Welcome to the

California Telehealth Resource Center 14th Annual Digital Health Summit

Bridging the Gap. Smarter Care for Sustainable Futures.

From Innovation to Sustainability: Payment and Policy Pathways That Make Digital Care Scalable

Chris Adamec, MPA, Executive Director, Alliance for Connected Care
Rebecca Gwilt, Esq., Co-Founder and Managing Partner, Elevare Law
Jan Ileto, MSPH, Policy and Regulatory Affairs Manager, CTRC

Time of Session 11:00 – 11:45(PT)

Disclaimer

This session is purely for informational purposes.

The California Telehealth Resource Center has no relevant financial interest, arrangement, or affiliation with any organizations related to commercial products or services discussed during the Summit.

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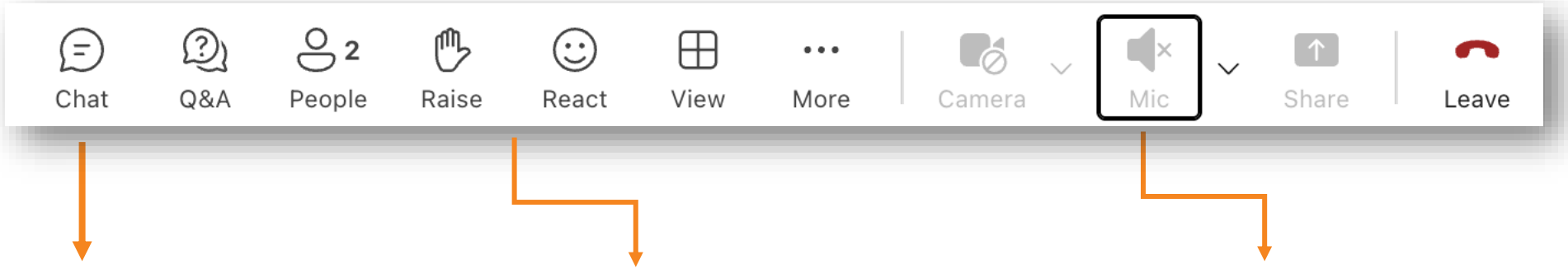
Summit Sessions

8:30 am	Opening Remarks| Setting the Vision: Digital Health, AI, and the Future of a Sustainable Health Ecosystem
9:00 am	Opening Keynote | Setting the Foundation: Statewide Digital Health Priorities under California's Rural Health Transformation Program
10:00 am	From Clinic to Community: Scaling Chronic Disease Management Beyond the Visit
11:00 am	From Innovation to Sustainability: Payment and Policy Pathways That Make Digital Care Scalable
1:00 pm	Trust Is Built, Not Bought: Making AI Safe and Defensible in Clinical Care
2:00 pm	Building What Lasts: Rural Digital Health Sustainability in Practice
3:00 pm	Clinical AI That Delivers: Evidence, Workflow Fit, and What Actually Changes Care
4:00 pm	Closing Keynote | From Promise to Practice: Preparing Care Teams for Generative AI in the Next Year

Register Here

All times are in Pacific Time Zone (PT).

Microsoft Teams Tips



Open the Chat

Please open the chat and use it liberally; we want to hear from you!

Raise your Hand or React

Attendees will have an opportunity to ask questions. Raise your hand or send reactions!

Muted on Entry

You are muted on entry.

Session Recording

Today's session is being recorded! Keep an eye out for attendee announcements when recordings are available.

Thank You, CTRC Funders

Established in 2006, the California Telehealth Resource Center (CTRC) exists to share **unbiased, no-cost digital health resources and consultative support services** with providers and patients located across all 58 California counties and beyond. As part of a collaboration of 12 regional and 2 national Telehealth Resource Centers, CTRC is **committed to implementing digital health programs for rural and underserved communities.**

The work of the CTRC would not be possible without funding and support from the Health Resources and Services Administration's **Office for the Advancement of Telehealth** and the **CA State Office of Rural Health**, part of the Department of Health Care Access and Information.

CALIFORNIA TELEHEALTH RESOURCE CENTER
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Meet Your Presenters

Chris Adamec, MPA

Executive Director

Alliance for Connected Care

Rebecca Gwilt, Esq.

