Centers for Medicare & Medicaid Services
Special Open Door Forum:
Medicare Imaging Demonstration Project
Thursday, October 1, 2009
2:00 pm – 4:00 pm ET

The Centers for Medicare & Medicaid Services (CMS) is holding a Special Open Door Forum (ODF) in order to share the proposed key elements of the Medicare Imaging Demonstration design.

This demonstration was authorized by Section 135(b) of the Medicare Improvements for Patients and Providers Act of 2008 (MIPPA) for the purpose of collecting data regarding physician use of advanced diagnostic imaging services. For purposes of this demonstration, advanced diagnostic imaging services are defined as diagnostic magnetic resonance imaging, computed tomography, and nuclear medicine.

Tentative Agenda:

1. Demonstration overview
2. Advanced imaging procedures
3. Decision Support Systems and guidelines
4. Quality

For a copy of the presentation slides and more general information about the demonstration, please see the demonstration website:
http://www.cms.hhs.gov/DemoProjectsEvalRpts/MD/itemdetail.asp?filterType=none&filterByDID=-99&sortByDID=3&sortOrder=descending&itemID=CMS1222075&intNumPerPage=10

Telephone participants will be given an opportunity to speak and will be asked to limit comments to 2 minutes.

Interested parties may submit comments or input in written form to ImagingDemo135b@cms.hhs.gov by noon ET on Wednesday, September 30, 2009.

We look forward to your participation.

To participate by phone:
Dial: 1-800-837-1935 & Reference Conference ID: 29805623
Persons participating by phone are not required to RSVP.
Note: TTY Communications Relay Services are available for the Hearing Impaired. For TTY services dial 7-1-1 or 1-800-855-2880. A Relay Communications Assistant will help.

An audio recording of this Special Forum will be posted to the Special Open Door Forum website at http://www.cms.hhs.gov/OpenDoorForums/05_ODF_SpecialODF.asp and will be accessible for downloading beginning Tuesday, October 13, 2009

For automatic emails of Open Door Forum schedule updates, E-Mailing list subscriptions and to view Frequently Asked Questions please visit our website at http://www.cms.hhs.gov/opendoorforums/ .

Thank you for your interest in CMS Open Door Forums.

Audio file for this transcript:
http://media.cms.hhs.gov/audio/MedicareImagingDemo100109.mp3

Centers for Medicare & Medicaid Services
Special Open Door Forum:
Medicare Imaging Demonstration Project
Moderator: Natalie Highsmith
October 1, 2009
2:00 pm ET

Operator: Good afternoon. My name is Sarah, and I'll be the conference facilitator today.

At this time, I'd like to welcome everyone to the Centers for Medicare & Medicaid Service Special Open Door Forum on Medicare Imaging Demonstration.

All lines have been placed on mute to prevent any background noise. After the speakers' remarks, there will be question and answer session. If you would like to ask a question during this time, simply press star and the number 1 on your telephone keypad. If you'd like to withdraw your question, please press the pound key. Thank you.

Ms. Highsmith, you may begin your conference.

Natalie Highsmith: Thank you, Sarah, and welcome, everyone, to the Special Open Door Forum to share the proposed key elements of the Medicare Imaging Demonstration Design that was authorized by Section 135(b) of the Medicare Improvement for Patients and Providers Act of 2008, also known as MIPPA.

Today, our CMS staff will do a brief demonstration overview, give advanced imaging procedures, and discuss quality and the decision-support systems and guidelines.

I will now turn the call over to Ms. Linda Lebovic, who is the Project Officer for the Medicare Imaging Demonstration Project.

Linda Lebovic: Thank you, Natalie.

And let me say welcome also to the second Open Door Forum on the Medical Imaging Demonstration. As Natalie said, I am Linda Lebovic. I am the Project Officer for the Demonstration.

Here with me today are Linda M. Magno, Director of the Medicare Demonstrations Program Group, John Pilotte, the Director of the Division of Payment Policy Demonstrations, and others from around the agency who work on CMS issues related to advanced imaging.

