CENTERS FOR MEDICARE & MEDICAID SERVICES

Moderator: Barbara Cebuhar
April 3, 2012
2:00 p.m. ET

Operator: Good afternoon. My name is (Nicole) and I will be your conference facilitator today. At this time, I would like to welcome everyone to the Centers for Medicare and Medicaid Services Initiative to Reduce Avoidable Hospitalization among Nursing Facility Residents, Special Open-Door Forum.

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 during this time, simply press star then the number one on your telephone keypad. If you would like to withdraw your question, press the pound key. Thank you.

Ms. Cebuhar, you may begin your conference.

Barbara Cebuhar: Thank you, (Nicole) for you assistance today. My name is Barbara Cebuhar and I work in the Office of Public Engagement at the Centers for Medicare and Medicaid Services here in Washington.

We would like to welcome you to our special open-door forum on the Initiative to Reduce Avoidable Hospitalizations among Nursing Facility Residents.

There are slides available at the following Web site. So if you all could write this down. It's http://www.innovations.cms.gov/resources/duals_rahnfr_apply.html. You'll scroll down and you'll see it under resources.

I'll repeat that address so you can use them to follow along with the call. That's http://www.innovations.cms.gov/resources/duals – D-U-A-L-S – _rah – as in Harry – nfr_apply.html.

More information about this initiative including the solicitation is available at www.innovations.cms.gov/initiatives/rahnfr/.

Finally, you can send any questions you might have about this initiative to NFIinitiative2012@cms.hhs.gov. That's capital N, capital F, capital I, initiative2012@cms.hhs.gov.

I'd like to introduce two of our speakers today who will be explaining the basics about this effort. Today, we are joined by two staff from the Medicare and Medicaid coordination office who will be providing an overview of this initiative.

Melissa Seeley is a technical policy director and Evan Shulman is a technical director. To help answer your questions, we also have Tim Engelhardt from the Medicare and Medicaid Coordination Office, Dan Farmer from the CMS innovation center and then Mary Greene from the Office of Acquisition and Grants Management on the call.

After Melissa and Evan's presentation, we will take questions. At that point, the operator will tell you how to get into the queue.

The call is yours, Melissa and Evan. Go ahead, please.

Melissa Seeley: All right. Thank you so much, Barb. We really appreciate the introduction. And thank you to our audience today for your interest in the Initiative to Reduce Avoidable Hospitalizations among Nursing Facility Residents.

As Barb indicated, my name is Melissa Seeley and I work with the CMS Medicare and Medicaid Coordination Office. I am joined by my colleague, Evan Shulman, who will also be leading the conversation today.

Today's Webinar is a joint collaboration of our office along with the Center for Medicare and Medicaid Innovation. I want to make a quick note that there is no Web technology per se or link for this Webinar.

The call-in information is all that you need along with the slides that can be found at the Web site that Barb mentioned. They are available on the innovation center Web site. We will spend the first part of the session walking through the slides and we will reserve the final portion for questions and answers.

So, with those announcements, we'll begin with slide one of the presentation.

So, the objective of this initiative is to reduce avoidable hospitalizations among nursing facility residents who are enrolled in both in Medicare and Medicaid programs. They are also sometimes called dual eligibles or Medicare and Medicaid enrollees.

Two-thirds of nursing facility residents are enrolled in Medicaid and most are also enrolled in Medicare, making many of them Medicare-Medicaid enrollees.

Nursing facility residents are hospitalized with great frequency, theses hospitalizations can be disruptive, disorienting and expensive. And residents are vulnerable to risks that accompany hospitalizations and transitions of care including medication and hospital acquired infections. Thus, preventing hospitalizations is an important quality improvement objective which may also reduce cost.

These avoidable hospitalizations can stem from multiple system failures. For example, physician preference to send a resident to the hospital due to lack of access to diagnostic services or scheduling inconvenience. Skill level of staff available can also be a contributing factor.

Moving on to slide two, I want to point out that oftentimes these hospitalizations can be avoided.

Research has estimated that a substantial percentage of hospitalizations among nursing facility residents could be prevented with well-targeted interventions.

In fact, CMS research found that 44 percent of hospital admissions among Medicare-Medicare enrollees who've received Medicare skilled nursing or Medicaid nursing facility services could have been avoided, accounting for 314,000 potentially avoidable hospitalizations to the tune of about 2.6 billion in Medicare expenditures. And that's from 2005.

We do know from past interventions that hospitalizations can be avoided. We've cited some examples here. For example, Evercare INTERACT, a nursing facility employer provider model that was tested in New York. These demonstrated positive results.

I want to put in a plug that that we will be talking about these and other models on an upcoming Webinar to be held on April 17th from 2 to 3:30 PM Eastern. Please see slide 26 for more information on that upcoming Webinar.

Moving along to slide three, with that background, on March 15th, we announced the funding opportunity announcement for the initiative to reduce avoidable hospitalizations among nursing facility residents. And when we refer to funding opportunity announcement, we mean solicitation or request for application.

Again, this initiative is a joint collaboration Innovation Center and the Medicare-Medicaid Coordination Office.

And on slide three, we outline the primary objectives of this initiative; namely, to reduce the frequency of avoidable hospitalization, improve resident health outcomes, improve care transitions between inpatient hospitals and nursing facilities and reduce overall health care spending without restricting access to care or choice of providers.

On slide four and five, we outlined the intervention requirements that we are looking for applicants to propose in their applications.

I want to highlight that CMS will select participants through a competitive process. We are not prescribing a specific clinical model per se but rather we are intentionally open to various models.

However, all interventions must meet certain requirements which are outlined here and are provided in more detail on pages nine to 10 of the funding opportunity announcement.

And these requirements include hiring staff who maintain a physical presence on site at a nursing facility and partner with nursing facility staff. I want to note that we are not requiring a specific number of hours that staff must be on site. But we are looking to applicants to define how much time staff would need to spend in a facility to meet the initiative's objective.

In addition, intervention must also work in coordination with existing providers including residents of primary care physicians, nursing facility staff and families. For residents who are hospitalized, the initiative would facilitate transitions to and from inpatient hospitals and nursing facilities. It would provide support for improved communication and coordination among existing providers including existing nursing facility staff, resident primary care physicians, hospital staff which includes attending physicians among others.

And the interventions must also coordinate and improve management and monitoring of prescription drugs, including psychotropic drugs which is an important emphasis of CMS in recent years.

Continuing to slide five, we outline some additional intervention requirements including the proposed interventions must demonstrate a strong evidence base. We're not expecting that proposed interventions have already been tested exactly as proposed. We are asking that interventions are built upon the existing available evidence.