Co-Founder & Managing Partner

Elevare Law

Jan Ileto, MSPH

Policy and Regulatory Affairs Manager

CTRC

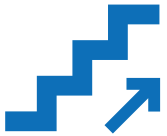
Digital Care Will Not Scale by Accident

In a fast-moving payment and policy environment, not having a digital health strategy is itself a strategy, and it is a risky one.

Federal and state policy on AI, telehealth, RPM/RTM, and digital care is **evolving quickly**.

Payment pathways are shifting from one-time encounters toward longitudinal, technology-supported care.

Rural providers may see new opportunities through Rural Health Transformation Program (RHTP), but **sustainability will require more than funding.**



Scalable digital care requires a sustainability lens: payment pathway, documentation, workforce capacity, governance, measurement, and outcomes

AI Policy and Payment in Digital Health

CMS's ACCESS Model, FDA's TEMPO Pilot, and the AI Policy Landscape — What Providers and Digital Health Companies Should Do Now

elevarelaw

Agenda

1 The landscape
Federal flexibility meets a fast-moving state patchwork

2 The two programs
CMS ACCESS (payment) + FDA TEMPO (regulatory)

3 What it means for you
The questions providers and digital health companies should be asking

Federal Policy **in 2026**

Washington is signaling flexibility on regulation regarding technology policy, working to preempt state action, and pushing payment beyond the billing code.

Regulation — flexibility, then consolidation

Executive order seeks a national framework and challenges state AI laws (Dec 2025)
FDA: 1,350+ AI-enabled devices cleared; lifecycle draft guidance
FDA TEMPO adds enforcement discretion for select devices

Payment — beyond the code

CMS ACCESS: pays for outcomes, beyond the CPT code
CMS WISeR: AI + human review for Medicare prior auth (6 states)
Direction of travel: pay for results, not volume

…but the States **Aren’t Waiting**

As federal policy loosens, states are passing binding AI rules across 4 fronts — and the strictest one sets your floor.

Clinical decisions

AI can't make the final call — California’s SB 1120 ("Physicians Make Decisions Act") requires a human to decide; other states are following.

Patient Disclosure

Informing people when AI is involved

Mental Health and Companion Chatbots

This is the fastest-moving front: Illinois bans AI-only therapy (WOPR Act); Nevada, Utah, California (SB 243), New York, Washington, and Oregon add guardrails. Around 100 chatbot bills across 34 states.

Consumer Protection, Bias

Colorado's AI Act — a moving target (effective date slipped to June 2026, then narrowed in 2026). Also, training-data disclosure (CA AB 2013) and no implying AI holds a license (CA AB 489).

Two Doors Opened Together in 2026

CMS ACCESS changes how care gets paid; FDA TEMPO changes how a device reaches the market.

CMS ACCESS — The Payment Door

Pays care organizations for chronic-care outcomes

Original (fee-for-service) Medicare

Performance period starts July 5, 2026

FDA TEMPO — The Regulatory Door

Lets select devices deploy before FDA authorization

Enforcement discretion — used inside ACCESS only

Federal Register notice published Dec 8, 2025

CMS ACCESS

Payment Evolution

What It Is

A voluntary, 10-year Medicare model that pays for measurable outcomes, not visit volume.

The Model

- Advancing Chronic Care with Effective, Scalable Solutions
- Recurring, condition-specific payments tied to clinical improvement

Timeline and Status

- Performance period 10 years beginning July 5
- Rolling applications accepted for future quarterly cohorts, starting Jan. 2027
- 150+ organizations accepted

Who's In It

- Original (fee-for-service) Medicare beneficiaries
- Medicare-enrolled with an ACCESS participant

Why It's Different

- Outcomes-based, not volume-based
- Brings new, tech-enabled players into Medicare
- Built from the start to be copied by other payers (e.g., MCD)

Four Clinical Tracks

Four chronic-condition tracks — covering ~two-thirds of Medicare beneficiaries — each paid on standard, validated measures

Early Cardio-Kidney-Metabolic (eCKM)

- Hypertension, dyslipidemia, obesity, prediabetes
- Measures: BP, LDL-C, HbA1c, weight
- $360 initial / $180 follow-on, PPPY

Cardio-Kidney-Metabolic (CKM)

- Diabetes, chronic kidney disease, ASCVD
- Measures: BP, LDL-C, HbA1c, weight, eGFR, uACR
- $420 initial / $210 follow-on, PPPY

Behavioral Health (BH)

- Depression, anxiety
- Measures: PHQ-9, GAD-7, PGIC
- $180 initial / $90 follow-on, PPPY

Musculoskeletal (MSK)

- Chronic musculoskeletal pain
- Measures: PROMIS PF & PI, NRS pain intensity, PGIC (by site)
- $180 PPPY(no follow-on period)

An opening, not a revolution — Is the money enough?

