

Health Homes Webinar
Member Referral and Assignment Process
March 18, 2014

Presenter: Rebecca “Becky” Ross – Medicaid Initiatives Coordinator, KDHE Division of Health Care Finance

Moderator: Sonja Armbruster – Public Health Initiatives Coordinator, WSU Center for Community Support & Research

Sonja: Welcome to the Health Home webinar series. These webinars will continue to be scheduled the last two Tuesdays of each month throughout the spring and are intended to highlight the tools and resources that are available to potential Health Home Partners. Just a few quick housekeeping items: this, and all of our presentations are recorded for future viewing from the KanCare website. Today, all of your lines have been muted and should remain so for the entire presentation. You should all have a question box that appears on your desktop as part of the GoToWebinar layout. This will be the method for asking questions during the presentation. You may type in your questions related to today's discussion at any time and our staff will see these and ask them to the presenters. So, I encourage you to consider your questions as we are going along, rather than waiting until the end so that we can be sure we have time for those. Please limit your questions to the topic of today's webinar. Any other questions can be referred to Samantha Ferencik and her email address will appear at the end of the presentation. If you're interested in the Q and A from the last couple of webinars, those questions and answers have been posted on the KanCare website.

Today's primary presenter is Becky Ross, Medicaid Initiatives Coordinator for the Kansas Department of Health and Environment, Division of Healthcare Finance. Becky, I'm ready to pass off to you.

Rebecca Ross: Thank you. If we can move over to our Agenda slide. I'm going to talk just briefly about the target population for the Health Home and those of you that have been following along on helping the initiative know that we have two groups of folks that we are targeting. We will talk about those and we will talk about how members are going to be assigned to Health Homes and then we'll cover some reasons why Health Homes could refuse to serve somebody. We'll talk a little bit about the referral form with the health initiative, and then we'll be responding to questions and answers. So next slide please.

Today we really want you to understand our target populations. We have the two groups of folks that we'll be serving and there is a State Plan Amendment to initiate both of those Health Homes. We'll talk a little bit about member identification assignment and as I mentioned, the referral form and reasons that a member might be refused by Health Homes. Next slide.

We always like to remind folks of our website; we think we have lots of good information out there for you. If you go to the KanCare website and that's the page you are seeing right now, the highlighted red box shows you where to click for Health Homes and if you click on that, it takes you to the next webpage and as providers, you're going to be most interested in the provider section, so click on that picture and that will take you to the next page. The bulk of the information that you want to know is in the area where the red arrow is pointing, so that

will get you to the page where you can find information by the target population. So we have things laid out there for the serious mental illness target population and the chronic conditions. Next slide.

Now let's talk a little bit about the two target populations. For our first target population and that's our First State Plan Amendment related to Health Homes – essentially it's individuals, both adults and children, who have a serious mental illness. So that includes anybody with a primary diagnosis of one or more of the following conditions, and they are all listed there. So those are the actual mental health conditions that we would expect to see someone in this particular Health Home have. And note that it's not limited to just adults; so children can have some of diagnoses, as well and they would be eligible for Health Home. Next slide.

Our second target population is what we call the chronic conditions group and those are people that have asthma or diabetes and that includes pre-diabetes and metabolic syndrome who are also at risk of developing one of those conditions you see on the right hand side of the slide. So they must have asthma or diabetes AND be at-risk for one of those conditions OR have some other risk factor as laid out here. For example, people with asthma who are smokers or live with a smoker or have had some environmental exposures or generally some other issue that would complicate their asthma. Or they have a missed quality of care indicator. They might have had an emergency room visit or been to the hospital for an asthma related condition in the last 12 months. Finally, if they are in that top 25th percentile of the Lead Entity's, and remember, the Lead Entity is the managed care organization with stratification software, so each managed care organization has a tool that they use to stratify their members to identify them to give more attention from care coordinators because they are likely to have high rank and high cost in terms of their service. So any one of those things on the right-hand side of that slide plus asthma could result in the person being eligible for the chronic condition help. Next slide please.

And the same is true for diabetes. So if the individual has diabetes and they exhibit or have one of these things happening with them so again, a current smoker or living with a smoker, some evidence that their diabetes is uncontrolled and that can be based on their blood tests, could be a missing quality care indicator, or that they are not getting the blood test that they are supposed to. Again, ER visits or in-patient admissions or diabetes-related complications, or being in that top 20th percentile and also non-compliance in taking the medication regularly. So any of those things could be combined with diabetes and make them eligible.