We're looking to find interventions with strong potential for replication and sustainability. The enhanced care provider through this initiative is meant to be additive and thus the intervention will supplement rather than replace existing care.

It's important for interventions to coordinate closely with state Medicaid and survey & certification agencies and other health reform efforts given there are other efforts underway in states and we'll talk about this more later.

Finally, interventions must allow for nursing facility residents such as the patient without any need for residents or their families to change providers or enroll in a health plan.

Slide six lists some considerations that applicants may want to incorporate in their proposals. This is not an exhaustive list. But some examples include education for family and caregivers, support for facilitating successful discharge of nursing facility residents to the community as appropriate, health information tools and emphasis on behavioral health services.

Moving on to slide seven, we focus here on the target population for this initiative. And the primary target is fee-for-service, long-stay Medicare-Medicaid enrollees residing in nursing facilities. We are seeking to direct the clinical interventions to long-stay residents rather than those who experience a brief post-acute stay and then return home.

Applicants may also propose to target the intervention to long-stay residents who are not yet Medicare and Medicaid enrollees if they would similarly benefit for the initiative. And we ask that applicants will describe how they will target their proposed intervention to these long-stay residents.

I also want to point out that we prefer that an intervention target all the long-stay Medicare-Medicaid enrollees in a facility as opposed to just some of them.

So, with that, I will turn the presentation over to my colleague, Evan Shulman, to walk us through the next several slides.

Evan Shulman: Thanks a lot, Melissa.

We are on slide eight of the presentation. And we're going to start talking about eligibility. We've been getting a lot of questions about eligibility and a lot of interest which is great and we're very excited about that.

And we want as many applicants to be eligible to qualify as possible. But we do have t have some requirements that may make it difficult for some. We understand that.

With that said, we are looking to fund generally a small amount of entities. And we believe that we should have enough that qualify.

When you are thinking about eligibility, you could really think about it in terms of two categories. The first category is the organization that is applying to be the enhanced care coordination provider. And then, two, the partnering facilities that would be on your application. We're going to talk separately about both of those in a little bit.

For organizations applying, I refer you to page 26 of the funding opportunity announcement. For more information on the (partnering) facilities you should refer to pages 11 through 13.

So the guiding principles, we had to isolate the measurements of new interventions of services on the fee-for-service long stay Medicare and Medicaid enrollees. We'll look to demonstrate impact above and beyond other services and models. We need to ensure beneficiary protections and we need the applicant to adhere to the interventional requirements that (Melissa) just went over.

No, CMS will not provide individual confirmation of an organization's eligibility until after submission of the full application. Again, we've been getting a lot of calls and we've getting a lot of e-mails from such a wide variety of entities which is great. And we're very excited to see that.

We do not know about the other circumstance that may exist that may not be evident from the e-mail or questions that we're receiving. So, we cannot confirm an entity's eligibility. What we're going to do is provide guidance

about what types of organizations may be eligible and some of the rule in or rule out factors.

But, again, we won't be able to confirm eligibility. So, you'll probably see responses like "Yes, this organization would be eligible provided they meet all other eligibility and program requirements."

Moving on to slide nine, so eligible applicants, so this is the first category we spoke about, again, on page 26. CMS will make cooperative agreement awards to enhanced care and coordination providers to implement these interventions.

The eligible applicants may include but are not limited to organizations that provide care coordination, case management or related services, medical care providers such as physician practices, health plans, public or not-for-profit organizations such as aging and disability resource centers, area agencies on aging, behavioral health organizations, centers for independent living, universities or others, integrated delivery networks and non-profit and for profit organizations are also eligible to apply.

A note about this slide, just because the type of organization is not listed here does not mean they are not eligible. For example, hospitals, technology companies, pharmacies, health associations, they may be eligible, again, provided they meet all other eligibility and program requirements. But just because your type of organization is not listed on here does not mean that you are not eligible.

Moving on to slide 10, so nursing facilities, entities controlled by nursing facilities or entities for which the primary line of business is delivery of nursing facility. Skilled nursing facility services are not eligible to serve as enhanced care and coordination providers.

Nursing facilities are essential partners in implementing this initiative. They are required partners of the applicants that wish to be considered to be an enhanced care and coordination provider. And we are only planning implementing this initiative at nursing facilities that are willing partners.

Participation is voluntary for nursing facilities. And discussions about how the partnership between the applying entity and the facility should occur prior to the application being submitted and those discussions should center around how that partnership – what the partnership would look like.

Moving on to slide 11, so organizations that are generally eligible – individual hospitals, physician practices, public or private not-for-profit or profit organizations, care management or coordination companies. And, again, entities cannot be controlled by a nursing facility or have delivery of nursing facility or skilled nursing facility services as it' s primary line of business.

So, as stand alone entities, these organizations are generally eligible with some other provisions that I mentioned earlier. It may depend on the facilities they intend to partner with. And we'll talk about that in a minute.

Moving on to slide 12, organizations generally eligible but – these would include assisted living, independent living and CCRCs – we'll talk about that in a minute – integrated living networks or health systems and entities with a common nursing facility ownership, management or other related operations.

So, with regard to integrated delivery networks or health systems, these are typically systems that are comprised of multiple hospitals. There may also be nursing facilities that are within that health system. The entity of the health system is eligible to apply and eligible to receive an award as an enhanced care coordination provider.

However, they may not partner with the facilities that are within that network or health system or under the same common ownership. So, for example, if a health system has two nursing facilities that are within it' s system, it can apply but it would need to partner with a minimum of 15 other nursing facilities not including – not listing those two that are under the same ownership.

Assisted living, independent living and CCRCs, many of these entities have nursing facilities on the same campus or in close proximity. The entities themselves can apply to be enhanced care and coordination providers. However, similar to health systems, they could apply but they would need to

partner with nursing facilities that are not under the same common ownership (inaudible) unaffiliated facilities is who they would need to partner with.

And also, we've been getting some questions about, can entities apply with the intent to partner and insert an intervention into an assisted living or independent living. No, the – and per the funding opportunity announcement, the requirement is that you partner with a minimum with 15 Medicare and Medicaid traditional certified nursing facilities.

Excuse me – health plans are generally eligible, just making note this is not managed care. And we must ensure beneficiary protections. And, again, just restating what we've already said in a couple of slides, the entities cannot be controlled by a nursing facility or have delivery of nursing facilities, skilled nursing facility services as it' s primary line of business.

Moving on to page – excuse me – slide 13, other federal initiatives. We'd reference you to page 12 of the funding opportunity announcement for more information on this. This really applies to many of the other demonstrations or opportunities that have been launched by CMS and the Center for Medicare and Medicaid innovation.

