Federal Coordinated Healthcare Office Conference

November 1, 20102:00 PM ET

Operator: Good day, ladies and gentlemen and welcome to the Federal Coordinated Healthcare Office conference call. At this all participants are in listen-only mode. Later, we'll conduct a question and answer session and instructions will follow at that time. Should anyone require assistance at any time during the conference, please press * then 0 on your touch-tone telephone. As a reminder, this conference call is being recorded. I'd now like to turn the call over to your host for today's conference, Ms. Cora Tracy. Ms. Tracy, you may begin, ma'am.

Cora Tracy: (Inaudible) at the federal, state and local level. Among his many positions, Henry has worked at the centers for Independent Living, served as a Director of Disability Services at the University of Colorado, Boulder, and as the Policy Director at Independence Care System in New York City. Henry has also advised the federal government on disability issues, holding positions as Senior Advisor on disability policy to the Clinton administration and to the Social Security Administration's office on disability. In 2007, he was appointed by Governor Tim Kaine of Virginia to serve on the Commonwealth Healthcare Reform Commission. Welcome, Henry.

Henry Claypool: (Inaudible) and we'll then turn it over to Melanie Bella for her introduction on the office that she's heading. So just by way of background, the community living initiative was established in 2009 when President Obama announced the Year of Community Living and Secretary Sebelius formed an interagency working group basically around community living, and our charge was really to address barriers to community living across the department. So we've organized that work and we're working in areas around services and supports, housing, workforce, and quality.

For examples of some of our work, in services we are working to improve the participation of disability organizations in aging and disability resource centers. In the housing arena, we're working what HUD to ensure that vouchers are made available to states that have Money Follows the Person Grants, so that they can aid in the transitions of individuals from nursing homes and other institutions. And in our workforce group, we promoting disability specific core competencies for direct care workers so that they can better serve people with disabilities.

Now a little bit on the Affordable Care Act. Many of you may know that there are significant private health insurance reforms in the Act. Namely, they end pre-existing condition, which is probably the single largest civil rights victory for people with disability since the ADA. In effect now, youth under age 19 no longer can be discriminated against in these small group and individual markets based on the fact that they have a disability. And in 2014, it will be applied to all of those health plans that operate in those markets.

Another example of an activity that's included in the Affordable Care Act is the Medicaid expansion. Medicaid eligibility will be raised to 133% of poverty.

These benchmark plans will provide services to folks that are eligible up to that level. And many of you know that Medicaid may do a better job at serving people with disabilities than say private employer based coverage. So this is a significant step forward for people with disabilities.

Finally, we have a number of long-term services and support provisions in the Medicaid program that are included in the law. An extension of the Money Follows the Person program, which adds an additional $2 billion and extends the program through 2016. There's a state balancing incentive payments program which really helps states that are having a hard time rebalancing their long-term care systems find additional incentives to move forward and provide more community based services. There's the Community First Choice Option which many in the advocacy community worked long and hard for to basically enhance community based services so that they would be available on par with institutional services.

And the Class Act, which will make long-term services available -- will make a benefit available to folks that want to participate (inaudible) things like long-term services and supports if they've paid into the fund and they have significant earnings and are eligible for the benefit. So with that, I'd like to turn it over to Melanie. She's going to talk about one of the other incentives that's included in the Affordable Care Act, that may be significant for states, but also for beneficiaries; the opportunity to enhance the coordination of the Medicare and Medicaid program.

Cora Tracy: Henry, this is Cora. Can you hear me?

Henry Claypool: Yes.

Cora Tracy: Okay. Thank you so much for your presentation. We had some technical difficulties in the Bella -- it's my pleasure to do so -- who has recently been appointed as the Director of the Federal Healthcare Office at the Centers for Medicare and Medicaid Services. Prior to joining CMF, Ms. Bella was Senior Vice-President for Policy and Operations at the Center for Healthcare Strategies where she led efforts to integrate care for complex populations, including people with multiple chronic conditions, disabilities and mental illness. Prior to CHCH, Ms. Bella served as Medicaid Director for the State of Indiana from 2001 through 2005. Welcome Melanie.