As Natalie stated, we will first go through the slides that were posted on the Demonstration webpage, then we'll open up the phone lines for any questions or comments.

Which brings us to Slide No. 2.

We've introduced Linda, John, Natalie, and myself. Now let me take a minute to introduce the leaders of our Design and Implementation Contractor team from the Lewin Group.

Dr. Charlie Bruetman, Senior Vice President, Sharman Stephens, and Carol Simon, both Managing Directors at the Lewin Group.

Second, we'll go back to the authorizing legislation and provide an overview of the proposed demonstration design. We'll talk about which imaging procedures will be included in the demonstration and how we chose them. Then, we'll talk about the decisions support systems and guidelines. Finally, we'll talk a bit about quality.

Slide 3.

Natalie has already reminded you to please identify yourself and your organization before you speak. Please also be aware of our 2-minute limit per caller. We would like to hear all the comments and encourage you to both comment and allow others the same opportunity.

Slide 4 actually shows the authorizing legislation for this demonstration. It comes out of the MIPPA Law, Section 135 (b). The goal of the demonstration and our understanding of the Congressional intent of this law is to collect data regarding the physician use of advanced diagnostic imaging services to determine the appropriateness of services in relation to established criteria and physician tiers.

Slide 6.

The law specifies MRI, CT, and nuclear medicine are to be included in the demonstration. The law also specifically excludes x-ray, ultrasound, and fluoroscopy.

Slide 7.

Furthermore, the law specifically excludes the use of prior authorization in this demonstration.

Slide 8.

We will be describing the proposed design for the demonstration. First, the duration of the demonstration is, as required by law, a two-year demonstration period. We'll also talk about the advanced imaging procedures selected for the demonstration, decision support system, the role of conveners and physician practices, and pay for reporting; lastly, also required by law, physician feedback.

Slide 9.

There are 11 procedures selected based on expenditures, availability of appropriateness guidelines, and utilization in Medicare fee-for-service. We first looked at the Medicare Part B claims. We looked at the expenditures and the utilization in the Medicare fee-for-service population for advanced imaging and targeted procedures with high utilization and high expenditures.

As required by Section 135(b) of the law, we looked for relevant medical specialty appropriateness guidelines. As part of the design effort, CMS and its contractor have outreached to medical specialty societies and the AQA Alliance to get their input and information on their available guidelines.

We selected the 11 advanced imaging procedures to be included in the demonstration using those criteria. Note that we are using Spect MPI to fulfill the requirement for nuclear medicine based on the high expenditures, high-utilization growth, and appropriateness for the Medicare population.

Slide 10, Decision Support System.

The law described two models. One, a Point-of-Order model that uses a computerized order entry system and requires inputting information at the time of referral and provides feedback about appropriateness of the order based on the input. For example, this could be a system that is embedded in an electronic health record or an electronic medical record or a DSS that is web-based.

Slide 11, the second model, called the Point of Service or POS model. This model allows the physician practice that furnishes the imaging procedure the ability to participate in this demonstration without using a computerized order entry system, although the order must ultimately be submitted electronically. This permits systems that are less sophisticated to participate in the demonstration.

The POS model, for example, may be where one physician practice both orders and furnishes the procedure.

Another example may be most applicable to radiology or cardiology practice, or to practices in rural settings, or for practices that telephone or fax is ordered. Feedback regarding the appropriateness of the order is provided.

Slide 12.

A DSS provides decision support feedback regarding the appropriateness of the order. For the demonstration, we are going to be looking at only those 11 procedures selected. Under the demonstration, a Medicare-covered service cannot be denied.

Guidelines. We spoke with medical specialty groups and the AQA Alliance to get their input and information on their available guidelines. The guidelines included in the demonstration come from the medical specialty groups -- for example, the radiologists, cardiologist, neurologists, ENTs, and the North American Spine Society -- and they all involved other specialties in their guideline development process.

The guidelines must be transparent to the physician. And let me just take a minute here to say thank you on behalf of the Lewin Group and CMS to all the folks we spoke with over the past many months for their assistance.