The payments are modest and the risks are real — but the precedent and the template are what matter.

The hard truths

ACCESS pays LESS than today's codes: RPM ~$48/mo, CCM ~$60/mo

Rates came in low — analysts flag thin or negative margins

CBO: CMMI raised federal spending >$5B in its first decade

Public reporting + selection-bias pressure; a 10-yr model can still be cut

Why it still matters

Low rates are intentional — and work at scale (high-volume, tech-driven)

The real product is the TEMPLATE: outcomes paid beyond CPT codes

Medicaid, MA & commercial can copy it (ILOS, Payer Pledge)

TEMPO's value is the regulatory on-ramp, not the check

How The Money Works

Three money flows and one big condition — about half the payment is at risk until outcomes are proven.

Payment to the organization (OAP)

- $180–$420 PPPY (Initial Period)
- "Allowed amount" = 80% Medicare + 20% patient coinsurance
- +$15 rural add-on (eCKM/CKM); 5% multi-track discount

Timing & risk

- Paid monthly at 1/12 of the Medicare portion — capped at 50% during the year
- Remaining ~50% withheld and reconciled after the 12-month care period

The two reconciliation thresholds

- Clinical Outcome: full pay if ≥50% of patients meet all targets
- Substitute Spend: ~90% must avoid duplicative services
- Targets are improvement-based

The other two flows

- Treating clinician: co-management fee ~$30, up to ~$100/yr
- Patient: only the 20% coinsurance (free–$7/mo, waivable)
- Drugs, labs, devices billed separately

FDA TEMPO

Regulatory Evolution

The Regulatory Side Door

A small pilot that lets select digital health devices deploy inside ACCESS before authorization — under enforcement discretion, not clearance.

What it is

- Technology-Enabled Meaningful Patient Outcomes pilot
- Up to ~10 U.S. manufacturers per track (~40 total)

The Mechanism

- FDA enforcement discretion on certain premarket rules
- Can set aside 510(k)/PMA, IDE, and IRB/informed-consent requirements
- Device used only inside ACCESS

The Strings

- Must collect real-world data on the intended use
- Must still pursue FDA marketing authorization
- Can't market the device for that use outside ACCESS

The takeaway

- Enforcement discretion is NOT FDA clearance
- Participation guarantees nothing about eventual approval
- For providers: a tool offered in ACCESS may be pre-authorization

What to ask **before you act**

Three stakeholders, three different question sets — the referring provider, the at-risk ACCESS participant, and the digital health vendor.

Referring provider (refers patients in, co-manages)

- Is the ACCESS participant I'm referring to credible — validated tools, real outcomes?
- What's my ongoing clinical role and liability for a patient I refer but don't control?
- How do I document the co-management review to bill it correctly (~$30, up to ~$100/yr)?

ACCESS participant (the at-risk organization)

- Do the OAP amounts cover our true cost to deliver this care?
- Can our population realistically hit the ≥50% outcome and ~90% substitute-spend thresholds?
- Is the tool/device FDA-authorized — or operating under TEMPO discretion?
- Can we capture and report the required measures (FHIR API), and who carries the risk vs. the vendor?

Digital health vendor (builder)

- Can we bill ACCESS directly, or do we need a Medicare-enrolled clinical partner?
- Is our evidence tied to the actual OAP outcome measures?
- What's our path from TEMPO enforcement discretion to full FDA authorization (if relevant)?
- Do our pricing/promo terms clear Anti-Kickback / Stark?