Melanie Bella: Thank you very much and thank you, Henry. It's always a pleasure to be tag teaming with you. I know we both look forward to answering questions at the end. I wanted to take a few minutes and talk to all of you about the Federal Coordinated Healthcare Office and give you an update on where things stand. I wanted to start with -- I assume everyone has received the slides in advance. Is that right, Cora?

Cora Tracy: Yes, they have. Thank you.

Melanie Bella: Okay. So just talking at the highest level starting out with CMS strategic aims, the opportunity to improve care for individuals duly eligible for both Medicare and Medicaid is a priority of the Secretary and certainly on down through the

leadership of CMS. Dr. Berwick, the Administrator of CMS, has made this one of his top priorities and it really does fit nicely into the strategic framework of CMS generally, which covers these four areas on the second slide.

The first is cost of care and excellence in operations. So there is a focus here on operational excellence and this directly relates to the duals and terms of simplifying some of the administrative and regulatory policies and procedures and making it easier for beneficiaries to navigate the system.

The second area is focusing on better care for patients and we'll talk a lot about this, but certainly we know that for those individuals who receive both Medicaid and Medicare, when they experience care, it may not be in the most optimal way. So how do we make that better, whether it's care transitions or readmissions or health homes and navigator -- there's all sorts of opportunities.

The third area is on integration of care and this obviously really gets to the heart of what we're trying to accomplish for dual eligibles and thinking about how do you make the totality of an individual's needs seamless? And by this, I think for the folks that we are here to represent, that means the medical and the non-medical and making sure that none of that gets lost in the process.

And the last is really looking at improving the health of populations and communities. So it's not about a CMS that is here just to pay claims. It's about a CMS who is here to take responsibility for improving the health status of communities. And for the duals again, that gives us a lot of room to think about what we might refer to as pre-duals and how are we going to do some things on the preventive end that are going to delay spending down of assets, for example, or to think about being smart about how we deal with some of the institutional placements and the different funding streams, again thinking about our pre-duals.

So that is the strategic framework for CMS, out of which the duals are one of the top priority areas. If you go to the next slide, and by virtue of the fact that you're on this call, it means I probably don't need to spend much time on this slide, but it's often important just to remind ourselves, who are we talking about? And we're talking about nine million individuals who are eligible for both Medicare and Medicaid. They are responsible for a significant amount of spending in both programs -- approximately 46% of Medicaid and close to a quarter of Medicare spending annually. Estimates range that that is anywhere from 300 to $350 billion a year total that we're spending. I think most of us would agree that we're not getting high quality, high value care for beneficiaries, yet we're spending an awful lot of money on that.

Bottom line is really what's important is to focus on what's at the bottom of this slide which is there are tremendous opportunities to improve in so many ways when you think about it from the beneficiary perspective; whether it's access or quality or beneficiary experience, and most importantly we hope that will begin to slow and over time perhaps even reduce costs.

If you go to the next slide, I'm going to talk a little bit about the Federal Coordinated Healthcare Office and I like to joke that we're referred to as Section 2602. So those of you familiar with the Affordable Care Act will know this

section well. And at the highest level, we are here to improve quality, reduce costs and make the beneficiary experience better. And it really is that last point that guides all of the efforts of this office. It is thinking about how do we make the experience better for individuals to ensure that they get what they need in the most appropriate setting, in a way that isn't driven by two programs that work at odds with each other.

So specifically some of the areas that we are charged to focus on had to do with ensuring that duals have full access to benefits. So access is an important element of what we will be doing; improving the coordination between the federal government and states. States are very interested in working on new programs and policies with regard to the dual eligibles and how do we make sure that the federal, state partnership is enhanced and strengthened. We'll be looking for innovative care coordination and integration models. And I should say, this is not to say that we will abandon those models that have been successful in the past.

So we've seen some very important programs for the original Medicare and Medicaid demonstrations in Massachusetts, Minnesota and Wisconsin. We've seen some other special needs plans emerge that really know how to care for these populations well. And certainly there's been successes with PACE programs over the years. So we seek to enhance and build on those, while we also look to develop new models. And lastly, and this one is a real important one, it has to do with tackling the financial misalignments of the program that really lead to cost shifting and it's that cost shifting that oftentimes is the entire reason why we see patterns of utilization of care and poor qualities that are not desirable. Because honestly, we've designed -- both of these programs are working exactly as we designed them to work, so we shouldn't be surprised that we have these problems.