Slide 13.

One of the challenges of designing a demonstration is striking a balance between the real world, a robust study, and what is mandated by law. We are using multiple systems that will meet certain core requirements, and we are not mandating physician participation.

We talked with many stakeholders in the advanced imaging community, and concluded that we should establish critical and specific criteria to integrate DSS into routine use and invite the community to propose a geographic area in which to operate the demonstration. CMS needs a point of contact, an entity which leads and coordinates the necessary components and participants and through which the data and payments flow.

The convener recruits physician practices, brings a DSS that's specific to the selected procedures and guidelines, ensures the DSS remain current with those guidelines, collects and transmits data, and distributes payments to practices who are reporting data.

The convener brings that package in a proposal to CMS and responds to our solicitation or requests for proposals, and meets the criteria defined in the solicitation. CMS will select up to six conveners depending on budget limitations and the merit or quality of the proposals submitted.

Slide 14.

We will be looking for claims for those 11 selected procedures ordered by a practice and for a minimum of five claims per practice during that prior year. It is not 5 of the 11 procedures; rather, a minimum of five procedures of any or all of those 11 procedures included in the demonstration for which there are claims during the prior year by the practice. Physician practices must order all of their advanced imaging services using the DSS.

In evaluating proposals, we will be looking to see if the convener brings a mix of practices. A practice of primary care, cardiology, or neurology, therefore, easily could be part of one convener or demonstration area providing they have a history of at least five claims during the prior year.

Slide 15.

Incentive payments for physician practices and conveners are based on the completeness of reporting. Physician practices will be paid for submitting data to the convener using the DSS. Completeness is determined by the claims for image procedures furnished relative to the number of DSS records received. Conveners will also be paid for collecting data from the practices and submitting that data to CMS.

The initial payment will begin after CMS receives the baseline data. Completeness of reporting is defined as 80% in Year 1 and 90% in Year 2. This means that in Year 1 at least 80% of the procedures ordered must have a DSS record, and at least 90% of the procedures ordered must have a DSS record in Year 2.

Slide 16.

The goal of the demonstration is to determine the appropriateness of imaging services in relation to established criteria and physician peers. It is not to compare DSS. All physicians within a practice must participate in the demonstration. The guidelines must be transparent to the physician and provide feedback about the appropriateness of the procedure ordered. And data is submitted to the convener using the DSS.

Slide 17.

We talked about identifying comparison groups, matching on practice characteristics, et cetera, and that proved to be quite a challenge for the evaluation and for our budget. We are instead employing a pre-post design where practices serve as their own comparison group.

For the pre-intervention or experimental phase, practices will use the DSS, but the DSS will not provide feedback regarding appropriateness or provide access to guidelines. This will yield six months of baseline data.

For the post-intervention or experimental phase during the following 18 months, practices will use the DSS, which will provide feedback regarding appropriateness and access to transparent guidelines.

Slide 18.

We were very concerned about providing an incentive for increasing volume. Therefore, the payment to participating practices is based on historic ordering rates, providing no incentive to order more imaging procedures during the demonstration. And it addresses practice size, but in terms of advanced imaging and not simply on the number of physicians in a practice.

Practices will be classified by CMS into approximately six payment tiers based on the prior year ordering volume. For example, a large primary care practice may order the same historic annual volume for any of the imaging services of the 11 selected demonstration procedures as a small cardiology group. Under the demonstration, both of these practices will fall in the same payment tier.

The number of tiers and payment amount in each tier will be determined by the mix of practices in and across selected proposals and the budget limitations of the project. Each practice will know what annual payment amount is possible given the completeness of reporting threshold is achieved.

Slide 19.

As I stated earlier, conveners will also be paid for collecting data from the practices and submitting that data to CMS. Let me say it again. Physician practices are paid for submitting data to the conveners using the DSS. Conveners are paid for submitting DSS data to CMS. Conveners will be selected based on their proposals, and we hope to select up to six conveners or demonstration areas based on what we received in response to the solicitation and our budget.

Slide 20.

