that.

And now I'll provide, just a quick overview of the ACO transformation track. This track is the second track within CHART and it's the second and final. This track builds upon the successes that the ACO investment model or AIM had by encouraging ACOs to participate in rural areas and take on greater financial accountability than is required under the new participation options that was established by the Pathways to Successful for the Medicare Shared Savings Program.

Under this ACO transformation track, we're going to have CHART ACOs receive advanced shared savings payments to help the rural entities engage in value-based payment reform and improve care coordination, quality of care for beneficiaries in their rural community, as well as making investments necessary to reduce the total cost of care. So you can almost think of this track and CHART as building on AIM for sure. And then also, if you participate in this track as a CHART ACO, you will also be concurrently participating in the Shared Savings Program. So you'll sign, if selected, you'll sign a participation agreement with CHART as well as the Shared Savings Program.

We'll be selecting up to 20 CHART ACOs to receive those advanced shared savings payments to join and participate in the Shared Savings Program. The payment amount that we're going to offer under this track will depend on two things, the level of risk that the ACO signs up for under the Shared Savings

Program. And the second item is the number of assigned rural beneficiaries underneath the ACO network.

For this track, we're going to be releasing a Request for Application. And we plan on releasing that in the spring of 2021, in parallel with the Shared Savings Program application cycle. Our participation selections will occur in the fall of 2021, with the first performance year starting January of 2022. So that's a high level overview of the two tracks within CHART. As far as next steps and some resources for you all to think about, like I said, the NOFO for the community transformation track is out today. You're welcome to start reading through that and any questions you may have you're welcome to send to our help desk, which is CHARTModel@cms.hhs.gov. If you're looking on our website, on the CMMI Innovation Center website, there's a specific web page devoted to the CHART model with resources there. We have a fact sheet as well as the overview webinar that we gave last month. There are slides as well as the recording of that webinar so you can listen to it On-Demand. And we will be posting a frequently asked question. So over this application period for the community transformation track, we anticipate getting a number of questions, and any that can't be directly addressed with content in NOFO, we'll be posting through this mechanism of the frequently asked questions and then posting them to that CHART website.

So I recommend you checking that website often to see the latest information and guidance around that application. And then for the ACO track, be on the lookout for a Request for Application in the spring. Some potential thoughts to leave you with: if you are interested in the community transformation track, I encourage you to start thinking about who you'd like to partner with. Those partners can range from payers, providers, different community stakeholder groups. I do recommend viewing either the overview webinar slides or the NOFO that was released. We have a listing of all the memberships for this

advisory council, and so you can see who all needs to be a player within the community to participate in this track. You can start thinking about who that could be and beginning some preliminary conversations there.
Thank you for this opportunity to present an overview and look forward to your questions.

Jill Darling: Great. Thank you so much, Sally. And last, we have Jean Moody-Williams, who will talk about the public health emergency rule. That's COVID-19 related flexibilities.

Jean Moody-Williams: Great. Thanks so much and hello, everyone. Thank you for calling in today. And thank you so much for all that you do on a routine basis. I just want to acknowledge that but especially for the challenges that you were working through during this COVID-19 pandemic. Don't take your time for granted. So I really do appreciate you joining today.

I want to - I also have with me on the call when we get to the Q&A section, several subject matter experts from our lab, CLIA lab reporting division, Division of Nursing Home and Clinical Standards Group, so that we can address any questions you might have. But just wanted to give you a few highlights of the recently released third interim final rule as we really, a part of our efforts to combat COVID-19.

And overall, I'm sure by now you've had the opportunity to review the rule. You will note that there was a primary theme to this regulation, with a really a goal toward increasing the reporting of test results and other COVID-19 data elements from laboratories, nursing homes, hospitals, clinical care sites and other sites, and to increase the testing of nursing home residents and staff.
So just briefly on the testing - the nursing home, while we have provided testing guidelines in the past, we're now mandating regular testing of both

residents and staff for COVID-19 in the nursing home as a requirement for participation in the Medicare and Medicaid Program. So, the rules specifically required testing-based on parameters identified by the secretary. And the following day after the rule, we did provide additional guidance and information on some of the specificity of reporting. And the guidelines were developed in collaboration with our partners at the Center for Disease Control and Prevention, the FDA, and the Office of the Assistant Secretary for Health. So specifically, the guidelines I think very, importantly, prioritize in nursing homes. Those facilities, which family - which residents or staff have signs and symptoms, and that probably goes without explanation. But then also, where there considered to be an outbreak in a nursing home, and that really is defined as one new case and previously COVID-free facility that would require testing by the staff, for the staff and for the residents as well. And that would - you would test previously tested negative until no new cases are identified.

