

CENTERS FOR MEDICARE & MEDICAID SERVICES

Moderator: Mandy Cohen
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Operator: Good afternoon my name is (Adrian) and I will be your conference facilitator today. At this time I would like to welcome everyone to the Centers for Medicare and Medicaid Services Stakeholder Call for Bundled Payment Initiatives Open Door forum.

All lines have been placed on mute to prevent any background noise. After the speaker's remarks there will be a question and answer session. If you would like to ask a question during this time, simply press star then the number one on your telephone keypad. If you would like to withdraw your question press the pound key.

Dr. Mandy Cohen from CMS Innovation Center, you may begin your conference.

Mandy Cohen: Great, thank you so much and welcome to everyone, this is Mandy Cohen from the CMS Innovation Center.

I just want to thank everyone for taking the time. We've had quite an exciting afternoon here and it's not just because we're talking about this exciting new initiative, the bundled payment initiative but as many of you know on the East Coast here we just had an earthquake and we hope that you are safe and those of you and your family and your friends are safe as well.

So we are regrouping here over at CMS and are excited to talk to you about our new initiative from the Innovation Center. I do want to mention that this

is a stakeholder call only, not for press. If you are a member of the press and do have a question please contact our press shop here at CMS.

And again, so this is off the record and for stakeholders only. And for those of you who might not be able to stay for the whole call but would like to potentially hear a recording, one will be available after this call and about a couple of hours if you call 855-859-2056. And I'll give that number again later in the call.

So with that I'd like to introduce the leadership here from the Innovation Center this year to talk about the bundle payment initiative.

I'm joined by the Innovation Center Director Dr. Richard Gilfillan, the Senior Advisor Dr. Nancy Nielsen and Valinda Rutledge who is the director of the Patient Care Models Group.

And with that I'll turn it over to Dr. Gilfillan to talk to us about the bundled payment initiative.

Richard Gilfillan: Thanks very much, Mandy. And thanks to everyone out there for being on the call, for your interest in the activities within CMS and health care reform in general, and for taking the time to talk with a little bit today about this exciting initiative.

And I know as well, many of you are folks who are actively working on initiatives, new ways to improve care and meet the three-part aim goal of improving health care and reducing cost through improvements. So thanks for being with us today.

We have an exciting announcement we think today and we think this marks a significant step forward towards fulfilling the promise of health care reform.

We think that this initiative we are launching today in conjunction with the many other projects that are already going on out there in the health care system, some led by hospitals, some by physicians, some by insurers, some by community organizations coming together, all of whom are focused on improving health care for their communities, as well as the efforts that have

already been undertaken by CMS, HHS, and other sectors of the administration are really coming together now at a time to make a difference in our ability to deliver a high quality and financially sustainable health care system which has never been more needed than it is at this time in our country's history.

Today I'm proud to announce this next set of opportunities in the form of our bundled payments for care improvement initiative. In this initiative we will be asking providers and other health care system participants to submit applications to participate in one or more categories of episode-based payments.

Our goal is to partner with providers and others out there already who are pursuing this new kind of approach to improving care through bundled payment approaches and we're looking for providers who are interested in programs that affect broad categories of conditions, improve the quality for a large number of Medicare beneficiaries and are able to offer significant savings to the Medicare program.

Now I should say that this initiative is a result of the many conversations we have had with stakeholders, providers, hospital leaders, physician leaders, nursing industry leaders, and who have given us many ideas about how we should be thinking about delivery system improvements and have given us many written submissions for our gate portal and case studies that we've seen from around the country.

We've held dozens of listening sessions, attended many national and local health conferences, visited hospitals and health systems across the country looking for communities and individuals who are leading the way towards better care, the best health homes, the best cancer care, the best cardiac care and doing it in ways where people are healthier, yet we produce and deliver care at costs that were lower than they were before.

And we know that's possible, we know it's possible to innovate our way to better health and better care and lower costs because we have seen you all in

communities doing that around the country and we've experienced it as we've gone across the country.