The DSS provides immediate feedback on the appropriateness of the order. Feedback derived from the data submitted to CMS from the participating practices will also provide comparisons on a physician practice convener level, generate some appropriateness and utilization rates and image results.

We anticipate providing quarterly payment and feedback. However, based on the capability of conveners and data lag, we may entertain semiannual payment and feedback once we have final sites selected for the demonstration.

I also want to share with you that our colleagues in the Office of the Clinical Standards and Quality recently examined the trends in ionizing radiation exposure due to diagnostic imaging services among fee-for-service Medicare beneficiaries from 1997 through 2007. Annual ionizing radiation exposure increased dramatically during this time. Thus, the potential for this demonstration to help reduce unnecessary ionizing radiation exposure has the most definite impact on the quality of care provided to Medicare beneficiaries.

And I want to thank you for participating. We've made it to our last slide. And Natalie, now we can start taking some callers.

Natalie Highsmith: Okay. Sarah, if you can just remind everyone on how to get into the queue to ask a question.

And everyone, please remember when it is your turn to restate your name or state you're calling from and what provider or organization you are representing today.

Operator: At this time, I'd like to remind everyone, in order to ask a question, please press star and the number 1 on your telephone keypad.

Your first question comes from Joseph Guiffrida of NC.

Your line is now open.

Joseph Guiffrida: I have no question, I'm sorry.

Operator: Your next question comes from Steven Brotman.

Your line is now open.

Steven Brotman: My name is Steven J. Brotman, and on behalf of AdvaMed, the Advanced Medical Technology Association in Washington DC, I am pleased to provide comments to the October 1, 2009 Special Open Door Forum of a Medicare Imaging Demonstration Project.

AdvaMed represents manufacturers of medical devices, diagnostic products, and health information systems that are transforming healthcare through earlier disease detection, less invasive procedures, and more efficient treatment.

AdvaMed members produce nearly 90% of healthcare technology purchased annually in the United States, and more than 50% of the healthcare technology purchased annually around the world.

AdvaMed members range from small to larger technology innovators and companies. Nearly 70% of our members have fewer than $30 million in sales annually.

As CMS continue - considers the design implementation of the Medicare Imaging Demonstration, AdvaMed has a number of comments and concerns which are outlined below.

AdvaMed supports this imaging demonstration for the purpose of determining the impact of physician use of appropriateness criteria on advanced diagnostic imaging services. If designed properly, we test that. If appropriate decision criteria are utilized, then the appropriate image would be ordered to meet the patients' - meet patients' needs (right test at the right time).

However, the supporting information that has been provided to this Open Door Forum is sparse, and AdvaMed has several comments which we hope that CMS will address concerning issues that are likely to affect the outcome of this demonstration.

First, from presentation materials provided, it is unclear how a broad representation cross-section population - broad representative cross-section population of practicing physicians will be obtained from the demonstration.

The materials seem to be (unintelligible) that physicians may be chosen by a convener. We would like to know more details concerning who these conveners will be, how they will be chosen, how they will be interacting with the physicians in the demonstration.

This has potential to affect the outcome of the demonstration especially since this sampling - since sampling a volunteer population of physicians could have inherent selection biases and, therefore, potentially represent a skewed population of physicians being sampled. The success of this demonstration relies partially upon the selection of a representative physician population in various geographic distributions to ensure the findings of the demonstration are generalizable.

Second, considering the decision support systems dealing with the Point of Service and the Point of Order model is unclear how these will be selected. Key questions include, will conveners select the product -- example, a software -- that this system will utilize; will conveners use a single DSS for their portion of their demonstration; will all conveners use the same DSS; will

the demonstration assess the impact of different DSSs; how will CMS ensure the differences - that differences between conveners do not affect the outcome of the demonstration.

Third, the guidelines on appropriate use for 11 imaging procedures are critical. Will guidelines differ across the demonstration sites?

We commend CMS for working closely with the American College of Radiology and the American College of Cardiology and other professional societies in formulating appropriateness guidelines. If additional stakeholders will be involved in developing appropriate guidelines by which physician practices will be assessed, we believe there should be full transparency regarding communication - regarding communicating which organizations will be used and the criteria that they have provided.

