

Centers for Medicare & Medicaid Services

Moderator: Susie Butler
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12:00 p.m. CT

Operator: Good afternoon. My name is (Melissa) and I will be your conference operator today. At this time, I would like to welcome everyone to the Healthcare Delivery Facility Reform Conference Call.

All lines have been placed on mute to prevent any background noise. After the speakers' remarks, there will be a question-and-answer session. If you would like to ask a question at 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. Thank you.

Ms. Susie Butler, Director of Provider Affairs in the Office of External Affairs, you may begin your conference.

Susie Butler: Thanks so much, (Melissa) and I want to thank everyone for taking the time to attend today's call on Healthcare Delivery System Reform.

CMS as a whole is working to improve our healthcare system. We have begun to implement CMS' new vision to be a constructive force and a trustworthy partner for continual improvement of health and healthcare for all Americans.

Key to accomplishing this CMS vision will be to transform our current, fragmented high-cost delivery system to one that delivers a seamless care experience with better health and healthcare for patients at a lower cost through improvement.

CMS has been given a great opportunity under the Affordable Care Act to improve our healthcare delivery system and provide new ways to deliver streamlined, seamless care with better quality and at reduced cost. This is an enormous, challenging and exciting opportunity for CMS but we can't do it alone. We do need your help.

Today, you'll hear from three leaders at CMS in charge of three different programs, all at different stages of development. As our stakeholders, we're excited to engage you in the process.

The three areas that you're going to hear about are the Accountable Care Organizations Shared Savings Program, John Pilotte, the Acting Director Performance Payment Staff Center for Medicare who will be sharing with you about that.

Then we'll hear from Dr. Rick Gilfillan, Acting Director Center for Medicare & Medicaid Innovation about that new center, and then finally, from Melanie Bella, the Director of the Federal Coordinated Health Care Office.

If you're like me, the best ideas occur often after the opportunity has passed and we don't want that to happen to you. So we provided mailboxes for each of these areas where you can send your thoughts and ideas if you don't get a chance to speak on the call today.

I'll be reminding you of those mailboxes throughout the call and also at the end of the call. But for now, let me tell you, the Innovation Center is innovate@cms.hhs.gov or visit the new Web site, www.innovation.cms.gov, the next, the Accountable Care Organizations, aco@cms.hhs.gov, and then finally, fchco@cms.hhs.gov. And again, I'll remind you of these as we proceed.

Now, let me tell you about the purpose of today's call, what it is and what it isn't. We'll be sharing information with you on these three important areas and it's a chance for you to share ideas and give thoughts and input about each of them.

Your remarks will not be considered formal or official responses or remarks of record. CMS will be in a listening mode after these three introductory remarks are given.

As your facilitator, I may ask you to clarify a question or ask you for a follow-up remark, but today, CMS is in a role of listening to you. Please keep your remarks to two minutes or less. We'd like to give as many people a chance to share as possible.

With that, I'm going to turn it over to John Pilotte to talk about the Accountable Care Organizations Shared Savings Program. John?

John Pilotte: Thank you, Susie. I would like to share with you all today Dr. Berwick's vision for Accountable Care Organizations as well as provide a brief overview of the statutes and post several questions that we recently released in a request for information last week for you to consider both providing comment on today as well as officially submitting formal comments through the process outlined in the November 17 Federal Register Notice announcing that Request for Information.

And we just point out, as Susie mentioned today too, we are in listening mode. We are in the process of rulemaking around the Medicare Shared Savings Program and we do welcome your input and comment into that process and the best way to do that is through that process outlined in the Federal Register Notice as well as our comments from the audience today.

Recently, Dr. Berwick described Accountable Care Organizations as the new approach to delivering care that reduces fragmented unnecessary care and excessive costs for Medicare Fee-for-Service beneficiaries by promoting population health management, coordination of Part A and B services and encouraging investment and infrastructure and redesign care processes.

Accountable Care Organizations – I want to say that Accountable Care Organizations will promote the delivery of seamless coordinated care that promotes better health, a better patient and caregiver experience to lower cost by putting the beneficiary and family as the center of care, remembering patients over time and place as they journey the healthcare – throughout the

healthcare system, attending carefully to handoff and care as patients move along the continuum, proactively preventing illness and promoting population health especially for chronically ill beneficiaries, tracking and reporting outcomes and giving timely feedback to providers in a data-rich environment with IT infrastructure and support as well as other resources, innovating and improving approaches to achieving better health, better care and lower cost for its patient population over time and continually investing in team-based care and its broader workforce to serve both patients and caregivers.

As called for in the Affordable Care Act, the provisions outlined eligibility for this Medicare Shared Savings Program as well as describe the financial model, the quality model and the requirements for ACOs, briefly existing newly informed organizations that are eligible to apply would be eligible to apply to participate in the program and include group practice arrangements, physician network, joint ventures and partnerships as hospitals and ACO professionals and hospitals employing ACO professionals. In addition, the secretary has granted discretion to designate other providers and suppliers of services as well.

The statute requires that Accountable Care Organizations accept responsibility for aligning patient population and define processes to promote evidence-based medicine, report on quality and cost measures, coordinate care and meet patient-centeredness criteria and have sufficient capacity to provide services to at least 5,000 patients – I should say, and has sufficient capacity to provide primary care services to at least 5,000 aligned assigned patients.

The assigned patient population is the basis for establishing and updating the financial benchmarks, quality measurement and performance and the focus of the Accountable Care Organizations' efforts to improve care and reduce cost.

Accountable Care Organization providers continues to be paid under regular Medicare Fee-for-Service payment systems as outlined in the statute and are eligible for Shared Savings that they meet both the quality performance standard and their spending for the aligned patient population below is updated benchmark.

We welcome your thoughts and comments today on the above and specifically, the following questions that we recently published in our Request for Information again on the November 17 Federal Register Notice.

Specifically, we welcome your thoughts and input on what policies or standards should we consider adopting to ensure the groups of solo and small practice providers have the opportunity to actively participate in the Medicare Shared Savings Program as well as ACO models tested by our colleagues in the Center for Innovation that Dr. Gilfillan will be talking about.

Many small – second question is many small practices may have limited access to capital or other resources to fund efforts from which Shared Savings could be generated and specifically, what payment models financing mechanisms or other systems might we consider either for the Shared Savings Program or as models under the Center for Innovation to address this issue. In addition to payment models, what other mechanisms could be created to provide access to capital.