One of the ideas as we've done this and it has kept coming up over and over around the country was the idea that we should pay for health care the way a patient experiences health care.

When a patient is admitted to the hospital for hip surgery they're not thinking about individual pieces of service that they receive either before, during or after the time they're in the hospital. They're thinking about regaining mobility and improving the quality of their life and therefore they are most interested in making sure that the care that they receive is done well. It's done right the first time and that they coordinate a seamless care experience that's based around their needs as a patient.

And yet we don't pay for health care in this country that way. We don't pay for episodes, rather we tend to pay for pieces of care, pieces of service and not, we break up the patient's experience and delivering it and then we break it up when we come to paying for it.

The result is oftentimes providers, who are providing care to these folks, are not given the incentive and the opportunity to work together to improve the care experience and to improve the outcomes for these patients.

Today we are following the lead of hospitals and physicians around the country who are already (inaudible) in the way they are delivering care and redesigning care and finding new ways to be reimbursed for care.

They went to businesses and other health care purchasers and said why don't you pay us for hip surgery and other services and include everything that a patient would need in their episode of care and then hold us accountable for the quality of that care. So we have the incentive and the ability to provide the highest quality of care and coordinate care across the patient's episode.

I've heard people say in communities we're working together, we're already doing this, we're working with other payers, we're working with hospitals and

doctors and we're working with, in some cases, Medicaid. Where is CMS?
Where is Medicare?

Today we are saying that we are there with you to these progressive groups and communities and that we want to work with you as you redesign care for your patients and your community. And we have, now, tried to set up an arrangement under which we can align payment for Medicare with these other initiatives.

Now this builds on work that we've done previously in the acute care episode where innovative providers in the Southwest have done a great job of improving care while reducing cost. This program will lay out some significant guidelines for how we'd like to pursue this initiative and the kinds of proposals we would like to get from you all.

But it is a flexible, broad based, broad (funnel) approach, we call it, where we're asking you to tell us what you're doing already or what you would like to do. And we will, from the proposals made to us select what we think are the most promising, those that will improve the quality of the care the most and that will ultimately provide significant savings to the Medicare program.

We'll work with these most promising proposals. We'll try and implement them in multiple places around the country and ultimately find our way to making this the way that we pay for care in the future.

To talk more about this initiative I would like to introduce Valinda Rutledge, who was a former CEO of a well respected health care system in North Carolina and has developed programs like this and has seen for herself how improving care to bundled payments can improve patient experiences and move our system towards better health, better care and lower cost to improvement.

Valinda?

Valinda Rutledge: Thank you, Ric.

First of all I'd like to thank all of you that have met with us over the last six months in terms of your ideas. We've taken all of your ideas and the passion that you have in terms of working with us and partnering with us in transforming health care.

And as Ric has said we have developed this program using those ideas that you have had in terms of developing as much flexibility as we can in terms of meeting where you want to go in terms of working with your physicians and redesigning care.

So I'm going to take us through the four different models and then we'll open it up for questions. First of all, model one is focused on the acute care in-patient hospital stay. The episode payment will include all part A services in the hospital. The applicant will propose a discount amount based upon the payment rates as under (IPPF). The hospital then will be permitted to share any gains with physicians and other providers arising from better coordination of care.

This model one has been built upon the gain sharing demonstration project that has been done in the past at CMS.

Model two then takes us beyond the hospital and model two is an episode of care that will consist of an in-patient stay followed by post-acute care for select (DRGs). The episode could be as short as 30 days or even longer than 90 days. So the applicant will propose what selected (DRGs) they want to have in it, the amount of discount that they are willing to give CMS and the episode length on at least 30 and could be longer than 90.

It will include both part A and B services and that is a different model. One is different than model two. Model two is both part A and B. Model one is just part A.

All the claims in Model two will be processed under a fee-for-service and that a retrospective reconciliation will be done. If the aggregate fee-for-service payments are less than agreed upon price than a difference will be paid by CMS and that difference can be shared among the participants. So again model two allows gain sharing with your provider.