More Info

PRIMARY SOURCES

- ACCESS model: cms.gov/priorities/innovation/innovation-models/access; https://www.cms.gov/priorities/innovation/access-primary-care-providers-referring-clinicians
- ACCESS payment amounts & performance targets — CMS PDF: https://www.cms.gov/priorities/innovation/files/access-payments-amts-perf-targets.pdf
- FDA TEMPO: https://www.fda.gov/medical-devices/digital-health-center-excellence/tempo-digital-health-devices-pilot-frequently-asked-questions; Federal Register, Docket FDA-2025-N-6461 (Dec 8, 2025)

Rebecca Gwilt

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Thank you!

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Alliance For Connected Care

ALLIANCE for CONNECTED CARE

Alliance Priorities

ALLIANCE for CONNECTED CARE

Stabilize the Virtual Care Foundation

- Eliminate Medicare geographic and originating site limitations
- Eliminate burdensome Medicare distant site practitioner list
- Remove in-person care requirements under Medicare for mental health services furnished through telehealth.
- Ensure Federally Qualified Health Centers (FQHCs), Critical Access Hospitals (CAHs), and Rural Health Clinics (RHCs) can furnish telehealth in Medicare and be reimbursed fairly for those services
- Make permanent the Medicare Acute Hospital at Home (AHCaH) Waiver
- Limit regulatory overreach on telehealth prescribing by the Drug Enforcement Administration (DEA

Strengthen Tech-enabled Care Capabilities

- Drive better and more coordinated care by supporting remote patient monitoring (RPM) technology and reimbursement tied to the value these services provide.
- Reinforce the healthcare workforce by lessening burdensome location (home address) reporting constraints on Medicare practitioners offering fully remote care.
- Address duplicative state licensing regulations that limit patient access to care while reducing health care competition and exacerbating provider shortages.
- Modernize health plan network adequacy requirements by replacing telehealth time and distance credits with outcome-based measures of patient access.

Shape the Evolution of AI-enabled Care

- Facilitate AI-enabled care as an extension of existing care delivery and avoid repeating mistakes made in other digital health areas, where narrow allowances later hampered patient access
- Pursue regulatory and reimbursement changes that allow for modality-agnostic care.
- Further the growth of AI-enabled care delivery through models based on outcomes.
- Adopt a regulatory framework that is proportional to the potential for patient harm, while exploring new flexibility subject to rigorous due diligence, safety constraints, and narrowly scoped use cases at the state and federal level.

KEY: EXPIRED | DEA REGULATION | CMS REGULATION | CONGRESSIONAL ACTION | PERMANENT

May 11, 2023	August 9, 2023	December 31, 2023	December 31, 2026	December 31, 2027	December 31, 2029	September 30, 2030	Permanent
Established Patient Requirements							
Physician Self-Referral Law							
Medicaid Section 1135 Waivers							
State Licensure Flexibilities							
Individual and Group Markets							
Cost-Sharing Waiver							
Managed Care Organizations							
HIPAA							
Telehealth as an Excepted Benefit							
Prescribing Controlled Substances via Telemedicine (fourth temporary extension)							
Consolidated Appropriations Act, 2026 *Removing Geographic Requirements and Expanding Originating Sites for Telehealth Services* *Expanding Practitioners to Furnish Telehealth Services* *Expanding Telehealth Services for Federally Qualified Health Centers (FQHCs) and Rural Health Clinics (RHCs)* *Delaying the In-Person Requirements Under Medicare for Mental Health Services Furnished Through Telehealth and Telecommunications Technology* *Extending Use of Telehealth to Conduct Face-to-Face Encounter Prior to Recertification of Eligibility for Hospice Care Program Instruction Authority* *Expanded Audio-Only (No Limitations to Originating/Distant Site Locations)*							
CMS 2026 Medicare PFS & ***Consolidated Appropriations Act, 2026*** – Medicare Diabetes Prevention Program – Online Delivery Modality							
Consolidated Appropriations Act, 2026 *Acute Hospital Care at Home Waiver*							
*CMS Telehealth FAQ (11/2025) – Allowance for Providers to Report/Bill Physical Location Instead of Home Address***							
CMS 2026 Medicare PFS Final Rule Removal of frequency limitations on inpatient/Nursing Facility Settings, Critical Care Consultations Virtual Direct Supervision for all Incident-To Services Teaching Physicians Virtual Presence in Clinical Instances When Services is a 3-way telehealth visit							
HDHP-HSA Safe Harbor for Absence of Deductible for Telehealth*							
CMS CY 2025 Medicare Physician Fee Schedule – Allowing for the Furnishing of Audio-Only Telehealth Services under Certain Requirements *CMS CY 2022 PFS Audio-only Telehealth for Mental Health in Certain Circumstances*							
CMS CY 2024 Medicare PFS – Telehealth Services Paid at Non-Facility PFS Rate							
State Authority through Medicaid							
General Supervision Under Incident-to Billing for Behavioral Health							
Prescribing Controlled Substances via Telemedicine – Veterans & Buprenorphine Effective December 31, 2025							