So how are those people going to be assigned? We're going to send assignment letters. They have to be currently eligible for Medicaid and I just want to remind people of that. We do have children in KanCare who are serviced through the Children's Health Insurance Program (CHIP), they would not be eligible, even if they meet all of the other criteria because the federal government has said Health Homes are for the Medicaid population. So they have to be currently eligible for Medicaid and be assigned by the MCO based on the information that they have on claims or other data or a referral by a provider in the community. The assignment then is based on being in the target population, whether or not there are Health Home Partners available in the geographic area where the individual lives and that individual, that member's existing relationship with Health Home Partners. For example, if I have a serious mental illness, and I am seeing therapist and other folks at my community mental

health center and the community mental health center is a Health Homes Partner, it's very likely the MCO would assign me to the community mental health center or my Health Home Partner. Next slide.

It's important to remember that members always have the right to choose their Health Home Partners so the assignment is a tentative assignment. And if I decide I don't want the community mental health center, you know, I want my primary care physician and my primary care physician is a Health Home Partner, that's okay. The MCOs will help members find a Health Home Partner. So the member is identified, the Lead Entity and the MCO will send out an assignment letter that explains all the good things about Health Homes, talks about why the member is eligible and gives them information about their choices for Health Home Partners and how to opt out. These letters will be sent on the first of each month and the referred members will review that letter. The referred members will actually receive Health Home services the following month. Next slide please.

So members can opt-out, there will be a form in their welcome letter, their assignment letter that allows them to opt-out. It will tell them how to do that, they can either check a box on the form and send it back or they can call a phone number. They can opt-out at any time and if they do opt-out, the MCOs will reassess them annually to see if they are still eligible for Health Homes and we will make that offer again on an annual basis. People who opt out can come back in at any time as well simply by calling their MCO and letting them know they want to be in Health Homes.

Our enrollment broker, Hewlett-Packard Enterprises (or HP) will receive the opt-out information and they will verify that when they receive the files from the MCO of people that they send letters to. So there's a few special rules around children in foster care. The assignment letter will go to the foster family but the foster family won't be able to opt-out or request a change in Health Home Partners - that will have to come from the child welfare contractor. Some of you may know that DCF contracts with two companies or two agencies who manage their foster care homes so those are the entities who will be sending back the opt-out form or if they need changes for Health Homes Partners. It's also important to know that the contractor and that Lead Entity, or the MCO, have to coordinate if that child moves to another area or state and they need to coordinate the Health Homes Partner assignment so that services are not disrupted. Next slide please.

Let's talk a little bit about how Health Home Partners may in fact refuse an assignment of a member. There are some limited reasons and we list those there. We will consider other reasons, but these are the ones we consider right now. As we launch the program and get more experience, we may add to this. For example if the Health Home Partners reach capacity, they can't serve any more members, it doesn't make sense to assign them another member, but it might happen and so the Health Home Partnership would be able to receive that. Tribal organizations using health facilities, they serve a certain population, they may refuse to serve someone who's outside that population. The I/DD providers...a similar kind of situation. If I'm a Health Home Partner and I'm out in Hays and I'm assigned a member who lives in Kansas City, I can refuse that member. We hope that doesn't happen, but it could. So there will be a process for refusal of member assignments and the Health Home Partners will have to get approval both from our State Health Homes Manager (yet to be hired) and the

Lead Entities or the MCO. We have developed a refusal form and we put it out on the web as soon as we launch, so that will be available to the Health Home Partners. And the lead entity, the managed care organizations, will also spell out details around refusal of member assignment in the contract that they execute with Health Home Partners.

Enrollment and disenrollment – the Lead Entity is going to notify the Health Home Partner of member assignment. They will be sending out the letters and they'll simultaneously be sending them to the Health Home Partners letting them know that that they are assigning members. They will verify that the person hasn't opted out and contact the Health Home Partner and that will trigger the Health Action Plan process. Remember, that's the first step in setting up the Health Home for the person that we develop that Health Action Plan. The Lead Entity will then take requests for change in Health Home Partner assignments so if I call up the MCO and say I don't like the Health Home Partner that you assigned me, I want another one, they will let me know who is available and then they will set me up with a different Health Home Partner. The Lead Entity has to coordinate that transfer of information when a Health Home member changes KanCare MCOs. Remember, annually people get to choose a different MCO if they want to. If that happens, we expect the MCOs to work together to transfer information so there is minimal amount of disruption. Hopefully Health Home Partners are going to be in all three networks so that there's minimal disruption, but if I were to change KanCare MCO, it might mean that I would have to change the Health Home Partner if my Health Home Partner was not in that MCO's network.