We are not seeking to fund intervention that compete or interfere with existing demonstrations. If you are an entity that is participating with another demonstration or initiative, you are eligible. However, and some of those initiatives are listed there in the second bullet, you must disclose the current participation and notification and notify us of future participation in another initiative.

Describe how participation in this initiative will complement and support the other initiative. We need to ensure no duplicative funding or sharing of Medicare savings for the same individual served through this initiative. Describe how the impact of this initiative will be measured above and beyond the existing initiatives.

And, again, you can see the full section on this in pages 11 through 13 of the funding opportunity announcement. Again, we're really looking to isolate what is the added intervention or service that is being brought into this

environment and we need to isolate the measurement and unique impact of that intervention.

Moving on to slide 14 – billing. We'd refer you to page 21 of the funding opportunity announcement. Participants funded through this initiative will not be permitted to bill – to separately bill Medicare or Medicaid for services delivered to the nursing facility resident's involvement initiative.

For example, if an awardee hires nurse practitioners as part of this initiative, those nurse practitioners cannot also bill Medicare or Medicaid for services rendered to nursing facility residents at the facilities participating in this initiative, again, section 4.5 on page 21 of the announcement.

Moving on to slide 15 – nursing facility partnerships. So this is the second bucket of two that I mentioned earlier. The first bucket being who is the entity that is applying to be the enhanced care and coordination provider and then who are the facilities they are seeking to partner with.

So, success in achieving the aims of this mission will depend both on the strength and efficacy of the clinical intervention and the effectiveness of engagement between enhanced care and coordination provider and it' s partnering nursing facility. As I mentioned earlier, nursing facility participation is voluntary.

We need applicants to demonstrate a high level of engagement with the nursing facilities included in their application and those are discussions that need to occur prior to the application so that all parties know what the partnership would look like.

Applications must include letters of intent from a minimum of 15 Medicare and Medicaid certified nursing facilities within the same state with an average census of 100 residents or more per facility, the average census of 100 residents or more per facility is across all 15 plus nursing facility partners rather than each facility.

We've been receiving many questions on this. So, again, just an example if an application – if an entity wanted to partner with a facility we've got 90

residents and another facility with 115, both of those would qualify to be listed on the application as the average of those two is above 100. Again, assuming the other 13 plus would also be averaging over 100.

So, each facility does not need to have a minimum of 100 residents. But the average of all 15 facilities needs to be an average of over 100 residents. And a final note on this, we are encouraging entities to partner with more than 15. We'd like to see more than 15 on each application. We'll talk about the numbers of the opportunity in general in a few minutes.

Moving on to slide 16, nursing facility partnerships again continued, preference for implementation in geographic locations where high Medicare cost, high hospitalization readmission rates and where Medicare and Medicaid enrollees represent a high percentage of nursing facility residents.

On page 13 of the funding opportunity announcement, there are some links that could help you research some of these locations. We've already received some interest from some of these (inaudible) locations which is great. We'd love to see some more. But, again, on page 13 you'll find some links.

Some of the restrictions for nursing facility partnerships, facilities in which more than 25 percent of the long stay residents are enrolled in Medicare managed care. Again, we're looking to measure the unique impact of the added intervention. And if a substantial amount of the residents of that facility have already been managed with another type of care coordination model or other type of model, we need to be – we can't have the results of this model impacted by that other model.

Hospital nursing facilities are also excluded. Special focus facilities, please see (inaudible) page 12 for more information on what a special focus facility is. And then nursing facilities with outstanding major survey violations for immediate jeopardy to resident health or safety.

Moving on to slide 17, the role of the state, we'd refer you to page 11 of the funding opportunity announcement, states are critical parts in achieving these initiatves, objectives, they obviously will play a significant role in setting payment policy in other monitoring activities.

We are only interested in planting this initiative where states will be willing partners. Therefore, applicants must obtain a letter of support from their state's Medicaid director and also the survey of certification director.

Note for states, they may, at their discretion, offer to support multiple applicants or none at all. It is the applicant's responsibility to obtain and submit the letters. CMS is going to be keeping an eye on this, we're interested in feedback from applicants as they go down this road. So feel free to e-mail us at the e-mail address that was mentioned earlier.

Moving on to slide 18, continuing on the state role, states where enhanced care and coordination products are selected, CMS will sign an MOU with the state Medicaid and state survey and certification agencies. You can see Appendix B of the announcement for a sample memorandum of understanding.

Some of the responsibilities include providing Medicaid claims data to support the monitoring and evaluation and communicate the state’s support of the initiatives, to survey participating nursing facilities. This would greatly help the state survey at least from not being surprised if there's another entity – excuse me, a new type of intervention operating in those facilities.

Moving on to slide 19, funding. We'd refer you to page 24 of the announcement. Overall initiative size, approximately seven cooperative agreement awards implement the initiative in approximately 150 nursing facilities. Please note that these are just – that these are just estimates.

So there could be more than seven, I guess there could be less than seven. And the 150 could go up or down. But again, we would encourage entities to apply with more than 15 nursing facilities on their application. We're more interested in the quality of nursing facility partners than the overall number. And that again (inaudible) to propose more than 15 partners.

Total funding is up to $128 million plus another $6.4 million in supplemental funds that may be allocated based on operational quality and savings criteria. Awards would range between $5 million to $30 million.

So CMS is going to enter into cooperative agreements with the enhanced care and coordination providers. These providers will be responsible for how the funds are to be used. We'll refer you to page 39 of the announcement and that will explain how applicants should explain how they would use the funds in their application.

Moving on to slide 20, multi-state applications. CMS anticipates that each award will take place in one state. Applicants may propose to implement an intervention in multiple states but it' s application must include a letter of support from each state Medicaid director and each state survey and certification director, and again, must include letters of intent from at least 15 Medicare and Medicaid certified nursing facilities.

So, again, if you are interested in applying for – to implement this initiative in more than one state, you can do that on the same application. But within that application, you need to have the requirements for each individual state. So if you're applying for two states, that's a total of a minimum of 30 nursing facilities, two Medicaid state – two state Medicaid directors and two state surveying and certification directors for each of those states. You can also submit separate applications for each state.

With that, I am going to turn it back over to my colleague, Melissa.

Melissa Seeley: Thanks, Evan.

Before I pick up with slide 21, I just want to note that the slides that we're walking through can be found on the CMS innovation center homepage by going under what's new and you can find them there. You can also find them by clicking on initiative to reduce avoidable hospitalizations among nursing facility residents.

So picking up on slide 21, this slide indicates that there will be several implementation oversight activities that occur under the initiative. These include conducting readiness reviews to make sure enhanced care and coordination providers which are selected under this initiative are prepared to implement the proposed interventions.