Model three then is the episode of care will consists upon just the post-acute care. And this post-acute care needs to be followed by acute care stay. The episode anchors the beginning of this episode and will begin at the initiation of the post-acute services which have to be done within 30 days of an in-patient stay.

This episode could be as short as 30 or as long as the applicant proposes. So again the applicant will propose what selected (DRGs), the discount amount and the length of the episode.

Model three will also include part A and B services also. Again all the claims will be processed under a fee-for-service and then our retrospective reconciliation will be done.

Now model four will be our only prospective. Model four will be an episode and will be the acute in-patient stay. CMS would make a single prospective bundled payment to the hospital. It will include A and B.

The physicians and other practitioners will submit a no-pay claim to Medicare and everyone will be paid out of the bundled payment amount that is sent to the hospital. The applicants will be able to propose which (MSD or Gs) and the discount. And again, any savings that can be shared among the participants can be developed. This is built upon the past (ACE) demonstration project that is continuing.

So as I said model one is just the in-patient stay. Model two is the in-patient plus post acute. Model three is just post acute and then model four is the prospective in-patient.

Now all these models will require extensive and comprehensive quality improvement measures and we need to have that to make sure that we protect the beneficiaries. We will also monitor a 30-day post episode to ensure that there is no increase in aggregate expenditures and we need to see from each of the applicants plans to notify the beneficiaries of their participation in this project and ensure that the beneficiaries will have choice.

We also have to have the applicants submit detailed gain sharing proposals that will discuss the design quality insurance and payment methodology of their gain sharing agreements between themselves and different providers.

There are two ways in which all of you can partner with us. You can partner with us through as individuals or you can partner with us as conveners and what conveners are is that they would bring large numbers of providers with them.

As conveners you can be awardees which mean that you will take the risk or you can be a facilitator which means that there will be no risk. Each of you can apply for one of these models or several of these models.

So for instance if a hospital decided that they wanted to apply for model one and model two, what we would do is we would take whatever (DRGs) that they are putting into model 2 out of the model 1 payment. And so they would be doing the two care episode in model 1 redesigning that care, and then in model 2, they would take a select number of DRGs and redesign that care along the continuum from at least 30 days as long as they would like.

The letters of intent from model 1 is September 22nd and model 2 through 4 will be November the 4th for letters of intent. We expect model 1 to be up and running January of 2012; model 2 through 4, we do expect that it probably will not be implemented until close to the (inaudible) because we are – what we have committed to is to be able to give you data for models 2 to 4 to be able to put your proposals in for the amount of discounts.

So, with that, we will open it up to questions.

Mandy Cohen: Before we do that, this is Mandy Cohen again. And I just wanted to say we presented a lot of information just now on the call and wanted to direct you to our website so that you can read more about this in detail. Our website is [www.innovations –with an "S" – innovations.cms.gov](http://www.innovations-with-an-S-innovations.cms.gov).

And right from our homepage you'll see a link there to the Bundled Payment Initiative. There you will detail fact sheet, frequently asked questions, as well

as the request for applications, the letters of intent, and the applications themselves for all four models.

And again, we're going to go into a question and answer period right now. But if you do have questions that come up after this call or throughout this process when you're looking to submit a letter of intent or the application itself, you can send an email to bundledpayments@cms.hss.gov. Again, that's bundledpayments@cms.hss.gov. And with that, we'll open to questions.

Operator: At this time, I would like to remind everyone. In order to ask a question, press star then the number one on your telephone keypad.

The first question comes from the line of (Caroline Steinberg) from American Hospitals. Your line is open.

(Caroline Steinberg): Good afternoon. Thank you very much for the call today. Our understanding in CMS' design of the ACE demonstration was that a component of the demonstration feature recognizing sites that accept bundled payment as a center of excellence. We're wondering if that component will also be use in this bundled payment effort.

Male: There – there was a component of these demonstration programs that provided members or patients, I should say, beneficiaries, the opportunities to share in the savings. We have not included that provision in this proposal at this time.

(Caroline Steinberg): Thank you.

