CENTER FOR MEDICARE & MEDICAID SERVICES

Moderator: Gwen Sampson
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8:30 a.m. CT

Operator: Good morning. My name is (Sarah) and I will be your conference operator today. At this time, I would like to welcome everyone to the Centers for Medicare and Medicaid Services listening session on health care delivery system reform.

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

Thank you. Ms. Gwen Sampson, you may begin your conference.

Gwen Sampson: Thank you, (Sarah). Good morning all. I'd like to thank you all for attending today's call on health care delivery system reform. Again, my name is Gwen Sampson and I am the Deputy Regional Administrator of the Centers for Medicare and Medicaid Services, Chicago Regional Office.

I'd like to start by introducing the host for today's call. Jackie Garner, the CMS Consortium Administrator for Medicaid and Children's Health; Cristal Thomas, the Regional Director for the U.S. Department of Health and Human Services; and John Hammarlund, Regional Administrator for the CMS Chicago and Seattle Regional Offices, who will moderate this call.

Jackie, would you like to begin?

Jackie Garner: Thank you, Gwen. And thank you to everyone on the call especially for coming out so early on a Monday morning. We really appreciate you taking time out of your busy schedules to attend this listening session on health care delivery system reform.

I want to welcome everyone today on the call. We have consumers, clinicians, employers, hospitals, health systems, state representatives, health care experts and more.

We can begin by really thinking about that all of us want the highest quality health care system possible. A system that coordinates and integrates care, eliminates waste and encourages the prevention of illness. With new provisions in the Affordable Care Act, we have more opportunities than ever before to work with both the public and private sectors to make real improvements in our nation's health care delivery system.

We can all agree that our current health care system is broken. We pay a lot of money for a system that is fragmented, disorganized and failed to meet many patients' needs. The problems of our health care system have been created by payment and delivery systems that reward care that is delivered piece by piece, not care that is delivered in a seamless, coordinated manner. Patients want care that is high quality, timely and efficient and they don't want to pay more than they need to for this care. Patients also want to be treated like individual. They want their doctors to take into account their values and wishes.

Health care professionals want to care for people. That is why they chose their careers in the first place. And everyday health care professionals work to provide the best care to their patients. They want to help others. But our current health care system often doesn't provide many patients with the care they should receive and doesn't support health care professionals in providing that care.

So the purpose of today's listening session is to hear from you on how CMS can best undertake the important work of reforming the nation's health care delivery system. The Affordable Care Act has given CMS new opportunities

to improve the care delivery and the payment system. We will spotlight three areas of interest today. First, "Accountable Care Organizations" Shared Savings Program; second, the CMS Innovation Center; and third, the Federal Coordinated Health Care Office.

So thanks to everyone for your participation here today and for your hard work to follow in the weeks, months and years ahead. Gwen?

Gwen Sampson: Thank you, Jackie.

The next voice you will hear would be that of Cristal Thomas, who again is the Region V Director of the U.S. Department of Health and Human Service, also known as HHS, servicing Illinois, Indiana, Michigan, Minnesota, Ohio and Wisconsin. In this role, Ms. Thomas represents Secretary Sebelius and HHS in interactions with key external and inter-governmental partners.

Prior to her appointment as regional director, Ms. Thomas held position as Executive Director of the Ohio Executive Medicaid Management Administration, the Ohio Medicaid Director and Assistant Director of the Illinois Department of Health Care and Family Services. Cristal?

Cristal Thomas: Thank you very much, Gwen, and thank you, Jackie, for your opening remarks.

Good morning everyone. It's really a pleasure to have so many of our partners on the line this morning.

I've had the chance to meet or speak with many of you about implementation of the Affordable Care Act. We've talked about the great work that is already happening in Region V and how anxious you are to continue that work in partnership with the new CMS Innovation Center. We've talked about the new opportunities for support in partnership of Innovation and Health Care Delivery through the Affordable Care Act.