We'll be conducting chart reviews, there will be learning and diffusion activities through a CMS learning community as well as other monitoring and oversight activities.

On slide 22, sorry, we cover very broadly here some of the components of the evaluation. We will be engaging an external evaluator to measure the impact of the initiative. Some of the broad examples of evaluation measures are listed here on slide 21 and we'll be getting into more specific of that in the future.

On slide 23, we want to emphasize that potential applicants must submit a notice of intent to apply to be eligible for a funding award. These notices are non-binding but must be submitted by 3:00PM Eastern Time on April 30th, later this month. Applicants that do not submit a notice of intent to apply cannot submit a full application, so please submit a notice of intent to apply if you plan to submit a full application which is due in June.

These notices require some basic information about the applicant organization and proposed geographic area for the intervention. We want to clarify we've gotten some questions about what we intend by the names of the operating partners. And I want to clarify that we are not asking organizations in the notice of intent to apply to name specific nursing facility partners.

By operating partners, we mean other organizations that applicants may collaborate with in implementing this initiative. So by operating partners, we're meaning organizations other than the nursing facility partners.

Nursing facility partners, of course, will need to be identified at the point of application and that will happen in June. These notices of intent to apply can now be submitted through the Web site identified here on slide 23. And the functionality is now live, I know we have received some questions about that as well and we are open for business as far as receiving those notices.

On slide 24, I want to bring your attention to some other key dates. Full applications are due by 3:00PM Eastern on June 14th. We strongly encourage organizations to apply in advance of that date. The funding opportunity

announced that required applicants to obtain something called a Dunn number through (Dunn and Brad Street). It also requires applicants to register with a potential contractor registration database.

There are some other steps outlined in the funding opportunity announcement that required some lead time, so we recommend the applicant to begin these processes soon.

Applications must be submitted through grants.gov. We anticipate making award by August 24th. And once awards are made, startup activities will commence in advance of implementation beginning. Again, this initiative is expected to last for four years, spanning from August 2012 through August 2016.

Turning to slide 25, you can find more information about the initiative including the full funding opportunity announcement that we have been referencing throughout. That funding opportunity announcement, other information about this initiative can be found on the three Web sites indicated here on slide 25. Please e-mail questions that are not answered today or others that may come to mind after today to our dedicated e-mail back at nfinitiative2012@cms.hhs.gov.

And finally, moving on to slide 26, we want to bring your attention to two links that provide guidance to the state survey and certification agencies as well as state Medicaid agencies about this initiative. Those are the first two links identified here.

We're also hosting a Webinar on April 17th from 2:00-3:30PM Eastern Time. The goal of this Webinar which will be held on April 17th is really the provided overview of intervention and models to reduce avoidable hospitalization. This April 17th Webinar will not be an opportunity to discuss the technical aspects of preparing and submitting an application for this initiative but rather the April 17th Webinar will include external experts from the research field to discuss successful models.

So with that, at this point, Barb, I think we are ready to take questions.

Barbara Cebuhar: Great. Thank you very much, Melissa.

And, (Nicole), if you could please instruct the people how to get into the queue, I would be grateful.

Operator: As a reminder, ladies and gentlemen, if you would like to ask a question, please press star then the number one on the telephone keypad. If you like to withdraw your question, please press the pound key.

Your first question comes from the line of (Allan Sanders), from (Premier Inc). Your line is open.

(Allan Sanders): Thank you very much. Two quick questions. One, has there been any outreach to the state directors announcing the program so they're aware that they'll be receiving contact information? Then secondly, can you tell me where the exact funding for the program originates?

Thank you.

Melissa Seeley: Sure, I'd be happy to answer those questions. Thank you for asking.

We did connect some outreach to the state Medicaid directors, the state survey and certification directors. I want to point you to some information that we have provided on slide 26, which are informational bulletins that were provided to these communities. So they have been made aware of the opportunity and the requirements of it. And those are available to everyone at the links that we indicated.

The funding for this opportunity is made available through the CMS Innovation Center. Again, this is a joint initiative of the Medicare/Medicaid Coordination Office and the CMS Innovation Center.

Barbara Cebuhar: Nicole, our next question please.

Operator: Your next question comes from the line of Harrison Fox, from CCITI. Your line is open.

Harrison Fox: Hi, thank you. This is Harrison Fox. And our question has to do with the definition of whether an organization is considered to be controlled by nursing homes and that we have a question around whether board – an organization with board members employed by multi-service long-term care organizations that have at least one nursing home facility in their organization be considered eligible as a lead applicant for this initiative?

Male: OK, so a couple of notes just in general on eligibility questions. First, just to reiterate, we cannot provide a regional confirmation or denial about eligibility until the full proposal and application is submitted. We are providing guidance.

Yes, as I mentioned earlier, we've been getting a lot of question from such a wide variety of types of entities and owner/operator, controller, controlled by or even just simply interactive facilities and (inaudible) research in them, so some we may be able to comment on, some we may not. And you know, we would ask you to submit the question more specifically to the e-mail address that was mentioned earlier.

With regard to your specific question, again, it's tough to answer not knowing the entire makeup of the entity that you're talking about. But generally speaking, if an entity is controlled by a nursing facilities which could include an entity that is acting on behalf of nursing facilities. Then they would also be considered as being controlled by nursing facilities and therefore not eligible to participate. But again, not having the specifics, we couldn't make a determination.

Barbara Cebuhar: Thank you, Mr. Fox.

And our next question, please, (Nicole)?

Operator: Your next question comes from the line of (Robert Adams), from PDA Incorporated. Your line is open.

(Robert Adams): Yes, ma'am. Is there a specific diagnosis that you guys are going after with this program, you know, such as CHF, or like you mentioned, the long-term term state residents? Can you guys give any guidance on that?

Evan Shulman: The – well, you know, this gets back to the point that we're not really being prescriptive about exactly the types of interventions, initiatives, or in this case, diagnosis that should be targeted. We are relying on (inaudible) that are applying to propose the types of interventions what they seek to treat that would reduce the – reach the overall goals of the program of reducing avoidable hospitalizations. (Inaudible), anything to add on that?

Melissa Seeley: I would agree with that. I mean we are – there is evidence showing that about 80 percent of potentially avoidable hospitalizations are due to about five different diagnosis/condition, the so-called ambulatory sensitive conditions. So those are some that you may want to consider. I know DHS is among them.

But again, as Evan said, we're not being prescriptive as to the particular diagnosis or the model. We're just asking that that applicants do include or address I should say the intervention requirements outlined in the funding opportunity announcement, and reiterate that the target population for this initiative is fee for service, long stay, Medicare, Medicaid enrollees residing in nursing facilities.