There are some reasons that people can be discharged or disenrolled from Health Homes. Say I get set up in Health Homes and six months down the road I decide I want to opt-out. That's okay. Then I will just be disenrolled or discharged from the Health Home. It might be that I have some sort of catastrophic illness, you know I have terminal cancer, I'm going into Hospice. It doesn't make sense for me to be in Health Home as Health Home is not going to be able to do much for me at that point. So I would be discharged from the Health Home. We will have a handful of people who, perhaps would pose a danger to themselves or to staff at the Health Home Partner. Those folks could be disenrolled and to do that the Health Home Partner is going to have to complete a discharge form that we are in the process of developing and then send that to the Lead Entity and to the State Health Home Manager. The process for that is still being worked out, but there will be a clearly spelled out process with a form as mentioned.

Now we also are going to folks in Health Home who have a spend-down. They are part medically de-eligibility groups. So they have to meet their spend-down amount in order to remain eligible for Medicaid. Sometimes they don't, so these folks may be out of Health Homes for that period, but the federal government has made it clear to us that we can't continue providing them Health Home services and get federal money for it as long as they don't meet the Medicaid eligibility requirements. For them, part of that requirement is meeting their spend-down.

Let's talk about the referral process for a few minutes. Hospitals are required by the Affordable Care Act to refer individuals with chronic conditions who they see in their emergency department that they reasonably believe would be eligible for Health Homes. So they have a requirement to refer people. Other Medicaid providers don't necessarily have to,

but we want to encourage them to. So I may be seeing a physician and he thinks I'm eligible for Health Homes, he can complete a referral form and send that to my managed care organization to refer me to Health Homes. The MCO would then take that information and verify that, in fact, I do meet the criteria and then they would set me up with a Health Home. There are going to be times when the referred member is not going to meet Health Homes requirements or the Health Homes eligibility requirements and the MCO will simply inform the provider that that person isn't eligible for Health Homes. That form will be available on the website. Next slide.

So here's a look at part of the form; it is a fillable form and we're trying to make all of our forms that you'll be using fillable Word documents so that you can just quickly complete them and then attach them to an email or some other way to get them to the MCO and to the State. So you can see that we've got information for all 3 MCOs up there because this form could be going to any one of them. We want to know which MCO, obviously, the person is assigned to so that we can get it to the right MCO. We are going to want to know some information about not only the individual, but who is referring them so in the next two boxes we're collecting that sort of information. Next slide please.

Further down on the form we see in Section 2, the diagnoses. So for the seriously mentally ill and even for asthma and diabetes, we want to see an appropriate diagnosis, so we need to see one or more of those boxes checked as a beginning point for determining eligibility for Health Homes. Next slide.

So the next box talks about the at-risk conditions. You can see again, those things that are risk factors. And then the form segues into whether or not that person has been in the emergency room or admitted as an inpatient for an asthma or diabetes related complication. So this form really just lays out the criteria that we are using to define our target population into a form that providers can easily check boxes on to indicate that the person meets the criteria and the eligibility requirements. Then Section 5 goes into the quality of care indicators that we have already talked about. Next slide please.

And finally, the last section is the area of the form that the MCO will complete. So they will take a look at all of the information they get on this form and they will make the determination that, "yes this person is eligible for Medicaid and they meet the criteria for either the one chronic condition and is at-risk for another or that they have a serious mental illness." Or it may turn out that the person doesn't meet eligibility criteria. Maybe it's a child who is CHIP eligible, so they would not meet the Medicaid eligibility criteria. They will list in end of that Section 6 there, the reason for ineligibility, if the person is not eligible. Then you will see that there are some follow-up activities that the MCO will take in response to receiving this form. So we think it's a pretty self-explanatory form and it will be very helpful in terms of getting referrals from the community providers for people to go into Health Homes. And with that, we are ready for questions.

Sonja: Excellent, thank you Becky. We have just a handful of questions and so that's an invitation to all of you who are on the line to continue to ask questions. So I will just take them in the order that they have been received. So Becky first – how long does a person remain assigned to a Health Home? One year? Their lifetime? How long does a person remain

assigned to a Health Home?

Rebecca Ross: Well they would remain assigned as long as they met the target population criteria, have a goal that they were working on in the Health Action Plan and wanted to be in the Health Home.