Today's session is the one opportunity for engagement and dialog on some of the most significant ways in which the health care system is going to be transformed in collaboration with all of you. Know that going forward, I will

continue to be available to you as Secretary Sebelius' senior representative in this region with my leadership team across HHS and in particular with CMS on the initiatives that we are going to hear about today.

I look forward to continued dialog and partnership with you on this important work. And it is now my pleasure to turn the line over to John Hammarlund, who's Regional Administrator for CMS, who will moderate the next portion of our session. John?

John Hammarlund: Thanks a lot, Cristal.

Good morning everybody. Well, as you just heard from Jackie and Cristal, this is an enormous and challenging and exciting opportunity for CMS. But, we cannot do it alone. We need your help. So you're going to hear today, shortly, some two leaders at CMS who are in charge of three different programs all at different stages of development. Dr. Rick Gilfillan and Cheryl Powell who I'll introduce in a moment will be speaking today about three new programs – the new "Accountable Chair Organizations" share savings program; the Center for Medicare and Medicaid Innovation; and the Federal Coordinated Health Care Office.

We are excited to have you engaged with us today and we have three opportunities that we've established online for you to have a continuing dialog with us to send in your thoughts and ideas. Sometimes, of course, the best ideas occur after the opportunity has passed and we don't want that to happen to you.

So here are the opportunities. For the Innovation Center, we have a website, www.innovations.cms.gov and at that site you can sign up for e-mails and be part of the Twitter alerts and (RSS) newsfeed. Shortly, we will have an e-mail box as well that will be launched for the Innovation Center and we'll let that – we'll let you know about that through upcoming e-mail opportunities.

Second, for Affordable Care Organizations, we have an e-mail box aco@cms.hhs.gov. Also, to comment on the Federal Register Notice that was published on November 18, 2010, you can go to www.regulations.gov. That's

the opportunity to comment formally on the Federal Register Notice on ACOs.

And then finally, for the Federal Coordinated Health Care Office, their e-mail box is fchco@cms.hhs.gov. Now, if you weren't able to note those, Gwen Sampson, our co-host is going to be repeating those addresses for you at the end of today' call.

So during today's call, what we're going to be doing is sharing information on the three important areas that we just mentioned and you're going to have a chance to share ideas and give your thoughts and input. I want to emphasize to you and to all on this call that this is a chance for you to give us your comments. We will be in listening mode.

So to clarify from what the operator said earlier, this is not a question and answer session, this is a listening session.

Your remarks will not be considered formal or official responses or remarks of the record. That is to say this is not the equivalent to commenting formally on a proposed rule that's published in the Federal Register. But, of course, your comments are important to us. They're instructive and timely and we are listening today.

As your facilitator, I may from time to time ask for a clarifying question or a follow-up, but generally we'll be sitting back and listening for your input. I'd also if you can to please keep your remarks to two minutes or less because we'd like to get as many people as possible the chance to share their ideas with us.

I'd like to now introduce our first speaker, Dr. Richard Gilfillan, Acting Director for the Center for Medicare and Medicaid Innovation. In this role, Rick works with CMS leadership to develop and implement innovative programs that will help improve and update the nation's health care system and delivery systems. Dr. Gilfillan joins CMS last July as director of CMS' performance-based payment policy staff, where he was responsible for overseeing Accountable Care Organizations and value-based payment initiatives.

Prior to joining CMS, Dr. Gilfillan served as president and CEO of Geisinger Health Plan and Executive Vice President for systems insurance operations at the Geisinger Health System in Danville, Pennsylvania. Dr. Gilfillan began his career as a family practitioner.

I'll hand it over to you, Rick. Thanks.

Rick Gilfillan: Well, thank you, John. Thanks, Jackie and Cristal and thanks to everyone who's out there.

It's a pleasure to be talking with you all this morning and recognizing that I did my training out in Region V. Now, I think back on it, in Minnesota.

And it's, you know, much of what we're talking about I think this morning, what is envisioned in the Affordable Care Act are things that you all in that region have been working on for many years. So I'm sure much of it will sound familiar. Much of it still there's a lot more work to be done, and we're anxious to get your perspective and understand how you think about ways that we can – we can work with you as partners to be helpful.