Barbara Cebuhar: Thank you, Mr. (Adams). Our next question please, (Nicole).

Operator: Your next question comes from the line of (Hillary Dylan) of NCAO. Your line is open.

(Hillary Dylan): Hi, everybody. Thank you. It's (Hillary Dylan) from NCOA. Some folks have been somewhat concerned about this initiative will distinguish between nursing home residents who are, in fact, long term and those who really should be directed more towards de-institutionalization initiative like money follows the person and other rebalancing initiatives. And I wonder if you could address that for those on the call who might be interested in bidding on this thing.

Evan Shulman: Sure. So, first off, the distinction to be made through the NDS criteria and the NDS blogs that are – and surveys that are done for each patient. I just want to make clear that this initiative in no way diminishes CMS' interest in reducing

institutionalizations or placement of Medicare/Medicaid individuals in nursing facilities long term.

In fact, there are several recent initiatives that have been launched to even further reduce the amount of placements in long stay facilities, things like, I think as mentioned, money follows the patient, the partnership per patients, community based care transitions program. So there is a huge emphasis on ensuring that as much as possible when appropriate, beneficiaries can remain in their homes.

That said, this initiative is targeting the one million plus beneficiaries that reside in nursing facilities today. Those are the long stay beneficiaries that I mentioned and how we would identify them earlier. So these are the target, those individuals and reduce the hospitalizations and avoid hospitalizations that they are often subject to.

Barbara Cebuhar: Thank you, (Hillary). Our next question, please.

Operator: Your next question comes from the line of (Joe Besting from Health Services). Your line is open.

(Joe Besting): Thank you. My question is revolving around work that Medicare Quality Improvement Organizations for the state of Arizona. And I wanted to see if you perceived any conflicts of interest with our current scope of work, and especially that we're working with the hospitals to reduce rehospitalization rates and that's under the technical assistance for communities.

Would that be considered, you know, potential conflict? Or do you see that as an enhancement to existing CMS initiatives?

Evan Shulman: Sure. You know QIOs, that's an example of an organization that has recently come up in our conversations. We're looking into that now so we won't be able to drive a specific guidance to you. It would tell you though that we're encouraging QIOs and other organizations as well to look in your other contracts and you should internally be assessing through your compliance department your own eligibility and there maybe other requirements in those

contracts that you need to follow in order to be deemed eligible. But we're looking at that right now.

Barbara Cebuhar: Thank you, (Mr. Besting). Our next question please.

Operator: Your next question comes from the line of (Kit Stickman) from ICP – sorry, from IPC. Your line is open.

(Kit Stickman): Thank you. We have heard that there will be 15 states with the highest population of dual eligible that will either be preferred or eligible for this program. If that is true, could you let us know what those states are please?

Evan Shulman: I think if you go to slide, excuse me. It's not necessarily 15 states, number one. We are showing preference to entities that apply to implement models in geographic areas where there are high Medicare and Medicaid costs.

Slide 16 – and we talked about that, and there are links on page 13 of the funding opportunity announcement where you could research some of these areas for yourself. And that again, a funding opportunity announcement can be found by accessing the links that are on the second to last slide on page 25. But there is no specific number of states that we are, especially not 15 that we're looking to implement this in.

Barbara Cebuhar: Thank you, Mr. (Stickman). Our next question please, (Nicole).

Operator: Your next question comes from the line of (Thomas Howard) from (inaudible).Your line is open.

(Thomas Howard): Yes. Good afternoon. Thank you for a very informative session. I'm just wondering, as a provider of a specialty product, how can we be assured of having access to these successful, the successful applicants in this process? Will vendors be assured access? And what advice can you offer us along those lines?

Melissa Seeley: I think as far as vendor access, we're really looking to – again, we've outlined the types of organizations that are eligible to apply. Again it's not an exhaustive list so we recommend that organizations consider their eligibility

against the criteria outlined on page 26 of the funding opportunity announcement. And again that we highlighted in the eligibility section of the slides.

I think with direct respect to vendors, I think it would be incumbent upon if a vendor is able to meet the eligibility criteria as well as the intervention requirements. They may be a candidate themselves, but otherwise, they may want to identify other applicants in their particular geographic area and try to establish a partnership in that way.

Barbara Cebuhar: Thank you, (Mr. Howard). Our next question please, (Nicole).

Operator: Your next question comes from the line of (Eli Amadeus) from (First Healthcare). Your line is open.

Barbara Cebuhar: You may wish to take your phone off of mute.

(Eli Amadeus): Yes. Hi. I was wondering if an adult daycare centers are eligible for this or if it's considered something which is already – in New Jersey, since we're already funded by Managed Care?

Evan Shulman: So, the providers that may be employed by an adult daycare center or providers an adult daycare center may wish to employ, they may be eligible to apply as an enhanced care and coordination provider which is that first bucket I mentioned.

The second bucket of these facilities that need to have the intervention applied to would need to be nursing facilities and an adult daycare center would not be eligible for, to use some of those facilities.

I guess as a final reminder, because just since you mentioned Managed Care, facilities with greater than 25 percent of their long stay residents enrolled in a Medicare Managed Care, they are not eligible to be part of an application.

Barbara Cebuhar: Thank you very much. (Nicole), our next question please.

Operator: Your next question comes from the line of Toby Edelman from Centers for Medicare. Your line is open.

Patricia Nemore: Yes. Thank you very much. My name is Patricia Nemore at the Center for Medicare Advocacy. I'm wondering what the baseline would be against which success would be measured. And if a particular model is successful, what exactly would happen in terms of broader implementation of that model since it seems that a part of this might have to do with actual improved staffing in nursing homes if we have external forces in nursing homes? So those are my questions.

Melissa Seeley: Well, thank you for those questions. Those are great questions.

With respect to the baseline, we anticipate, as we indicated, we'll be engaging with an external CMS evaluator. Or I should say not a CMS evaluator but CMS will be engaging with an external evaluator to conduct the evaluation of this initiative. We do anticipate that the evaluation would involve identifying appropriate comparison groups to identify what the impact of this initiative is.

As far as – and we'll – some of the – the measures that we'll be considering are outlined as part of the funding opportunity announcement, I pointed to Appendix A which really talks about the supplemental funds. Some of these measures will be used with respect to the evaluation, but we'll also be looking at a broader set of measures when it comes to the evaluation. Of course, quality of care as well impact on combined Medicare and Medicaid costs will be, certainly to be primary evaluation measures.