Finally, it is unclear the purpose of development of a physician incentive tier which is referenced on Slide Number 18. The presentation noted CMS will classify practices into six payment tiers defined by prior year ordering volume, (not stated that CMS' implication) for this tier system namely whether or not this will result in a change for reimbursement for specific imaging modalities in the future. We do not believe that reimbursement rates should be tied in any way to the ordering volume of specific tests.

In conclusion, thank you for the opportunity to provide comments.

Woman: Linda?

Linda Lebovic: Other questions...

Natalie Highsmith: Okay. Thank you.

Next comment please?

Operator: Your next question comes from Liz Quam of Minnesota.

Your line is now open.

Liz Quam: Good afternoon.

My name is Liz Quam. I'm the Executive Director of the CDI Quality Institute of the Center of Diagnostic Imaging. We're headquartered in Minnesota.

I represent the Imaging e-Ordering Coalition, whose members, in addition to CDI, include the American College of Radiology, the Connecticut State Medical Society-IPA, GE Healthcare, INSIGHT IMAGING, LifeIMAGE, Med - Current Med, Medicalis, Merge, and Nuance Communications.

Our mission is to promote evidence-based DSS through real-time embedded access in an ambulatory or hospital electronic information system.

We applaud the intent behind the demonstration project and look forward to meaningful data from its effective implementation; thereby allowing us collectively to achieve much of what is part of the national HIT vision. Our members stand ready to assist the CMS in any way appropriate to make this happen.

To amplify our written comments, we raise the following issues.

First, independent, non-self-referring radiology practices need to be allowed to participate in the POS component of the demonstration project. This is important to allow comparisons of deployment models as CPOE is not and will not be a reality for some time. We also are seeking clarification that in the POS model the feedback regarding appropriateness is conveyed to the ordering physician.

Second, our coalition believes that certain types of approaches do not constitute valid decision support systems, including approaches premised on physician profiling or based on service costs or opposed - as opposed to medical necessity. We request confirmation of our understanding that such approaches would not be included.

Third, the proposed approach to collect six months of baseline data from providers after they're accepted into the demo may very well produce an artificial result not reflecting historic ordering behavior. CMS should instead utilize the most current ordering data for the 11 identified procedures for measuring the impact of DSS. We also request that the utilization rates be shared with the conveners during the course of the project to continue to track progress.

Fourth, we request that CMS provide clarification as to the specific reporting requirements and what would be considered to constitute "completeness" of those reports.

We very much appreciate your consideration of our comments.

Natalie Highsmith: Okay. This is Natalie Highsmith. I just wanted to let you guys know that we are just - the staff is going to be taking these comments and concerns that you have, and the document will be posted on the Demonstration Project website, which is on the CMS webpage, and that is on the last slide of today's presentation. A notice will be sent out when that document is posted for your review.

Okay, Sarah, we can go on to the next question.

Operator: Your next question comes from Greg Allen of Tennessee.

Your line is now open.

Greg Allen: Yes. Dr. Greg Allen here, Chief Medical Officer at MedSolutions.

Well, I again want to applaud CMS for entering into this - thoughtfully into this demonstration project, and we have appreciated the opportunity to give some input to the design of the demonstration project at this point.

I had two very brief questions. I think both have been already alluded to. But I think there needs to be some clarity here about whether all the conveners would be using exactly the same set of criteria for each of the modalities in the demonstration project and how decisions might be made related to the selection of those criteria.

And secondly, again, I agree with other commenters that there is a lack of clarity still about the Point-of-Service ordering option and to what extent evaluation of those services would be a part of this program versus the Point-of-Order option.

It would seem that the Point-of-Service option is almost exclusively related to self-referral scenarios wherein a physician in his or her own office orders a test and performs that , test and by nature may very well provide a different set of information for evaluation than the Point-of-Order information set.

I appreciate your - the opportunity for comment.

Operator: Your next question comes from David Kurth of Virginia.