For a moment – a couple of moment (down), I'm going to just – I'm going to take Don's role, who can't be with us this morning but he'd like to be. But Don Berwick I think has laid out a pretty clear vision for CMS, and let me share that with you and use that as kind of a prelude to where we want to go in the conversation.

Don has said that CMS will be a constructive force and a trustworthy partner for continuous improvement in the health and health care of all Americans. That is the mission that we are all focused on and we're thinking very concretely about in terms of how we manage our operations to be that trustworthy partner with many of you in trying to deliver better health and better health care for all Americans.

Going back to the earlier comment, I think we want to say, one, we're all providers, many of us are providers who care and we understand what it means to be on the frontline taking care of people every day, taking care of

sick folks, trying to do the right thing many of you for thousands of patients a day. It's a busy world out there and it's excellent work. And here we are saying, well, we need to do better and asking you to be partners and letting us be partners with you and improving care.

We recognize the challenge. We don't want to be presumptuous, but we do want to find a way to work together to help make the systems even better and deliver better outcomes. When we think about that mission and we think about outcomes, we think about a three-part aim. Our efforts will be judged by the degree to which we improve the health – the health care and we reduce the cost of care through continuous improvement for all Americans. That's our measure of success. That's how we think about framing our activities. They need to be focused on delivering quantifiable improvements in those three areas of better health, better care, and lower cost.

And we think that's quite possible and frankly we know that many of the areas in Region V have demonstrated, in fact, one can provide outstanding quality at a lower cost and we're anxious to find ways to work with you to better understand how you do it and help other folks do the same thing.

So that's kind of our overall mission at CMS is to transition from a fragmented care system to a seamless care system. And we know today, when we pay, we do a great job at CMS and at other insurance companies other payers were wonderful at supporting a fragmented care system. The way we pay does that beautifully. The problem is it results in care that is expensive and of highly variable quality and provides a (pasty) experience. It's not what we could provide.

So we know that as we move to a system that provides a seamless care experience that meet those – those three-part aim, we need to deliver care differently and we need to pay for care differently. The job of the Center for Innovation is to identify, evaluate and diffuse new models of care and new models of payment to support you providers the delivery system in providing that new type of care. That's our job within Innovation Center.

The legislation that created the Innovation Center gave us some unique capabilities to pursue those goals. They basically gave us $10 million a year over 10 years – or $10 billion over 10 years. A lot of liberties from some of the normal constraints that one faces in doing a project like this within the federal government.

And at the end of our process said that if we can demonstrate that new care model, the new payment model, actually achieve lower cost and better quality then the secretary can change the way we pay for care here at CMS. That we can write new regulations to create those new payment mechanisms as the standard payment mechanism for CMS via regulations. That's a new capability that the Fed will bring to the federal government and to CMS and we like to think it's going to be an important part of how we can support the transition of the care system.

Where are we today in terms of the center? We are – we were just launched on the 16th of last month, so we're a little over two weeks in business. We are beginning our planning process. We're hiring staff. We're looking for great people to join our team and we're going to a budget process. So we're also actively engaged in activities in communities in evaluating new care model.

Let me talk about those initiatives and then I will introduce folks to talk about ACOs and the Federal Coordinated Health Care Office. We identified four new initiatives during our recent press conference that begin CMS' efforts to support CMS care system. Two of these are coming directly from the Center for Innovation and two of them are coming from other sections of CMS.

The first initiative is a personal – was a requirement under the Affordable Care Act and instituting a health home option for Medicaid State Plan. This program will provide 90 percent federal funding for the first two years of any state-based Medicaid health home pilot program.

The second project announced was a multi-payer advanced primary care practice program. Under that program, which will be run by the ORDI unit of CMS, we will be supporting over 1,000 medical homes serving almost one

million Medicare beneficiaries in eight states of Maine, Vermont, Rhode Island, New York, Pennsylvania, North Carolina, Michigan and Minnesota.