Sonja: So what if the member's diagnoses changes during treatment?

Rebecca Ross: Well we hope for that for some people they could get better and obviously if they are getting better and they no longer meet the target population criteria they wouldn't be in a Health Home. They could potentially still receive some case management services from the MCO because they also have case management that they provide to other populations or disease management. So perhaps the diabetes has become very well-controlled and they no longer have those risk factors. They could potentially no longer be eligible for the Health Home, but they could still receive some disease management or case management from the MCO.

Sonja: Thank you and the questions are still coming in, so I will step up my pace. What if a member has a primary SMI diagnosis that doesn't qualify for Health Home, but has a secondary diagnosis that does? I think this question relates back to that slide 26 that had the listing of diagnoses.

Rebecca Ross: Now in terms of primary or secondary, some of that is really how the diagnoses are laid out and claims are filed. But if someone has a secondary diagnosis of one of the serious mental illness diagnoses, I think the MCOs would take a look at that and just see what else is going on with the person to determine whether or not they would meet eligibility and would fall into that category of SMI. So someone could have a diagnosis of substance use disorder and maybe that's listed as a primary diagnosis, but they also have bipolar disorder. That would still qualify because we said if somebody has a diagnosis of a substance use disorder and even if that's a primary diagnosis, if they have one of those SMI diagnoses, they would be eligible for the SMI target population.

Sonja: Thank you. We have a good number of questions coming in. Some people... this is a clarification question... Some people who are diagnosed with diabetes or asthma will not be assigned to Health Home. Correct?

Rebecca Ross: That's correct. If their asthma or diabetes is well-controlled and they don't have any other of those risk factors, they would not be eligible for Health Home.

Sonja: I think you answered this later in your presentation after the question was asked, but how often can a member change their Health Home Partner?

Rebecca Ross: Theoretically, once a month. We are limiting it just for management purposes to no more than once a month. We hope people won't change that often, obviously, but that's the maximum that we would let them change.

Sonja: We have a question about child disintegration disorder and whether or not that would

continue to be on the referral form under eligible diagnosis?

Rebecca Ross: No, it should not be, we need to take that off. We've actually taken it off our definition of the target population and those of you who are familiar with the Diagnostic and Statistical Manual, you know that there has been an update of that and that particular diagnosis has sort of gone away and those children have been moved into a different diagnostic category. So we are just removing that diagnosis and we will take that off the referral form. Thank you for pointing that out.

Sonja: Thank you, Becky. Now a couple of other different kinds of questions – will this program be available to Kansas Rural Health Clinics to participate?

Rebecca Ross: Yes, that is one of the provider groups that we have called out as a potential Health Home Partner. They must also, of course, meet all of the requirements to be a Health Home Partner, but certainly rural health clinics are providers that would be eligible to become Health Home Partners.

Sonja: And one could find the list of 12 possible Health Home Partner types in the program manual available on the website that you shared at the beginning of the presentation?

Rebecca Ross: Yes.

Sonja: This is a question about spend-down. When will we be notified when a patient is on spend-down and if so, how?

Rebecca Ross: The MCOs get that information in their file that goes back and forth between HP or the State, to the MCOs, so they will know whether or not somebody has met spend-down. And they should be able to let the Health Home Partner know that and that will be part of the information that you'll have to share back and forth between the MCOs and the Health Home Partner.

Sonja: Thank you. Related to when will the potential Health Home Partners know their patient pools, the question is: when will the Health Home Partner know who was referred to them before July 1st? Will we know before July 1st the agencies interested in determining staffing needs for Health Home core services? Is that a question for the MCOs perhaps?

Rebecca Ross: It could be, but let me preface that by saying Medicaid eligibility changes for some people month to month and spend-down is an example. So coming out with very far ahead of time is not actually going to work because there will be people who aren't going to meet Medicaid eligibility criteria the next month. So you will get your list fairly close to time and I will let the MCOs talk about the actual timeline for when letters go out and when Health Home Partners will be notified.

Sonja: So if we have MCOs on the line, if you press *6, you can unmute your line to help answer that question. And just so you know, we have about a dozen more questions. Which is good

Ron: This is Ron McNish from Amerigroup. Can you hear me?

Sonja: Yes we can, thank you.

