



## Payer Participation in the CMS Oncology Care Model

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## PRESENTATION

### **Introduction:**

**Moderator:** Thank you for joining us today for the CMS Innovation Center's Oncology Care Model Payer Participation webinar hosted by the OCM program team. During this webinar, we'll provide an overview of OCM for payers. Please refer to the RFA and other materials on the OCM website for further details on the model.

If you have questions during today's webinar, please submit them through the Q&A feature, and we will address them following the presentation. To submit a question, click on the "Q&A" button located at the top of your screen, enter your question in the textbox, and click "Send." Participant phone lines will remain muted during the webinar. Following the Q&A, you will be asked to participate in a short survey regarding today's webinar. Please take a moment to complete the survey to help inform future OCM webinars.

Thank you again for joining us. We look forward to engaging with you through the new Oncology Care Model.

**K. Cox:** Thank you for joining us today. My name is Katie Cox, and I'm joined by my colleagues Laura Mortimer and Dr. Heidi Schumacher. During this webinar, we will provide a quick overview of OCM, discuss the role of other payers in the model, and review the application process. As a reminder, additional information, including the Request for Applications (or RFA) and Frequently Asked Questions page are located on our OCM website.

OCM fee-for-service is a five-year payment model that focuses on episodes of cancer care. The goals of the model are to appropriately align financial incentives to improve care coordination, appropriateness of care, and access for beneficiaries undergoing chemotherapy. Participants in the model are physician group practices or solo practitioners who furnish chemotherapy to Medicare beneficiaries. Practices that partner with other entities for the infusion of chemotherapy may also be eligible to participate in OCM. Additional information regarding practice eligibility will be added to our updated FAQs, which will be posted to the OCM website by the end of the day. Practice transformation is key to this model and is supported through the OCM practice requirements. These are described in detail in the Request for Applications. Episodes within Medicare's fee-for-service arm of the model are defined as six-month periods initiated by chemotherapy and include all Medicare Part A and B

services that OCM fee-for-service beneficiaries receive during the six-month episode. Certain Medicare Part D expenditures will also be included. Finally, OCM is a multi-payer model, which is the feature we will be discussing in today's webinar.

As a multi-payer model, CMS invites other payers to participate along with Medicare by aligning their own payment models with that of the Innovation Center's. By engaging other payers in OCM, we increase the opportunity to transform care across the broader patient population by providing robust and aligned support. We also see great opportunity for other payers through their participation in OCM, including improving quality of care, reducing overall expenditures, as well as moving us toward a value-based payment system. Our goal is to work with each and every interested payer to provide opportunities for them to participate in OCM. We want to be good collaborators and really allow for the maximum level of payer participation. We see participation from other payers as a core feature of this model and key to our success in driving greater delivery system reform together.

All OCM physician practices will be participating with Medicare Fee-for-Service. We are strongly encouraging practices to engage with other payers, and during the application selection process, we will be giving preference to practices who propose higher levels of participation with other payers. CMS welcomes participation from commercial payers, including Medicare Advantage plans, state Medicaid agencies, other governmental payers such as Tricare and FEHB plans, and state employee health plans. We understand that participation from other payers may involve working through complex processes and may include additional levels of approval from other entities, but we really want to be as inclusive as possible, and we will continue to work closely with other payers throughout the process. Following application selection, the Innovation Center will enter into participant agreements with physician practices and memoranda of understanding with other participating payers. Other payers will then enter into an agreement with practices they participate with separately.

In order to facilitate collaboration, as well as communication between interested practices and other payers, the Innovation Center is interested in publicly posting the list of payers and practices who submit letters of intent (or LOIs) to the OCM website. This posting would only include the name, location, and points of contact for payers and practices, as well as information regarding lines of business and geographic areas the plan may wish to include in OCM. However, to be clear, this is not a requirement for participation, and payers who do not wish to have their information posted publicly can indicate this in their LOI. At this point, I will now

turn it over to Laura Mortimer, who will discuss payer participation in more detail.

## **Payer Participation:**

**L. Mortimer:** Great. Thanks, Katie. Hi, everyone. This is Laura Mortimer from the OCM team here at the CMS Innovation Center. As Katie said, our goal really is for every single payer that's participating in this webinar to apply for and participate in the model. We at CMS are so happy that you've joined us today, and we are prepared and excited to collaborate with you on this model during the coming months and years. As payers, we share common goals around payment and delivery system reform and cancer care. We at CMS completely understand that other payers will need leeway to structure and implement their oncology care models in ways that work best for them.