The third initiative would be coming directly from the Innovation Center and will be supporting advanced primary care medical home demonstrations in FQHCs. We expect to support approximately 500 FQHCs in their efforts to develop primary care medical homes.

And the fourth demonstration – the fourth project will be in conjunction with the Federal Coordinated Health Care Office where we will be supporting states who are interested in developing new program to address the needs of individuals that are eligible for both Medicare and Medicaid. That is for dual eligible individuals.

All four of these programs are basically aimed at improving care coordination for important segments of our population. In the MAPCP case, we are demonstrating the partnership approach where we are actively joining with programs where other payers are already in place working with these primary care sites. So, I think there's a theme for this first set of activities. It is reaching out, partnering with, working directly with providers in their efforts to deliver more integrated coordinated care.

Let me finally say that this is not the end of our activity for year one. This is just the beginning. We are interested in working in other areas and will be looking for opportunities with regard to more medical homes, ACO potentially, ACOs, bundle payments, and patient safety, all important areas that we believe there's a great opportunity to work with the delivery system folks in improving the care and cost for our population.

At this time, I'd like to hand it back to John and the Regional Office for an introduction of our – my colleagues from CMS. Thank you, John.

John Hammarlund: Thank you so much, Rick.

It's now my pleasure to introduce to you our second presenter, Cheryl Powell. Ms. Powell has recently been appointed as a Deputy Director of the Federal Coordinated Health Care Office at CMS, which is established by the

Affordable Care Act. As the deputy director, Cheryl will assist the director in leading the work of this office, charged with more effectively integrating benefits for individuals eligible for both Medicare and Medicaid, and improving coordination between the federal government and the state for the dual eligible beneficiaries.

Ms. Powell has held leadership positions in both the public and the private sectors and had extensive experience in Medicare, Medicaid and private insurance. At CMS, she's led policy and implementation and oversight of the Medicare program and financial management areas as well as in Medicare Fee-for-Service and Medicare Advantage. Cheryl previously served as a senior research analyst in Medicaid policy and evaluation at the Hilltop Institute and as the director of Medicare policy for Coventry Health Care.

Cheryl, I'll turn it over to you.

Cheryl Powell: Great. Thank you. And I do just want to say before I jump in how excited I am to be on this particular call. As I spend a substantial portion of my career with CMS in the Chicago Regional Office and certainly anticipate that many of those that I worked with while I'm in that office, they're on the line today. So I'm very excited to be on this particular call.

The Federal Coordinated Health Care Office, as John said, was established under the Affordable Care Act. It was Section 2602. And it's clear our job is to make the care experience better for beneficiaries who are eligible for both Medicare and Medicaid. And a large part of, that depends on improving the relationship between state and the federal government as state and the federal government are partners in delivering care to that population.

We are working towards seamless coordinated care system. We really think that there's no better opportunity to help individuals who are dually eligible. Over 95 percent of dual eligibles are currently in fragmented Fee for Service care systems and we spent upwards of 300 billion combined annually for their care. So, again, we see that this is the time for delivery system and payment reform.

So we're up and running. We've established our office, and currently the office is focusing in two areas. The first is program alignment. In that area, we are going through and identifying every place that Medicare and Medicaid bump against each other (with various misalignments) which prevent the programs from working together seamlessly for dual eligible beneficiaries. So we're looking at administrative, regulatory and statutory misalignments.

So we're coming up with a list. It's literally a list. Then we have come up with anything and everything where the two programs are at odds with each other and with the beneficiaries having a seamless experience. We're then prioritizing the list and taking it around to make it very public. We are dedicated to making this a transparent, living document that faired continuously with stakeholders so that we can continue to improve it and to work towards creating seamless care for dual eligible beneficiaries.

We encourage you to send any ideas to our e-mail box which was mentioned at the beginning of the call and will be reiterated later at the end of the call. Of any ideas that you have at any areas, you know, of where the two programs are misaligned in such a way that it causes cares to be provided in a less than (optimal) way.

The list is developed with lots of input so far from external and internal stakeholders, and we look forward to continuing to improve it. And, again, it will be transparent and a living document.