They were not designed to work together for a population that was going to be eligible for both. And so the benefit of this office is having for the first time an entity in CMS that is responsible for nothing more than trying to work on the care experience for this population, and service a resource within CMS to do translation, interpretation, kind of language differences, help us understand each other's worlds and focus on providing coordination both internally and externally as a resource or a central point of contact.

So what are some of the critical issues in integrating care? The first one really gets to what I was just speaking of which is aligning the incentives. We have got -- with the complexity of the population and the amount of money that we are spending combined on their care, we have to get better value and improved outcomes. It is irresponsible of us not to hold ourselves accountable to pushing the envelope in both value and outcomes. And there are several priority areas that lend themselves to immediate action, if you will. Those have to do with care transitions, looking at avoidable institutional admissions across the spectrum. There's a lot of activity and preventable readmissions and preventable emergency room visits that apply to this population as well.

Again, a lot of activity around health homes and thinking about how to provide navigators for folks that are designed around people's needs. Medication

management is a huge opportunity for this population. Particularly, there are some opportunities for folks who are institutionalized in doing a better job of managing the medications and sharing data with all the different caregivers. Behavioral health -- I want to spend a minute on behavioral health. Behavioral health will be a huge priority area for this office. It is something that obviously is -- it is a critical part of the care needs of the population, particularly for folks under 65, and one of the things that we'll really be spending a lot of time doing is getting a much better sense of the subsets of the populations within the duly eligible population as a whole and we'll be looking at those under 65 and over 65, the presence or absence of mental illness, the presence or absence of dementia.

But obviously, behavioral health is a huge driver in this arena, and this also gets to issues with states where the programs are structured either in carve out or carve out fashion. All of these are areas we will tackle, and the last is health literacy. Again, those of you familiar with the language in the statute, you will know that much of it speaks to improving the beneficiary experience, the ability to navigate the system, the ability to understand the programs. That really comes back to what sort of tools and supports are we going to have to enhance individual health literacy, self-care management, understanding of the system as a whole.

Another issue that's going to be critical that the office planned to take a leadership role is in the whole realm of analytics. And this gets to something I just mentioned in terms of better understanding subsets of the population. So we have a lot of data. There are a lot of data internally. There are a lot of data externally. And linking those data and being able to analyze them in strategic way where CMS and its partners, both internally and externally, have the same set of assumptions. We know where the data integrate and we know where our gaps are, so we can be building that picture. That's going to be really critical for this, as is enhancing access to data for states and for others who are providing care to this population who today, arguably, sometimes are blindfolded because they're not able to see the full picture of what a beneficiary's care needs are or what sort of care they have or have not received.

In addition to this, the office will be taking a leadership role in the areas of performance measurement and evaluation capacity. Again, this all fits with the notion of really enhancing the analytic framework and having a common strategic agenda from which we're all working, if we're going to move towards system improvements.

So some additional critical issues; moving on to the next slide, talks about care models. So as I mentioned, we will be looking to enhance existing models and also develop new models. These are going to be focused on payment system and delivery system reforms. Some new models that might be explored -- there are any number of different types of care management entities out there. The importance for us will be that these are entities that are looking at the totality of an individual's needs. They're not just looking at the acute care side or they're not just looking at the long-term care side. There really is an attempt to bring all of that together.

Accountable care organizations -- how do we take a lot of the work, the good work that's being done on accountable care organizations and think about developing models that are appropriate and meaningful for individuals receiving both Medicare and Medicaid. And then again, other variations of integrated care entities. So the point here is to think about how we begin to provide a more coordinated or integrated experience for the beneficiary and have someone or an entity accountable for improving health outcomes and rewarding value.

Moving on to the last slide in this section, it's just again to emphasize the focus is on the beneficiary and it really is about being person-centered and thinking about new delivery models. So just to reiterate, for us, improving the beneficiary experience in terms of satisfaction, awareness of the program, health, functional status, well-being, all of those things -- we're charged with doing that and being able to measure it and showing that we're making real improvements. And so that is an area where we'll be seeking input from our internal and external partners, and perhaps some of you may have some thoughts on that at the end of the call.