Ron: We've been asked by the CMHC's, at least, to produce, not a member list at this point, but a list of potential members by category since there are different tiers for reimbursement. We have been asked to pull together part of potential members and their catchment areas, by tiers so they would know 'x' number in each of the tier groups. That's more for their ability, not only to know the potential members, but also to be able to estimate some potential revenue that might be involved. So we are working on pulling that together. Certainly we would anticipate having that well before the date that was identified.

Sonja: Thank you. I think this also speaks to this question and others are welcome to chime in from the various MCOs. How soon, prior to the start-up of enlisted members assigned...can a list of members be assigned to their Health Home? Slightly different but related.

Ron: Well I don't know if Becky is taking that or not. As she's already identified... It's the kind of thing we can't do too early because of the potential for shifts in the membership, so it is one of those things... You are speaking member specific now rather than whether the groupings of members or the numbers of members in each group.

Sonja: Right.

Ron: So that does have to be done as we get closer to July 1.

Rebecca Ross: I think that... And Ron can correct me if I'm wrong here, but we've had discussions with the MCOs and with our partners at HP and even though folks can opt-out at any time, the MCOs really have to sort of set a timeline for how long they're going to wait to hear back from a member once they send that letter out and I think they've agreed to just a 15 day period. So they will wait a couple of weeks and if they don't receive opt-out information, then they will work with the Health Home Partners and say these are the members that we have assigned to you. Some of that may be going on during that two weeks, but certainly they're not going to wait any longer than 15 days to get started getting people set up in Health Homes, with the understanding that, you know, we get somebody set up and then maybe they decide to opt-out after you've done the work.

Sonja: Before I go on and we have at least a dozen questions, are there other MCOs who would like to chime in there? I don't want to short change anyone the opportunity to speak.

Jeanine: This is Jeanine with Sunflower, can you hear me?

Sonja: Yes Jeanine, thank you.

Jeanine: Now just real quick, I'd like to say with the time lapse is to... The members will... The MCOs will mail our letters to members on the first of each month. Then we will be sending the files to the State the 15th of each month and like, the letters will go out on the first

of each month and then like, I think Becky said, if we have any changes or anything, then, the 20th is the date that members have to opt-out by. And so when they opt-out, they have by the 20th of the month and then the changes that they go in... If they opt-out before the 20th of the month, then those changes are effective by the first, so like if they will receive letters on July 1st, they opt-out before July 20th, then that opt-out will be effective August 1st? Otherwise it would be effective September 1st, and that would be pretty much, the routine for the timeline for each month. If they received their letters on the first of August or first of July, the effective moving in to Health Home membership on August 1st, then that will just keep going each month.

Sonja: Thank you. Now this is unique question – are patients with an SMI diagnosis in nursing homes eligible for Health Home services, such as nursing facilities for mental health?

Rebecca Ross: No they are not. The federal government has been pretty clear that they expect nursing facilities of any type to essentially be performing similar services to Health Homes for their folks who are in them. Now, as someone is getting ready to be discharged into the community, they could potentially be eligible then to be in the Health Home once they move into the community.

Sonja: Thank you. A couple of folks have asked about when the slides will be available to be posted and they should be on the website in a couple of days. I could PDF them and send them out to all participants though today and then we usually get the slides with the webinar and the transcript, which takes a little bit of time to get transcribed, posted together at the same time on the KanCare website.

Rebecca Ross: Sonja, I think that the slides are actually out there right now.

Sonja: OK great. So for those of you who are wanting to share the slides with your staff and there are about a dozen, they are available. Okay, a couple more questions – I/DD is usually the primary diagnosis, but many have an SMI diagnosis, are they eligible for a Health Home and I think we answered that with it's not the order of diagnosis that will make a difference there, but Becky, you had suggested that might be a conversation with the various MCOs.

Rebecca Ross: Right, and remember, the MCO is going to be looking at claims data to see what services people are using and what their connections are to various providers as they get folks assigned to Health Homes.

Sonja: Thank you. A number of questions are related to timelines and I have a couple of those suggested here that letters would be mailed the first of each month and the partners will be or the members will be able to make decisions and then in 20 days there... When will the first letters go to clients? Or what date will a member referral begin?

Rebecca Ross: Those letters will go out July 1 and members will be set up then for August 1 for Health Homes.

Sonja: Thank you. A couple more very specific questions. If the patient has not met spend-down, when they do meet it, does all of the paperwork have to be redone?

Rebecca Ross: No, I'm not sure what paperwork you might be talking about. I think the MCOs will have that information and they'll know where the person is in the Health Home and you know, things will be suspended for that person and then they can get them going again. So if you've got somebody who's assigned to you as a Health Home Partner with spend-down, the MCO's will let you know if they haven't met their spend-down so you can suspend your services and then the MCO's will let me know when they've met spend-down so that you can start them up again.