ALLIANCE for CONNECTED CARE

Medicare Telehealth - 2026 Extensions

Medicare Telehealth Issue	Extension
Originating Site & Geographic Restrictions – Patients can receive telehealth at home.	Ending on December 31, 2027
Eligible Practitioners – All Medicare eligible providers and OT, PT, Speech-Language Pathologist, and Audiologists can provide telehealth.	Ending on December 31, 2027
FQHCs & RHCs – Qualified to provide telehealth services.	Ending on December 31, 2027
Telemental Health – Delayed in-person visit requirements for tele-mental health care.	Ending on January 1, 2028
Audio-Only Telehealth – Statutory allowance of audio-only telehealth	Ending on December 31, 2027
Hospice Recertification – Use of telehealth to conduct face-to-face encounter prior to recertification	Ending on December 31, 2027

Medicare Change

Requiring Modifiers for Telehealth Services in Certain Instances

Required use of modifiers in certain instances. – Not later than January 1, 2027, the Secretary shall establish requirements to include one or more codes or modifiers, as determined appropriate by the Secretary, in the case of:

Claims for telehealth services under this subsection that are furnished through a telehealth virtual platform—

- by a physician or practitioner that contracts with an entity that owns such virtual platform; or
- for which a physician or practitioner has a payment arrangement with an entity for use of such virtual platform; and

Claims for telehealth services under this subsection that are furnished incident to a physician's or practitioner's professional service.

No definition for “telehealth virtual platform” exists, so there is an opportunity to influence implementation before the modifiers go into effect January 1, 2027.

Commercial Market Expansion – Permanent Pre-Deductible Telehealth

Temporary safe harbor that allowed employers and health plans to provide pre-deductible coverage of telehealth services for individuals with a high-deductible health plan coupled with a health savings account (HDHP-HSA) made permanent in the summer 2025 reconciliation package.

Real-world impact -

- Implementation of this flexibility in 2026, contingent on plan/employer interest – will likely be offered for “high-value” telehealth services.
- Patients with high-deductible plans could have copayments for telehealth services waived

Other Notable Expansions

Policy Change
Sec. 6210. Extending acute hospital care at home waiver flexibilities.
Sec. 6211. In-home cardiopulmonary rehabilitation flexibility
Sec. 6214. Inclusion of virtual diabetes prevention program suppliers in MDPP Expanded Model.
Sec. 6216. Report on wearable medical devices.
Sec. 6220. Requiring Enhanced and Accurate Lists of (REAL) Health Providers Act.
Sec. 6213. Guidance on furnishing services via telehealth to individuals with limited English proficiency.

Medicare Telehealth Wins For 2026

Provider Location Reporting

- The Alliance for Connected Care led a successful advocacy campaign that resulted in CMS making this flexibility permanent for providers with a physical practice location – protecting access for telehealth for patients and providers.
- The Alliance is actively working with CMS on a path for low burden location reporting option for fully virtual providers.

Virtual Presence for Teaching Physicians

- Permanently allow teaching physicians to have virtual presence in all teaching settings when the service is a 3-way telehealth visit

Virtual Direct Supervision

- CMS is expanding services allowed under direct supervision for all incident-to services, except for services that have a global surgery indicator of 010 or 090.

Other

- Telehealth Services List Review
- MDPP Expansion
- Frequency Limitations
- New RPM Coding (slide later)

RHC & FQHC Billing (New)

On May 27 the Centers for Medicare & Medicaid Services (CMS) recently released Change Request 14468, instructing Medicare Administrative Contractors (MACs) to modify the billing system through which FQHCs & RHCs bill for Medicare distant site telehealth services.