Before we move on to the next slide which really sort of reiterates some of the short term actions, I'll just take a minute to mention the office currently is structured into two buckets, if you will. One is what we're calling program alignment. That division or group will be responsible for working on every area where Medicaid and Medicare butt up against each other. That could be eligibility enrollment, marketing, grievances and appeals, performance and quality measurement issues, you name it -- all of the places where the programs haven't been designed to work together.

Then that work will entail making sure we have "the list," so every one of those areas is on our list and we have a way of assessing the impactability in terms of how many beneficiaries are we going to help once we tackle this. Then understanding if tackling it requires sub-regulatory or regulatory or statutory change. And then, having a process by which we prioritize getting to those things on, again, the infamous list. And I want to emphasize, everything will make the list and everything is very important, but we have to level set expectations about how quickly we can get to everything. So we are -- there are -- all told when we get done hiring, there will 14 of us, and we will be mighty, but we will be small. So it really will be very important to have a process for prioritizing that is very transparent and is open to input, but let's everybody know what we're able to get to and when, and that there is a rationale behind that plan.

The other bucket, if you will, will be models, demonstrations and analytics. And as I discussed, the types of models and the types of analytics that the office will be pursuing, we had the fortune to work hand-in-hand with the Centre for Medicare and Medicaid Innovation to exercise its authority and to use some of its funding to support demonstrations focused for improving delivery system and payment mechanisms for duals. So that just gives you a little bit of backdrop as to how the office is structured.

The next slide references some short-term action plans that support the aims and the overall goals of the office. So the first one gets at the analysis issue, which is

looking, doing a system-wide analysis of care patterns. We hope to do state profiles that get at, again, utilization, care patterns, and spending patterns for the duals across the country. We will provide states information and analytical tools to help them better understand their population. So part of our charge is to improve the state/federal relationship, to improve state/federal contracting, and to provide TA to states and plans and other entities.

As I mentioned, under the program alignment work we will be identifying administrative, regulatory and legislative priorities and policies to improve care integration. We have an opportunity also to provide some statutory recommendations on an annual basis through the secretary's reports to Congress. Technical assistance and collaborative learning are opportunities we hope to provide to states and health plans and providers and others. And lastly, again, to reiterate that we'll be looking -- we have started thinking about the design, implementation and evaluation of various models that we might be interested in testing through the innovations center.

As far as an update, again just a little bit more concreteness about what the office has been up to. We're starting to staff up. I'm thrilled to be on board. I couldn't imagine something more exciting. So it's a great privilege to me to be working on this and to be able to be building my team. We have established coordinating committees. So we have one that's a CMS committee that brings together all the Medicaid folks and the Medicare folks and the Office of Policy and the research and demonstration folks, and the quality folks. So everybody within CMS has been working on this issue. We have a broader HHS coordinating committee; so it's very important to reach out to our HHS partners, the Office of Disabilities, OAO, ASPI (ph), SAMSA -- I probably shouldn't be using all those acronyms.

But again, those of you on the call are probably familiar. Essentially, what we're trying to do is get an inventory, if you will, of all the programs, policies, data, analytics, initiatives underway that touch duals and serve as a clearinghouse, if you will, for making sure we have a good handle on that and we're leveraging existing efforts and not duplicating or unnecessarily going in an opposite direction. We have begun interaction with both MEDPAC -- that's the Medicare Commission, and MACPAC, that's the Medicaid and CHIP Commission. I see real opportunity for the three entities being the duals office and MEDPAC and MACPAC to work together on a common research agenda and to be smart about how we invest our resources in doing analytic work around this population.

We are in an ongoing process of doing stakeholder outreach. We appreciate the opportunity to be in front of all of you today on this call and have been doing a series of other calls and/or in-person meetings just to make sure that we are hearing from all the people that are interested in this very important issue. As I mentioned, we're in the process of developing state profiles and we have selected an external contractor to assist us in a variety of areas. That contractor is Thomson Reuters and Thomson has several subcontractors and they will be working with us on some analytics, on focus groups, on state site visits, on some rate setting and some actuarial work.