Mandy Cohen: Thanks, Caroline. Next question?

Operator: The next question comes from (Jane Elbocker). Your line is open.

(Karen Fisher): Hi. This is (Karen Fisher) with the (WMC) and I (will echo) the previous callers. Thank you for all the information. We haven't had time to go through it all, but we're curious about the payments that are part of the bundles. When you mentioned A and B services, are you including (IME and dish) payment? And also, what about passed through payment such as direct (GME) (inaudible) acquisition costs?

Female: No. (GME and dish) payments are part of it, OK, and no capital payments also. It's just your base payment.

(Karen Fisher): All right. So that sounds like from that answer that it would not include then the (GME) or (inaudible) acquisition either, right?

Female: Right. Correct.

(Karen Fisher): Terrific. Thank you.

Mandy Cohen: Thank you. The next question?

Operator: The next question comes from Joanna Kim from American Hospital. Your line is open.

Joanna Kim: Hi. I was curious to ask if you could elaborate on how you're going to monitor the program to ensure that beneficiaries have choice. Does that mean that, for example, the inpatient hospital will not be able direct the beneficiary to their select post-to-queue providers? Or is there a different provision you had mind there?

Richard Gilfillan: Yes. No. This – remember, this is – this program is occurring in the Medicare fee-for-service program and for the Medicare fee-for-service population. Nothing about this program is intended to change the ability of members to ultimately decide where they can go, much as we had had conversations around ACOs.

The idea here is that people still have the opportunity to choose where we go. We expect the opportunity for providers is to demonstrate that the services that they provide are the services that are most desirable and that folks will choose to use. And I believe is in the – majority of the cases, people will go to what is the most, the most straightforward arrangement where care is being arranged and coordinated. But this is not – members will continue to have the opportunity to go where they go, and those services that go to other providers will be considered in the ultimate reconciliation of expenses.

Joanna Kim: All right, thank you.

Richard Gilfillan: You're welcome.

Mandy Cohen: Thanks, Joanna. The next question?

Operator: Comes from the line of Robert Minkin from Camden Group. Your line is open.

Robert Minkin: Thank you for the call today. It's been wonderful to hear where CMS is going with this. As with the current ACE demonstration, demonstrations, are you still planning to include beneficiaries as to receive a portion of the savings?

Female: No. At this point, we are not in this initiative.

Robert Minkin: Thank you.

Mandy Cohen: Thanks, Rob. The next question?

Operator: Comes from (Chris Bailey) from VA Hospital. Your line is open.

(Chris Bailey): Good afternoon. I'm calling from Richmond, Virginia, a very exciting place this afternoon.

Mandy Cohen: You're OK.

Richard Gilfillan: Everything OK down there?

(Chris Bailey): Oh, we are fine. Thank you all. My question related to the share savings opportunities assuming the retrospect of analysis demonstrate there is lower expenses related to the benchmark that 50-50 split. Is that part of the proposal negotiation? What's the thinking there?

Female: Yes. First of all, it's not a shared savings. It's a discount. And so, right at the first, the applicants would propose what is the discount that they will be giving CMS. So whatever is saved from that payment they get to keep. So there is no, there is not a shared saving.

(Chris Bailey): Thank you.

Mandy Cohen: Thanks, (Chris). The next question.

Richard Gilfillan: I should add just to clarify, perhaps around that. We are looking for proposals to come in with bids, if you will, discounts offered for these different programs. We'll evaluate the proposals. This will be a competitive process. We will evaluate proposals based on the arrangement proposed to measure quality, demonstration of the approach they're taking to care redesign which is the central component of this effort, redesigning care to improve outcomes, so we will be evaluating their – the proposals to redesign care. We'll be looking at the quality matrix proposed. We'll be looking at beneficiary satisfaction and functional outcome metrics that we'd like to have proposed. And looking at the number of (DRGs), the number of patients covered, the amount of services covered, etcetera, as well as the discount being offered.