The process – the third question is the process of aligning beneficiaries to an ACO is important to ensure that expenditures as well as any savings achieved by the Accountable Care Organizations are appropriately calculated and the quality performance is accurately measured. Having a seamless attribution process will also help Accountable Care Organizations focus their efforts to deliver better care and promote better health.

Some argue, it is necessary to attribute beneficiaries before the start of a performance period so that the Accountable Care Organizations can target care coordination strategies to those beneficiaries whose cost and quality information will be used to assess the ACO's performance.

Others argue, the attribution should occur at the end of the performance period to ensure that Accountable Care Organizations held accountable for care provided to beneficiaries who are aligned to it based upon services there receive from the ACO during the performance year.

We are seeking comment on how should we balance these two points of view in developing the patient attributions models for the Medicare Shared Savings Program as well as those ACO models tested by the Center for Innovation.

The fourth question is how should we assess beneficiaries and caregiver experience of care as part of our assessment of – as part of our overall assessment of Accountable Care Organizations performance.

The next question is the Affordable Care Act requires us to develop patient-centeredness criteria for assessment of ACOs participating in the Medicare Shared Savings Program. What aspects of patient-centeredness are particularly important for us to consider and how should we evaluate them?

The next question is, in order for an ACO to share in savings under the Medicare Shared Savings Program, it must meet a quality performance standard determined by the Secretary, specifically, what quality measures should the Secretary use to determine performance in the Shared Savings Program?

And finally, what additional payment model should CMS consider either under the authority provided in Section 3022 of the Affordable Care Act for partial capitation and other alternative model or using the authority under the Center for Innovation that Dr. Gilfillan will be talking about shortly? And then what are the relative advantages and disadvantages at any such alternative payment model?

Again, these are questions that we recently announced in a formal Request for Information on November 17 in the Federal Register Notice. There is a process outlined in there for formally submitting comments and we encourage you to do so but we also would like to hear your thoughts and views on these and other questions you may have during this call today.

Thank you and I'll turn it back to Susie.

Susie Butler: Thanks so much, John. And I'll remind folks, if you have comments on those questions that you'd like to submit in the formal way, you need to go to

www.regulations.gov and look for the November 17 Federal Register Notice and submit your comments there.

Although like John said, we're very eager to hear just briefly some thoughts or ideas you might have today and what to share with us but they wouldn't be considered part of the formal comment response period or response to those – to that notice.

Next, I'd like to introduce Dr. Rick Gilfillan. He's the Acting Director of the Center for Medicare and Medicaid Innovation and he'd like to share some thoughts about that area. Rick?

Rick Gilfillan: Thanks very much, Susie, and thank you to everyone on the phone taking some time out of your busy day to join us today and share your thoughts and perspectives on our initiatives here at CMS.

I think Susie and John talked about Dr. Berwick's vision for positioning CMS to be a partner in delivery systems change so that we move from a fragmented care system to a seamless coordinated care system.

And the process of doing that we know is we will need to discover, identify new models of care, new ways of delivering care and also just as importantly, finding ways to support physicians, hospitals, other healthcare providers in those new models of care.

The mission of the Center for Innovation really coming out of the legislation is to identify, validate and diffuse those new models of care and payment to support that alternative approach to care that we think everyone would like to deliver.

So we think of our job then at the center is to listen to communities, providers, hospitals, physicians and learn from you, your ideas, about what we could do differently in delivering care and how we could pay you differently in supporting those alternative approaches. That's really our job.

We need to help you get started in those new models. We need to validate as the new models make a difference that is that they either improve quality and

lower cost -which we think is quite possible - or deliver the same quality for lower cost. We need to validate that that's the case.

The legislation also gives the Secretary of Human Services the opportunity to -- if we can demonstrate to the satisfaction of the CMS actuaries that the new model saved money and improved quality -- change the overall Medicare or Medicaid payment policies to support providers in delivering care in those new ways.

So that's our mission. From there we say, "Well, if we want to really kind of execute on that [mission], how should we think about that? Where should we look to work with care systems to that end?"

And we were thinking about three levels of care where we want to focus our activities. The first level is the level that we call the patient care model and that level says, "Gee, how do we find out what's the best way is? How do we support people in delivering the best OB care, the best hip surgery, the best back surgery, the best outpatient care for a patient with a particular condition or knee setup condition?" So that's one level we'll be looking at closely and looking for new models in.

The second level is in the level of seamless care systems, that assistance that actually put together all those different providers of care to deliver a seamless experience to patients and that delivers the three aims that -- of better health, better care lowest cost through improvement for patients. So that's that second level. That level might be the level of ACOs, medical homes, pace programs, other systems of care that deliver that experience with those outcomes.

And then the third level we will look at is at the population level in the community level and that asks the question, "How can we fundamentally affect the key determinants of health as a (QD) level?" That is, how can we improve smoking rates, lower obesity rates, increase rates of activity, physical activity, et cetera, to affect people's underlying health status?

So three levels of care, three levels of models that we will be looking at and we'll be trying to – and hopeful today that we get some idea from you all on initiatives that we might be interested in pursuing in those areas.

What are we doing right now at the center? Well, we have just officially been launched as a result of a notice placed in the Federal Register two weeks ago. So our doors are opening. We're doing the basic startup. We're hiring staff. We're building out some of our core functions.

Second, we have begun a planning process of which this call is an important part. It's reaching out to get input from stakeholders in the entire healthcare industry and in the broader community with – from patients, employers, payers, providers of care.

And we're interested in a couple of things. One, what can you tell us about your thoughts about what you'd like to see from the center, what priorities you'd like to see and how can we engage effectively with you all?

The third activity we're currently pursuing is to begin the work of actually getting out there and doing some care model work. So we have announced recently for specific proposals that represents the first four models that we, at CMS, will be working on.

The first is coordinating with other components of CMS to launch a multi-payer medical home demonstration project that positions Medicare to participate in already existing state-based medical home initiatives.

We announced our intent to contract with medical homes in eight states which will include over 1,000 medical homes serving about one million Medicare beneficiaries.

Second, we'll be working with our Medicaid colleagues as they release and begin soliciting interest in the Medicaid health home state plan option that was created by the Affordable Care Act. This program will provide 90 percent federal funding for the first two years of any state-based Medicaid health home pilot program.

Third, the center will be supporting advanced primary care medical home demonstrations and federally qualified health centers. We expect to have over 500 health centers participating in providing care to almost 200,000 patients.

And finally, we will be supporting the new federally coordinated healthcare office on demonstrations that are aimed at evaluating care models that better integrate care for the dual eligible population. And Melanie Bella will be talking about that project in a moment.

So we are engaged in those activities coming out of the gate and we will also in the not distant future be beginning a process of formally soliciting proposals for work to be done through the center.