So we are fortunate to have an extension of our resources via Thomson Reuters and its team. I think in closing, I want to reiterate that this is a very big priority

for this administration and it's going to take a lot of partners to get it done, and so it's very important to us to have stakeholder input. So we have listed three questions here that we throw out as starting points that you all might want to comment on. But certainly are open to other suggestions and other avenues of input as you might want to share them with us. So with that, I think, Cora, I'd like to wrap up and leave plenty of time for questions for Henry and for me.

Cora Tracy: Thank you, Melanie and thank you, Henry, for your presentations. And I would like to open up the call, operator.

Operator: Thank you, ma'am. Ladies and gentlemen, if you have a question or a comment at this time, please press * then 0 on your touch-tone telephone. If your question has been answered or you wish to remove yourself from the queue, you may press the # key. Once again, if you have a question at this time, please press * then 1 on your touch-tone telephone. Our first question comes from Mr. Cliff Hymowitz. Mr. Hymowitz, your question, please? If your line is muted, please unmute your line, sir. Mr. Hymowitz, if you have a question, please unmute your line at this time. We'll come back to your question, sir. Our next question comes from Ms. Renee Stout. Ms. Stout, your question, please?

Renee Stout: Hi. Yes, this is Renee Stout. I'm the Executive Director of Managed Care here at HRA in New York City and I thank you for that update, Melanie, and I'm sending a question or a statement to you and to Frank. Actually, this morning I was in a meeting with Sue Kelly's (ph) office and Mike Melendez, and one of the things that I've posed to them, and this may help with some of the coordination of benefits, is whether or not HRA can get a file of all dual eligibles that are enrolling in the Medicaid Advantage plans, because we are the entity that is responsible for enrolling on the Medicaid side. However, we have to rely on either the plan or the enrolment broker to send us that information. So it's not always a timely enrollment and/or disenrollment of this population, which I'm sure affects their ability to access care. So I just want to put that issue out there. I asked Mike to look into it. And if you could also take it up under advisement with the committee that looks at coordination of care, I would appreciate that.

Melanie Bella: Okay. Thank you very much for that suggestion.

Operator: Thank you, ma'am.

Renee Stout: Thank you.

Operator: Our next question comes from Mr. Cliff Hymowitz. Mr. Hymowitz, your question, please sir?

Cliff Hymowitz: Yes, I actually have two questions. I wasn't able to get the slides. So if somebody could email them to me, I'd really appreciate it. And the second question is this. It deals with Medicaid transportation. The federal government is doing everything they can to work out coordination of transportation resources and Medicaid has not come to the table. And we spent a lot of money on Medicaid transportation and it could be done more efficiently, but they should join the table at the federal government where they have the coordinated council on Uniservice (ph) and public transportation. Are you familiar with that?

Henry Claypool: I believe so. Can we get your email address so we can follow up and we can get you a copy of the slides and then give you some information about our activity on transportation?

Cliff Hymowitz: Okay. It's chymowitz@brookhaven.org. I'd also like to mention that I'm on the National Steering Committee of Project Action also.

Henry Claypool: Thanks, we'll be in touch.

Cliff Hymowitz: I appreciate that very much.

Henry Claypool: Of course.

Operator: Thank you, Mr. Hymowitz. Our next question comes from Clarissa Kripke. Ms. Kripke, your question, please?

Clarissa Kripke: Hi, this is Clarissa Kripke, the Office of Developmental Primary Care in San Francisco, California working on trying to develop a pilot model to serve the needs of adults with developmental disabilities. I'm wondering if what you are doing to work with departments of developmental services and DD waivers, because one of the chief challenges that we're having is with different eligibility requirements for those services in different service areas and matching eligibility and service areas to create more coordinated systems of care.

Henry Claypool: Before Melanie arrived, we've been doing outreach to the National Association of State DD Directors and we're very familiar and very interested in working on the area of Medicare and Medicaid eligibility that comes around the DACs, the disabled adult children. So we're familiar with the issues that need to be wrangled and we're going -- we're pulling them together now. I think we'll have something more specific to say about how we might go about addressing those in the future. Are there specific suggestions that you have for dealing with the issue, that we should consider?