Your line is now open.

David Kurth: Hi. This is David Kurth from the American College of Radiology. I just had a couple of quick questions.

One, if there is any clarification on what is meant by imaging result on the quality slide?

And second, do you have a timeline when you plan to publish the RFP for this?

Thank you.

Natalie Highsmith: Okay. Sarah, next question please.

Operator: Your next question comes from Mike Kirschner of Indiana.

Your line is now open.

Mike Kirschner: My questions have been addressed. Thank you.

Operator: Again, if you would like to ask a question, please press star then 1 on your telephone keypad.

Your next question comes from Thomas Gilbert of Minnesota.

Your line is now open.

Thomas Gilbert: Thank you very much for allowing us the opportunity to comment on the appropriateness project.

I represent the North American Spine Society, which is devoted to developing and deploying best practices in spine care. Diagnostic imaging is an important tool in spine care, and I'm a radiologist who specializes in spine imaging.

I've led the efforts of my company, the Center for Diagnostic Imaging, to adopt DSS three years ago. And as with most other providers and payors in Minnesota, we can detest - attest to the robustness and the efficiency of this best practice to assure that the right test is provided at the right time.

It supports the efforts of CMS to expand this project across the country. I have a couple of concerns.

One, to implement a demonstration project that is effective, I recognize that DSS has chosen to use guidelines developed by medical societies including NASS. I think it's really important in today's context to recognize that many guidelines are conflicting and incomplete with respect to clinical practice and strongly recommend that you have physician representatives from the societies in the application and implementation of different appropriateness criteria.

Second, I think it's most important that not a single DSS be applied to the entire demonstration project, but that CMS is open to different approaches to applying appropriateness criteria. In particular, I'd like to urge CMS to focus on cost and efficiency and to make sure that the implementation of appropriateness criteria do not significantly impede on the ability of small, independent practices to deliver cost-efficient care.

And finally, to the extent possible, we'd like to see that the appropriateness process enhanced decision making and not second-guess decision making by physicians in the offices.

Thank you very much.

Operator: Your next question comes from Michael Bettmann of North Carolina.

Your line is now open.

Michael Bettmann: My name is Michael Bettmann. I'm a radiologist and practice in Wake Forest. I also chair the American College of Radiology appropriateness criteria. I appreciate your taking my question and comments.

I'd like to second some of the comments that have already been made and to expand a little bit on them.

In regard to the decision support system or systems that are utilized, I think if a variety of systems are used, there's going to be great confusion with the results. So, I would urge that, if not a single system, at least a single, well-accepted set of appropriateness criteria be utilized throughout to remove that variable from this important study.

In that regard, I assume that a decision hasn't been made as to which guidelines or appropriateness criteria should be utilized. I think that's a very difficult decision and it should be looked at very carefully and hopefully with a lot of input. And I would urge the decision makers to look very carefully to ensure that whatever are used are completely transparent and are as evidence-based as possible.

And then I have a question about how the outcomes of the imaging are going to be evaluated. I think it's really important to look not just to adherence to specific criteria in performing the imaging, but also to the yield of imaging itself and, if possible, to establish ways of looking at the effect of those imaging studies on patient outcomes on the actual health.

Thank you for your efforts and for this project.

Operator: Again, if you would like to ask a question, please press star then 1 on your telephone keypad.

Your next question comes from Cally Vinz of Minnesota.

Your line is now open.

Cally Vinz: Well, thank you. This is Cally Vinz from the Institute for Clinical Systems Improvement. We're a healthcare collaborative in Minnesota across the State -- healthcare providers, hospitals, and the health insurers.

We've been working on the high-tech diagnostic imaging actually as an initiative for the last many years. And a couple of areas that we would like to encourage more clarity around would be the immediate feedback on the quality side. It says that decision support would provide immediate feedback. We would urge to have a definition of "immediate" because with Point of Service decision support, immediate varies greatly in length of time compared to Point of Order decision support and how - the time lapse between the communication back to the provider who's ordering the order.