So that's where we are right now in the first 60 days. We're excited to be here today and this is one of a series of open door forums we will have as well as on-the-ground listening sessions in different regions of the country as part of this effort to reach out and get your thoughts on how we can most effectively meet our mission and our objectives.

We look forward to working with you. We know this is not about inside the beltway activity. This is about an activity that occurs in every community out there that fundamentally is about finding new and better ways to meet patient needs and we look forward very much to engaging with you all and hearing from you all today any inputs you have on how we can best do that.

Thanks, Susie.

Susie Butler: Thanks, Rick.

And as you noted, we do have here in the room in us, Melanie Bella, the Director of the Federal Coordinated Health Care Office. So Melanie, would you like to share your perspectives today?

Melanie Bella: Yes. Thank you very much. I echo the same for those of you on the call and look forward to your input.

The Federal Coordinated Health Care Office was also created under the Affordable Care Act Section 2602. And really, for those of you who are familiar with the statute, it's clear that our job is to make the care experience better for beneficiaries who are eligible for both Medicare and Medicaid and in large part, that depends on improving the relationship between states and the federal government as states and the feds are partners in delivering and providing care for this population.

So echoing the thoughts of the prior speakers, the whole idea here is to create a seamless coordinated care system and there is not a better opportunity to do this than for individuals who are duly eligible.

Over 95 percent of dual eligibles are in fragmented Fee-for-Service systems and we spend upwards of \$300 billion combined annually on their care. So again, this is time for delivery system and payment reform.

Currently, the office is focusing on two areas. The first is program alignment. And in that area, we are identifying every place where Medicaid and Medicare bump up against each other.

So this is administratively, regulatorily, statutorily coming up with literally a list and the list is populated with anything and everything, again, where these two programs work at odds with the beneficiary having the seamless experience.

We will be compiling that list then assessing the impact of the items on that list, and how many beneficiaries who we help. We'll be thinking about what it would take to make that change, does it require administrative action, regulatory action or statutory change?

And then we will be prioritizing that list and turning it back around and making it very public. It will be a transparent living document that is shared continually with stakeholders so that we can continue to assess it and improve it. And we would encourage you to submit any ideas to the email box that Susie mentioned at the beginning of the call and then we'll reiterate at the end of the call.

This has – this list has been developed with lots of input so far from external and internal stakeholders and we look forward to continuing to perfect it.

The second area that we're working on has to do with demonstrations and models and that is, as Rick mentioned, one of the key areas that was announced last week with the Center for Medicare and Medicaid Innovation involved testing, new delivery system and payment models for dual eligibles.

These are models that fully integrate the Medicare and Medicaid services that these recipients are eligible to receive. So this means acute care services, long-term services and support and behavioral health services. It's very important that there is an integration of all of the services.

And we will be working first with states. What was announced last week was the upcoming availability of design contracts of about \$1 million each for up to 15 states. That solicitation will be out in early December and then we will work with the Innovation Center to focus system and provider level demonstrations at the integration of care and services and financing for dual eligibles as well.

So I would encourage you all to make sure that we have all of your input and feedback and we look forward to hearing that on the rest of this call.

Susie Butler: Melanie, thanks so much. Well, everyone, I want to thank everyone who presented so far.

Now, folks from the phone, it's time that we hear from you. CMS is going to enter in listening mode now and we'd like to hear some of the good thoughts and ideas that you come up with either prior to this call or as you've listened to the three presenters share is forward your thinking and you've come up with some ideas you'd like to share with us.

Let e remind you once again of the ground rules as I know many of you were joining the call even as we began the presentation.

We've got three different programs that were shared today that are in various phases of development. And for the account – for the ACOs, they are under

the – for the pilot period where if you have comments on their program, you can share with us, but if you want to share a comment for consideration formally, you need to go to www.regulations.gov and look at their notice that was posted on November 17.

As a reminder, the three topic areas are the Accountable Care Organizations Shared Savings Program, the Center for Medicare and Medicaid Innovation and the Federal Coordinated Health Care Office.

You're sharing ideas today. You're sharing thoughts. We wouldn't be able to answer a lot of questions so I ask that instead, you think about ways to give us provocative ideas and information.

And try to keep your remarks to two minutes. If you get too long, you're going to force me to be in the role of the gong person and catch up. So let's make sure we have lots of room for other people to share.

(Melissa), I'd ask for you to open up the phones, have people, make sure they share their name, affiliation and if possible, which area – which of these three areas they'd like to share comments about.

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. And again, we do ask that you please state your organization prior to asking your question. We'll pause for just a moment to compile the Q&A roster.

Your first question comes from the line of (Lisa Graybert). Your line is now open.

(Lisa Graybert): Good afternoon. I'm commenting on behalf of the American Hospital Association. My name is (Lisa Graybert) and I'm going to be commenting on the CMMI and the ACO program.

One of the things that many of our members are very excited about right now is participating in many of the initiatives underway under the CMMI, but we're not really sure how to educate them and direct them to access the

CMMI. So we recommend that CMS establish a transparent process instructing entities on how they can work with the CMMI.

Another area concerning ACOs that we hear a lot from our membership on is how ACO will be able to address world providers. We feel it is especially important to find a way to foster delivery reform in rural areas and we are concerned at the statutory requirements for ACOs limit the ability of world providers to participate in the Shared Savings Program. We encouraged CMS, perhaps to the CMMI to explore opportunities to extend similar arrangements to world providers who are interested in adopting delivery reform.

A final comment I'd like to make on ACOs is investment in the program. It is important to recognize that forming an ACO and participating in the Shared Savings Program involves significant investment on the part of providers who form the ACO.

Those front and investments need to be covered at least in part by the expected savings to be generated under the program.

One of the potential draw back to the physician group practice demonstration, the precursor to the ACO program was that participants have to first overcome a Shared Savings threshold for random variation so we recognize CMS' need to build this capacity in.

We would ask that CMS think about how to use these funds perhaps in providing a fund to put those variation funds into and deliver that out for potential successes in the program that are early on or so they consider periodic interim payments to ACOs to help in investing an infrastructure.

Since the Medicare program benefits from the first dollar savings, it is reasonable to expect the program to share in the investment cost to generate the Shared Savings.

Thank you very much.

Susie Butler: Thank you so much, (Lisa). We took careful notes.

Operator: Your next question or comment comes from the line of (Lorrie Cortell). Your line is now open.