Sonja: I want to acknowledge that we have a couple of very specific questions that have been asked that we will get answered in the Q and A, but might not happen right here and now today on the call. Now two more questions – how will Health Homes know if the diabetic or asthmatic patient they are seeing, who may not be their own patient, is being assigned to a different Health Home Partner? So if a client is a patient at a particular health delivery center and they have diabetes or asthma, how will their primary care home perhaps find out if the patient has been assigned to a Health Home that is not is not the primary care home?

Rebecca Ross: Well remember that the first thing that happens when people are set up in Health Homes is that Health Action Plan gets going and the Health Home would be working with all of the providers that that individual sees to involve them in the development of that Health Action Plan. So that whenever that primary care physician would be contacted by the Health Home to get involved in the development of the Health Action Plan and so they would know who the Health Home Partner is for that individual.

Sonja: Excellent, thank you. One more question and it's related to a previous webinar... We are in the process of completing the preparedness tool now. How soon after submitting it will we know or hear back from the MCO?

Samantha: This is Samantha. I don't have the timeline memorized but if the providers wants to look at the instructions and in the first few pages on the tool itself, it lays out a timeline stipulating that the MCO will indicate that they have received the tool, I believe within 10 days, and they will schedule either face-to-face or over the phone talk with the provider to discuss contracting and I believe that's an additional 10 days. But the timeline is very specific and it's laid out in the Preparedness and Planning Tool itself, so you should have access to it. If you are concerned about the timeline for any reason, you can go ahead and email me and I will be happy to check into it for you.

Sonja: Excellent. Thank you Samantha. Two more questions. One, does the State have a goal or estimate as to the number of patients that will be assigned to a CCHH? And I'm sorry I don't know what that stands for.

Rebecca Ross: Chronic Conditions Health Home. No, we don't. We expect the MCOs and the Health Home Partners to work out as they're contracting what is an appropriate capacity for the Health Home Partner and a lot of things are going to play into that. What type of provider the Health Home Partner is? How many patients or members they are already seeing for other things? And how many Health Home Partners are available in a particular area? So a lot of things come into play here and we really don't want to set any before the fact

expectations that each Health Home Partner can serve 'x' number of members.

Sonja: Excellent and the last question which I'm asking last because I think it's nice to remind ourselves where we're going with this with this whole point... The question was, what is the goal of a Health Home? It's nice to be reminded of the purpose.

Rebecca Ross: Well we actually have four goals and I'll see if I can remember all of them: 1) To keep people out of the hospital, or emergency rooms and inpatient as much as possible, so avoiding unnecessary ER visits and inpatient stays; 2) Improve care coordination - to make it as tight and comprehensive as possible so the individual gets all the services that he or she needs and in as timely a fashion as possible; 3) To make sure that there is a comprehensive transition plan if somebody does have to go into the hospital for an extended stay, that they come out and everything that they need for their discharge plan is in place. So if I've gotten some new prescriptions, those prescriptions will be filled. If I need a follow up with a specialist or some other physician, that it's been set up and I have help to get there. If I need to have some follow-up lab work, that is scheduled and it gets done. So all of those things that need to be done for someone when they come out of an inpatient stay get done in an effective and timely manner so that they're not going back in unnecessarily; 4) Making sure that people have the community support and services that they need to remain in the community and be as healthy as possible.

Sonja: Thank you Becky. I believe that gets us most of the questions that were asked. There are a couple more, and we will make sure that they are included in the Q&A that we provide on the website. Becky, do you have any closing remarks?

Rebecca Ross: No. I would just thank you all for participating in this and encourage you to spread the word to other providers about these webinars and remind you that all of this will be on the website in a few days. We'll not only have the slides, but the transcript and the recording.

Sonja: Excellent, thank you. And as you can see on the screen now, our plans for the next few webinars are set and we are working on the "Just In Time" topics for May. Stay tuned next week, as we will be talking about the Payment Structure. For those who might be interested in having a little more time to dialogue and revisit some of these issues or visit new ones, there will be regional in-person meetings and registration is currently available for that and you can see that on the screen. We are doing those regional meetings in Hays, Dodge City, Wichita, Chanute, Kansas City, and Topeka. So if you want to attend one of those regional meetings, the registration information is available. Thank you all again for participating. Have a great day. Thank you.