Now, in addition to those areas, which probably most facilities were already doing, we did get that line for routine testing. And this was really based on what's going on in the community around, and looking at the county positivity rate for the prior week as a trigger. And we did publish a table that looked at low, medium and high rates with low being defined as less than 5 percent, you would test once a month. Medium being 5 to 10 percent once a week, and then if you fell into the high category which is greater than 10 percent of the county positivity rate, then you would test twice a week.

And I am aware that certain state and local officials may also direct facilities to monitor factors such as risk of COVID transmission and looking at emergency department rates or what's happening in the clinics, or what's happening again in the community around.

Now, I know that there's been a lot of discussion because there are some counties with small populations or numbers of tests that have high positivity rates. However, high positivity rate is the result of a low amount of testing rather than actual positivity in the community. And this results in facilities having to conduct their test twice a week, which may not be called for, and this is especially impactful for rural communities.

So, we are in the process of making some adjustments for small rural providers, while still maintaining protection for residents, which of course is what this is all about. And we do have enforcement remedies for facilities that are not in compliance with this. However, we do understand the challenges exist in performing some of these tests, getting the testing equipment, having appropriate turnaround time. And so we are using enforcement discretion in this area where these types of situations are identified.

Now, there's also a provision that requires clear laboratory reporting. And this really came out of the CARES Act, which required all laboratory performing testing related to SARS-CoV-2 to report data daily for individuals tested, and if you're reporting to the appropriate state and local public health department within 24 hours. But what this regulation did is to also attach to it, the requirement as well as the enforcement of remedies for this.

And the thing to point out is that, this applies to lab or other entities such as nursing homes, pharmacy clinics, other clinicians. If you are performing the testing, even though it could be through a point of care test, after a certificate of waiver, this reporting is still required. And CMS will use graduated civil money penalty approach with $1,000 for the first violation and $500 in increments for subsequent violations.

Again, as I've mentioned, we will be using employment discretion as we are implementing through - for any barriers to reporting, which are adequately documented. However, we really are looking for this testing to be done and, again, and to protect the community. And one of the things I know, some of his question about asymptomatic testing and the FDA did put out some guidance in that area related to congregate care settings and settings where people might be exposed. Even though they're not shown symptoms, I would refer you to that.

We also included in this ISP, a hospital reporting regulation, which held hospitals, including critical access hospitals accountable, that are working to reduce the spread of COVID-19 that requiring that these facilities report their COVID-19 cases, bed capacity, ventilating usage and other such elements. And these guidelines have really been in place since June, so, probably most of you, if you're in a hospital, you're already reporting this. But I just want to make you aware that this is now a requirement.

And we also revised previous policy that allowed the treated COVID-19 testing for Medicare beneficiaries without physician oversight during the public health emergency and what this interim final rule did, was revised the policy and clarifies that after an initial test, Medicare will cover further COVID-19 tests with a treating physician as a healthcare practitioner order. So first test doesn't require an order, a subsequent test, would require an order.

Aside from testing and reporting goes, the other divisions then, which I won't go in great detail, but I do hope that you did notice that we did address the quality data programs and value-based purchasing program in recognizing that we may not have sufficient data to be able to determine certain performance measures, some adjust scores, the court publicly report. And so we've made provisions for that.

And also made a few provisions as it relates to coverage decisions, for our national (coverage decisions) Some of us have (physicians) require certain number of procedures to be performed in order for them to be covered and assembled, which would be considered perhaps non-urgent procedures, and thus clinicians would not able to perform the required number. And so rather than that, prior to the public health emergency, they would go on coverage. So those are really the things that I wanted to point out to make sure and to see if you have any questions with that. So with that, I'll say thank you and turn it back to Jill.

Jill Darling: Thank you so much, Jean. And thank you to Sally and to Darci. (Carolyn), will you please open the lines for Q&A?

Coordinator: Thank you. We will now begin the question and answer session. If you'd like to ask a question or make a comment from the phones, please press star one. Make sure your phone is unmuted and record your name to introduce your question. And to withdraw that request, you may press star two.
Once again for questions or comments at this time on the phones, press star one and record your name. One moment, we'll stand by for questions or comments.

And we do have a question or comment coming from (Lorenze's) line from HRSA. Your line is open. Please go ahead with your question or comment.

(Lorenze): Hi, thank you. This one is to final from, I didn't get the name, the lead who presented on the CHART model. If you could please speak to any TA assistant that CMS is going to offer to the lead organizations on the CHART model.

Sally Caine Leathers: Hi, yes. 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.

(Lorenze): Thank you.