The other area I wanted to speak to is with the baseline data. The six months after system implementation will significant - and not a surprise to any of you who are working on this, it will skew the data and you won't get a true baseline.

But I also would have you consider all organizations or states or providers who have used something such as a prior notification, authorization, or decision support at this point are all going to also have impact in their organizations on ordering. So your baseline is not going to be reflective of the, you know, the true impact on the new decision support tool.

So what I might encourage is baseline on data back prior to implementation of any of those kinds of activities. And, therefore, you're only going to be able to get utilization trending, but you would be able to see a better impact on utilization trending prior to any implementation of any kind of decision support or a prior notification activity.

Thank you for your consideration.

Operator: Your next question comes from Bradley Towle of Tennessee.

Your line is now open.

Bradley Towle: Thank you very much. This Brad Towle. I'm the Vice President of Medicare from MedSolutions.

I want to agree with the last caller related to the concern about the pre-group. I had a few questions.

The first one was you're asking for 200...

Woman: Yes.

Bradley Towle: ...physician...

((Crosstalk))

Bradley Towle: ...or practices? I...

((Crosstalk))

Bradley Towle: I'm sorry. Can you hear me?

Natalie Highsmith: Yes, we can.

Bradley Towle: Okay.

The second question was, can physicians who are already using some kind of DSS for other patients such as commercial or Medicare Advantage members, would they be allowed to use the same system for Medicare fee-for-service with perhaps different - based on the days of the pilot - of the demo?

The third question was, with so many physicians interacting already today with DSS systems -- we (unintelligible) over 109 million members nationwide are already on some kind of a system -- how does CMS propose to limit their access to existing guidelines in order to establish the no access to guidelines in the pre-period?

And that sort of relates back to the previous caller.

And finally, since physicians are self-selecting to participate in this pilot, if you look at the usual 80-20 goal where 20% is where you're going to find the problem, what is the method to encourage that 20% to participate in the pilot? It seems like it would want to avoid being in a pilot of this type.

Those are my primary questions. Thank you very much for allowing comments today.

Operator: There are no further questions or comments at this time.

Natalie Highsmith: Sarah, can we have the last gentleman get back into the queue please so we can have a - we can clarify his first question, please?

Operator: That's no problem. Mr. Towle, your line is still open.

Bradley Towle: Thank you. I'm here.

Linda Lebovic: Would you please repeat your first question?

Bradley Towle: Yes, ma'am.

I was asking the PowerPoint indicated there was a request for 200 to 1,000 physicians. I just wanted to be sure that that was - that meant physician, individual physician and not practices.

Linda Lebovic: Thank you, sir.

Natalie Highsmith: Linda?

Linda Lebovic: Well, I want to thank everybody again for participating in the call. As Natalie said, we will collect the questions and we will post a Q&A document on the project's webpage. And I will send out something on our project listserv so you know when we do post this so you won't have to keep checking back. I'll let you know as soon as that is posted.

There was one question about timeline, and I should have included that in my overview.

We are anticipating the solicitation will hit the streets probably early 2010. I know that the law says we need to implement this demonstration by January of 2010. We're implementing. We're just at a different date of implementation, perhaps, than some of you assumed meant by implementation by January 2010. So, we then expect - again, this is kind of moving because, as most of you know, that we do move our solicitations through some clearance. So there are some time frames that we do not have control of here at CMS. But that is our good estimate of when that will hit the streets.

Then we'll give you probably about six weeks to develop a proposal and get them back here to CMS. We'll have a panel review and then we will announce the award of the demonstration sites.

So again, let me say thank you so much. If there are any questions or comments that you thought of subsequent to the Open Door Forum, please use the project email box and continue to send those questions in there. If you would be so kind as to use that box, then I can make sure we capture all the questions and we include those in the Q&A document.

Natalie Highsmith: Okay. Just to remind everyone, that mailbox is ImagingDemo135b, as in boy, at cms.hhs.gov.

Sarah, can you tell us how many people joined us on the call today?

Operator: There was a grand total of 300.

Natalie Highsmith: Okay, wonderful. Thank you, everyone.

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

END