CENTERS FOR MEDICARE & MEDICAID SERVICES

Moderator: Lynn Riley
June 21, 2011
2:00 p.m. ET

Operator: Good afternoon. My name is (Melinda), and I will be your Conference Operator today. At this time, I would like to welcome everyone to the Demonstration Applicant 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 during this time, then simply press star then the number one on your telephone keypad. If you would like to withdraw your question, then please press the pound key.

Thank you. Lynn Riley, you may begin your conference.

Lynn Riley: Greetings, everyone. I am Lynn Riley, Division Director in the Center for Medicare and Medicaid Innovation, Medicare Demonstration Group.

On behalf of our Center Director Dr. Richard Gilfillan and our Group Director Ms. (Linda Monyo), I would like to welcome you to our Federally Qualified Health Center Advance Primary Care Practice Demonstration Application Conference Call. We are excited about the demonstration and working with the FQHC Community, as well as our partners, to make the demonstration a success.

The purpose of today's call is to do several things – first, to provide a background about the design of the FQHC demonstration; second, to identify our key partners and their roles in the demonstration; third, to provide demonstration expectations; fourth, to describe the application process; fifth, to describe how CMS will monitor participant progress; and, sixth, to describe elements of the demonstration evaluation.

I have a few logistical tidbits about today's call. We expect that there will be questions as we go along; however, we ask you to hold them until the question-and-answer portion of the call. In addition, we will not be addressing individual FQHC site-specific questions or issues, as addressing those concerns is time-consuming and better addressed individually. Instead, we ask that you send individual FQHC-specific concerns or questions to our demonstration mailbox at F-Q-H-C_M-H_D-E-M-O@cms.hhs.gov.

We will introduce each speaker at the beginning of his or her presentation and announce the slide number as we are speaking about it. We thank you for your participation in today's call, and we will now begin our presentation with Slide Number Two.

CMS's mission – we want to be a major force and a reputable partner for the continual improvement of health and healthcare for all Americans. If you have ever heard our CMS Administrator Dr. (Don Burwick) present before, then you have heard him mention the triple aim – better health for populations, better care for individuals, and lower costs through improvement. The triple aim is the basis for our CMS mission.

Slide Number Two – we have our Innovation Center mission. We are a trustworthy partner to identify, validate, and diffuse new models of care and payment that improve health and healthcare, and reduce the total cost of care.

The FQHC demonstration falls under the Innovation Center's authority and is one of the first Innovation Center demonstrations implemented to support its

mission. You will see more information about the Innovation Center on the Innovation Center website, which you can access through our CMS website. So we are really excited about this and look forward to, again, your participation.

We have two main objectives for the demonstration on Slide Number Four – to evaluate the impact of the advanced primary model, commonly known as the Patient Center Medical Home, on improving health, improving care, and reducing healthcare costs among Medicare beneficiaries served by FQHC.

Then we have another objective to assess the impact that additional support, which we believe will help the FQHCs to transform their practice and help them to become formally recognized by the National Committee for Quality Assurance (NCQA) as a Level III primary care medical home.

The support that we are talking about are quarterly care management feeds and technical systems. CMS strongly believes that the medical home practice transformation is one way to achieve better care for individuals.

On Slide Number Five we talk about the goals for the demonstration. Our first goal is to achieve better health, better care, and lower costs for beneficiaries receiving care from FQHCs. You will notice that our demonstration goal supports triple aim. As you can see, there is a repeating theme to the demonstration messages related to better health, better care, and lower costs, and we believe that this demonstration definitely falls within those messages, so you will hear them over and over.

Another goal that we have is to have 90 percent of participating FQHCs achieve Level III NCQA recognition by the end of the demonstration. That is no short feat. We know that it is going to take a lot of work, but we are definitely here to help you. We will talk about that as we get further along in the presentation.

On Slide Number Six – "The Patient-Centered Medical Home Model" – we talk about the medical home and what the medical home does. It provides patients with coordinated healthcare delivery, promotes the development of strong physician-patient relationships, encourages communication, and incorporates electronic tracking systems to monitor health outcomes.

The patient-centered medical home model is not necessarily a new model. However, it is a model of care that has risen to be a gold standard for providing team-based coordinated care. Therefore, one of the things that we will certainly encourage is, again, strong team-based care, coordination, and all members of the healthcare team working together to improve care for the patient that comes into the FQHC.

We invite you to visit the demonstration recruitment website at www.fqhcmedicalhome.com for more information about the medical home model.

At this time, I am going to turn it over to Dr. (Matthew Burke) for Slide Number Seven.

Dr. (Burke) is a Senior Clinical Consultant in the Office of Quality and Data, Bureau of Primary Healthcare in the Health Resources Services Administration.

(Matt)?

(Matthew Burke): Thanks very much, Lynn. I appreciate it.

Welcome, everyone, to the call. I cannot express how enthusiastic we are at the Bureau of Primary Healthcare that CMS has taken this opportunity to launch a patient-centered medical home demonstration in the Health Center. This is great opportunity to be at the forefront of some really innovative

reform that is very focused on quality improvement and is very patient-centric and could, theoretically, really in a positive way change how we practice, which is wonderful for providers and patients alike.

There is the strong expectation that we are going to stay involved with this demonstration and help CMS wherever possible for where we are about to go next. This is something that is, as Lynn had mentioned, as really strong element within the Department of Health and Human Services, that is the patient-centered medical home for is capacity to transform care in a meaningful and really positive way. Therefore, we have full philosophical support for what is going on here and look forward to working with CMS and the health centers going forward.

Participating health centers will be supported in the entire application process, and we will get into some logistics in a few minutes. There are both financial support and support in terms of technical assistance, as well as logistical support for the health centers. And while we would encourage health centers to go directly to the aforementioned Web link for direct information about this demonstration, we are also working very hard internally to make sure that our Geographic Division directors and project officers are very aware of this process so that calls, questions, or information that is needed from the perspective of the Bureau of Primary Healthcare will be very readily available to those of you out there in the landscape initiating and going through this process.

Furthermore, we look forward to working with our CMS colleagues longitudinally and making sure that we are maximizing your chance for success going into this demonstration in order to make it as easy as possible, as logistically streamlined as possible, and to ensure that you achieve the maximum best under the demonstration, as you would hope.

We're really excited about this. At this point, I would like to turn it back over to (James Cohen), who is the Project Office of the FQHC Advanced Primary

Care Practice. Like Lynn, he is also with the Centers for Medicare and Medicaid Services.

(Jim)?

(James Cohen): Thank you, (Matt). Again, welcome, everyone.

We appreciate very much the help and cooperation that we have been getting from the (HERSA) folks. Their guidance, their insights, and their experience have meant an awful lot to us in being able to provide what we think is a well-designed demonstration, and to help us to provide for the logistics.

In addition to the (HERSA) support, we are also in partnership with the National Association of Community Health Centers, as depicted on Slide Eight.

NAC is a terrific partner for us. I know that all of you are very, very familiar with who they are and what they do. We appreciate their dedication to providing care to the most underserved populations, and the fact that they provide advocacy and training on behalf of FQHCs and their patients.

The partnership that we have with NAC and with (HERSA), combined with the resources at CMS and our Innovation Center is going to enable us to work through this demonstration in an effective and efficient way, and also be able to address many of the needs of all of our organizations combined.

I am going to switch gears now to Slide Number Nine. I think that it is important that we address right up front some of the expectations of this demonstration and those that choose to participate in it. It is very important in managing expectations that people understand what exactly CMS is expecting.

One of the first things that we are expecting out of this demonstration is that it will result in change. Change has to occur. At the end of the demonstration, we don't expect to have business as usual-type practices, but those that are participating have indeed developed capacity and transformed their practice culture to a more coordinated and less fragmented style of delivering primary healthcare.

We expect that participants will achieve Level III NCQA recognition. We realize that we have presented this as a goal of 90 percent, and that is still a heck of a lot of FQHCs achieving. But we believe that Level III is a very reachable goal, that it can be achieved, and we expect that our participating FQHCs are going to work toward that.

Another expectation is that the participants will remain in the demonstration. We learn nothing if the practices drop out. We lose a lot of the strength of the framings that we might get, and I want to make sure that everyone understands and thinks about this before they decide to apply, to make sure that they are comfortable with accepting this responsibility.

We expect our participating FQHCs to cooperate with the evaluation contractor. The results of this demonstration are intended to inform future decisions, and we expect our participants to provide additional data, if necessary, for purposes of evaluation. We will not make this particularly onerous or burdensome, but there will probably be the need to collect additional data from time to time, from participants.