We've spoken with many of you during the development of this model, and since we released our RFA last month, and we've heard your concerns loud and clear. You all have different business models, different patient populations, you operate in different markets, so we appreciate that a one-size-fits-all Oncology Care Model is probably not realistic and not the best way to maximize everyone's chances of success.

That said, we hope that you can appreciate from the providers' perspective the need for consistency across payers in OCM. That need for consistency is the main reason why we ask you as payers to align your models with Medicare's as much as possible and in ways that will help maximize practices' chances of success, as well as your own. So, as we think about and discuss payer participation in OCM, keep in mind that our goal is to strike the right balance between flexibility for payers and consistency for practices.

This slide lists the activities that OCM practices will be engaging in to transform their practices during the model. We strongly encourage other payers to support practices as they work to fulfill the OCM practice requirements listed here. I'll speak more about the OCM payment approach on the next slide, but know that practices will receive enhanced payments from Medicare to fulfill these requirements for Medicare Fee-for-Service beneficiaries.

We very much hope that other payers will want their enrollees to receive similar services from OCM practices so that practice transformation can look more uniform across the patient population. And again, so that practices can implement change more consistently for all their oncology patients, not just for Medicare beneficiaries.

We're not asking payers to align perfectly with us on these requirements. We know many of you already have models in the works where practice transformation may look very similar to what we envision here. Many of you already require compliance with, for example, clinical guidelines, or extended hours, around-the-clock access to care management and other such practice enhancements. Several of you already use data in highly sophisticated ways to drive quality improvement and direct physicians and patients towards the best courses of treatment. We applaud those efforts and hope to learn from you ways that Medicare might improve upon our own models during OCM.

Practice transformation will take a village of supportive payers, not just Medicare, so we hope that you'll work with us over the next few years to support practices and figure out the best ways to drive this transformation. We all know that payment is a key driver of any change at the practice level, so the OCM payment approach focuses on two key payment changes.

The first is a payment for enhanced services, namely all the requirements you saw on a previous slide, which really center around better care coordination, care management, and patient navigation. Medicare will pay practices a \$160 per-beneficiary-per-month payment for these enhanced services for Medicare Fee-for-Services beneficiaries. But we want to stress today that other payers can structure their payments however they see fit and can choose the amounts of these payments for themselves.

A per-bene-per-month payment is just one example of a payment that would work here. Other payers might rather do advanced lump sum payments, or other types of episode payments, depending on what model they think would work best for their market. We leave the structure and schedule of these payments entirely up to payers. Our goal is for payers to be investing in practice transformation as demonstrated by the enhanced services that OCM practices provide for patients in the model.

The second part to the OCM payment approach, which is payment for performance, allows payers to have just as much flexibility as the enhanced services payment. Payers can define and incentivize high performance however they choose and can make this payment in many different ways. Some may focus on performance around certain quality measures such as patient satisfaction scores or data from claims, while others may look at reductions in expenditures below a target price, as Medicare Fee-for-Service does. However you decide to define quality performance and pay practices for it, we at CMS support you and support practices as they do their best to meet all our expectations.

Ultimately, we seek to test the effects that these two types of payments have on practice transformation, quality of care, and overall cost of care. We're happy to share with you all more information about Medicare's methodology here, but really want to stress that you do not have to do exactly what we're doing. Your models may look quite different from ours, and that's okay as long as this basic two-part payment approach is there.

The next model components we'll discuss are quality measures and data reporting. CMS has worked with many different stakeholders to develop our list of quality measures for the Medicare Fee-for-Service arm of this model. Those measures are listed in our RFA, which is available on the website. We do not expect other payers to collect data for all these measures. We understand that Medicare is in a unique position when it comes to data collection and evaluation, and we often have access to data sources that other payers might not. Our goal in the Oncology Care Model is to work with OCM payers to develop a core set of quality measures that all payers in the model will collect. We're talking perhaps five or ten measures that payers agree are most important because they best reflect the practice transformation that's happening through this model.

Some examples of possible core measures are listed on the slide, but please take a look at the comprehensive measure list in our RFA to get an idea for some of the other measures that could be included in this core set. I also want to note that payers are welcome to collect additional measures that are not on the CMS list if they so choose; it's entirely up to them. We know it's important to think about quality measurement from the practice perspective as well and to do everything we can for payers to minimize practices reporting burden. So, we strongly encourage payers to align not just on the core measure set but also on data reporting schedules and formats where possible.