(Lorrie Cortell): Hi. My question regards individual providers because you've said you had – this initiative would work for private practices or single provider practices. The practice that we have provides home services for homebound patients who can't get out easily saving the Medicare across and Medicaid across of providing for ambulant services and also bringing the patient into the hospital or services paying it or somebody to go with them. Is this going to factor into any of these programs helping providers to provide the service for home care to these programs?

Susie Butler: (Lorrie), we cannot take note of your questions.

(Lorrie Cortell): Yes, it is a rule setting so this is something I'd like you to take note of that. I head (Lisa)'s comments regarding rule settings. We do work in a rule setting and it's something I'd like you to consider with these programs.

Susie Butler: OK. (Lorrie), where are you from? I didn't catch that?

(Lorrie Cortell): We do Rocklin and Orange County.

Susie Butler: And what area is that and what company are you with?

(Lorrie Cortell): It's New York State and its podiatry office.

Susie Butler: OK. Thank you so much.

(Lorrie Cortell): You're welcome.

Susie Butler: Appreciate your comments. All right. (Melissa), we're ready for the next.

Operator: Your next question or comment comes from the line of (Kim Kirkwood). Your line is now open.

(Kim Kirkwood): Hi. I'm calling from a single family practitioner in a town of 4,000 people. We live in Indiana. Indiana had a system and it did integrate the care for Medicare and Medicaid.

We – as primary cares, we were assigned ethic number of patients based upon what we thought are load could take and so let's just say that the panel size was 100 folks that had dual eligibility.

Recently, as of October 1, they decided that – as a cost-saving measure, they were going to move 75 percent of the people that were in this dual eligibility program which had a primary care home in which the primary care directed and authorize all the care for the payment whether that would be outpatient testing or inpatient services.

As of October 1, they decided that cost-savings was the name of the game and so they got rid of 75 percent of these patients and threw them back into just the traditional Medicaid system where they can go to the emergency room whenever they want, they can see as many physicians as they want and there is no accountability.

And I find that they want to move this chronic disease management of the patients that they kept in the program to Indianapolis which is two hours away. And my concern is that unless you live in a rural community and to understand that there are two restaurants and there are once grocery store and these folks are not the best educated and frail and have multiple problems.

Calling them on the phone once every two months does not manage their disease process. We need to be able to have management in place at our local hospitals where these people can become somewhat accountable. And until we ask them to be accountable and that we actually hit them at the core of where they live, we're not going to change the chronic disease processes.

Susie Butler: (Kim), thank you for your comments.

Operator: Your next question or comment comes from the line of (Deborah Fitrin).
Your line is now open.

(Deborah Fitrin): Hi. This is (Deborah Fitrin). I'm with the New Mexico Human Services Department in New Mexico and I want to add on to the list of people encouraging you to really look at rural and in our case front care services and in new innovative ways to support the practitioners that are out there specifically looking at independent practitioners that Medicare currently isn't credentialing or accepting assignments from and – you know, that they could be because they're useful.

You know, we're all aware of the primary care issues that we're having, it's also happening in the behavioral health side where I work and look at – you know, really look at innovative ways that you can use these independent – people who are independently certified here in the states but not to Medicare which makes our lives a lot very difficult at times. Thank you.

Susie Butler: Thank you, (Deborah).

Operator: Your next question or comment comes from the line of Katrina Russell. Your line is now open.

Katrina Russell: Hi. Katrina Russell. I'm with Dialysis Consulting group in Seattle, Washington. I work with independent dialysis providers and I'm trying to figure out where the Medicare in-stage room that the program is going to sit in.

We certainly have an innovative payment policy that's going to be effective January 1st as well as the Quality Incentive Program in 2012 and we have a significant number of dual eligibles. Where do you envision particularly independent dialysis providers perhaps sitting into anyone of these models?

Susie Butler: We'll take that back. Thank you, Katrina. That's certainly provocative.

Katrina Russell: Thank you.

Susie Butler: (Melissa)?

Operator: Again, if you would like to ask a question or make a comment, press star then the number one on your telephone keypad.

Your next question or comment comes from the line of (Geronimo O'Brien).
Your line is now open.

(Bill O'Brien): Yes, hi. My name is (Bill O'Brien). I'm with UMass Memorial Healthcare in Western Massachusetts. And my question I believed would be towards the third group, the coordination of healthcare.

And I was wondering if consideration will be offered at all in projects that relate to patient populations that are defined by particular kinds of illness, and I'm thinking of coordinated care around individuals with intellectual disabilities.

Susie Butler: OK. We'll take that, John.

John Pilotte: You know, Susie...

Susie Butler: Go ahead.

John Pilotte: ...let me just give one piece of guidance from the innovation side. You know, if you think about the mission that we're describing, there are lots of different ways and this kind of goes to the dialysis question a little bit too.

Lots of different ways, you know, you can think about identifying opportunities for innovative models and you can kind of figure out geographic, you know, location kind of approach, you could think about a disease specific approach, you can think about the type of provider approach.

And, you know, we are open at this. As I say, we're kind of in a period where we're trying to identify and try to identify really how we're going to operate and what the priorities are.

And so we're open to hearing from folks who have seen the world and thinking about opportunities from any of those perspectives but what I would ask you to do is this about patients, individual patients, think about needs that are going unmet or not adequately met and think about kind of what that population might be in terms of how many those folks that are out there and

how much – how great the opportunity is to make a difference, and focus on opportunities to make a major difference for those patients.

Start there and then think about, you know, how can we provide that seamless care experience, how can we improve health, healthcare the total cost of care for those folks, and those are the kinds of proposals that we're hopeful to get from people thinking through that kind of a very concrete approach to starting with patients, think about what the measures are, think about – and what your interventions are, what is the new model of care and how is it going to change the experience of those patients.

And I think in response to what several people have asked, if you think about that way and think about a proposed new model of care and/or payment for folks coming out of that framework, that's the way we're going to be thinking about this and going to the first question of – first point about a more formal way of engaging really is we will be developing that, will be part of our process over these 60 days so we certainly intend to do that.

We intend to be very transparent, very upfront and open about what we're doing and how to get engaged and how to make proposals to it. So I'm just a little foreshadowing there, if you will, of how to think about a proposal.

Operator: Your next question or comment comes from the line of (Scott Charles). Your line is now open. (Scott Charles), your line is now open.

(Scott Charles): I'm sorry. I had my phone on mute. This is (Scott Charles) with (inaudible) Corporation in Atlanta, Georgia.

We own and operate skilled nursing facility home health agencies, hospices and a variety of other post-acute operations. Among those is a wavered program in Georgia for the care management of Medicaid patients who are at risk of institutionalization.