Now I am going to go to some background on Slide Number 10. These are basic parts of the demonstration that I will run through.

Duration, size, and scope – this is intended to be a three-year Demonstration Project that will begin when the demonstration begins, actually on September 1, 2011, and it will run for three years following that.

The next two points are fairly self-explanatory. We are looking to target up to 500 FQHCs from across the Country, and up to 195 Medicare fee-for-service beneficiaries, including (dual) eligibles, will probably participate in the demonstration.

On Slide 11 – Eligibility – the first point must be an individual physical location. This has been the cause of some confusion based on questions that we have received in our mailbox. Basically, what we are saying here is one application for one site. We cannot accept applications on a group level, from a grantee who is sponsoring several other satellite locations. FQHCs, by definition, at CMS are individual brick-and-mortar locations. They each have an individual number that identifies them and separates them from a group practice. That is not to say that groups or community health centers that have several FQHCs cannot participate; they just simply must submit an application for each individual site.

The FQHC is going to have to provide medical services to at least 200 fee-for-service Medicare beneficiaries, in a 12-month period, which we call a look-back period, which we have recently done. Those that we identified as having 200 or more – or I should say serving 200 or more Medicare beneficiaries within the previous 12-month period were selected and sent an invitation letter to participate in the demonstration. That is one of several pieces of criteria, but it is a key critical first criterion for determining a cutoff. This provides us with a baseline for participation. Everybody in all of the practices will start out with a minimum level of beneficiary involvement.

The FQHC must be a physician- or nurse practitioner-led practice. By this, we mean that the clinical direction and decisions will be coming from one of those two clinicians and not from another source that might not be a medical entity or perhaps a physician assistant. At the present time, recognition can be achieved only for practices that are directed by a physician or a nurse practitioner.

The FQHC must be providing primary care services as opposed to only specialty services such as dental or vision. This demo is about primary care, not about specialty services. It does not mean that we discredit any practice that might be providing dental or vision care to a needy population, but, for the purposes of this demonstration, which is a research project, we are looking at the primary care element of their patient population.

FQHCs must provide medical care to a general population and not exclusively to specific populations such as migrant works or the homeless. We recognize that there are migrant clinics that sometimes operate on a seasonal level. This would not be appropriate for this kind of a demonstration, and we recognize that it can be difficult for a practice to follow a homeless population for the sake of care coordination. Again, this does not mean that we are not sensitive to the needs of these individuals, but, for the purpose of this demonstration, it would not be an appropriate for us to measure effectively.

On Slide 12, in continuing with eligibility, the FQHCs are going to have to be able to receive electronic funds transfer. We will not be issuing physical checks or paper checks, so the EFT is necessary because that is how we are going to pay. And they must be submitting their claims to one of two payment contractors – National Government Services or Meridian Administrative Services. These two paying contractors represent approximately 97 percent of all claims that are processed from FQHCs. This is logistically desirable for the demonstration so as not to have to do extraordinary contracting work for a very, very small number of FQHCs that are not submitting their claims to those two payment contractors.

On Slide 13, I'll talk a little bit about beneficiary eligibility. Who are the beneficiaries that you must have seen at least 200 of in a previous 12-month period? They will be enrolled in Medicare Part A and Part B, having both Part A and Part B fee-for-service during the most current period that we have looked back. They will not be currently in hospice care, nor will they currently be under treatment for end-stage renal disease.

Beneficiaries would include those that are both Medicare and Medicaid dually eligible, and they must not be in a Medicare Advantage plan. Medicare Advantage plans do not give us the data that we need in order to measure effectively. These are elements of how the patient panel will be comprised.

Now, I am going to turn it over to (Claudia Lamb), who is Project Officer of Payment Contracts here at CMS, in the Innovation Center. She will talk about beneficiary attribution.

(Claudia)?

(Claudia Lamb): Thanks, (Jim).

We are now on Slide 14. I am going to give you a little bit of an overview on how beneficiaries are attributed to an FQHC. We will be looking at Medicare as an (inaudible) claims process by the two payment contractors – NGS and Meridian – and a beneficiary that is seen most at one FQHC will be attributed to that FQHC.

If there are two FQHCs that have seen the same beneficiary the same number of times, then we have a tiebreaker, which is the FQHC that has seen that beneficiary most recently. So that would make up your initial beneficiary population upon whom you will be paid.

At the time of payment, you will get a roster that will (determine) rates of patients among other things, and that payment is made quarterly. At the time that we run that attribution, we will also, of course, be checking beneficiary eligibility so that, for example, if they have gone to Medicare Advantage or have died, of course, we would not be processing a payment on behalf of those beneficiaries.

At the time that you get paid, you will get the roster and the quarterly payment, as (Jim) mentioned, by EFT to our two payment contractors. We have determined that we are not going to entertain challenges to the rosters that we get. This is not meant to be like a per-head TM payment but more an approximation of payment for the share of beneficiaries that we see, and so we call it a care management fee for that reason rather than a PMPM, and it is a proxy for the patients that we, by virtue of administrative claims data, perceive to be in your panel.

We expect you to see all Medicare fee-for-service beneficiaries that appear and not as you would in managed care in not seeing a patient who is not on a list.

A little bit about the payments – they are going to be quarterly payments through the EFT process at $6 per month, which would be $18 per quarter. That fee is above the other fees that you are paid by Medicare for the all-inclusive payments.

Every quarter, we will do a look-back of a (mirror) toward the claims data, which will be a rolling period. For example, we will drop the oldest three months of claims, and we will add the newest three months of claims so that we are always looking at a year, but it is a rolling year every quarter.

Again, the fee is automatically paid. No claim needs to be submitted. And it will automatically be paid based on the roster and the attributions for that quarter.

We will also not be making adjustments to these. For example, if a patient died in month one of the previous quarter, then we will not deduct those two months of fees for which you provided no care. On the other hand, if someone would have been eligible for your practice in month one of the previous quarter, then you will not be paid until they hit the rosters this

quarter. So we think that those payments will be wash, and it will not hit you potentially in any way because one kind of offsets the other.

The roster that you will see will enumerate the patients for whom you were attributed for that quarter, by name, (tick) number, and date of birth, I believe. Then, there will be some aggregate information at the bottom of that roster that will indicate how many patients you were paid for that quarter, how many patients that you lost in that quarter just by number, and how many patients you gained newly in that quarter.

So that is a basic, general overview of how the payments will work. Now, I would like to turn it back to (Matt Burke) from (HERSA), and he is going to talk a little bit about the benefits of participating in the demonstration.

(Matthew Burke): Thank you, (Claudia).

Hello again, everyone. We are now on Slide 16. I wanted to talk for a minute or two about the benefits of becoming a patient-centered medical home.

The first slide here – Number 16 – is sort of the really high-order and philosophical ideas about why the patient-centered medical home matters. Certainly, as (Jim) said, this whole demonstration, in addition to sort of changing practice behavior, is a real cultural change. It is moving the ball forward in terms of the quality of care that we deliver for patients and how we actually deliver modern healthcare.

The first thing that it does is re-entrenches the concept of quality outcomes and very patient-centric care. The patient-centered medical home is a model that is really designed around the chronic care model that emphasizes easy access for patients and longitudinal tracking of coordinated measures, which is the second bullet there. The ability to take complex patients with complex needs and not just treat them retroactively in a fee-for-service environment is

really what you are looking at – the ability to develop a cultural model of clinical care that follows patients over time, gives them the preventative care that they need, does it in a very culturally competent, patient-sensitive way is really a major benefit here.

This is one of those areas where we all strongly believe that health centers, for the last 45 years, have been outstanding leaders in this department. In terms of reducing disparities and meeting the social safety net needs, they have been absolute leaders in this area. Finally, under health reforms, here is an opportunity to go ahead and think about this even more aggressively and raise the bar even further with this, and this demonstration is a really wonderful way to get started in thinking about that.

The third bullet – improving patient and provider satisfaction – is very important. Certainly, the patient piece is wrapped up in these other bullets, so I want to emphasize that this is not something that is designed to be a burden that is onerous on the folks that are actually delivering care. While, certainly, we recognize that it can be a big lift to make these transformations to this new culture of care delivery, one of the major pillars, the absolute fundamental tenets of the medical home is that providers are happier, as well. There is a change in workload; there is a change in delivery; there is an opportunity to do more for the communities that you love and the communities that you serve, to push their outcomes further up the hill. That is something that is just supposed to be, when done well, very much something that is provider-centric, as well, and allows them to be happy, focused, and just really engaged with the kind of work that they do out there in the primary care world, which is really a fantastic thing.