Clarissa Kripke: Well one -- we're trying to work on a pilot in two different counties. One county is a single Medicare, Medi-Cal HMO area, and the other county has a private and a public Medi-Cal HMO, and it certainly worked a lot better to have a single HMO, because they're going to be responsible for everyone. Without -- well, it's -- in a county that has two providers, they just compete against each other to provide the worst possible care so that people will choose the other HMO, because they're expensive clients to take care of.

Henry Claypool: That's important information and we will definitely take it under advisement.

Clarissa Kripke: Thank you.

Operator: Thank you, Ms. Kripke. Once again, ladies and gentlemen, if you have a question at this time, please press * then one on your touchtone phone. If your question has been answered or you wish to remove yourself from the queue, you may use the # key. Once again, if you have a question at this time, please press *

then 1. We have a follow up question from Mr. Cliff Hymowitz. Mr. Hymowitz, your question?

Cliff Hymowitz: Yes. I'm a head injury survivor and on the waiver program and it's -- it's very, very difficult to grasp what exactly the waiver allows and requires for a personal like myself who is a participant in the waiver. I don't know if every state has a different waiver, but I think this would be really helpful, specifically with all these veterans coming back with head injuries, that you might consider rewriting the documents so that they're more easily understood and less, you know, run bureaucratically. I don't know if you've thought about that.

Henry Claypool: Actually, I think we have. The President is deeply committed to transparency in government and that filters all the way down to the Director of the Medicaid Program, Cindy Mann, who has been in conversation with beneficiaries around the country and really is deeply committed to ensuring that beneficiaries have a better understanding of what's available through the Medicaid program. But you're right, each state not only has one waiver, they may have more than one waiver. So there is a tremendous amount of diversity out there and it can be difficult to understand.

Cliff Hymowitz: And one last thing, before they made the change, at least in New York State, about the two different types of Medicaid transportation, one was administratively and one was something else; I can't remember exactly what it was. What it did was they got rid of the deterrents to having a brokerage. However, I don't believe the information is being corrected for efficiency. It's being corrected for payment, not for understanding where the people are coming from. They can tell you an individual, but if you give them -- like a hospital, and say how many people from the Town of Brookhaven go that hospital on Medicaid transportation, they don't have the ability to tell you that. So I think that Medicaid might consider looking at the record keeping that's being done and -- because there's a lot of good information out there that's not available.

Henry Claypool: Thank you for that recommendation and we just want to remind you that there's a resource out there about what's available in your state in regard to healthcare broadly and that's the website which is healthcare.gov. You can go there and learn more about Medicaid and other insurance in your state.

Cliff Hymowitz: Right. But you have to remember also that I'm a head injury survivor, so you know, it's not written -- I mean the woman brought up about the beneficiary being involved. Well then the documents have to be written so that the beneficiaries understand it and they're not solely relying on their service coordinator to assist you in making decisions. You should -- you understand what I'm saying?

Henry Claypool: Yes, we were very intent on keeping the language understandable there. And so when we follow up about your question on -- the earlier question on transportation, we look forward to the your feedback about the readability of the language on the website too.

Cliff Hymowitz: Okay. Thank you very much.

Operator: Thank you for your question, sir. Our next question comes from Susan Ellis. Ms. Ellis, your question, please?

Susan Ellis: I am calling from Birmingham, Alabama. I'm a parent of an adult who's a dual eligible and I'm also an advocate. I work for one of the (inaudible) and I did not have access to the slides either. So I wanted to get the slides and my email address is susaneellis@gmail.com. Did you get that?

Henry Claypool: Can you spell it one more time? A little slower?

Susan Ellis: It's susaneelli@gmail.com, So that's S-U-S-A-N-E-E-L-L-I-S@gmail.com.

Henry Claypool: Thank you.

Susan Ellis: And this new federally coordinated healthcare office, will it be organized on a regional basis?

Melanie Bella: We will certainly be working with the regions, each of the 10 regions. Right now, we are organized centrally, if you will, but we are reaching out to have partnerships in the region.

Susan Ellis: And under -- is that regions of the Health and Human Services Department?