Most of what I had read and heard due them today deals with a lead agency that would either be a physician's practice or a hospital. We currently have about 5,000 patients in our care management program. What consideration is

being given to a lead agency that would be other than a hospital or a physician – large physician practice?

Rick Gilfillan: Again, I'm just answering from the perspective of the Innovation Center and not on behalf of John of the ACO program.

But again, we're interested in that kind of proposals that start with patients and tell us about an opportunity to improve the lives of patients and whether that comes from a physician or a hospital or some other type of healthcare provider is not so much the issue. It is the question of -- how is it going to change the patient's life and how are we going to be able to document if that's the case. So it was not my intent to limit our folks who could make proposals to doctors and hospitals.

Operator: Your next question or comment comes from the line of (Kevin Gibson). Your line is now open.

(Kevin Gibson): Hello. This is Dr. (Gibson) in Buffalo, New York. And I have two questions. The first one is, have you made a comparison between ACO and the kinds of health system that exist currently in California?

Susie Butler: I don't think we can answer that right now. I mean I don't think we're in a position to answer that right now.

(Kevin Gibson): OK. The next question, how does innovation recognize the differences between traditional organ-based disorders versus bio psycho or social disorders that result from our emerging epidemic or chronic health conditions?

Richard Gilfillan: You know, I guess the story is the same. You know, we're interested in making patient's life better and proposals that talk about how patients' lives are going to change as a result of new care model.

And so the issues you raised are important. Obviously, people with chronic illnesses are going to be – represent, we think, great opportunities as better things for patients and no doubt, many of our models that people propose will be starting with the problems that those sorts of patients have. So that kind of fundamentalizes us back to what will be working on.

Operator: Your next question or comment comes from the line of Adam Chrisney. Your line is now open.

Adam Chrisney: Hi. My name is Adam Chrisney. I'm from the firm of Powers Pyles Sutter & Verville. A healthcare law firm in Washington, D.C. We represent a number of clients with a number of different healthcare interests.

I had a couple of different questions or comments to offer then we'll probably – or clients will probably be following these up with longer testimonials and questions through the comment process.

But with regard to accreditation, we're hoping that you were giving some considerations to the role of accreditation and, you know, concerns with transparency, insolvency and so on and so forth, but I wanted to urge you to consider using third-party accreditation. That comment is on behalf of the Commission on Accreditation of Rehab Facilities, CARF.

On the – it was interesting to hear your comments with regard to the ESRD population. We – one of the issues that we would urge you to consider would be to, you know, forming some sort of specifically tailored ACOs for the ESRD population considering the – you know, as the previous caller mentioned, you know, the high dual eligible concern for this population, you know, up to 40 percent.

And then we have a number of providers that – who represent – who are concerned with any sort of new entity like an ACO becoming sort of a gatekeeper and, you know, concerned about the potential for rationing of care where the bottom dollar would be the – saving the bottom dollar will be the consideration over quality of care and what are you doing to ensure against that. So we'll be offering comments along those lines as well.

Susie Butler: Thank you so much.

Operator: Your next question or comments comes from the line of (Aileen Roberts). Your line is now open.

(Aileen Roberts): Hi. My name is (Aileen Roberts). I'm calling from a solo community hospital in rural Western Kentucky, in Mary, Kentucky.

And I wanted to agree with the caller from Indiana talking about the personal responsibility as a beneficiary. But given not, sometimes, people, because they don't have access to primary and preventive care, their value is not in healthcare prevention. It's more in survival.

So because the access is limited and some of our – like some of our physicians in this community have closed their panels to the Medicare beneficiaries, and this is not unique to Mary, Kentucky. I mean it's unique throughout the contrary. And some of the physicians just have to limit, the patient ends up going to use ER as a clinic.

So what I would propose that you all think about is to have more of a primary focus for access which is a primary need that some of these patients especially with chronic conditions have. And another thing you might to think about is the re-emergence of some incentives of neighborhood clinics.

Home health is also a limited because you need to have that homebound status except for going to the doctor. I would propose that maybe it would be probably cheaper that pay for home health to go out and do some assessments on these chronic conditions and let the people be active but they can still have their chronic disease managed.

And I agreed with the caller from Indiana, a phone call is not going to get it. The hands on, daily wait for the congestive heart failure patients, I think would be more meaningful to the patient and perhaps bring that personal responsibility in because you'll not only be educating. You'll put them in the form of a stakeholder in participating in their care.

I hope that helps. Thank you.

Susie Butler: Thank you so much.

Operator: Your next question or comment comes from the line of Donna Stidham. Your line is now open.

Donna Stidham: Yes. A question and a comment. My question is, in the ACO construct, there are many huge hospital systems already that are very, very powerful. And the concern is for small plans or practices that have adverse elected patients where small special needs with HIV and AIDS and find it difficult to negotiate with large hospital systems because of our small size and their large size.

Also under ACOs, we are concerned about people with HIV and AIDS nationwide. Those providers having access because these are high-cost patients who will drive up the cost and need to be managed carefully so we want to caution and ask that protection for large systems to be all powerful be put in place.

Susie Butler: Donna, could you give me your affiliation? I missed that.

Donna Stidham: AIDS Healthcare Foundation.

Susie Butler: OK. Thank you and thanks for your comment.

Operator: Your next question or comment comes from the line of (Lovelyn Singh).
Your line is now open.

Chip Amoe: Hi. Actually, this is Chip Amoe and I'm calling from the American Society of Anesthesiologists. Thank you for holding the call today.

I had a question. I heard a lot of discussion from the presenters about the primary care models and focusing on those areas of care. What we were curious about are the plans, if any, for – to focus on the perioperative setting as – that's such a cost driver also at center for which, you know, a lot of conditions such as hospital-acquired conditions or the type of never events that I know CMS has been looking to try to avoid.

A lot of those stem from the perioperative setting. I know there is currently an ACE demonstration project that's ongoing and I was just wondering if you could speak to the kind of information, if any, you received from that ACE demonstration.

I know we've been trying to seek some information about the shared savings arrangements that are contained within that ACE demonstration project and we have not been able to get any feedback or anything posted from CMS about that Shared Savings to allow us to take a look at that and others to take a look at that to see if those Shared Savings plans are working at the current time.

So I know there are some good opportunities there just given the high cost and the types of events that are affected by the perioperative setting so I just thought I would throw that out and get a feedback from any of the presenters.

Rick Gilfillan: Yes, Chip, hi, this is Rick Gilfillan.

Chip Amoe: Hi. How are you?

Rick Gilfillan: Good, thanks.