As part of that, you will certainly have to opportunity to become a clinical and a teaching leader in the federally qualified health center environment. For those (centers) that are on the forefront of transformational change are going to be looked to as sort of shining stars. And someone who makes the transition successfully will certainly be someone that other groups look to later on to say, “How did they do that? How were they met with that success?

What can I learn from their best practices and their new model?" So one of the benefits, certainly, of this demonstration is to position yourself to be in a situation like that.

Then, an effective and efficient deliverer of care, which means everything from safer care to more cost-efficient care in this environment, the three aims – the reduced per-capita cost, the improved patient outcomes, and the improved population health – all sort of fall under that fifth bullet there, which speaks more toward efficiency. So that is all part of it.

If you move on to Slide 17, in addition to some of those larger things that are really important and really fundamental for how we would like to move the landscape at this point, there are also the more tangible benefits, of course, of being part of the demonstration. The first one is the financial support.

There is financial support both for the survey process through NCQA, which I believe will be discussed shortly. But there is also the financial support of what (Claudia) just mentioned in terms of the per-patient per-month fees, recognizing that there will be additional staff or workflow changes, or things that need to happen that cannot just happen in a vacuum, so CMS has very carefully and thoughtfully designed this demonstration to have financial elements directly as part of it, as well.

There is certainly technical assistance that comes in the form of the contractor who is providing the survey recognition tool. There is support for health centers going through this demonstration with respect to showing them how this tool works, how to fill it out, how to complete it. It is not just throwing you a survey and a large amount of work to do and saying, "Please move forward with this." There is direct support in allowing you to understand how that process works to maximize your application success.

Further, we also recognize that there is an opportunity farther down the road that certain health centers may appreciate additional support in terms of the

transformational piece, in saying, "There is an area of patient-centered medical home qualifications that is particularly challenging or is a particularly big change for us, and we would like some support in thinking about how we go ahead and harness lessons learned for people that have already gone through this." And the Centers for Medicare and Medicaid Services and the Bureau of Primary Healthcare and (HERSA) are currently, actively thinking about this and how to provide that kind of technical assistance.

Something that is maybe less of a direct tangible benefit but is certainly an indirect benefit to the entire health center world is that the findings through the evaluation component here in this demonstration would definitely lead to best practice information, potentially portals and other access points for information for others that come after, that could learn off of what you do as leaders in how they can leverage the lessons learned from your experience in the demonstration for them to become patient-centered medical homes in the future, as well. Certainly, that will help to pave the way for all federally qualified health centers as we move forward, as the patient-centered medical home is, again, the wave of the future, is well embraced, and, I think, has some real dividends here that are going to pay off for everyone.

With that, as we turn to Slide 18, I would like to introduce (Maheel Sintafaraja), who is the Project Director for the FQHC Advanced Primary Care Practice Demonstration. He is the Director for Performance Measurement at (Thompson Reuters). Without further adieu, I will turn it over to him.

(Maheel Sintafaraja): Great. Thank you very much, (Matt).

As (Matt) mentioned, I am with (Thompson Reuters). (Thompson Reuters) is the contractor hired by CMS to assist with the implementation of the demonstration. (Thompson Reuters) is working with the NCQA, and, specifically (Bill Tollock), Director of Government Relations Initiatives, will

also be available during the question-and-answer period to respond to any inquiries.

Both organizations are really delighted to be involved with this demonstration, which we think can make a big difference to the populations served by FQHCs. And, thank you, everyone, for being on this call today.

Over the next two slides, I will talk a little bit more about the nuts and bolts of the application process. So, starting on Slide 18, applications are being accepted from June 6 to August 12 of this year, so the application process is open. You can go after this call and start applying. We already have several applications in.

As (Jim) mentioned, there is one application per site. If you have any questions about that, then please do email the CMS website. There is a list of websites and email addresses on the second-to-last slide that we will be going over, so if you have any questions about your individual FQHCs and how to apply by site, then please refer any questions to that email address.

Moving to Slide 19, at a high level, there are two parts to the application process – the application form and completion of the NCQA Readiness Assessment Survey. So the NCQA's definition and qualification for medical home is really forming the foundation of an assessment of progress toward medical home status. Both the application form and the Readiness Assessment Survey must be completed in order to consider your application.

Moving to Slide 20, which discusses the application form itself, the form really serves several purposes. One, it confirms the FQHC's agreement to the terms and conditions of the demonstration, some of which we have previously discussed. Two, it collects the information that CMS needs to qualify and select FQHCs. Third, it creates an account on the NCQA's PCMH Web-based system. So, really, the NCQA's system that we are leveraging for this

demonstration, and so you will get an account with no cost on the NCQA's PCMH Web system.
Finally, it collects practice information for evaluation purposes.

The form itself can be accessed at the fqhcmedicalhome.com website. Just note that there are instructions for the completion of the application form, and so please do access those if you are going to the website. We should have a video up on that website, as well, within the week that will carry you through the application. As has been mentioned before, there is a lot of assistance with both the application and the survey, and so please do, if you have any questions, avail yourself to that assistance.

On Slide 21, to briefly discuss the Readiness Assessment, it is the second step of the application process. It really leverages the survey that the NCQA uses to assess medical home recognition, and so, in this case, for the application, it is really to set a baseline to assess the FQHC's readiness to become a medical home.

The survey – and there is information about this on the website – needs to be completed. But the formal recognition process actually requires submission of documentation that is not required for this application process. So completion of the survey is required, but the submission of formal documentation is not. That will be clarified as you go to the survey website.

On Slide 22, after you submit the application form, which is Step One, you will receive immediately an email confirmation that your application has been received. You will get a second email within two business days that provides access to the Readiness Assessment Survey. So please do look for that email within two days. If you do not receive it, then please do follow up at the email address, as you will see on the second-to-last slide.

The Readiness Assessment Survey itself follows the NCQA's PCMH 2011 standards and guidelines. If you want to see what those standards and

guidelines require, then they are available at no cost at the link on Slide 22. Those guidelines will show you how becoming a medical home is assessed and judged.

On Slide 23, again, only FQHCs that complete both of the application form and the Readiness Assessment by August 12 will be considered. There will be a selection process to ensure for evaluation purposes that we have a good representation of FQHCs within the demo, and so certain characteristics may be used to make that selection, like geography.

Finally, all applicants will be notified of their acceptance into the demonstration by August 26.

On Slide 24, as I mentioned, there is a lot of assistance available to complete the application itself and the survey, as well. That information will be provided on the application form and survey through a link. That, again, is on the second-to-last slide of this presentation.

With that, let me turn it back over to Lynn Riley, Director at the Innovation Center.

Lynn Riley: Thanks, (Maheel).

We are Slide 25 and talking about technical assistance related to practice transformation. We have mentioned practice transformation several times throughout the presentation, and you are probably wondering how we expect you to get there. We are looking at technical assistance to be delivered in several ways.

Currently, we are developing, as (Maheel) mentioned, technical assistance to look at and help you with practice transformation such as panel and panelists and continuity of care, expected use of care teams, and care across transitions.

Those are some of the topic items that would be included in the technical assistance and moving toward practice transformation.

We are aiming to provide support through the primary care associations or possibly through grantee support. We are also looking at a central learning curriculum and, as I mentioned, some kind of peer-to-peer learning.

In addition, on Slide 26, some of the delivery for the technical assistance could be through monthly Web-based training sessions on primary care, medical industry standards, and recognition process. It could include mock surveys on a limited basis. It could include individual consultations on a limited basis. And it could include transformation learning systems in a Web environment. As (Maheel) mentioned, we are working to finalize the details of our technical assistance plans, and we will share those details with you all at a later date.

Moving on to Slide 27, I would like to introduce Dr. (Rachel Henke), who is the Senior Research Leader with (Thompson Reuters). She will talk to you about monitoring activities.

(Rachel)?

(Rachel Henke): Thank you, Lynn.

As Lynn mentioned, I will be going through a series of slides about monitoring activities pertaining to this demonstration.

CMS will monitor the progress of participating FQHCs toward NCQA Level III PCMH recognition. These monitoring activities will include three parts. First, there will be Readiness Assessment Survey updates, then there will be corresponding random audits, and then, finally, FQHCs participants will receive feedback from CMS.

In the next three slides, I will review each of these in turn. Now to Slide 28.