So, it is going to be a competitive process. It's multi-dimensional in terms of evaluation. First and foremost, we're looking for programs that are seriously going to redesign care and thereby improve outcomes.

Mandy Cohen: OK, thank you. We'll take the next question.

Operator: From (Allen Nichols) from (Acute) Care, your line is open.

(Allen Nichols): Thank you very much. Hopefully, everybody is OK in the D.C. area. I have a two-part question. One is, any of these programs for bundled care, if pharmacists are involved in the team and they're currently, pharmacists are currently not listed as providers in the (inaudible) security act. Will they be able to participate with an existing provider, existing health system or (physician) group? That's the first question.

And then the second thing is do you have any idea (inaudible) topic when the bundled care issue is going to be brought forward toward (inaudible)?

Richard Gilfillan: I'm sorry. Can you repeat the very end there? When the bundled payments program...? Will what...? You got cut off.

(Allen Nichols): Will – will be, I mean, when you're (inaudible) proposals for bundled care in the medical home model.

Richard Gilfillan: You know, this will be described in the, in the or it's described in the RFA that's available online. This is the first of several approaches that we're taking to bundled payments. This one is addressing primary acute care and the follow on to acute care. We will be and we are working on alternative approaches to chronic disease care and we are also looking at, ultimately, developing the capacity to develop to pay many of these different bundles more prospectively than we are today. It's less involved the building of the grouping and episode based payments system here at CMS.

We have other initiatives addressing medical homes today. We have several initiatives specifically for (FQAC), for many age different states, from health homes, from Medicaid. And then we have those programs have shared or several of them have shared savings components associated with them. So, I'm not sure exactly what you were referring to in terms of bundled payment within medical homes, but we have a great deal of activity there.

In terms of pharmacists, we expect that they will be as always a critical part of the team caring for patients along the way. And while Part D specifically is not included in these programs. Obviously, they're going to be important roles and promises to play within the hospital and within the post-acute setting.

(Allen Nichols): Well, I wasn't referring to Part D at all. I'm talking about B. So, in a health system, right now we have an arrangement with the health system that we're moving forward on and we have visited the offices right now whether or not maybe the pharmacists will be allowed to participate in the bundled care aspect and that CMS would recognize that. And (inaudible) those bundled payments to be include the pharmacist's service.

Richard Gilfillan: Yes. You know, I'm going to defer on this because it's getting to sound a little bit technical. Well, I'm not sure exactly what's going. But what I'm saying is we expect the pharmacists to be critical members of the team redesigning care for sure. So, I'm not sure I can answer you in as quite a technical way as you're looking for an answer to, but they're certainly are expected to be part of the team coming to us as part of the proposals.

Mandy Cohen: Thanks, (Allen). We'll take the next question.

Operator: The next question comes from the line of (Robert Lowes), from Medscape.
Your line is open.

(Robert Lowes): Yes, thank you for taking my call. I just wanted to clarify something on the appendix and the fact sheet where you talked about the different models and you have a category or a row called "eligible awardees" and it includes physician group practices, acute care hospitals and so on.

Now, the way I understand it is, in model four, you're going to be making a prospective payment to a hospital. But now, I think you said – or somebody said earlier that the awardees are the ones who are going to be taking the risk.

So how can a physician group be taking the risk when the payments are going to a hospital?

Male: To my knowledge from model four is that that's going to be a hospital arrangement. Typically, the payments will be going to the hospital.

(Robert Lowes): But then, how can the physician group – how can a physician group practice be classified as an awardee and taking risk?

Male: You know, I'm going to have to go back and look at the application. As I said, our expectation is that the dollars for model four, the payment for model four is expected to flow to the facility.

(Robert Lowes): Right. So the fact sheet says that, in model four, the eligible awardees include physician group practices. So is that a mistake?

Male: We – we – you know, it could be the hospitals. Hospitals could be coming in with their physicians as joint entities. But it's not our expectation that we're going to make a follow-up payment directly to a physician group.

(Robert Lowes): OK.

Male: Sorry. We'll – and we'll look at that fact sheet and make sure that its clear.