We can't say too much about that but if you think about those three levels of care I mentioned, that first level, the care model level is the level in which I think the kind of issues you talked about kind of fall within that and we expect that, you know, new models of care they get at, redefining, re-engineering specific care episodes around best practices and teaming that with a alternative payment arrangement whether to that facility-based approach as with the ACE demonstration or others, that we will be interested in exploring opportunities to work exactly that space. I think overall, the experience has been favorable with that and we want to continue to build on.

Chip Amoe: Great. Thank you. We'd love to work with you on any efforts that you have with that and we hope to – beginning with some ideas for that as well.

Susie Butler: Great. Thanks so much.

Operator: Your next question comes from the line of Dennis Horrigan. Your line is now open.

Dennis Horrigan: Yes. This is Dennis Horrigan from the Catholic IPA in Catholic Health System in Buffalo. One of the current criticisms of the primary care

demonstration project is the membership and the utilization data is often delayed, you know, nine to 12 months, and I'd like to suggest that you consider providing any ACO organization with baseline utilization and cost data in a standardized actuarial format and then regular reports that could be used to compare baseline with actual utilization from year-to-year.

And I say that because you have standardized quality reports but from what I understand, the utilization data is very difficult to work with. And if your objective is to bend the curve or the per capita cost, the Accountable Care groups are going to want to be able to focus on those key areas in the trends that they need to deal with. Thank you.

Susie Butler: Great. Thank you very much.

Operator: Your next question or comment comes from the line of Larry Martinelli. Your line is now open.

Larry Martinelli: Good afternoon. I'm Larry Martinelli. I'm with the Infectious Diseases Society of America.

And in terms of different paradigms of care, I'd like to suggest one that's been in widespread use over the last 20 years in the private care arena but for various reasons, Medicare has not taken advantage of this, and this is home infusion.

And we look at home infusion as a way to keep people independent at home to decrease their risk of those comial infections by decreasing or minimizing their exposure to generate cost savings to the agency in the program by shifting their site of service from a high acuity inpatient, long-term acute care hospital or skilled nursing facility into the low-cost center of their home.

And we feel that this is beneficial not only to patients but to the program. I would appreciate you taking a look at the possibility of extending Medicare benefits for home infusion therapy for our patients who are currently impacted by the need for longer-term antibiotics essentially becoming incarcerated in the hospital or the skilled nursing facility or the LTAC simply because they require home antibiotic therapy which in patients that's 64 can be provided in

their own home, and if you're 65 and covered by Medicare, require you to be an inpatient. And I appreciate your attention and your chance to comment.

Susie Butler: Thanks, Larry.

Operator: Your next question or comment comes from the line of Tim Richardson.
Your line is now open.

Tim Richardson: Hi. Can you hear me?

Susie Butler: Sure.

Tim Richardson: Hi. My name is Tim Richardson. I'm a physical therapist and private practice in Bradenton, Florida. I'll try to keep this brief. I wanted to encourage CMS to – currently self-report functional skills are recommended but not required for outcome assessment of, for example, patients following hip surgery.

I would recommend requiring the self-report measures. A lot of these are in the public domain. Most of them have been around for many years and are validated and I think we'll find that as a process measure mandating the use of these skills.

They have directly been linked to outcome and so especially when we're getting everybody, orthopedics and primary care and physical therapists, together in the treatment of these patients, we would find that mandating the self-report measures, I think would improve process and outcome. Thank you. I'll wait for your response.

Susie Butler: Thank you, Tim.

Rick Gilfillan: You know, let me just take – actually, I think there is – as we've considered a variety of initiatives – I'm sorry, this Rick Gilfillan again – we've thought a lot about metrics as measures – always to measuring success and giving kinds of programs.

And we are particularly interested in the notion of patient reported information and as just described – as Tim described, it's an interesting and important area for us so I just want to highlight that as an area that we would

be interested in seeing. The extend with that is included in proposals and I encourage you to think about – some novel ways of using patient reported data particularly given the difficulties that we have been getting good outcome information.

Susie Butler: Great, thanks.

Operator: Your next question or comment comes from the line of (Mary Andres). Your line is now open.

(Mary Andres): Hi. This is (Mary Andres) with Easter Seals here in Washington, D.C. but we represent group of 75 affiliates around the country that provide direct services to people with disabilities – any disability.

And first, let me thank you for taking your time to do this today. This is a tremendous opportunity for us.

The comment that I wanted to make was just to say that we are concerned that the definition of the continuum of care be as broad as possible and be watched as the designs are created.

We need to go beyond the purview of just doctor's offices or urgent care and inpatient care to make sure that the endpoint is somewhere after the discharge from the hospitals. It is in the taking good care of folks when they get home that we are going to be able to reduce the number of the inpatient visits and reduce the number of times that individuals end up back in the hospital. The view needs to entail this broader definition so we can attain and maintain the highest function possible for people with chronic illness.

There are so many important services that go on at home. We just want to make sure this stays in the viewer as you all are putting together the different designs and want to be as helpful as we can in that process.

Thank you for your time.

Susie Butler: Sure. Thanks, (Mary). And Rick?

Rick Gilfillan: Yes. (Mary), thanks for that comment, and I think – I just want to highlight so we're clear. There is a scope of responsibility, if you will, for the Innovation Center that's pretty well defined in the statute as those eligible for A and B services and on the Medicare side and the appropriate title for Medicaid and CHIP as well.

And so we are interested in proposals that again start with patient's needs and tell a story about an intervention that changes those patients' experiences in a way that affect, you know, the cost, if you will, of course, those defined areas.

So as long as it's in there and as long as the impact is going to be on there – on those services and we can trace, you know, the improvement in quality and the improvement in cost within the confines of those programs then whatever the service is open for innovation and for new models but it does need to anchor – be anchored in, if you will, ultimately a story around change in those primary dimensions.

Susie Butler: Great, thanks.

Operator: Your next question or comment comes from the line of (Nancy Gaist). Your line is now open.

(Nancy Gaist): Yes. My question relates to timelines. Is there currently a projected timeline for making a decision on the different models that will be used for actual implementation of those models?

Susie Butler: (Nancy), where are you calling from just so I keep my record straight?

(Nancy Gaist): I'm calling from Integrated Medicine Alliance in Monmouth County, New Jersey. We're a large primary care practice.

Susie Butler: Thank you so much.

Rick Gilfillan: Yes, just to be clear, we announced four new initiatives. Two of those are coming directly out of the Innovation Center, two of those are coming from other areas within CMS.