As already mentioned, FQHCs will be required to complete a Readiness Assessment as part of the application process. Participants will be required to update their responses to this Readiness Assessment Survey every six months throughout the demonstration. FQHC participants will be reminded as the six-month deadline approaches that they will need to do this. And CMS will use those Readiness Survey data to ensure that FQHC participants are progressing toward PCMH Level III recognition. They will also use these results to target technical assistance resources for the demonstration.

Now to Slide 29. To ensure the accuracy of the Readiness Assessment Survey responses, at each six-month interval after the update is provided, 10 percent of FQHC participants will be randomly selected for audit. These audits will not be conducted onsite but, rather, over the phone. They will be conducted in a way that minimizes the burden on the FQHC.

Basically, the audit will consist of NCQA requesting documentations to substantiate the presence of core and PCMH capabilities recorded by the FQHC and the Readiness Assessment.

Now to Slide 30. Final monitoring activity is feedback to CMS. CMS will provide participating FQHCs with feedback reports, which contain information including that FQHC's change in survey scores over time as the demonstration continues. It will contain FQHC survey scores as compared to other FQHC participants. And, finally, it will provide claims-based cost and utilization data on Medicare (set up at that) practice.

Now, to talk about the evaluation of the demonstration, I will turn it over to (Suzanne Goodwin), Project Officer, Demonstration Rapid Cycle, the Evaluation Group at the Center for Medicare and Medicaid Innovation.

(Suzanne Goodwin): Thanks, (Rachel).

CMS will be conducting an independent evaluation of the demonstration. The purpose of the evaluation is twofold.

First, it will study the process and challenges involved in transforming FQHCs into advanced primary care practices. It also will assess the effects of the advanced primary care model on access, quality, and cost of care provided to Medicare beneficiaries served by FQHCs, as well as by Medicaid beneficiaries to advanced hospitals.

In terms of the FQHCs' expectations in participating in data collection associated with the evaluation, we expect that selected FQHCs will participate in data collection activities that are to be used for evaluation purposes. At minimum, FQHCs will be expected to complete the PCMH Readiness Assessment every six months. In addition, FQHCs may be asked to either complete surveys or facilitate the completion of, for instance, patient experience surveys, perhaps putting us in touch with some of the patients. In addition, a subset of FQHCs may be asked to participate in site visits, focus groups, and interviews periodically.

I will turn it back over to (Jim Cohen) for concluding remarks.

(James Cohen): Thank you, (Suzanne).

On Slide 33, I would like to touch on some important information regarding contacts. There is information on this slide that I think will be important to you as time goes on.

The first thing that I want to point out has to do with demonstration description and application. Anything that you want to know about the application process is contained on this website, which is listed as www.fqhcmedicalhome.com. This is also where you would begin to access the application and, ultimately following that, the Readiness Assessment and so on.

We want to direct you, also, to the NCQA homepage for the demonstration. We have to make a correction here, though. The actual address is www.ncqa.org/gri. This is the place that you would visit for information relative to the NCQA portion of the application, which is primarily the Readiness Assessment and also other questions, if they are relative, to completing the application itself.

For design questions about the demonstration, we direct you to, first, our demonstration mailbox at fqhc_mh_demo@cms.hhs.gov. If there are specific questions relative to your individual site, if you need clarification about some part of what we discussed today, or if you are in the process of applying and something pops up that you do not quite understand, and you would like get guidance on, then this is the way to get your answer quickly and accurately.

The application form and survey assistance can be found at pcmh-grip@ncqa.org. Process questions that have to do with the application, again, I guess that it is at the (Thompson) website – fqhc.medicalhome@thompson.com.

Those are the mailboxes to receive questions relative to those areas.

On the final slide, we will be periodically posting demonstration updates on the CMS and on the Center for Medicare and Medicaid Innovations websites.

This presentation is being recorded and will be made available shortly on that site as an MP3 for you to listen to, if you choose to go back and listen to the conversation. When we get to questions in just a few moments, of course, they will be recorded, as well. You might find this useful for future reference if you need to go back.

All updates relative to the demonstration, as they become available for us, will be posted on the CMS website. The address that is here is way too long to read, or you can find it at the Innovation website, which is much easier – http://innovations.gov.

I will ask (Melinda) if we can begin with the questions.

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

We will pause for a moment to compile the Q-and-A roster.

You first question comes from the line of (Joe Santini). Your line is now open.

(Joe Santini): One of the questions that we would like to ask is that we were recently accredited through the Accreditation Association of Ambulatory Healthcare – AAAHC – for both their accreditation and the medical home certification. How does that play into this for this process?

(James Cohen): That is a very good question. With respect to AAAHC, we respect the standards and the compliance with those standards. This is a research project and, as a demonstration, we had to make a choice.

Since we cannot assume that all standards are identical or necessarily comparable for all involved, I think that having accreditation under AAAHC will be a tremendous advantage to you, but we are going to ask that, if you participate, you receive recognition under the 2011 standards from NCQA by the end of the demonstration period.

It was not actually mentioned during the conversation, but, as an FQHC, you will not have any costs associated with the submission for recognition, which is the survey itself plus the documentation. It usually has a cost associated with it, so there will not be any additional cost for you to do this, and you probably have an awful lot of the capabilities already documented and things in place that might help you to achieve Level III recognition before the end of the demonstration.

(Joe Santini): OK, thanks. I have just one more question.

(Matthew Burke): I'm sorry, but can I also….?

(Joe Santini): Go ahead.

(Matthew Burke): Thanks. This is (Matt) from the Bureau of Primary Healthcare. We are, at this point, pretty agnostic about the standard between the patient-centered medical home, so it is fabulous that you have the recognition and the accreditation also under another entity.

I think that (Jim) said it very well, that that will probably position you to be well endowed to have the opportunity to do well in this demonstration. They end up being, as far as we can tell right now, separate processes but mutually reinforcing. So even though this demo is cost-free to the health centers, and those structures are already well supported between (HERSA) and them, it probably just sort of gives you some technical expertise and some understanding that would allow you to move very nicely forward with this

project. But, as (Jim) said, you must still go through all of the rigor or the NCQA process in its own right.

But we definitely, I think, from the Bureau's standpoint, encourage any and all of these so that multiple recognitions or recognition and accreditation at the same time mutually reinforce quality improvement and care delivery, and so we are very proud of what you have done and would encourage you to continue and to perhaps do more, particularly even the demonstration in support of it.

(Joe Santini): Thank you. One additional question ...

Lynn Riley: With regard to the 200 eligible Medicare beneficiaries in the last 12 months, is that by location or is that as an organization?

(James Cohen): That pertains to the individual FQHC site, the brick-and-mortar site. If you have more than one site, then it would have to be – each would have to have a minimum – have served a minimum of 200 eligible Medicare beneficiaries in that period of time.

Lynn Riley: OK, so I just want to repeat this back to you. If I have five locations, and only one of them meets the 200 members requirement, then only one would be able to participate? Correct?

(James Cohen): That's correct.

Lynn Riley: OK, thank you.

Operator: Your next question comes from the line of (Paul Smallwood). Your line is now open.

(Pam Smallwood): Hi, this is (Pam Smallwood). We are an FQHC in Kentucky and currently participate with NGS; that is where we submit our claims. But CMS is transitioning us to CIGNA as of October 17. We will still be eligible to participate in the Demonstration Project?

(James Cohen): No, I don't think that you will. I'm sorry. We have to reverify eligibility of beneficiaries on a quarterly basis. If your claims are going to be submitted to a different payment source, then we will not be able to track those claims.

(Pam Smallwood): Is there any way that we can petition CMS to allow us to set at NGS and as a switch into CIGNA?

(James Cohen): I am not aware of any process to do that. That is part of the Medicare Administrative Contractor work, and we do not participate in that. I'm sorry that we cannot be more helpful.

Lynn Riley: This is Lynn Riley. I would like to reiterate that we are not able to address any specific FQHC's site questions or issues. They really need to go to our mailbox because we need to read them in a (serve you), and so we would appreciate your questions being directed more to the demonstration, the application requirements, and the items that we talked about today.

Thank you.

(Pam Smallwood): All right, thank you.

Operator: Your next question comes from the line of (Gail Speedy). Your line is now open.

(Gail Speedy): I guess that I am looking for clarification. If you are participating in the Medicaid PCMH Program, then are you also eligible to participate in the Medicare Program? Is that sort of double jeopardy?

(James Cohen): If you are talking about the State Option Program in Medicaid – is that what you are referring to?

(Gail Speedy): Yes.