We will then be prioritizing the list by working with you and with others to make sure we have everything on it. We're going to go through – we're going to go through those opportunities for better alignment to make sure that we can make the programs work together better for these individuals.

So second area then that we're working on has to do with the demonstrations and models. It involves the testing and innovation of new delivery systems and payment model for dual eligible and beneficiaries. These are models that fully integrate the Medicare and Medicaid services that the recipients are eligible to receive. So this means acute care services, long term care services

and support and behavioral health services, we believe that it's very important that there's an integration of all such services.

We will begin working with the states and we announced a few weeks ago the upcoming availability of design contracts of up to a million dollar each for up to to 15 states, and that solicitation will be out soon in early December. And then we'll partner with the innovation center to further explore and enhance other opportunities for the integration of care services and financing for the dual eligibles as well.

So I encourage all of you to make sure that we have your input and your feedback, and we look forward to hearing that on the rest of this call as well as through your input and into our e-mail box.

Thank you. And I'm going to turn it back over to the regional office and to John.

John Hammarlund: Thanks a lot, Cheryl.

Cheryl Powell: Thank you.

John Hammarlund: We've now heard from Rick and we've heard from Cheryl. And now we are shifting gears. This is the time when we go into our listening mode and so that we can hear and appreciate your good thoughts and ideas.

So let me remind you once again of the ground rules for this call. This is your chance to share ideas and to give your thoughts and inputs to us. Your remarks will not be considered formal or official responses or remarks for the record. We're going to be in listening mode and we are taking comments today, not questions.

As your facilitator, I may ask for a clarifying question or a follow-up, but generally we're going to be sitting back and enjoying your input. Please limit your remarks to no more than two minutes so we can be sure to get as many people participating as possible. And if I may add, when you do speak, please let us know your name, your affiliation and which area that you are

commenting or addressing on – one, Accountable Care Organizations; two, the Innovation Center; or three, the Federal Coordinated Health Care Office.

All right. (Sarah), we are now ready and open for you to open up the lines for comments.

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

And your first question or comment comes from the line of Morna Smith from Nationwide Children's Hospital. Your line is open.

Morna Smith: Thank you. Hi. I'm Morna Smith. I'm director of Federal Relations and Health Policy at Nationwide Children's Hospital in Columbus, Ohio. Thank you very much for holding this session today and for your informative remarks.

You ask that we direct our remarks and I guess I would direct mine at both ACO and CMI and that's because I would like to talk about Pediatrics ACOs and where those fall, I guess, it's really up to you and your leadership moving forward.

Nationwide Children's Hospital has a Pediatric ACO and has for many years with currently nearly 300,000 children who are a part of Medicaid and who are at risk in the 37-county area from urban Columbus to rural Appalachia. We do that by partnering with Ohio's Medicaid managed care organizations. And so we subcontract and we have the business risk for clinical and financial outcomes. We think this model where we are – we subcontract and we have capitation – full capitation is one that really relates to your goals because it gives us incentives to keep kids healthy.

And so our questions for you and our recommendations are – revolve around when we look at Pediatric ACO keeping the potential open for not just partial cap but full capitation on the Pediatric Medicaid side, which I know is very different from Medicare ACOs where there is some reluctance to do that and

where many providers and associations are saying, no, Medicare needs to be the one responsible for the health and wellness and sickness of the population.

We think if you're going to really move the health of the population, then you need providers stepping up and partnering with others and their community to take – to take that responsibility as we have been doing, and would like to see you set regulations in place for Pediatric ACOs that allow that to be done.

John Hammarlund: Thank you very much for that. A great comment and we very much appreciate it and take under advisement.

Morna Smith: Thank you.

Operator: Your next question or comment comes from the line of Matt Anderson from the Minnesota Hospital Association. Your line is open.

Matt Anderson: Thank you, operator. This is Matt Anderson with Minnesota Hospital Association.