(Robert Lowes): OK, thank you.

Mandy Cohen: Next question?

Operator: Next – I'm sorry. The next question comes from the line of John McDonald, from Indiana Association. Your line is open.

(Jean McDonald): This is Jean McDonald, not John. I have had multiple calls from members today being very, very concerned because they have to – home health agencies and hospices have trouble now getting referrals from hospitals because hospitals have their own home health agencies. And they're extremely concerned that this is going to cut them out of the process altogether.

I'd like a comment, please.

Male: Yes, I think our comment would be, again, we – we have included post-acute providers that have any opportunity to participate. And we think that members will – we know members will continue to have the opportunity to make the choices that they want to make in terms of where they're going to provide services.

So we don't necessarily see this as creating more control on anyone's part. We think that ultimately, it makes sense for folks to work together in a community to provide the best care that people can. And we're not prejudging what exactly that arrangement should be.

Mandy Cohen: This is (inaudible). As a physician, let me – let me piggyback on that. Because as everybody on the call knows, many physicians have a healthy skepticism of hospitals and are concerned that in – when hospitals receive funding that they might – they might be left with what's left after, the fixed cost of the hospital aren't taken cared of.

The exciting thing to me about this initiative is, number one, the flexibility, and number two, the ability of physicians to step up as leaders and partners on an equal playing field. No hospital can do this without the people who are

delivering the front line care, whether that is in the OR, in the emergency room, in – in a post-acute setting. So it can't be done by a hospital alone.

And this is a really exciting opportunity to break down the barriers between Part A and Part B, which have kept people from partnering on an equal footing. So not only is it flexible, it clearly asks for those who are delivering the care to step up and say, you know, this is the way we think it ought to be done. We're here to help. We're here to improve care. Because the goal of everybody, and we all know that, the goal is to take the best care of patients.

But when you have fragmented care, then there has been no incentive to try to streamline that care in a way that acknowledges everybody's important contribution.

(Jean McDonald): This is Jean again. I understand where you're coming from. But living in the practical world, it will be the hospital-based home health agencies that are the only ones allowed to contract with the hospital because the hospital is controlling the money.

So we're basically cutting out not-for-profits and proprietary out of home health payments.

Male: Yes, let – let me be clear about this. Because this arrangement and these programs do not assume new contractual relationships, OK? If we think about models two and three, we're not assuming necessarily a new contractual or different contractual relationship. We're going to continue to pay the claims at Medicare per our contractual arrangement or agreements, provider agreements, I should say, that we have with folks out there.

So models two and three are really about reconciling retrospectively on the post-acute piece and seeing what the total cost of care is. That does not imply that there is new control or new contracts that are superseding the arrangements Medicare already has.

So home health care providers that are currently – and hospice providers – that are participating with Medicare will have the same ability to provide services to patients in these programs as they have today.

(Jean McDonald): Thank you.

Male: You bet.

Mandy Cohen: Next question, please.

Operator: The next question comes from (Hillary Stalin), from NCOA. Your line is open.

(Hillary Dow): Hi, everyone. Thanks very much. (Hillary Dow), National Council on Aging, and my question is a little different. We're a national voice for older Americans, particularly vulnerable older Americans who are hopefully going to benefit greatly from this new initiative. I was wondering, the relationship of this initiative to community care transitions and other rebalancing initiatives that you've also got underway.

Male: Well, that is a great question, Hillary, and I appreciate that. And the answer is, you know, as I said in the outset, there are a series of initiatives that we are all working on together, aimed at improving care coordination, improving transitions of care, et cetera.

So we are kind of finding our way towards understanding how to best coordinate all of those initiatives. And in particular, we've talked a lot about how to bundle payments with ACOs and making sure that there's not double-counting of payments, et cetera, and we all have language to that effect ultimately in the contracts that we do.

We are moving full steam ahead on the transitions of care program and building community-based transitions of care organizations. And we will see, I think, over time, how you all in communities will figure out what the pieces are and that fit and make the most sense to give folks the best care.