(James Cohen): There should not be any controversy there. That is a very different type of Demonstration Project, so I do not think that you will have any issues with that in participating in this one.

For clarification, for the group at large, the key element there in terms of which demos that you can participate in and which ones that you cannot really lie in the fact that you cannot be paid for providing services to a patient twice. So if there is any indication or any possibility that you would be getting reimbursed for care through two different processes, then you would not be eligible to participate and should indeed not be participating. But that should not be an issue with the State Option Program.

(Gail Speedy): OK, and one other question – if you do have a 2008 application out there but you have not had the survey yet, you can convert – because this is based on the 2011 PCMH standards – you can convert to a 2011 application. Is that correct? Do you have TA to help with that?

(Bill Tollock): This is (Bill Tollock) from NCQA. We can issue you and will issue you, if you participate in the Demonstration Project, a new 2011 survey tool. And we will certainly provide any assistance that we can in helping you to translate your 2008 responses to 2011.

Unfortunately, because of the change between 2008 and 2011 was relatively significant, there isn't sort of an automatic update process, but we can certainly work with you individually if we need to.

(Gail Speedy): OK, that's great. What was your email again?

(Bill Tollock): It is actually on Slide 33 – PCMH.

(Gail Speedy): OK.

Operator: Your next question comes from the line of (George Ward). Your line is now open.

(George Ward): Good afternoon. I think that my question may have been answered, but I just want to triple-check it one last time.

We have a truckload of satellite sites where Medicare patients are being seen. I thought that I heard someone say earlier that this is strictly for – what was the term? – brick-and-mortar FQHCs, meaning that it is only for the main clinic site that we need to be doing this?

(James Cohen): Not exactly. What we are talking about is an individual site. If you have more than one FQHC in your organization, then they are considered individually to be brick and mortar themselves, not just the main site; the main site is also brick and mortar.

If you have multiple sites that you want to participate, and they meet all of the necessary eligibility requirements, then they must submit an application individually. You cannot submit an application for more than one site.

(George Ward): Got it. Clear as mud. Thank you.

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

(Kevin Findery): I think that our question has been answered. We are currently recognized as Level III NCQA, so what I understand is that we would still have to go through the process as if we were not. Is that correct?

(James Cohen): That is correct. If you are currently recognized, then I have to presume that it is by 2008 standards.

(Kevin Findery): That is correct.

(James Cohen): And if you were recognized within the last three years, then you are probably due for renewal anyway.

(Kevin Findery): We were recognized in February.

(James Cohen): Oh, in February? OK, we are still going to ask you to continue to submit the Readiness Assessments on a six-month basis even though you are a currently recognized program. And we are going to ask you to submit documentation for 2011 recognition by the end of the demonstration.

(Kevin Findery): OK, thank you.

Operator: Your next question comes from the line of (Kathy Coleman). Your line is now open.

(Kathy Coleman): Hi, thank you. This sounds like a very collaborative project. I had a question about the patient and the provider satisfaction surveys. Have they been

developed yet? Who will be providing them and the frequency of these tools? Thank you.

(Suzanne Goodwin): We have not decided what our data collection efforts will be. We are in the process now of identifying them, so we do not know what surveys will be administered. The provider and patient satisfaction surveys were just examples of possible data collection that we will be doing because we do not know exactly which data collection yet, we don't know what tools that we may be using. But that information will be shared with the participating sites as soon as we make those determinations.

Operator: Your next question comes from the line of (Matt Sanidusky). Your line is now open.

(Matt Sanidusky): Yes, that was close enough. Thank you very much for putting this call together. Just a quick question – are FQHC look-alikes eligible for this program?

(James Cohen): Yes.

(Matt Sanidusky): OK, good. That's all that I needed. Thank you very much.

Operator: Your next question comes from the line of (Marty Lynch). Your line is now open.

(Marty Lynch): Sure, thanks for putting the program together.

I wanted to ask two questions. Number one is simply the $6 care management fee – what everyone calls it – is good, and help with the certification process is good, but I really feel like shared savings is the type of incentive that would

get health centers to participate strongly and would be their look at how we are doing in terms of overall cost of patient care in the Medicare Program. We think that we make a difference. We would like to understand that data and see that, and see some benefit from it, so I wanted to ask if any thought was given or will be given down the road as the demonstration moves forward for that type of reimbursement. Then I have a very simple question after that, but let's do the first one.

(James Cohen): To your first question, we look at all available models for this demonstration. We decided not to use shared savings. Shared savings is, as you probably know, a little bit difficult in these circumstances to really validate, particularly in the population that we are talking about. So, without going into a whole lot of detail, yes, we did give it consideration, and we have noted your point – your comment, and we will consider that down the road. But, at this point in time, we have no plans to change the design.

(Marty Lynch): Thank you for consideration.

The second brief question is simply does size matter in this demonstration? In other words, if we have sites with a large number of Medicare participants versus sites that just make it 200, is it likely that the smaller or the larger would get any special consideration as you make your selection decisions?

(James Cohen): No, size won't have any bearing on consideration for participating. What we are looking for is as good a balance as we can get among large-, small-, and medium-size practices along with certain other characteristics. It is not that we are trying to restrict, but we are trying to have a good distribution of different-sized clinics so that we can more generalize the results that we are finding.

(Marty Lynch): Right, thank you.

Operator: Your next question comes from the line of (Bethany Gadzinsky). Your line is now open.

(Bethany Gadzinky): Thank you. You did answer my first question, so I will ask the second question, and you might not be able to answer it. What was the pool or the number of application letters that you sent out? So how many people are vying for the 500 spots that you are looking at?

(James Cohen): It is approximately – I'm going to say 1,340, give or take.

(Bethany Gadzinky): Thank you.

(James Cohen): I don't have an exact number, but it is very close to that.

(Bethany Gadzinsky): Great, thanks.

Operator: Your next question comes from the line of (Debra Workman). Your line is now open.

(Debra Workman): Thank you. We received letters for some of our sites that we believe are eligible, but not all of our sites got the invitation to apply letters. I'm wondering if we need to be invited for each site or whether we can just go ahead and apply if we think that we are eligible.

(James Cohen): What we tried to do as best we could is to identify the sites that met the initial eligibility criteria of 200 or more Medicare beneficiaries in a 12-month period, and a couple of other things such as being able to receive electronic funds transfers and things of that nature. We specifically invited those because we could verify those eligible FQHCs. So if you did not receive a letter for all of your sites, then it could mean that the other sites did not meet one or more of the eligibility criteria for being invited to participate in a demonstration.

(Bethany Gadzinsky): So would I possibly follow up by emailing that email address to find out whether it might still be appropriate to apply, or just limit our applications to the sites that received letters?

(James Cohen): If you would like, you can send an inquiry to our mailbox – fqhc_mh_demo@cms.hhs.gov – and we can look into it, but I think that your best bet is to stick with the sites that have been identified by invitation.

(Bethany Gadzinsky): OK, thank you.

Operator: Your next question comes from the line of (Al Flaggery). Your line is now open.

(Al Flaggery): Thank you. During the initial invitation letter, it indicated that our facility also needed to be enrolled with {Pecos), to be able to meet the criteria, yet it was not addressed during the conference here. Could you provide additional clarification as to whether (Pecos) must be completed before we apply or, if we are actually in the enrollment status, how that affects the consideration for the demonstration?

(James Cohen): You are going to have to be enrolled in (Pecos). (Pecos) is the means with which CMS is permitted to pay you, so if you are not in (Pecos), then you would be unable to be paid for participating in the demonstration.

(Al Flaggery): If we are enrolled at the point in time that we submit the application, with that process being underway right now, then that should not have an issue in enrolling or being selected to the demonstration, I assume.

(James Cohen): Actually, it will have a bearing. You must have recertified your (Pecos) information before you apply because it will kick out when we do our

checking on that. If you do not currently have a (Pecos) file, then we will probably disqualify you because we cannot find it, and we know that it is a lengthy process.

If you want to explore this further, then please send us an email inquiry to that effect, to our mailbox.

(Al Flaggery): OK, thank you.

Operator: Your next question comes from the line of (David Shifby). Your line is now open.

(David Shifby): I think you actually got the question earlier, which was relative to currently being (inaudible) recognized by the 2008 standards; that was there. But just one point of clarification – so the 500 participants that you are looking for are 500 brick-and-mortar sites, not 500 entities?

(James Cohen): Yes, you could state it that way. Just for clarify, we understand that there are two different systems that are functioning.