My comment is really directed to all three components – ACOs, the Innovation Center and the Coordination Office, and that is to the extent that CMS wants to pursue demonstrations or pilot projects. Minnesota's hospitals and providers have historically delivered high quality care at low cost by national averages and we are proud to participate in the advanced primary care practice initiative for medical homes as one of the eight states moving in that endeavor.

But historically, CMS has precluded states or providers from participating in more than one demonstration project at a time, and we believe that these integrations and payment delivery reforms need to move forward aggressively and would like the opportunity to provide our experience and abilities with integrated care delivery to participate in more than one demonstration at a time if that's appropriate. And we hope that you'll have the flexibility to do that.

Thank you.

John Hammarlund: Thank you.

Operator: Your next question or comment comes from the line of (Surab Agro) from Parexel. Your line is open.

(Surab Agro): Hi. This is (Surab Agro). I'm calling from Parexel International based in Bethesda, Maryland. I work with (inaudible) device companies to help them work with Medicare and Medicaid programs.

My comment is on basically the idea of the electronic health records and how we could have some kind of a national leadership to develop. Because what's happening currently is there are several hundred different types of that electronic health record (systems) which have been developed. And I think it would be – it's critical that we have some national leaderships for that these different programs can talk to each other, so that we don't have the same problem that we have right now that one (inaudible) system is not talking to another system, because it would be critical for the ACOs, for the (inaudible) that we have one nationally coordinated electronic health record system so that we can collect good data, which can be used both for reimbursement (at quarterly metrics).

John Hammarlund: Thank you very much for your comments. This is John Hammarlund. I trust that you and others on this call are aware of the high tech portions of the stimulus bill that was passed a while ago as well as the HHS Office of the National Coordinator for integrated health care and EHR.

So there are some efforts underway and we appreciate your comment today. Thank you. Next comment.

Operator: Again, if you would like to ask a question or if you have a comment, please press star then the number one on your telephone keypad.

And your next question comes from the line of Robert Hall from the American Academy of Pediatrics. Your line is open.

Robert Hall: Hi. This is Bob Hall. Thank you so much for all the work you're doing and these enormous changes that that you're trying to manage. Certainly, from the

academy's perspective, we're very happy to hear – actually if it's possible to be jumping on the line at first.

And we wanted to talk specifically about three issues in this brief two minutes. First off, in terms of some of the patient-centered medical home language under B1 in the testing of models, I'm wondering if there's any consideration being given to some of the core components of the pediatric medical home including family centeredness as well as cultural competency.

Those two things are really important and are sometimes not included in a patient-centered medical home combination, but in terms of pediatrics are incredibly important specifically considering the population of children and sort of the cultural competency components that arise because of those demographics.

Then the second thing we'd like to just highlight is the payment differential between Medicaid and Medicare. There was earlier discussion about a list of differences between those two programs and we would – for the folks on the phone and the other leaders at CMS to at least list on that that long group of differences, the real difference in Medicaid payment to Medicare that's, of course, in relation to the dual eligible population, but still has a large impact on the largest population in Medicaid which is – which is children.

Then the third thing that we like to highlight is we're, of course, very focused on this one particular section in the ACA – or these two particular sections – 3021 and 3022. Many children in Medicaid, however, are in managed care and so there's an open-ended question about whether or not some of the insurance reforms earlier in the ACA, things that deal with (inaudible) health plan, et cetera, might be impactful to children on Medicaid managed care.

States often contract with managed care companies in order to provide that care and certainly in the (CHIP) population, 80 percent of those kids are actually in managed care contracts. So it will be really great for those kids to receive bright futures. It will be really great for those kids to have a lifetime and (inaudible), et cetera, and so we would implore the center through the interaction with OIG and others at CMS to advocate or at least weigh in on

how those kids could – their care could be improved if some of those consumer protections in the insurance side might be applied to them.

Thank you again so much for all you're doing.

John Hammarlund: Thank you, Bob.

Operator: There are no further questions or comments in queue. But, again, if you would like to ask a question or if you have a comment, please press star then the number one on your telephone keypad.

John Hammarlund: So we'll just wait a moment here, (Sarah), until the brain cells have stimulated another thought. So we'll wait a moment.