We understand that payers collect different data in different ways. Some may rely on sophisticated EHR systems while others are just dipping their toes into quality measurement. So, again, the goal here is for us to work together to decide on a set of core OCM measures that everyone can collect from practices in a consistent way. We look forward to learning from what other payers have done and to sharing our experiences with you all.

This slide shows a few final components of OCM around which we hope to have significant payer alignment. We strongly encourage payers to include cancer types in their models that cover a majority of patients with cancer. This may only be a small handful of cancer types, or like the Medicare Fee-for-Service model, it may cover several different types of cancer at different stages and so on. We want practices that participate in

OCM to feel universally supported by their payers as they make major improvements in their cancer care. That's the goal of including many different cancer types in this model.

Next, we note that payers have the leeway to determine their own patient eligibility criteria and attribution methodologies. Once again, you're welcome to align with Medicare to whatever extent you choose. We just ask that the attribution methodologies make a good faith effort to capture all relevant beneficiaries and avoid cherry-picking. We are still finalizing parts of our methodologies here, but we'll be up front and open with our payer and practice participants in sharing those methodologies once they're complete. We understand that other payers have different patient populations than Medicare does, but we're happy to share our lessons learned around beneficiary eligibility and attribution if payers would find that helpful.

Lastly, we do ask that all payers interested in participating in OCM apply during this initial application period. And we encourage payers to start their models within 90 days of the Medicare Fee-for-Service start date of early 2016, although this is not a requirement for participation. We'll talk in more detail about the application process in just a few minutes.

Many of you have expressed interest in including your Medicare Advantage plans in your OCM participation, and we absolutely welcome those plans to participate. These plans are not automatically included in OCM the way Medicare Fee-for-Service is at participating practices. Instead, Medicare Advantage plans will participate in basically the same way that other commercial payers participate in the model. Payers can structure OCM payments however they see fit and are welcome to offer enhanced care management payments to practices through their MA plans.

Do note that per-bene-per-month payments, performance payments, or other enhanced payments are funded by the plan, not through additional funding from Medicare. So, OCM will not change the MA plan bidding process or the amounts that insurers receive to offer MA plans. Payers can plan for their MA plans to participate in essentially the same way that their other lines of business would.

We also welcome participation from state Medicaid agencies, whether through Fee-for-Service or managed care plans. Several Medicaid providers have already expressed interest in participating in the model, and we are excited that Medicaid will be working in tandem here with Medicare and private payers to help bring about practice transformation for a broader population.

Medicaid Fee-for-Service or managed care plans may apply to participate in OCM the same way that other payers do. The deadline for everyone's applications is the same, June 18<sup>th</sup>. We understand that OCM participation may require Medicaid State Plan Amendments, so we at the CMS Innovation Center are engaged with our Medicaid colleagues to better understand and support changes that would be necessary for states to succeed as payers in this model. We're glad to facilitate conversations between Medicaid agencies and our CMS Medicaid colleagues to make this happen. Now I'm going to turn it back to Katie who will go over the application process and deadlines before taking questions from you all.

**K. Cox:**

Thanks, Laura. I would like to first point out that we have extended our deadlines for letters of intent (or LOI) submission. Payer LOIs are now due on April 9<sup>th</sup> at 5:00 p.m. Eastern Daylight Time, and practice LOIs are due on May 7<sup>th</sup> by 5:00 p.m. Eastern Daylight Time. We would like to encourage any interested payers to submit an LOI. LOIs are non-binding and once submitted will allow us to continue to work with you to develop a plan for your participation in OCM.

All applicants must submit electronic LOIs to be considered for participation in OCM. LOI PDF forms may be downloaded from the OCM website, completed electronically, and then emailed back to the Innovation Center as attachments. Applicants who submit timely and complete LOIs will be sent an authenticated web link and password to complete an electronic application. Application templates are available now for anyone to view on the OCM website. Only applications submitted through the authenticated web link will be accepted.

That concludes today's presentation, and we'll now move to the question and answer period. Again, to submit a question, click on the "Q&A" box on your screen. As a reminder, once the Q& A period ends, please take a second to complete the survey that appears on your screen. Also, a copy of these slides as well as a transcript of today's presentation will be available on the OCM website. Thank you, again, for your participation in today's webinar, and we will now pause for a few minutes before responding to the questions that have come in. We'll be back in a moment.