As far as the next steps, of course, this is the first part of a process where we're hoping to identify some specific models that do prove to be successful in reducing hospitalization, avoidable hospitalizations among nursing facility residents. And at that point, we will determine whether to what extent, you know, the evidence supports scaling that up, testing it further or you know implementing it as a change to the Medicare and Medicaid program.

So, I think it's definitely too early to tell exactly what is going to happen. But we hope that through this initiative we can identify some successful models that we can take to the next – to the next level of incorporating further.

Barbara Cebuhar: Thank you, (Trish). Our next question, please, (Nicole).

Operator: Your next question comes from the line of (Stan Livinggood) from (inaudible). Your line is open.

Male: (Inaudible).

(Stan Livinggood): I represent area agencies on aging. So, one of questions that has come up is if we (inaudible) in the RFP, it mentions that the employees that would be empowered to conduct the initiative would be RNs, physician's assistants, nurse practitioners. Would we be able to partner with the nursing facilities that we are partnering with in their hiring process since they have more expertise in selecting those kinds of employees?

Evan Shulman: Great question. So, we're really looking for the applicants to describe how the intervention or how the services will be applied. And if that includes a partnership where a nursing facility is perhaps involved in your hiring process, I guess there is no prohibition of that being part of it.

I just want to make it clear though that the initiative is not just funds or (inaudible) has to supplant existing staff. So, it's a little bit difficult to answer your question which is a great question. It is actually an indication of interest to partner with facilities as much as possible. So, I don't want to discourage you. But I just want to make sure that we direct you to the right places in the funding opportunity.

You know the partnership part of your question is great. But we need to make sure that the intervention that is being funded is separate from the current staff that's in place in the nursing facility.

(Stan Livinggood): I have a follow-up question. If I can ask it?

Evan Shulman: Sure.

Melissa Seeley: Please.

(Stan Livinggood): These employees that would be hired for the initiative, I understand that the initiative is more to monitor and implement activities in the nursing

facility. So, I was going to ask if they were allowed to participate in direct patient care or if they are prevented from working directly with the patients?

Melissa Seeley: You know that's a good question. And, certainly, we outlined on I think it's page – I don't remember. It is…

(Stan Livinggood): Well, I haven't made it all the way through either yet.

Melissa Seeley: OK. We understand. It's a rather lengthy document. But we are looking for the staff that would be hired through this initiative and physically present in the nursing facility, that they could certainly propose to provide some bedside care in addition to enhanced communication, coordination with existing staff that are in the facilities.

So, that certainly is part of what we're looking for and what we've outlined in the intervention requirements, the intervention requirements we talk about on slide four. And they are also outlined on pages nine through 10 in the funding opportunity announcements. So, I am hoping that may address your question.

(Stan Livinggood): Yes. Absolutely. I've got a couple of others. But I'd hate to hog the phone lines if you got other people waiting. And I'll just e-mail them if you have other people waiting.

Barbara Cebuhar: (Nicole), do we have other questions?

Operator: Yes. We have quite a few.

(Stan Livinggood): OK. Thank you very much.

Operator: Your next question comes from the line of (Tom Cobble) from (Ellenbrook Management). Your line is open.

(Tom Cobble): My question – I operate rural skilled nursing facilities. And the hundred – average daily census of 100, that benchmark is discriminatory to rural skilled nursing facilities and also probably to many states that have high – or excuse me – have low occupancy rates. So, I was wondering, is there any leeway or reconsideration that CMS might have? Thank you.

Evan Shulman: At this time, there is no flexibility with that requirement. We are aware it will be challenging for some. We are also aware that there are many rural facilities that exceed that number of resident's census level.

That said, this may be an evolving process. I'd like to see what the applications look like when they come in, having organizations that are looking to provide a mix of metropolitan or urban facilities and rural facilities.

And, again, I just remind you that each facility does not need to have over 100 residents. It's the average for all the facilities.

Barbara Cebuhar: Thank you. (Nicole), our next question, please.

Operator: Your next question comes from the line of (Peter Johns, M.D.) from (inaudible). Your line is open.

(Peter Johns): Thank you very much. My question is given the assumption that if the provider applicant is one of the already named pioneer ACO sites, could you give some discussion as to the relative uniqueness of intervention model for this particular initiative that would be appropriate for this initiative if it were in fact working with one of the pioneer ACOs?

Evan Shulman: So, again, on slide 13 of the presentation and also on page 12 of the funding opportunity announcement, we talk specifically about other federal initiativex which a pioneer ACO would be considered as – you know as mentioned earlier, we are not looking to fund interventions that compete or interfere with other existing models even if they are demonstration models. And we are looking for applicants that are interested in testing an intervention for this opportunity to propose to CMS how this new intervention would complement or work along side the other initiatives that they may be involved with.

And in addition to how it would complement it and work along side, how we would measure the unique impact of this initiative. So, it's really incumbent on the applicant.

(Peter Johns): Thank you.

Barbara Cebuhar: (Nicole), our next question, please.

Operator: Your next question comes from the line of (Chad Harris) from (Paris Healthcare). Your line is open.

(Chad Harris): Hi. Thanks for taking my question. Thank you for the conference today.

I get back to the question regarding your average census for nursing facilities. And rather than repeating the question the gentleman asked, where do you guys see – I represent a small 32 and 31-bed – two separate facilities – where do you see us fitting in to this whole initiative?

Evan Shulman: Well, it would depend on the full application of the other facilities that are on the application.

You know again on this particularly item we know it may be difficult for some. On the other hand, we are looking for generally a small number of awards. And at the same time, it's an evolving process. So, we're keeping an eye on it. And if we do need to make any reconsiderations, we will.

(Chad Harris): I am a third generation nursing home administrator in a family business that has been looking to do our part to contribute to our communities. And I'd hate to see this dissuade any homes from partnering when they have bigger homes participating in a way that could get them off this initiative reimbursement.

Evan Shulman: Sure. And I'll just restate what Melissa mentioned earlier, that this is a process. It's the first step of the process. So, as an example, this is the eligibility criteria for this particular initiative, that's not to say that upon finding successful interventions, there would be next phases, next steps to advancing this which may or may not include other types of entities including smaller facilities.

But we hear you. We are sensitive to it. You know we definitely need that statistically credible sample size to draw conclusions from. But we definitely want to be sensitive to some of the smaller facilities out there and I appreciate your interest in us.

(Chad Harris): I certainly appreciate your time. Thanks again. And there are some great small homes that would want to participate so please keep us in mind.

Barbara Cebuhar: Thank you, Mr. Harris. Our next question, please, (Nicole).

Operator: Your next question comes from the line of (Ann Corgan) from (inaudible). Your line is open.