But we expect it to be an ongoing and continuous process. We haven't defined exactly what the timeframe will be at this point because as I say, we just kind of came live two weeks ago, but we are listing the folks and building out our model and that will be – all that information will be on the Web site.

So we're interested in your ideas but we'll be coming forth of the more specific approach of solicitation and all that will be noted on our Web site which is www.innovations.cms.gov...

(Nancy Gaist): Got it.

Rick Gilfillan: ...which is – it's just a little bit of information there yet but we're building it up.

Susie Butler: And you can also sign up on that Web site for the listserv so that you'll get information, would it happen as it happens. So make sure you do that.

(Melissa), we ready for our next question.

Operator: Your next question or comment comes from the line of John Derr. Your line is now open. John Derr, your line is now open.

John Derr: Can you hear me?

Susie Butler: Yes, now we can.

John Derr: I'm from Golden Living and also I'm on the Long Term Post Acute Care HIT Collaborative that formed here after President Bush did his Presidential Executive Order in 2004.

I just wanted to back up a lot of people in talking about the inclusion of other people besides hospitals and physicians in trying to create what I believe the objective of the health care reform bill as to have longitudinal care of person-centric system that's integrated and dynamic and to break down the silos.

And right now, I'm on a number of different committees and everything because of the way the regs are currently written are focused on episodic care even some presentations I went to where hospitals talked about ACOs or just a

re-hospitalization program within ACO bent to it. And I want to encourage everyone to look at the patient-centric longitudinal care which is dynamic so we can start working on wellness and pro-acting and cut down the silos.

And you also mentioned about pay models, most pay models including those for SNIPs and homecare and all that are in the silo effect and it's very difficult for us to come up with the longitudinal care when the system is set up for episodic care and the powers are really in the hospitals and in the doctors.

And I just encourage just us. LTPAC includes a SNIP and (ELS) and (IRFs) and LTAC and homecare and hospice care and independent care and all the things that a lot of the people on this phone call have encouraged CMS to include us even though we were left out in the ARRA and the incentives.

Mainly, we still want to provide the highest quality of care for our patients and the group – the company that I work for has over 30,000 LTPAC patients under our care at any one time and we are establishing our electronic health record and looking at patient-centric medicine across the whole spectrum of care.

We use the word spectrum instead of continuum because a continuum has a start and a finish where spectrum is really how we care for people at the right place at the right time and the right care setting and at the right cost. Thank you.

Susie Butler: Thank you, John.

Operator: Your next question or comment comes from the line of (Heather Boyd). Your line is now open.

(Heather Boyd): Hi. This is (Heather Boyd) from the American Medical Directors Association. I wanted to ask you how envision a long-term care setting today into the ACO model?

Susie Butler: I don't know that we can answer that right now, but I appreciate the thought.

John Pilotte: Yes, I would just add that – I mean if you look back at the first statutory provisions on that, you know, ACOs are looking at – and as the previous caller noted – you know, all – both Part A and Part B expenditures, so they do fit in, in terms of – to the extent of the expenditures are represented in the Medicare benefits package and service package, we would be looking at this whole approach of – and the whole continuum of those services throughout the Part A and Part B program as described in the statute. Thank you for the comment.

Susie Butler: Thank you, John.

(Heather Boyd): OK.

Operator: Again, if you would like to ask a question, press star then the number one on your telephone keypad.

Your next question or comment comes from the line of Patricia Nemore.
Your line is now open.

Patricia Nemore: Hello, thank you. This is Patricia Nemore from the Center for Medicare Advocacy.

I'd like to just make two points about evaluating proposals and I think this would really be across all three of the areas that are being looked at today but maybe more the CMMI and perhaps the office for duals.

Dr. Gilfillan just a minute ago talked about improving care or improving cost, improving our savings at being objectives for the CMMI models that they're looking for and we, at the Center for Medicare Advocacy work very hard to ensure that people with chronic conditions aren't held to a standard that requires them to improve functioning.

One way that we will improve care for people with chronic conditions is to recognize that they need services to maintain them in their current situation that they may not improve but to keep them from deteriorating or to postpone the speed or to slow down the speed of their deterioration. So that is an

important element in improving the quality for many people with chronic conditions.

The other point is that an earlier speaker mentioned keeping people out of the hospital as one important way to improve their health status and keep them from getting hospital-acquired infections and so on.

And we know from our peer that there is a tremendous amount now of assessing people who are in the hospital as being in observation status rather than as inpatient. And we also know that the quality measures that look at hospitalizations and re-hospitalizations do not identify observation status as an inpatient status.

So in fact, people can be in the hospital in exactly the same conditions that an inpatient would be but they are not going to show up as being an inpatient and therefore as being a hospital readmit or a hospital admit. And we think that's a very important thing to know when looking at quality measurements that measure keeping people out of the hospital. Thank you.

Susie Butler: Thank you.

Operator: Your next question or comment comes from the line of (Alice Smith). Your line is now open.

(Alice Smith): Yes. In the reform bill, there is language that we know that a specified number of ACO professionals would care for – specified number of Medicare beneficiaries.

My comment is that it is my understanding that that log is CMS has some degree of authority to specify who are those ACO professionals would be and I would just recommend that a considerable consideration be given to including mid-level practitioners namely physician assistants, clinical nurse specialists, as well as nurse practitioners.

My second comment has more to do with non-compliance. There has been a great deal of discussion earlier in this call on how ACOs can best manage care but in those instances where patients fail to comply with recommended

treatments and evidence-based treatments. I would advice and request that some criterion be developed to help ACOs better manage those patient that maybe noncompliant with the recommended treatment.

My last comment – well, just in there.

Susie Butler: OK. Thank you so much.

Operator: Your next question or comment comes from the line of Todd Ketch. Your line is now open.

Todd Ketch: Hi. Can you hear me OK?

Susie Butler: Sure can.

Todd Ketch: Great. Thank you.

Again, this is Todd Ketch with the American Health Quality Association. My organization represents the national network of private Quality Improvement Organizations that are – that was readily known for the work that they do with Medicare as you all know through the Medicare QIO program.

And then as we look at opportunities that come from the Affordable Care Act, so when looking at Accountable Care Organizations and feel as the QIOs, we're hopeful that as the CMS is looking at the statement of work that's underdeveloped and now as they look at the QIOs as the potential resource for implementing significant components of the Affordable Care Act.

And as we look at ACOs, we feel like the organization is to really serve as a local and trust mutual network of conveners to, you know, helping to establish the ACOs. It will be really critical.

We're getting role with a wide variety of stakeholders that will need to be involved in putting in place structures and policies ratios to be successful. We're going to recognize some integrated health system that participate in a pilot may not need direct (inaudible) in close distance.