Melanie Bella: Yes.

Susan Ellis: Okay. And Cindy (inaudible) does she have a staff that's in those regional offices?

Melanie Bella: Did you say, does Cindy Mann?

Susan Ellis: Yes.

Melanie Bella: Yes, she does. The regional offices house both Medicaid and Medicare staff.

Susan Ellis: Okay. (Inaudible).

Melanie Bella: I'm sorry. We missed that very last part. Your raised a very good point though, that when we think about coordinating and collaborating, we have to make sure we're doing so with the regional offices as well, as many of the program and policy decisions are made there. So thank for reminding us to stress the importance of that group as well.

Susan Ellis: Okay. So (inaudible).

Operator: Pardon me, Ms. Ellis. Could you repeat your question, please?

Susan Ellis: (Inaudible).

Operator: Ms. Ellis, we'll come back to your question, if you'll queue back up again. Our next question comes from Ms. Kimberly Crump. Ms. Crump, your question, please?

Kimberly Crump: Yes, can you hear me? Have to unmute my line?

Operator: Your line is open, ma'am.

Kimberly Crump: Can you hear me?

Operator: We can hear you fine, ma'am.

Kimberly Crump: Oh, thanks. Yes. I simply wanted to say well thank you for doing this and then just to mention, I don't think anybody got the slides that were referred to. Like none of us did. So I don't know how you want to handle that, but if you could just please send them to everyone, I think that would be appreciate. And thank you, that's all.

Operator: Thank you, ma'am. Our next question comes from Deborah Fickling. Ms. Fickling, your question, please?

Deborah Fickling: Hi, my name's Deborah Fickling. I work for the New Mexico Human Services Department in their behavioral health section, and this has been a very interesting phone call and I was very glad to hear about the interest, the promotion of the (inaudible) health and keeping it in the spotlight. One of my, not so much questions, but just observations. I've been working with a lot of people who are transitioning from Medicaid to being a dual eligible and it comes as quite a shock when they do for a lot of reasons. They can't get the services they were getting before. They have to change for maybe their therapist, because Medicare doesn't covered licensed professional counselors, even if they're master level therapists. Just things like that.

Getting all this money taken out of your check at least initially and I'm just -- I just wanted to bring that to your attention, and ask you to kind of pay attention to those issues when -- if there's some way we can help people ease the transition between going from Medicaid to being a dual eligible, that would be really great. The other thing I wanted to say was on behalf of people (inaudible) issues, everything seems to be -- all the talk seems to be centered around elders, people over 65, and there are a lot of people out there who are under 65 who for reasons not of their own making, don't qualify for waiver services because they can feed themselves, if they can find the table, but a lot of times they need help finding the table. So I just want us to pay more attention to people who don't necessarily need the direct feeding services or toiletry service, but need those kind of intermediate things that often keep them in institutions. Thank you very much.

Melanie Bella: Thank you very much for your comments. I know Henry and I are both sitting here nodding while you're talking about all of those things. The transition is something we need to note and as is having the appropriate emphasis on people under age 65 and understanding the differences in needs and how our policies and service packages need to differ as well. So thank you very much for those comments.

Operator: Thank you for your question, ma'am. Our next question is a follow up from Mr. Cliff Hymowitz. Mr. Hymowitz, your question?

Cliff Hymowitz: Yes. First of all, thank you for giving me the opportunity to ask so many questions. It's just that when some things are said, it triggers a light and I think of a question. One of the things that I want to bring to your attention is that when people -- I want to reiterate what the woman was saying about when you when age out -- however, I'm dealing with a constituent that sustained a head injury before 21, but was not diagnosed until after 21. If you could email me a link to a resource where I could find out how to provide him with information that this family could use to find out about it. I have contacted the local offices and I've emailed Albany and so far nobody has gotten back to me.

Henry Claypool: We will send some resources, but it sounds like we'll be in dialogue on email with you, Cliff. I think that there's a number of things that we can follow up with you.

Cliff Hymowitz: Yes. Because it seems that they're very clear on one or the other, but now I can -- you know what I'm saying?

Henry Claypool: We understand. We're definitely --

Cliff Hymowitz: Okay. Thank you.