## **Questions and Answers**

**H. Schumacher:**

This is Heidi Schumacher from the OCM team. I will look to my colleague Laura Mortimer to answer our first question. One attendee asks if we have an estimate of the number of practices and number of payers that we would like to enroll in the model.

- L. Mortimer:** Sure. So, we expect to enroll around 100 practices in the model. In terms of number of payers, the goal is really to have as many payers for our practice participants as possible. So ideally, a practice would have all the payers in its oncology space participating in OCM.
- H. Schumacher:** Great. Thanks, Laura. So, now to Katie Cox. Katie, we've gotten a couple questions from payers wondering if they are required to include all of their markets or all the geographic areas in which they operate, or whether they can select which geographic areas to enroll in OCM.
- K. Cox:** Thanks. We would like to encourage payers to include as many geographic areas or lines of business as possible, but that is not a requirement. Payers can choose which geographic areas, lines of business, or practices they plan to include in OCM.
- H. Schumacher:** Great. Thank you. Laura, back to you. We've gotten quite a few questions from folks about the LOIs and their role in terms of driving selection in the model. Specifically, we've heard many payers saying, "This is a complicated process. I need to engage a lot of folks from my board and from other leadership groups within my plan." Should those folks, if they're interested in participating but are not exactly sure what the model might look like for them, submit an LOI, or is there an opportunity later to submit an LOI?
- L. Mortimer:** Those folks should absolutely submit letters of intent now. As Katie mentioned, the LOIs are not binding. It's a two-page form, most of which is contact information, so relatively pain free. Also as Katie mentioned, we'll be posting the list of payers who submit LOIs and are okay with us publicly posting their names to the OCM website so that payers and practices in different markets can coordinate with each other during the application period and plan for their OCM participation. But please do go ahead and get your LOIs in and then you'll have a few more months to prepare your application.
- H. Schumacher:** Laura, if payers are just saying, "I'm interested in participating, but I'm not sure that I want my information posted publicly in that list," is that okay? Can they still submit an LOI and later apply if they don't want their information posted on the website?
- L. Mortimer:** Absolutely. We will not post information for payers who say they do not want their information posted.
- H. Schumacher:** One follow-up question that we got on the posting of payers who submitted LOIs—someone is wondering whether the geographic areas that the payers are interested in including in the model will also be posted on the website. The answer is yes, we do plan to include the geographic areas that plans think they might be interested in including in the model,

although that's certainly not required. If a plan prefers that we not post that information, that is okay. The benefit to posting though, again, is that practices then in those geographic areas can see what plans immediately surrounding them may be interested in participating.

Now I'm going to ask my colleague Ron Kline a question. Some folks from the payer community have asked about sharing best practices and how information will be shared amongst payer participants. Ron will speak to some of the work being done with our learning and diffusion group.

**R. Kline:** Great. Thanks, Heidi. Most of you already know that we will have a rapid learning and diffusion process for the practice participants. We want everybody to improve during the five years of the model. There will also be a similar voluntary process for payers that participate. We want to bring payers together to share best practices and some of their learnings throughout the model. I should emphasize that no proprietary information will be shared at these meetings, and only information that payers want to disclose will be shared.

**H. Schumacher:** Great. Thanks, Ron. And now I'll look to my colleague Andy York, who's done a lot of work on our quality measures in reporting. Andy, some folks have asked us how or if outcomes and quality data collected by other payers participating in the model, will that be shared with CMS and with other participants?

**A. York:** Heidi, thanks for the question. For data collection, what we're looking for at the bare minimum is for an aggregate report from payers on their thoughts on if the model was successful. CMS will work with other payers once selected to determine what level of aggregate data they might be willing to share to inform the model's evaluation. CMS won't require granular or beneficiary-level outcomes or expenditures data to be shared.

**H. Schumacher:** Great. And then, Andy, I'm going to ask you one other follow-up question. There have been a couple different questions on different payment types, schedules, amounts. Are other payers required to include a PBPM that's \$160, or is there flexibility on the dollar amount there?

**A. York:** No. There's going to be a lot of flexibility on the dollar amounts. We are asking for the two-part payment approach (including payments for enhanced services and for performance), but it's going to be very flexible to what the payers are paying for and what those amounts are going to be. And again, we're open for questions, so if you need any exact feedback on ideas that you have, we're happy to provide those as well.