If we look at the community health centers in general, then we have grantees and sites. The grantee is the main organization under which there are several other sites. Some of those sites may be FQHCs. The way that we look at is that all FQHCs are CHCs, but not all CHCs are FQHCs. An FQHC must have an individual provider transaction account number in order to be an FQHC, and deemed appropriate by CMS. So the brick and mortar actually attaches to that (P10) number that identifies you as an individual site. So when you are speaking of entities, then I presume that you are talking about some other satellite organization that is not necessarily clearly established as an individual unit so as to be called an FQHC.

(David Shifby): No, it's really the FQHC entity, which is the deemed organization, and you submit a change in scope or whatever you do to get different access points. So, basically, I think that what you are talking about are 500 individually recognized brick-and-mortar sites that CMS directs payments to versus the organizational entity itself.

(James Cohen): Yes, now I understand. I'm sorry. You are correct.

(David Shifby): Yes, OK. All right, that does it for me. Thanks.

Operator: Your next question comes from the line of (Elizabeth Julespy). Your line is now open.

(Paul Kay): Hi, this is (Paul Kay) from (Hudson River) Healthcare. You indicated before about the 2008 to 2011 standards change, so those of us who are recognized will go through that. What I wasn't clear about is that, if we have multiple sites currently through NCQA, then there is a multi-site application process where much of the documentation is common among the sites, and some of it is specific, and that is how NCQA recognizes us. Will we be able to use the same methodology, or will we have to submit documentation site by site and not use NCQA's multi-site process?

(James Cohen): We are interested in the FQHC sites that are participating in the demonstration, and that might not be all of the sites that you are talking about in a multi-site recognition from NCQA. So I would say, first, you would need to meet the requirements for the demonstration on an individual FQHC site basis.

We have not actually discussed multi-site recognition with NCQA, as we see it as an individual thing. But I will ask (Bill) to weigh in on this.

(Bill Tollock): There is sort of a technical side to this issue, and then there is what is seen as one to do the Demonstration Project. On the technical side, it is doable either way, so we can probably take that offline and have a discussion about it. So, technically, it would be possible, but I think that, as (Jim) noted, it's according to each individual site. For the Demonstration Project, each site will have to have a survey tool and have that survey tool completed, so that will have to be on a site-by-site basis. But as we mentioned, documentation is not required for all of those elements and, in fact, would not be required until such time as an audit where we would ask for documentation. That would be from an individual site.

So, for the Demonstration Project, you must have the survey tool per site and have that complete per site, so there will not be the ability to use the multi-site there. For the formal recognition, that is another issue that we will have to take offline.

(Paul Kay): It would be a shame to have to do two sets of processes, so I hope that you can harmonize that. I understand the intent of wanting each site to be recognized, but, as you know, you can do that but still use the corporate tool to populate the elements in multiple sites. So I hope that you can figure that out.

(James Cohen): Thank you.

Operator: Your next question comes from the line of (Susan Wilson). Your line is now open.

(Susan Wilson): Good afternoon, and thank you. I apologize for any noise, as I'm in an airport.

My question relates to the mention that primary care associations will be looked to to be part of the training and technical assistance activities. Could you expound on that?

Lynn Riley: Hi, this is Lynn. I said that the primary care associations are one vehicle that we are considering as part of delivery of technical assistance. We have not decided, we have not confirmed that, but that is something that we are looking at.

(Susan Wilson): OK, thank you.

Operator: Your next question comes from the line of (Rachel Kutcher). Your line is now open.

(Rachel Kutcher): Hi, we are also looking at applications for the Pioneer ACO and fee community-based care transitions. We are just wondering if either view is mutually exclusive with the FQHC Advanced Primary care Practice, or if we are able to apply for both or all three.

(Rachel Henke): CMS is current working on the policy related to its decision in that regard, so, at this time, we are unable to that question. I would recommend that you go back and send it to us in the mailbox and, when we have a decision, then we can get back to you.

(Rachel Kutcher): OK, do you have an estimate as to when – just because we've got deadlines for all of these – you can give an estimate as to when that decision will be made?

(Rachel Henke): Not until the early fall.

(Rachel Kutcher): So we need to go ahead and do applications, because the deadlines all fall before early fall?

(Rachel Henke): Yes, if you are interested in participating in this particular demonstration, then I would encourage you to apply.

(Rachel Kutcher): OK, so if we are accepted for multiple demonstrations, and they are supposed to begin on September 1 for this one, then what does that mean for that determination being made at a later date?

(Rachel Henke): It means that CMS would get back to you about the ultimate determination of whether you are eligible to participate in a demonstration. I can only comment on the FQHC Advanced Primary Care Practice Demonstration, not the other one.

(Rachel Kutcher): OK, thank you very much.

Operator: Your next question comes from the line of (Megan Lasher). Your line is now open.

(Dave Sintop): Hi, this is (Dave Sintop). Thanks.

Our question was answered in terms of NCQA 2008 certification. We are Level III now, so I understand that. I would just like to concur with the gentleman that spoke a couple of minutes ago about meshing and figuring out the multiple-site issue.

Lynn Riley: This is Lynn Riley. At this point, we are requiring all of the FQHC applicant sites to achieve the NCQA Level III Medical Home recognition. We have not changed the policy. At this point, we are going forward with our goal to have every site recognized as Level III Medical Home.

However, we hear you and appreciate your feedback. So we will take that back to our leadership for discussion, and if CMS does change policy on that, then we would certainly let the selected FQHCs know about it.

(Dave Sintop): Thank you.

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

(Mary Bartolo): I think there are a lot of FQHCs that are accredited by JAACO, and JAACO is in the process of becoming certified or (inaudible) certification (inaudible) medical home. Is that going to be something that is considered in the future, or do people have to be NCQA-accredited in this process?

(Rachel Henke): In this demonstration, FQHCs that are selected to participate must be NCQA-recognized as a Level III medical home.

(Mary Bartolo): OK, so we have to make this determination if we want to do both or switch?

(Rachel Henke): Correct.

(Mary Bartolo): I think that I will expand. (Matt Burke) from (HERSA) talked about the multiple benefits of participating in this demonstration, and so I would like to take an opportunity to reiterate that there are multiple benefits. I would hope that you all would take those into consideration as you think about applying.

(Matthew Burke): I could also add a little bit of background. When we were designing this demonstration – which, believe me, didn't start six months ago – I don't believe that JAACO actually had an accreditation program up and running at that point. For our purposes, we had to choose and had to use a single

standard because this is a research project, something that we could point to, something that was widely available and widely acceptable.

We support JAACO, AAAHC, (URAC), and others in that they have accreditation, that they have processes for identifying medical homes, and certifying that they have capability. But, for our purposes, many of these things were not online prior to our coming to this, or we are not widely used. So, for comparative purposes, it seemed logical from a research point of view to use NCQA.

Now that others are coming online, it is obvious that these questions do come to mind. I think that they are very good questions and worth considering, but our demonstration is designed at this point, and we are going to stick to the way that we have it for the time being.

Operator: Your next question comes from the line of (Jennifer Greentree). Your line is now open.

(Jennifer Greentree): Hi, I was wondering if, on FQHCs that have been accepted to participate in the Bureau of Primary Healthcare's Patient-Centered Medical Health Home Program, they are going to pay the fee for the NCQA, as well. How is that going to be coordinated, because I understand that CMS is also going to pay for that fee? So if centers were in both programs, then how would that work?

(Barbara Easterling): Hi, this is (Barbara Easterling) from the Bureau of Primary Healthcare. I am the Program Manager for the NCQA's Patient-Centered Medical Home Initiative.

You can participate in both projects, and your survey fees will be covered.

Lynn Riley: So it will happen behind the scenes, and the health centers will not need to….

(Barbara Easterling): You won't have to worry about that.

Lynn Riley: …Worry about it. OK, very good. Thank you.

(Barbara Easterling): You're welcome.

Operator: Your next question comes from the line of (Mike Cassidy). Your line is now open.

(Mike Cassidy): Thank you. My question has been answered.

Operator: Your next question comes from the line of (Gail Hedler). Your line is now open. (Gail Hedler), your line is now open.

(James Cohen): We can move on, (Melinda).

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

(Thomas Woodworth): Hi, I have a couple of questions, though I know that we have gone around this a couple of times.

We have about nine provider numbers for our different locations, with a couple of more applications on the bill. However, within about the past year, instead of our going for all of our locations under the individual provider numbers, we were instructed to only go under the one number. That is how we get paid and how we reflect it on the (CSNR)s. In light of that, are all of our locations considered one FQHC or, again, do I have to apply for each of the different sites individually?