Coordinator: Thank you. Our next question or comment comes from Jeremy Levin from RWHC. Your line is open.

Jeremy Levin: Thank you. This question is for Sally. So back in the webinar, 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? Hello?

Sally Caine Leathers: Sorry. Yes, I was on mute. I want to make sure I have the question correct. The - you're wanting to know if the participant hospital that owns an RHC, that that hospital itself could participate.

Jeremy Levin: That the hospital could participate in any services that might be included under the capitated payment rate to the services provided through their RHC and other owned entities that specific were listed in the webinar, as not being able to participate.

Sally Caine Leathers: OK. 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.

Jeremy Levin: OK, thank you. I'll look more to the NOFO.

Coordinator: Thank you. Our next question or comment comes from Tamar Swain from Ascension. Your line is open.

Tamar Swain: HI. I'm not sure. I'm assuming this question would be addressed by Jean Moody. And thank you for the presentation.

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?

Jean Moody-Williams: Thank you for the question. And I'm not sure we can provide calmness. But we can work to - I would say 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.

Tamar Swain: Thank you.

Coordinator: Thank you. Our next question or comment is from (Jenny Lin) from Providence Health and Services. Your line is open.

(Jenny Lin): Hello, thank you. I am looking for information regarding secondary billing to Medicare for specifically rural health clinics. And in light of, you know, it has been complicated by the G-2025, and how that is used for virtual visits now, and that doesn't match the primary commercial payers, you know, EOB. So, I was just wondering if someone could point me in the right direction for information regarding that.

Carol Blackford: Hi, this is Carol Blackford. And I'm not sure we have the right people on the line to answer that question, but if you could send it to me, in the Rural Health Open Door Forum email box, we can connect you with the right subject matter experts. And the email address is ruralhealthodf@cms.hhs.gov.

(Jenny Lin): OK, perfect. Thank you.

Carol Blackford: You're welcome.

Coordinator: Thank you. Our next question or comment is from Roger Wells from Lexington Regional Health Center. Your line is open.

Roger Wells: Thank you. I have a question for Jean Moody-Williams. Jean, 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. Can you help me out?

Jean Moody-Williams: Well, first, hello, Roger. Good to hear from you. Let me see if (Regina) from (IQVIA) Can you help with that question?

(Regina): Hi, sure. 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. Does that answer your question?

Roger Wells: That makes 100 percent sense. Thank you so much. I appreciate your help.

(Regina): You're quite welcome.

Coordinator: Thank you. And again, as a reminder for questions or comments from the phones, it is star one. Make sure your phone is unmuted and record your name to introduce your question. And you may press star two to withdraw that request. Again, for further questions or comments at this time from the phones, please press star one and record your name.

We are standing by for any further questions or comments. Again, that is star one and record your name, and star two to withdraw that request. One moment, please.

And again, as a reminder for further questions or comments from the phones, please press star one at this time and record your name, and star two to withdraw that request. One moment, we'll standby for questions or comment. One moment we have one question. And we do have a question or comment from Michele Lawrence, and please state your organization.

Michelle Lawrence: University of Rochester Medical Center. 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 solely for planning and development of the transformation plan?

Sally Caine Leathers: 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.

Michele Lawrence: Great, thank you very much.

Coordinator: Thank you. And again, as a reminder, if you have any further questions or comments at this time, please press star one. Make sure your phone is unmuted and record your name. And you may press star two to withdraw that request. And we'll stand by for any further questions or comments, one moment.

I'm currently showing no further questions or comments at this time. We'll turn it over back to the speakers for closing remarks.

Jill Darling: Thank you, (Carolyn) Oh, go ahead, Carol.

Carol Blackford: Jumping the gun a little bit. This is Carol Blackford. And I want to say on behalf of John Hammarlund and myself, thank you for everyone who participated on the call today, and we hope you found this information to be informative and helpful.

As always, these calls are designed for you, so please send us your agenda items. And any questions that you didn't have the ability to ask on today's call, please send those to us at our Rural Health Open Door Forum email box, which is ruralhealthodf@cms.hhs.gov. We do look forward to hearing from you and appreciate your suggestions on how we can continue to make these calls informative and helpful for you.

So with that, I think we can close out today's call. Thank you again and I look forward to connecting again at our next Rural Health Open Door Forum Call. Thank you. Back to you, Jill.

Jill Darling: Thank you, Carol. I was going to say it about the Rural Health Open Door Forum emails but Carol gave it to you all. So we will talk to you at the next Open Door Forum. Thank you and have a wonderful day.

Coordinator: Thank you. That concludes today's conference call. Thank you for your participation. You may disconnect at this time.

End