Effective October 1, 2026, **FQHCs and RHCs shall bill the individual HCPCS codes describing the telehealth services furnished to Medicare beneficiaries**, instead of G2025 for every service provided

Report modifier 93 for audio-only services, and modifier 95 for audio-visual telehealth.

Drug Enforcement Administration Telemedicine Restrictions

State of Play on RPM

2026 Codes and Reimbursement

- New codes adopted for data collection and care management
- Altered AMA valuation recommendations & utilizing OPPS geometric mean cost for valuation of the device supply codes (99454 & 99445)

Ongoing Concerns

- Coding that captures real cost of RPM delivery
- Medicare Utilization Growth
- Misbilling
- Payer Coverage

Future

- PFS next steps (coming soon)
- ACCESS / TEMPO Model Interplay
- AI-enabled care management

Digital Health > AI-Enabled Care

- Use agentic AI to strengthen clinical relationships, not fragment them.
- Recognize AI-enabled care as a natural evolution of connected care, not a new kind of care in need of unique policy or regulatory solutions.
  - Subsequently avoiding policymaking mistakes made in other digital health areas, where narrow allowances later hampered patient access.
- Clear the decks on longstanding barriers to telehealth and remote patient monitoring that will be equally burdensome to the expansion of AI-enabled care.
- Pursue regulatory and reimbursement changes that allow for modality-agnostic care delivery – allow care models that adapt to the best tools of the moment.
  - Such as addressing barriers like time-based reimbursement that constrain efficiency gains of AI-enabled care.
- Further growing AI-enabled care delivery in models based on outcomes, where these changes can be made most easily.
- Ensure regulatory frameworks proportional to the potential for patient harm.

Rural Health Transformation Program

- Established under H.R. 1 in July 2025 and administered by CMS
- $50 billion dedicated nationwide between 2026 and 2030, at $10 billion per year; all 50 states submitted plans and received awards
- First-year (2026) awards average $200 million per state, ranging from $147M to $281M depending on rural need and proposed impact
- Funding is split: 50% distributed equally among all approved states, and 50% allocated based on rural health needs and proposed impact
- Organized around five strategic goals: promoting preventive health and chronic disease management; improving rural provider sustainability; strengthening the workforce; advancing innovative care models; and leveraging technology for efficient care delivery
- Allowable uses include provider payments, workforce recruitment and training, telehealth and AI-driven remote monitoring, and infrastructure modernization for critical access hospitals and FQHCs
- States must meet ongoing reporting and monitoring requirements tied to milestones and measurable outcomes

Rural Health Transformation Program

What is happening now?

- CMS and states finalized cooperative agreements, authorizing states to begin dispersing funds in line with state procurement guidelines.
- States are establishing infrastructure, hosting information sessions, and developing and releasing RFI/RFA/RFPs.
- States are communicating with stakeholders regarding implementation processes, but communication is heavily monitored by CMS.

What happens next?

- 2026: Finalize implementation mechanisms, prepare and release RFAs/RFPs, solicit responses, announce recipients, release funding.
- 2027: Use 2026 funds by September 30, 2027, implement, prepare for funding redetermination.
- 2028 – 2031: Implementation and evaluation

Digital Health in RHTP

States, at the direction of CMS, proposed and are procuring/implementing digital health solutions including consumer-facing technology for chronic conditions, telehealth access points, RPM in schools, provider burden reduction via back-end AI use

Initiative	States Participating
Telehealth / e-consults	50
Remote patient monitoring	47
EHR modernization	46
Improved data sharing for rural providers	49
AI tools to support rural workforce	42
Patient engagement platforms	40
Cybersecurity improvements for rural providers	35

Rural Tech Catalyst Funds

Funds must go to support consumer facing, innovations that:

- Serve rural communities, with a focus on or special consideration for their particular needs and challenges;
- Benefit Medicaid, low-income, and/or vulnerable rural consumers;
- Focus on prevention and management of chronic diseases;
- Are significantly different from or fulfil an unmet need compared to the existing landscape of products and solutions; and
- Increase quality, affordability, and access to care.

Funding for startup companies that directly deliver or enable care;

- Less than 10 years since founding and with less than $50M prior funding raised; and
- Must be U.S.-based and U.S.-owned businesses

Alaska
Delaware
Georgia
Louisiana
Nebraska
South Carolina
Tennessee

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Questions?