(James Cohen): If you have been submitting claims under one number for all of your sites – in other words, rolling up the claims – then there are actually two issues here. Most of your sites would not be recognized as eligible because we would not show claims for 200 or more Medicare beneficiaries. Secondly, I think that it is inappropriate – I guess that is a good word – as you are supposed to be billing under each individual (PTAN) number for services provided to Medicare beneficiaries at each individual site. But this is not my area of expertise, and so I cannot speak to it.

So I guess that the answer to your question…

(Thomas Woodworth): OK, I'll check with my billing manager because, previously, that is how we were doing it, as we were instructed to do it under the one number. But I am going to find out exactly who gave us that instruction.

And my next question is…

(James Cohen): Why don't you do that? And if you find that there are some questions, then you can forward them to our mailbox.

(Rachel Henke): Or talk to your project officer at (HERSA), right, (Barbara)?

(Barbara Easterling): Yes.

(Rachel Henke): Yes, I think that it would be a good idea for you to get in touch with your project officer at (HERSA) about this specific issue, and then follow up with an email to our email box.

(Thomas Woodworth): OK, and the email box, again, is…?

(James Cohen): It is fqhc_mh_demo@cms.hhs.gov.

(Thomas Woodworth): OK, I see. If we apply for three of our sites, and they all are chosen, then within the next year – hopefully, the next 12 months – we are going to have a new building completed, in which we are going to combine two of those sites into one. Will that present a problem?

(James Cohen): Would you mind sending that question to our mailbox so that we can consider it? It sounds like a unique problem that we would like to discuss with you offline.

(Thomas Woodworth): OK, sounds good. Thanks.

Operator: Your next question comes from the line of (Marcia Carlo). Your line is now open.

(Marcia Carlo): Thank you. My question has been answered.

Operator: Your next question comes from the line of (Kay Benz). Your line is now open.

(Folene Hedslov): Thank you. My name is (Folene Hedslov) from Covenant House.

You may have already answered, but please affirm for us – we are an FQHC, but most our clients are primarily Medicaid enrollees. Would that automatically exclude us from this Demonstration Project?

(Matthew Burke): If you do not meet the minimum eligibility requirement, then, yes, it would. Your Medicaid recipients would have to be dual-eligibles, and they must have a minimum of 200 that you provided primary healthcare services to, in a previous 12-month period that we look back.

(Folene Hedlov): OK, I guess that really excludes us because we don't have Medicare, just Medicaid.

(Matthew Burke): I'm sorry, but this is a Medicare demonstration.

(Folene Hedlov): Yes, thanks.

Operator: Your next question comes from the line of (Sessa Riley). Your line is now open.

(Sessa Riley): Hi, thank you for all of your information. I have really enjoyed this.

I have a question – once the decision has been made of the 500 or so signed, within the next three years, then, are there going to be morning sessions, conference calls, listservs to where we help one another out? Or will we be working individually, by ourselves, alone?

(James Cohen): Our intention is that you will likely be working mostly independently. But we are, in the process, trying to develop some learning systems that might involved some peer-to-peer learning.

We have no immediate details on that, so I cannot comment to any great length on it.

(Sessa Riley): OK, thank you.

Operator: Your next question comes from the line of (Mary Agnes Gilman). Your line is now open.

(Mary Agnes Gilman): Hi, my question was previously answered by (Barbara Easterling). Thank you.

Operator: Your next question comes from the line of (Dinah Moyer). Your line is now open.

(Dinah Moyer): Hi. We have one permanent nurse practitioner and are recruiting for another provider, so how would that affect the application process if we don't have someone in place by August 12?

(James Cohen): You must have clinical leadership or a nurse practitioner- or physician-led FQHC. They would have to be onboard at the time of your application.

(Dinah Moyer): OK.

Operator: Your next question comes from the line of (Carla Bartlaw). Your line is now open.

(Carla Bartlaw): Thank you. Forgive me, as I missed out on the first part of this.

I just want to clarify something. We are currently participating in meaningful use. Where does that come into play here? For some reason, I had it in mind that we could not do both, that we had to do one or the other.

(James Cohen): My understanding is that you can do both. Meaningful use is actually something quite different. Recognition as a patient-centered medical home does not require an electronic health record. It is probably easier and better for you to have one at Level III, but it is not a requirement that one exist. So, going in that direction, meaningful use applies only to your obtaining or being reimbursed for clinicians/physicians that are in the process of using or

learning how to use electronic health records. I do not see that as being a conflict to participate in this demonstration.

(Carla Bartlaw): Thanks.

(Bill Tollock): This is (Bill Tollock) for NCQA. If I could just add, we have actually embedded a lot of the HIT meaningful use requirements into the 2011 standard, so, in fact, there is actually some overlap that might benefit you.

Operator: Your next question comes from the line of (George Ward). Your line is now open.

(George Ward): Hi, I am on the website and looking at the page dealing with joint principles of the patient-centered medical home. I am on the section that talks about payment. Just as a quick clarification here, one of the bullet points says that I should pay the services associated with coordination of care both within a given practice and between consultants, ancillary providers, and community resources.

So if I, for example, am a patient of Dr. (Burwick), and he sends me to the hospital for some type of specialty care that is not typically covered by Medicare or Medicaid, then is this saying that the FQHC clinic would have to pay for that specialty care?

(James Cohen): No, I don't think that is what it is saying. You are talking about the principles of the patient-centered medical home as described or ratified by the American College of Physicians, the American Academy of Family Practitioners, etcetera?

(George Ward): Yes, that one, where it talks about payment, down at the bottom? (Inaudible) bullets…

(Crosstalk)

(James Cohen): Those are seven principles that have been jointly agreed upon by medical professional organizations. They should not be considered explicit for the purposes of this demonstration.

(George Ward): All right, thank you. I just wanted to be sure about that.

Thanks a lot.

Operator: Your next question comes from the line of (Tina Hahn). Your line is now open.

(Tina Hahn): Just a question around requirements – once you achieve Level III recognition, then do you still need to complete the Readiness Assessment every six months, or do you stop doing that once you have achieved the recognition?

(James Cohen): No, we would expect you to continue to do that. Basically, a lot of participating FQHCs are going to need almost all of that time for recognition. For those that are a little further ahead, obviously, if you have already gotten recognized, then this is going to seem like a tedious process.

But I want you to recognize, too, that the Readiness Assessment that is updated every six months, you are changing only the answers that have changed. So if you are doing your updated Readiness Assessment after six months, and you were already recognized, and nothing has changed, then you are actually not changing anything on the Readiness Assessment, so you are kind of resubmitting it. But because we are doing research on this, we have to see the results from each participant so that we can see how the progress is changing or how the FQHCs are changing, even if they don't need to change.

(Rachel Henke): And part of what we are looking at in the evaluation is the transformational process. The purpose in asking you to fill out the survey every six months is so that we can look at how your are progressing and transforming into a medical home practice. So even once you achieve Level III recognition, I think that the medical home model is the idea, but you would not necessarily stop everything simply because you achieve Level III recognition, but it would be the ongoing continual process.

(Tina Hahn): OK, thanks. Then one other quick question – I'm sorry, but that has been answered. Thank you.

Operator: Your next question comes from the line of (John Rube). Your line is now open.

(John Rube): I just want to make sure I understand you. In the case that there is no (inaudible) you are accepted into the Demonstration Project, the survey (inaudible) (QA) will be offset?

(James Cohen): Yes, that is correct.

(John Rube): But we are hoping by FQHC. We have seven (inaudible), 10 across three counties, and I think that each of our places would qualify. But we have to have potentially seven applications to participate?

(James Cohen): For the sake of the demonstration, your Readiness Assessments will not have any cost. When you ultimately submit for recognition with the documentation, then those costs will be covered by our friends at (HERSA).

(John Rube): Great, thanks. They ought to do that for our Joint Commission stuff. That is very helpful..

Operator: Your next question comes from the line of (Cindy Stewart). Your line is now open.

(Cindy Stewart): Yes, I may have missed this information, but what I wanted to find out is if CMS is going to provide a roster that identifies patients at the beginning of this Demonstration Project, for the individual clinics as a starting point? I heard the discussion of a roster being provided with payment after the first quarter.

(Claudia Lamb): The payment is prospected, so you will, at the beginning of the demonstration, get a roster and a payment for the quarter, prospectively. So I think that the answer to your question is "yes."

(Cindy Stewart): OK, thank you.

Operator: Again, if you would like to ask a question, that is star, one on your telephone keypad.