So I think we're going to have to give that a little bit of time to kind of organically play out. The one principle we'd say is we want to, whenever possible, if we can, allow initiatives to overlap. But we can't allow double-

counting of savings or double-payment of savings or we don't want to create confusion out there.

So we are proceeding with the transitions of care program and we will look for better understanding the potential interactions as we kind of get proposals in and actually find communities where we're going to be doing this work.

(Hillary Dow): That's great. Well, thank you. And we likewise look forward to working with you on that aspect of, you know, making these things work all together. We have many grantees who are very interested in the community care transitions programs and also in money follows the person and related projects. It seems like there could be tremendous synergy here. So we look forward to just talking to you further about that.

Male: Great. We appreciate all the interest in the transitions – community-based transitions. And I just wanted you to know that the people doing this work, the community-based transitions work, the ACO work, the bundled payments initiative, we're all working very closely together, talking day to day. We're all part of the same large organization, many of us part of the same center here at CMS. So we're working very closely, trying to make sure that we are bringing you all greater capabilities and not increasing complexity.

Mandy Cohen: Great. Thanks, Hillary, for that question.

And operator, I think we have time for one last question.

Operator: OK, the next question comes from (Joan Taylor), from Trinity Home Health. Your line is open.

(Joan Taylor): OK, thank you. We're with Trinity Home Health Services. We're very excited about the different pilots that are coming out. So I just wanted to clarify. It looks like you can participate in more than one model on the bundled payment – the bundled payments. Can that be with different – different bundled payment programs?

And the other question is can you participate if you have – if you're active in the community-based care transition program that Hillary just mentioned. Can you participate in bundled programs as well as BCTT?

Mandy Cohen: Well, I'll answer the first part and then I'll let Rick answer the second part. The first part is absolutely – we – we've developed this program to have as much flexibility as possible for people that we've heard around the country.

And so, absolutely, you can participate in model one and two or two and three. You can participate in – with different partners, with different ones of those. You can also – we have not eliminated the option of you participating in the pioneer or FFP along with this.

So we are allowing as much flexibility as possible because we know that the mission that we have ahead of us in terms of redesigning health care for all the Americans is going to take all our commitment and partnership and want to be as flexible as possible, partnering with all of you out there.

And so with that, Rick, would you like to answer the question regarding transition?

Richard Gilfillan: Yes, I think, yes. Kind of fast and furious, folks. So I think the answer is I – in different markets, it's not an issue. In the same market, I – to be honest, I think we're going to have to think that through a little bit more.

I think – let me leave it at that. I think we just need to think it through and I would – one thing I'd say is I would urge folks not to worry about pursuing your current interest in the transitions program.

Obviously, both the transition, the community-based transitions program and the programs we're talking about today are competitive. Bidding processes, we don't do grants here. The innovations is that we have two contracts, provide agreements. And in doing that, we need to go through this kind of a competitive process.

So I would urge you to continue your application process if that's what you're looking at on community-based transitions and we will have more clarity I think around the potential interactions on that topic down the road.

(Joan Taylor): OK, thank you.

Richard Gilfillan: You bet.

Mandy Cohen: Thank you.

And this is Mandy Cohen again. And just to wrap up, I just want to thank everyone again for joining us on this call and for all the thoughtful questions. For those of you who joined us late or would like to hear a recording of this call, again, the number for that is 855-859-2056. It should be available as of five o'clock today for the next several days.

And if you didn't get a chance to ask your question today or if you have questions that come up over the period of writing your letter of intent or your application, please send those questions to bundled payments, with an "S" at cms.hhs.gov, that's bundledpayments@cms.hhs.gov.

And again, if you need more information about this initiative or about the CMS innovation center, you can visit our website at www.innovations.cms.gov. And with that, I thank you again for your time. And everyone on the East Coast, I hope you get home safely. And we'll be in touch soon with even more work that the Innovation Center is doing in the near future. So thanks again.

Richard Gilfillan: Thank you all.

Operator: This concludes today's conference call. You may now disconnect.

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