**H. Schumacher:** Great. Thank you. The next question I think we'll take relates to whether there's a minimum number of practices payers need to participate with in

order to join the model. And I'll take this one. There isn't a minimum number of practices. We certainly encourage payers to look at the list of practices that have submitted LOIs, reach out to practices that they know are in their network, and to consider partnering on the model, but there isn't a minimum number of practices that are required.

Laura, I'm going to give you a couple questions related to a phased-in implementation. Several folks have written in wondering whether there's the opportunity to either begin their models' performance periods at slightly different times from that OCM-FFS. Also, folks have wondered whether there will be an opportunity to phase in additional partnering practices over time.

**L. Mortimer:** Sure. In terms of timing for joining the model, like we said earlier, we require payers to submit letters of intent and applications during this initial phase regardless of what your exact plans are for your start date. And we, likewise, encourage payers to start their models within three months of the Medicare Fee-for-Service model start date. But we certainly can understand if payers want to start on the smaller side and scale up over time, perhaps include more geographic areas or more cancer types in their model over time, so we're very flexible to different options there in terms of timing.

**H. Schumacher:** Great.

The next question that we'll take relates to the two-part payment approach. A couple folks have written in wondering how they might be able to use their existing payment models to fit within the two-part payment model. The short answer from our side is we want you in. We want to work with you. We want to be able to figure out a way to make any current oncology-related model that you may have already implemented work within the OCM construct. The flip side of that again is we want to make sure there's at least some consistency at the practice level in terms of the types of funds they can expect.

So, again, if you are one of the payers listening here or are in communication with payers who might be interested, who are already running their own models, please reach out to us because we really do want to figure out a way to make your excellent existing efforts that are driving change in this space work within OCM. Laura, anything to add to that?

**L. Mortimer:** No, Heidi. I think that's a great overview. Just to reiterate for those of you who might not have had a chance to join the webinar in time for the payment slide. We do have a basic two-part payment approach in the oncology model, which you can read more about in our RFA. The first

part is a payment for enhanced services, which payers can structure and define however they see fit. Medicare is doing a PBPM here, but other payers that do not have to structure their payments for enhanced services in that way.

The second part to our payment approach is a payment for performance. And again, other payers can define performance and structure these payments however they see fit. As Heidi mentioned, many payers may already have a definition here and have calculations of shared savings or sets of quality measures that they use to assess how providers are doing on their performance, and so that's great. We encourage payers to utilize whatever existing structures they have and to build in the payments for performance into those structures. And again, happy to share the methodologies that Medicare is using here if that would be helpful for payers.

**H. Schumacher:** Great. Thanks, Laura. Katie Cox, can you help us answer the question we've gotten from a couple folks, which is, "Must episodes in the models designed by other payers be defined in the same way that Medicare Fee-for-Service defines them?" And specifically we've gotten questions about the duration of episodes: "Must episodes be six months long? Are there any other stipulations there?"

**K. Cox:** Thanks, Heidi. So again, we do want to encourage payers to align with OCM fee-for-service whenever possible, but practices are not required to use the same episode definition. Episode length can vary; other payers may choose to use shorter or longer episodes in their models. In Medicare's model, we define episodes as six-month periods following the initiation of chemotherapy and include the total cost of care, so all Medicare Part A and Part B services, as well as certain Part D expenditures. Other payers may choose to define their episodes differently and they do not have to include the total cost of care.

**H. Schumacher:** So in summary, flexibility, again, is sort of the name of the game. Great. And Laura I'll turn to you for a question we've gotten from a few participants. Several plans have asked, "If a plan submits an application and is selected to participate, is it a requirement that that plan stay in for the full five years or is there an opportunity to withdraw during the five-year period?"

**L. Mortimer:** We certainly hope that payers and plans that participate will do so for the full five years and will go into the model planning for five-year participation. Again, the goal here is to maximize consistency across payers for our practices and so, all payers having the same timeline is an important part of that. That said, if for some reason payers do need to consider withdrawing from the model before the five years is up, we're

happy to work with you to figure that out in order to maximize everyone's likelihood of success in the model.

**H. Schumacher:** Great. And then a couple more questions that are geographic in nature. Several other folks have written in saying if they express interest in participating in a certain geographic area, but only want to join the model with certain practices within that geographic area, is that a possibility. Can they limit their participation to only certain practices? Laura, I'll let you take that one.