Our next question comes from the line of (Elizabeth Julesky). Your line is now open.

(Paul Kay): Hi, this is (Paul Kay) again. Back to the multi-site, the technical application question, the more that I understand the process, it gets clearer to me. But I would ask that, I think that most of us that have multiple sites in our organizations will want to apply for those sites that are not part of this demonstration, using the same process because we are trying to improve our entire organization.

So, again, I would urge you to work with NCQA from a technical side, to let us use their multi-site system of documentation and proof even though we will, site by site, apply to the CMS Demo. I think that, in reality, we will be working on all of our sites whether they are part of the demo or not, so it

would be very helpful to coordinate those two. And I think that it would not in any way violate the spirit or the research that you need to do.

Lynn Riley: We appreciate your feedback.

(James Cohen): Thanks.

Operator: Your next question comes from the line of (Gail Hedler). Your line is now open.

(James Cohen): Perhaps she is on mute. This is the second call for (Gail).

Operator: (Gail Hedler), your line is now open.

(James Cohen): We can move on, (Melinda).

Operator: I do actually have a couple of lines that we have not gotten to transcribe yet. If you want, I could open the lines and have them state their names for you.

(James Cohen): OK.

Operator: The next question comes from a line with user information that I did not collect from yet. Could you please state your name? Your line is now open.

(Marnie Holder): This is (Marnie Holder). Hello, and thank you.

I would like to ask about, as a multi-site grantee, as we council our boards, I think that it is my understanding that, if we have four sites invited to participate, then when we hit that button on all of those applications, if CMS

accepts one site into the demonstration, then we have agreed to participate with just one site. Is that correct?

(James Cohen): That is correct.

(Marnie Holder): Thank you.

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

(Mary Erb): Hi, we are doing a 2008 standards. We have not been recognized as a Level III medical home, and we were wondering if we were still eligible for the demo.

(James Cohen): If you meet the eligibility requirements, then, yes, you are. But you have to meet the standards for the 2011 NCQA recognition at this point, within the demonstration.

But if I understood you correctly, you were working on 2008 standards but actually have not submitted for recognition. Is that correct?

(Mary Erb): Yes.

(James Cohen): Then you can apply to participate in the demonstration as long as you meet the other eligibility requirements.

(Mary Erb): OK. I have another question that has to do with the fiscal year – or the year or reporting. My accountant wanted to know, did you mean the fiscal year or – it said "look-back year." What does that entail?

(James Cohen): We chose a 12-month period for which we have the most complete data available to us from our payment contractors. That happened to coincide with the calendar year 2010. So we looked back for all eligible FQHCs for the period of January through December 2010, and during that period of time, there needed to be at least 200 Medicare beneficiaries that were served at the site at least once in that period of time.

(Mary Erb): So it's just the calendar year, not the fiscal year?

(James Cohen): Yes, in this particular case, yes. But our 12-month period is going - - obviously, we are going to verify eligibility on a quarterly basis, so in – well, we will go to – in December, I guess that we will go back and revisit and look at a 12-month period that now runs from…

Lynn Riley: March…

(James Cohen): …March the previous – March through that point in December, so it is a rolling period of time that we will be looking back. It's not a static time.

(Mary Erb): OK, and I have one more. I'm sorry.

Sometimes, they have only one Medicare patient that will come for, say, like an annual physical, but they come regularly for other services. Would we still get money for that patient?

(James Cohen): If they remain eligible to participate, then, yes, you would collect a fee for that.

(Mary Erb): What exactly entails a beneficiary? How many times do they have to come? Does it have to be a certain amount of time that they visit the FQHC?

(James Cohen): No, when we do our look-back, we are actually look at as few as an individual visits for that individual beneficiary, in that 12-month period.

(Claudia Lamb): Let me just add that, if another FQHC in that quarterly look-back happened to see the beneficiary more often than you did, and they were also participating, then it would fall off of your roster and be attributed to that other FQHC, which I think is answering your question.

Does that help?

(Mary Erb): Yes, thank you.

Operator: Your next question comes from the line of (Rhonda Twig). Your line is now open.

(Rhonda Twig): Hi, thank you. I have two questions.

One, what does the reimbursement schedule look like? And, two, would you consider a blog site for sharing site process information?

(James Cohen): Reimbursement schedule? I'm not sure I know what you mean.

(Rhonda Twig): If the sites that are approved and participating are being paid to be in the demonstration, then what does that look like?

(James Cohen): You will get a prospective payment that is the equivalent of $6 per member, per month, each quarter without having to submit any claims. It will be calculated by our payment contractor to determine how much the FQHC has earned by virtue of the number of Medicare beneficiaries that are eligible and attributed to your facility. That translates into six times whatever that number is, and it will be paid on a quarterly basis.

I'm not sure that I'm answering your question.

(Claudia Lamb): Let me just interject. We plan to make our first payment on September 15 and then quarterly thereafter. Does that help?

(Rhonda Twig): Yes, thank you.

(James Cohen): Do you have another question?

(Rhonda Twig): Yes, the second question was, would you consider a blog site for sites to share their process information during the demonstration?

(James Cohen): I don't think that we have plans to do that. If FQHC wants to establish one on their own, then I think that is a fine idea.

(Rhonda Twig): OK, thank you.

Operator: Your next question comes from the line of (Sessa Riley). Your line is now open.

(Sessa Riley): Hi, this is something that I don't think is much (inaudible), but care managers – I know that is a huge part of patients from the medical home – what is your recommendation – say that you have 200 Medicare patients, is one care manager per 200 – do you have any thoughts or recommendations about these care managers that we need to hire?

(James Cohen): No, actually, we don't. I think that the idea here is that we are leaving it up to the individual site to determine what their needs are and to address them. That is the nature of the kinds of questions that you would be answering in the

Readiness Assessment and ultimately in the Recognition Survey as to how you address those.

You might want to take a look at the 2011 standards and see what examples or insights that they give in terms of how you might meet their criteria. That might give you some better information and better clues.

There are also websites that you might consider going to such as the American College of Physicians website – aco.org – or some of the other – well, if you Google "patient center medical home," then you might find some other examples. I'm blanking on an exact site for you. I'm sorry.

(Maheel Sintafaraja): (Jim), this is (Maheel). If you go to the FQHC Medical Home website, then there are also references there that might help you.

(Sessa Riley): OK, thank you.

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

Your next question comes from the line of (Molly Ferguson). Your line is now open.

(Molly Ferguson): Good afternoon. Thank you very much.

I am curious if there will be an opportunity for this call to be replayed or perhaps added to the website for our colleagues that were not able to participate.

(James Cohen): This call is being recorded and will be transferred into an MP3 file, which will be posted on the CMS and the Innovation Center website that appear on Slide

34, in the not-too-distant future. I don't know how long it will take to get it up there, but the answer to your question is, yes, this will be available for replay at some point.

(Molly Ferguson): OK, great. Thank you very much.

Operator: Your next question comes from the line of (Tina Hahn). Your line is now open.

(Tina Hahn): I know that you had said that you are still working on this TA plan, and I wondered if there are opportunities for us to give input to that; if so, how might we do that? Are those decisions already made but just not yet finalized?

Lynn Riley: Could you repeat that question, please?

(Tina Hahn): It is regarding the TA plan. It sounded as though there were still some decisions being made about how TA was going to be provided and by whom. I just wondered if we had any opportunity to give our input into that decision-making process; if so, how would we go about doing that?

Lynn Riley: Actually, at this point, CMS has not entertained accepting feedback about technical assistance from any of the FQHCs in the demonstration. We have been looking to our partners and ACHC and (HERSA) about that, as well as NCQA.

However, that being said, if you would like to send an email note to our email box regarding your ideas for technical assistance, then please feel free to do so.

(Tina Hahn): OK, thanks.

Operator: Your next question comes from the line of (Gail Hedler). Your line is now open.

Male: I had another conference call from…

Hello?

In fact, new information, really.
I have no idea. Do you think they would say "shut up" because we…

Lynn Riley: Excuse me. We can hear you, so if you would like to ask a question, then please do so; otherwise, please disconnect.

(James Cohen): (Melinda), let's move on.

Operator: OK, there are no further questions in the queue.

(James Cohen): No more questions. Thank you.

We did pretty well on time. I will ask if there are any parting comments.

Lynn Riley: I would just like to thank you all for joining us today. We look forward to looking at your applications and any feedback or questions that you want to send to us via our email box.

Feel free to look at all of the resources through the contact information that we have provided in the slide deck.

With that, we will adjourn.

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

END