(Ann Corgan): Hi. I would like to know what the rationale is for excluding hospital-based nursing homes.

Evan Shulman: Sure. This is one of those things that's an evolving process. So, this is Evan Shulman again, by the way.

So, when that requirement was put into the funding opportunity it' s intent was to – again, since the focus of this initiative is on long-stay Medicare-Medicaid enrollees, quite often hospital-based facilities are comprised of more short-stay or transitional beneficiaries who are going to be discharged to another setting.

That was initial intent behind that, that those facilities would have a smaller percentage of long-stay residents as compared to short-stay which is, short-stay is not the target population of that.

I will let you know that we are looking at that definition because there may be some hospital-based facilities that do fit the more traditional picture of a nursing facility with predominantly long-stay beneficiaries than short-stay. So, we will be providing some more guidance on that.

Barbara Cebuhar: Thank you, (Miss Corgan). Our next question, please, (Nicole).

Operator: Your next question comes from the line of (Roxanne Tanner-Nielsen) from (CCLC). Your line is open.

(Roxanne Tanner-Nielsen): Hi. I just wanted a little bit of information on when the intervention targets a long-stay fee-for-service population and particularly in some states that are moving from fee-for-service into managed care. How do envision this playing out over four year as some of that population may need

to drop out because of the state's overall plans, for example, under dual eligible waiver, other initiatives that are moving from a fee-for-service into a managed care kind of environment?

Melissa Seeley: So, (Roxanne), that is a good question. And, certainly, there are a lot of different opportunities that have been made available through the Affordable Care Act and states are making some of their own decisions to move to a managed care as you indicated.

And so, it's a blessing that there are these great opportunities and it also presents challenges as far as kind of making a determination as to how one may apply for this initiative versus participate in others, et cetera.

So, with that, we would really encourage you to consider as Evan indicated – again, this is more (inaudible) from CMS – but to consider the applicants as well as the partners that may be considering implementing the initiative with and the other factors that are occurring in those nursing facilities and the geographic area.

In particular, we are really hoping to identify through this initiative some particular facilities that are good candidates, we're seeing the outcomes that we hope to achieve through this initiative. And also being able to measure and tease out the impact of this unique initiative above and beyond existing initiatives.

So, I know that, that may not exactly answer your question. But it's a really individual basis and we hope that you will kind of consider the factors that are in play in the particular geographical area you are considering and the nursing facility partners and kind of make the determination whether you can indicate – you can demonstrate the impact of this initiative could be measured above and beyond other factors.

Barbara Cebuhar: Thank you, (Roxanne). Our next question, please, (Nicole).

Operator: Your next question comes from the line of (Aheema Asher) from (inaudible). Your line is open.

(Aheema Asher): Hi. Good afternoon. We just had a couple of questions regarding the base period, what the base period for the data would be and the measurement period. And then, also would the base be our experience or that of the region or which defined area?

Melissa Seeley: Thanks for that question. That's a great question. It also kind of goes to some of the earlier evaluation questions that we received.

We will – through our evaluation contractor, we will be measuring the experience of the participants as well as that of selected comparison groups. So, they will both be measured with respect to determining the impact of this initiative.

And, again, we'll be contracting with an external evaluator to help kind of identify the specifics around exactly what those comparison groups would look like, et cetera, but we would anticipate trying to match those comparison groups to the participating nursing facilities as best we can.

Barbara Cebuhar: Thank you for your question. Our next question, please, (Nicole).

Operator: Your next question comes from the line of (Nancy Hayworth) from (CAHS). Your line is open.

(Nancy Hayworth): Hi. This is (Nancy). I represent the nursing facilities in California and we do have an educational foundation where – they're not for profit – but we provide classes.

Could they apply for the grant or are they considered – would that be controlled by a nursing facility since we're a trade association?

Male: Again, good question and we'd like to keep all these questions, we're very interested and having as many people qualify for this as possible. So, you know, please also send these to others out there, send this to the e-mail address.

Again, we cannot confirm eligibility until the full application is received. I would, you know, refer back some of the things you mentioned before that

entity is controlled by nursing facilities which would included groups that act on behalf of nursing facilities would be considered ineligible to serve as the primary (inaudible) applicant on this initiative.

Female: OK, yeah, this one I figured. Thank you.

Male: Sure.

Barbara Cebuhar: Thank you, Ms. Hayward.

Our next question, please, (Nicole)?

Operator: Your next question comes from the line of Amy (inaudible), from Spectrum Health. Your line is open.

(Amy): Are services provided to dual eligibles including the populations that the grant funding may be applied to?

Evan Shulman: I'm sorry, you mean services that that they currently have or have access to or what type of services are you referring to?

Amy): Yes, that they currently have access to.

Evan Shulman: So the intervention funds here, Melissa, correct me if I'm wrong, that the funding of this intervention is not to supplant or subsidize the funding of any services or benefits that beneficiaries currently have access to. This is – the intent is to be additive.

Melissa Seeley: Yes, that's (inaudible) right. I would concur with that. I mean the target clearly is – the pay-for-service (inaudible) state dual eligibles and nursing facility residents. So we're really – the goal of this initiative is to provide additive service above and beyond the services that are already being provided through the Medicare/Medicaid programs to the dual eligibles.

(Amy): Great. Thank you.

Barbara Cebuhar: Our next question, please, (Nicole)?

Operator: Your next question comes from the line of (Lisa) (inaudible), from Oklahoma's Foundation. Your line is open.

(Lisa): Hi. My question is about the staff that we would hire nurse practitioners or physician assistants. Are you expecting a 1:1 ratio so that we would have one – if we have 15 homes, we would have 15 nurse practitioners and one would be full-time in each facility or can that resource be shared?

Or you could have three or four nurse practitioners that would each have their set of homes that they supported?

Female: OK, now, that's a great question. And I think we have been getting some questions along those lines through our e-mail inbox, so I appreciate you raising that. Yes, we're really leaving decisions like that up to the applicant to really determine whether they believe they need kind of a 1:1 or if they need a full-time versus a part-time that's shared across the nursing facility. So there's flexibility there.

We put that question out to applicants to think about what the staffing ratio may need to be, how many they may need, how many staff they may need to be per the number of facilities rather than participating in this initiative the type of staff that would be employed through this initiative, how many hours they would be participating and beyond five with respect to the facilities.

So those are all questions that we ask you think and for you to propose as part of the application.

(Lisa): OK, thank you. That makes sense. I just want to make sure that you didn't have an expectation that it was a 1:1.

Female: No, excellent question. We appreciate having the chance to clarify that.

(Lisa): Thank you, Ms. (inaudible)

Our next question, please?