Ongoing Support

TECHNOLOGY ADVANCES

The technology continues to advance and the evidence base grows.

CONNECT WITH US

Shoot us an email, join us for a webinar, give us a call, visit the website, or even better, sign up for our newsletter to ensure you are informed on updates, events and opportunities.

OUR RESOURCES

DIY kind of person? We have numerous resources and a reliable network to get your answer. We're federally funded so our information and resources are at your disposal.

THE CTRC

CTRC is committed to advancing equitable and sustainable access to our communities via the adoption of digital health services.

INTRODUCING THE 2026 AI COHORT

VIRTUAL SERIES WITH AVAILABLE OFFICE HOURS | NO-COST REGISTRATION

SESSION 1
June 24 | 1:00 pm
CTRC Summit

Trust Is Built, Not Bought: Making AI Safe and Defensible in Clinical Care

SESSION 2
June 24 | 3:00 pm
CTRC Summit

Clinical AI That Delivers: Evidence, Workflow Fit, and What Actually Changes Care

SESSION 3
June 24 | 4:00 pm
CTRC Summit

From Promise to Practice: Preparing Care Teams for Generative AI in the Next Year

SESSION 4
July 29 | 2:00pm

AI Scribes in Action: Real-World Lessons from a Practicing Physician
Yimdriuska Magan, MD, MPH

SESSION 5
Coming Soon

Harnessing AI to Advance Maternal Health Outcomes
Melissa Wong, MD, MHDS

SESSION 6
Coming Soon

From Policy to Practice: Designing an Effective AI Governance Strategy
Maria Liu, Healthcare VP

Scan the QR Code or visit HealthcareAIbootcamp.org

We value your input!

Please take a quick minute to complete our exit poll.

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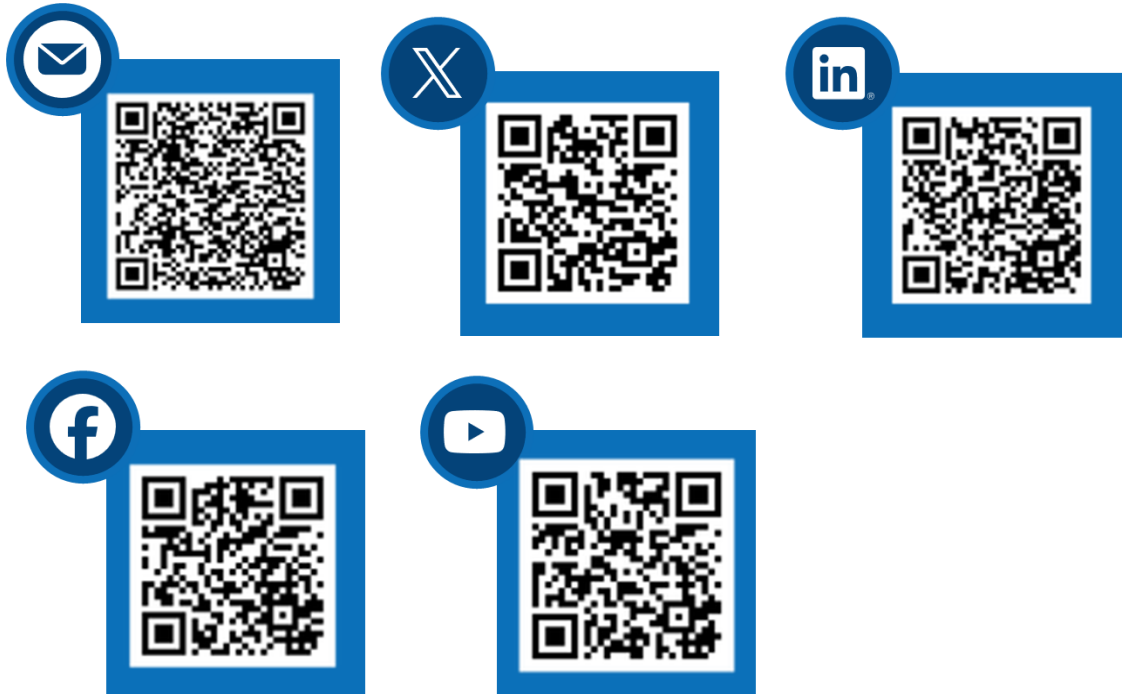

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