Henry Claypool: Sure.

Operator: Thank you again, Mr. Hymowitz. Our next question comes from Ms. Julie Ward. Ms. Ward, your question, please?

Julie Ward: Hi, this is Julie Ward. I'm with the ARC and United Cerebral Palsy and I really appreciate your having this call and outlining all of these really important issues that we need to be dealing with and the opportunity to provide some comments. I just kind of want to reinforce that the people that we represent that would be duals are primarily younger individuals and I think people with developmental disabilities and there's a real need, I think, for assistance to help these individuals navigate the system that exists, simplification of the system, reaching out to the caregivers and also for folks that don't have family, the people that are providing services to them need to be involved in the care coordination and figuring out a good mechanism for doing that.

I just think there's a lot of barriers out there. The networks -- whatever new systems we look at have to include enough providers for care. But we have an additional concern for individuals with developmental disabilities, they may be transitioning from their pediatrician. There may not be an adult provider for them to transition to anyway. So there's -- which this office can address, but it is a factor when you think about access to care and the best care, those issues. But I also would like to ask on the data, I heard you say that there's a lot of data on this population and I -- any information that you can provide back to the community that kind of summarizes some of the data of really who these individuals are; how many by disability type, by program type? I don't feel like I have access to a lot of information or data about the population of people that make up the dual eligibles. So I would certainly appropriate your sharing any information.

Melanie Bella: Thank you, Julie for your comments. I think I should clarify. There's a lot of information. It sits in a lot of different places and one of our jobs is to put it all together and to give us all a much better picture, espy breaking down the population into different subsets and being more precise about that than we've been in the past. Starting at the highest level of the under and over 65 and looking within those groups to understand what's driving those needs, but then according to service setting and just a variety of other things as well. So I wish I could tell you that we had it already to put out there. Part of my message was we are charging ourselves with getting it all together for that very purpose, so that we can make it more useable for ourselves as well as for the outside world.

Julie Ward: All right. Thank you.

Operator: Thank you, Ms. Ward. Once again, ladies and gentlemen, if you have a question at this time, please press * then 1 on your touch-tone telephone. If your question has been answered or you wish to remove yourself from the queue, you may use the # key. We have another question from Mr. Cliff Hymowitz. Your question, sir?

Cliff Hymowitz: Yes, I apologize for asking all these questions. The ADA being a law that is complaint driven, it's very hard to enforce ADA regulations without having to go to the FDA or the Department of Justice. And so there should be a way to cross-reference -- and I know this is again, each state has it differently and stuff like that, but to cross reference the building code and the ADA so that you can find easily what building code addresses the ADA requirement. Does that make sense?

Henry Claypool: It does and I know of a resource that I'll be able to refer you to and you can talk with them about this and they should have some information that will really help.

Cliff Hymowitz: Okay. Thanks a lot.

Operator: Thank you again, Mr. Hymowitz.

Cora Tracy: Damon, we can take one more call.

Operator: Thank you, ma'am. Once again, ladies and gentlemen, if you have a question, please press * then 1 on your touch-tone telephone. And we are currently showing no further questions from the phone lines.

Cora Tracy: Great. Thank you so much. And I want to thank everybody who joined us today for this really important call. And before we conclude, I want to truly apologize for the technical difficulties we had at the beginning of this call and want to give a heartfelt thank you to both Henry and Melanie for their time and information and for really being transparent and answering a lot of the questions here today. I also want to let you know that for additional questions or requests for slides from today's presentation about the Federal Coordinated Healthcare Office, that you may direct them to an email box that we created for this call. It's a F for Frank, C as in Cat, H as in Henry, C as in Cat, O as in Operator@cms.hhs.gov. Again, it's fchco@cms.hhs.gov. And you can request the slides via this email box. For information about the office on disability, please go to their web page at

www.hhs.gov/OD and for updates on the community living activities, please go to www.hhs.gov/OD/topics/community/(inaudible).html. I thank you again for your participation in today's teleconference and have a wonderful day.

Operator: Ladies and gentlemen, this does conclude today's presentation. Thank you for joining our conference. You may now all disconnect and have a wonderful day.