Operator: Your next question comes from the line of (Amy Harold), from Carolina's Healthcare. Your line is open.

(Amy Harold): Good afternoon. I just want to clarify again that I work for a large health care system with multiple hospitals along with four owned nursing homes. And my understanding is to be eligible and I realize to can't say yeah or nay, but the four would be excluded from the 15 we would include in the application. Is that correct?

Male: That's correct. I appreciate your following along this conversation. So, yes, those four could not be listed as nursing facilities on your application.

(Amy Harold): OK, very good. Thank you very much.

Barbara Cebuhar: Nicole, our next question, please?

Operator: Your next question comes from the line of (Lesley) (inaudible), from Alzheimer's Association. Your line is open.

(Lesley): Hi, it's (Lesley). And thank you for the session. My question actually has to do with a lot of long-stay nursing home residents or also in hospice. And so my question – my sense from the discussion is actually if they're receiving hospice care that they may not be eligible for this, ineligible residents, but I wanted to find out?

Evan Shulman: The number of residents that are on hospice is not a factor in determining whether a facility is eligible to be listed on the application.

(Lesley): So even if 70 percent or 80 percent of long-stay residents in a certain facility might be also receiving hospice, will those residents also be eligible to receive this care coordination?

Melissa Seeley: Yeah, I think that would be part of the – we identify the target population for this initiative to be pay-per-service, long-stay, Medicare/Medicaid enrollees residing in nursing facilities.

Nursing facilities, certainly some of those individuals may be receiving hospice services. So we don't believe there's anything in the funding opportunity announcement that would exclude that population. And we

would ask that you explain how this intervention would benefit that population and it could be part of the population that's included.

So we kind of have given a broad parameter as far as pay-per-service, long-stay, dual eligibles residing in nursing facilities. But within that, we would welcome you, explaining in your application specifically the target population if you want to hone in on the subset.

Again, I should also mention that we really – you know, maybe I'm contradicting myself a little bit here, but we are looking for applicants that are applying with their nursing facilities to really focus the intervention on all of their pay-per-service, long-stay, Medicare/Medicaid relief. So keep that in mind as well, that we're looking for really a broader group rather than a small subset.

Barbara Cebuhar: Thank you, (Lesley).

Our next question, please?

Operator: Your next question comes from the line of (Jessica Mullen), from the School of Nursing. Your line is open.

Barbara Cebuhar: (Jessica), we can't hear you. You may be on mute.

(Jessica Mullen): That's it. Now, can you hear me?

Barbara Cebuhar: Yes.

(Jessica Mullen): OK, thank you. In the memorandum of understanding, in Section 2, the state Medicaid agency is to provide Medicaid claims data to CMS which you have mentioned during your presentation. Do you have any more detail? It becomes difficult to talk to cash strapped state agencies about more work without being able to provide with them some real detail about what it is they're asking.

Melissa Seeley: So in this situation, we're really – and again, I should emphasize that we have put out guidance directly to State Medicaid agencies as well as the state

Survey and Certification agencies. So they should be aware of this initiative and also understand that potential applicants may be approaching them.

With respect to that data, we're really – we're hoping that the states will provide access to Medicaid claims data. It's something that they do provide to CMS right now. There is quite a lag time there and we're hoping that through establishing these Memorandums of Understanding that we can facilitate a more rapid process of sharing those Medicaid claims data for the purposes of evaluating this initiative.

Female: This is (inaudible) again. If we – could we put a staff person into the budget that could help with the Medicaid office? Is that any obstacles from your perspective?

Melissa Seeley: You mean…? I guess I should say, I mean we are open in terms of the type of staff that could participate or be included as far as a budget. We do emphasize that we want, or we're looking for staff who are – who maintain a physical presence in nursing facilities. But we recognize there may be other staff efforts that are required, so I think to the extent that there is someone who may want to think about that, the data, that could be fine.

I should emphasize that in this Memorandum of Understanding is really something that would, that CMS would enter into with the state Medicaid agency and the data would be shared between the state Medicaid agency and CMS. So we do hope to kind of maintain their relationship of sharing data at that level as opposed to requesting that the enhanced care and coordination providers be responsible for achieving that kind of – achieving the data. Does that help?

(Jessica Mullen): It does help. It's just right now it's very difficult to get, as I said, cash strapped state employees to sign up to do what they're viewing as additional work. And you just said you want to improve the data turnaround time and they have less employees today than they did, you know, two years ago. So that, in our state at least, is becoming a bit of the challenge.

Melissa Seeley: As we, I mean, we will be monitoring that situation. We understand that states are underfinanced – a tremendous burden when it comes to finances

these days and staffing, et cetera. So to the extent you are, I mean, we will be monitoring that but we welcome you to come to us with questions or concerns about that through our dedicated mailbox, the MSInitiative2012@cms.hhs.gov. Please alert us to that and we will discuss and we'll see if we can help facilitate that engagement.

(Jessica Mullen): Can you tell me that e-mail address? On the slides? OK. Thank you.

Melissa Seeley: Sure.

Barbara Cebuhar: Thank you, (Jessica). We have time for one more question. And just so everybody knows, the place where you can send any questions you have about this initiative is MSInitiative2012@cms.hhs.gov. Go ahead please, (Nicole).

Operator: Your next question comes from the line of (David Norversy) from Central Arkansas. Your line is open.

(David Norversy): Thank you. I don't want to belabor the point of (Mr. Clover and Mr. Harris) that coming from Arkansas was – I have the simple question of if we were to put something together of 20 plus facilities in over 2,000 dual eligibles, is that even worthwhile? Are you saying that you'll actually consider the application if the average facility is not over 100 even though the aggregate of 20 or 25 plus facilities is well over 2,000? Are we wasting our time to fill this in in our application?

Evan Shulman: Yes. I'm running over out of time here, too. If you would do us a favor and send in that question along with your name to the e-mail box – again, we don't want to discourage you from applying. We do have the current data requirements that we have to adhere to, but we do want to consider questions like that.

(David Norversy): Thank you.

Barbara Cebuhar: Thank you very much. This is Barbara Cebuhar again. I just want to make sure that folks know that a copy of a transcript in the recording from this call will be available to special open door forum Web site. That's www.cms.gov/opendoorforums/05_ODS_SpecialODS.asp.

And you can get access to it that way. Also more information about this initiative including the solicitation is available at www.innovation.cms.gov/initiative/RAHNSR/. If you have any questions about this effort, we would encourage you to send them to MSInitiative2012@cms.hhs.gov.

Thank you so much for joining our call today. We do appreciate your interest. (Nicole), it's time for us to close the call.

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

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