Operator: And you have one more question or comment. This comes from the line of Stephanie Fallcreek from Fairhill Partners. Your line is open.

Stephanie Fallcreek: Yes. I just wanted to note that as we try to integrate more and more evidence-based health promotion programs into our primary care situation, that a number of those are based on using live leaders and volunteers in the community to deliver those programs, whether we're talking about Stanford's Chronic Disease Self Management Program or various fall prevention and awareness programs or caregiver education program.

And that for us to implement that is probably going to require very serious creativity, whether we're talking about the actual nature of how we figure out budgets for payments or the fact that you may need to contract with a brand-new set of community-based providers, whether we're talking about the Children's Care Network or the aging network where just where my specialty is.

John Hammarlund: Thanks very much.

Operator: Your next question or comment comes from the line of (Alison Merlag) from Michigan Medicaid. Your line is open.

Steve Fitton: Hi. This is Steve Fitton from Michigan Medicaid. Michigan was fortunate to receive the patient-centered medical home grant that you referenced earlier.

And I guess I'm interested in how that is going to coordinate with the health homes for – both that are chronically ill in this Affordable Care Act as well as in the advanced primary care medical home demonstrations in FQAC.

And I think, you know, we're very interested in pursuing the medical home concept as vigorously as we can. But I think we're going to – we feel somewhat challenged in terms of trying to keep those initiatives sorted out. So I guess my comment would be that we would be looking for you for assistance in doing that trying to move forward on all those fronts but not tripping over ourselves.

John Hammarlund: Thanks very much for that comment and we'll be sure to follow up. Thank you.

Operator: Again, if you have a question or comment, please press star then the number one on your telephone keypad.

And your next question or comment comes from the line of Kayla West from Lake Superior Hospice. Your line is open.

Kayla West: Hi. You may have covered this already. Can you say where things are in the concurrent care demonstration project for health (inaudible) at the same time?

John Hammarlund: I don't – I don't know unless anybody right now on the line can -- wants to characterize that if we are able to do that now or can provide you with some information after the call.

Gwen Sampson: Yes. I think we likely have to follow up and provide the information after the call.

John Hammarlund: OK. Thank you.

Operator: There are no further questions or comments in queue.

John Hammarlund: All right. Let's just wait one more minute again. Sometimes these things bubble up. I'll check in just a second. And if not, we'll go ahead and close up the call.

Final thoughts from anybody? Want to check in one more time, (Sarah), see if there's anything else in the queue.

Operator: There are no further questions or comments in queue.

John Hammarlund: All right. Well, again, this is John Hammarlund from CMS. I want to thank you everybody for being on today's call and giving us some great comments. We really appreciate them. They were constructive, timely and instructive to us.

With that, I'm going to hand it over to Gwen Sampson to close out today's call.

Gwen Sampson: Thank you, John. And to – as our hosts have alluded and expressed on today's call, in the end, getting all of this right, creating the health and health care we need, it's not a task that CMS alone could ever achieve. That is why we truly appreciate each of your comments today and I thank our leaders who explained more about the health that each of you can provide in the years to come.

A special thank go out to Dr. Rick Gilfillan and to Cheryl Powell as well as to you our internal and external partners for your participation.

If you were unable to provide your comments today or if you have something you like to share after today's meeting, you may contact, as John stated earlier, contact us at Health and Human Services and CMS by e-mailing us at aco@cms.hhs.gov and at fchco@cms.hhs.gov and by visiting the center's website at www.innovation.cms.gov.

Please note that for those of you who may have missed some or all of this call or if you have colleagues or friends that were unable to join us today, the presentation will be available through the Encore feature in approximately two hours after the completion of this session. Participants should call 800-642-1687 and enter the participant pin code 28569986 to listen. This is the same number that you use to dial in to this session. Please be advised that this feature will be discontinued after December 8th.

Again, thank you everyone for your participation and for your hard work to follow in the weeks, months and years ahead. Goodbye.

John Hammarlund: Operator, can you let us know how many who have joined us today please?

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