We know that any providers in areas of the country are not certified in the system and may probably need support. This maybe particular to – into smaller rural providers as well as long term care facilities into a health system (inaudible) so it's a unique local pricing that, you know, you have in the QIOs as an infrastructure will be essential so their ability to understand and respond to the needs in insurance of local communities as they work through the ACO development process.

(Inaudible) are positioned as the individual providers to be prepared to operate effectively with your environment, there will be a system that we knew to help with utilization of HIT in connection to local health information exchanges, analyzing data, redesign care processes and really linking to the network of providers that we need to work together to manage the care for patient as it transition across to seamless care.

The ACOs, you know, also will be called to measure report improvement to quality and efficiency in supporting the ACOs through technical assistance with measurements and improvements happen to a (inaudible) QIOs have as a motivation key.

Without the assistance through the term providers, we may not be able to operate effectively in an ACO structure and thereby limiting the potential to improved quality at reduced cost.

But just briefly say that in the couple of the other areas that we're talking about here with Center for Medicare and Medicaid Innovation, that that intended to foster improved transitions of care to reduce possible readmission and to improve the evidence-based coordinated care for Medicare, Medicaid and shift to (inaudible) to be drawn upon to assist CMS in meeting the requirements of the center and certainly the QIOs have a track record of independent community-based organization to people offering technical assistance program design as well as acting as an implementation field force from innovation to local providers.

And finally, on Medicaid, there is a wide array of experience for QIOs working in the Medicaid program at the state level and certainly there's

opportunity for coordination there to really apply kinds of quality improvement (inaudible) that these organizations have in place working with CMS to reach across these programs in a more coordinated fashion.

So I'll just stop with, we do hope that CMS will look carefully and we know that Dr. Berwick is – he can do all as well at how to utilize its resource and the quality improvement organizations program to help with implementation of important aspects of the Affordable Care Act. Thank you.

Susie Butler: Thank you, Todd.

Operator: Your next question or comment comes from the line of Rebecca Scott. Your line is now open.

Rebecca Scott: Hi. Can you hear me?

Susie Butler: Sure.

Rebecca Scott: Hi. Rebecca Scott. I'm from the University of Kentucky. We're an academic medical center. I work in the area of clinical trials research and Medicare coverage.

My comment would be that as we move forward both with innovation and ACO models that we consider redefining what we mean by qualifying and deemed criteria for clinical trial coverage in order to expand coverage for participants in trials which often provide potentially a life-saving experimental treatment for our patients.

This comment goes sort of to the patient-centric care model that we were discussing earlier and thanks for hearing me.

Susie Butler: Thank you so much, Rebecca.

Operator: Your next question or comment comes from the line of (Alex Ferali). Your line is now open.

(Alex Ferali): Hello. Hi. And thanks again for holding this session. I work for Intel and also I'm a part of the Continuum Health Alliance. And I wanted to just

commend you to team of the issue of the handoff as being really critical to the process for coordinated care.

The handoff in terms of the Medicaid state health homes, as well as the home and community-based services, these all seem to rely on having data that will be shared on the patient.

And since the – our stimulus spending bill, only provided the spending the incentive program for the hospitals and the physicians and really didn't include the continuum of care.

We're just wondering how you will address this. Will there be additional incentive moneys in order to ensure that EHRs are provided for the continuum of care including the patient reported information from their homes or assisted living or wherever they fit into that circle.

Susie Butler: OK. Well, we'll take that comment back. Thank you very much.

(Alex Ferali): Yes.

Operator: Your next question or comment comes from the line of (Brett Berman). Your line is now open.

(Brett Berman): Hello. CMS does not – I work for a company called (DFP). We're specialty pharmacy focusing on the treatment of hemophiliac and hepatitis C and we're currently developing some proprietary software to help with the some of innovation that's being discussed.

However, CMS does not currently recognize pharmacists or pharmacies as healthcare providers. Will this in any way impede our inclusion in any kind of innovation plans regardless of what we're doing and if so, is there any – is it possible for our classification as providers to be changed? Thank you.

Susie Butler: OK. Thanks for your comment.

Operator: Again, if you would like to ask a question or a comment, press star then the number one on your telephone keypad.

Your next question or comment comes from the line of Rhonda Williams.
Your line is now open.

Rhonda Williams: Hi. My name is Rhonda Williams and I represent LTAC Partners of America and also postacutenetwork.com. We support professionals in post acute care industry.

And I'll be very brief because a lot of this was covered by previous callers, but I just wanted to maybe encourage CMS to publicize the need or the fact that what I'm hearing on the call was that you are really very open and interested in receiving information and proposals from other providers outside of this short term acute care hospitals.

But many post acute providers are not aware of that because of the way things were initially structured when we initially started talking about the ACO model. So I would encourage CMS to publicize the fact that you are looking for those comments and those proposals from the post acute care providers.
Thank you.

Susie Butler: Thank you, Rhonda, and we'll make sure that we get that message out far and wide.

Operator: There are no further questions or comments at this time. Ms. Butler, I'll turn the call back over to you.

Susie Butler: Thanks, (Melissa). And again, I want to thank everyone for taking their time today to join us. I know you have a lot of things on your schedule and demands on your time.

I also know that there was rather short notice for this call, and a lot of people did want to participate. We had so much fun today that we're going to do it again next week – same topic and just give other people the same opportunity to participate.

If you participated today, don't call in next week unless you just want to. It's going to be the same information sharing, but we're trying to, as some of our callers noted, make sure that people know that we're interested in ideas and

getting information out for folks so that they can share with us their innovative ways. You've been waiting a long time to tell CMS how to do their business, well, this is the chance to do it.

We have people who are listening but we're looking for ideas and ways to look at ways to look at ways to streamline across and provide better care. So help us with that and we'll – you should be seeing the invitations come out later today for next week's meeting just so confused with today's, know that we're doing this again.

And in addition as Rick mentioned earlier, we'll be doing listening sessions and open door forums in each of the 10 regions over the coming two to three months, so look for invitations to those as well at a local level.

As I promised to you, I said I would give you those email boxes, the email addresses one more time, we have innovate@cms.hhs.gov or the Web site is www.innovations.cms.gov. And for the ACOs, aco@cms.hhs.gov for general ideas, but if you're commenting on the Federal Register Notice, remember, go to regulations.gov to submit a comment and look for the November 17 notice. And then finally, fchco@cms.hhs.gov, and that stands for the Federal Coordinated Health Care Office.

So thanks again, everybody, for participating today.

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

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