**L. Mortimer:** Sure. Payers are totally welcome to do that. It is really up to them to define the extent of their participation however they see fit and however they think would work best given their different markets, which they certainly know better than we do here at CMS. So, yes. Payers can include whatever geographic areas or practices they wish in their models.

**H. Schumacher:** Great. Thank you. Then finally, another plan asks, "If the payer looks at the list of practices in their geographic area who have submitted an LOI but doesn't see any practices within the plan's network, what is the plan to do in that case?" This is in part why CMS has decided that we're going to post the plans submitting LOIs, followed by the practices submitting LOIs. And the goal there is to allow practices time to look at the website, to see which plans in their area have submitted LOIs, and to coordinate with those plans. For example, a practice may say "I work a lot with this Aetna or BlueCross BlueShield or other plan; I see that they've submitted an LOI. I'm really interested in participating with them."

The hope is that the time leading up to the submission of LOIs and applications gives folks an opportunity to really partner with one another.

The next question I'll take is a logistic one. Someone is asking where on the CMMI website the payer LOI is posted and additionally where plans can find further details about their participation. The CMMI Oncology Care Model website, <http://innovation.cms.gov/initiatives/Oncology-Care/>, features the payer LOI forms as well as our Frequently Asked Questions, our Request for Applications, and other relevant model details. That webpage also has a link to our email address, which is [OncologyCareModel@cms.hhs.gov](mailto:OncologyCareModel@cms.hhs.gov). We welcome, again, questions, logistical or technical, at any point.

A couple questions have come in wondering about the calculation of performance payments, the use of the total cost of care, and alignment with the discount that CMS plans to take. I'll let our economist, Dan Muldoon, answer that question.

**D. Muldoon:** Hi. This is Dan Muldoon. Payers need not align directly with how CMS is calculating its performance-based payment. So there they have

flexibility in terms of what expenditures they want to include for consideration when calculating that performance-based payment, and then also how they structure the payment. They don't need to take the same approach as CMS of setting a benchmark and then incorporating a discount. They have more flexibility to view that differently as long as they do include some type of performance-based payment in their approach.

**H. Schumacher:** Great. Again, lots of flexibility. Certainly as details come out with some of our more technical components, we're certainly happy to share those as we're able if useful but do acknowledge that other payers might have different approaches they prefer to take, and that's fine.

The next question I'll give back to Andy York, who has done a lot of our work with quality measures. Andy, some folks have been asking, "What will be the process for coming up with the core set of quality measures? How will practices be expected to report to the various payers?" Can you speak about alignment efforts there?

**A. York:** Yes. Thanks, Heidi. As Laura mentioned before, what we're going to be trying to do is set up a core list of quality measures that are collected across payers, and that's just to promote consistency for practices. The one thing we can say is this core list is going to be a small list of measures, probably in the range of 5 to 10. A lot of them are also going to be claims-based. The main thing that we're looking for is alignment around those measures and then also alignment on which ones will require practice reported data.

Other payers can certainly analyze their claims data in as many different ways as you would like. We are hoping to limit the amount of practice reported data just to make sure that there isn't an overwhelming reporting burden for a number of different practice reported measures. The way it's probably going to look is similar to what was done for some of the other models at CMMI. Once we find the payers that are interested in participating through the LOI process, we'll be engaging them to try to come to a consensus on what that core set of measures should be.

**H. Schumacher:** Great. And I think the final question that we've gotten relates to the timing of the posting of payers who submitted LOIs and agreed to public posting on the OCM website.

We will be posting that list one week after the LOI deadline for payers. That will be around April 16<sup>th</sup> or so for payers. Again, only those that give us their permission to post will be included. And then similarly, the list of practices that submit LOIs will be posted one week after that deadline, and that will be mid-May. That still gives folks over a month

after both of those LOI postings to coordinate participation and certainly we welcome lots of discussion between now and then. I will turn it back over to Laura for our sign-off.

**L. Mortimer:**

Great. Thanks, Heidi. And thank you to everyone, for joining today's call. There is a short survey to complete right after we sign off, so please take a second to do that so that we can improve our webinars in the future. Again, email any follow-up questions to the address you see on your screen ([OncologyCareModel@cms.hhs.gov](mailto:OncologyCareModel@cms.hhs.gov)) or submit them through the survey tool.

Thanks again for joining us, and we look forward to working with you soon.