Administration on Aging
Affordable Care Act Training
Aligning Systems for Medicare-Medicaid Enrollees
July 5, 2011
2:00 - 3:30 pm Eastern

Coordinator: ...again thank you for standing by. At this time, all participants are on a listen-only mode until the question-and answer session of today's conference. At that time you may press star 1 if you'd like to ask a question. I'd like to inform all parties this call is being recorded. If you have any objections, you may disconnect at this time.

I now would like to turn the call over to Ms. Marisa Scala-Foley. You may begin, ma'am.

Marisa Scala-Foley: Thank you so much, Laurie. And thank you all for joining us for the Administration on Aging's latest in a series of webinars focused on opportunities for the aging network, both state and local agencies, within the patient protection and affordable Care Act also known as the Affordable Care Act or the ACA.

My name is Marisa Scala-Foley and I work in AOA's office of Policy, Analysis and Development.

This month we're focusing on care coordination and systems alignment for people with Medicare and Medicaid or also known as dual eligibles or Medicare-Medicaid enrollees.

Currently about 60% of this population have multiple chronic conditions and 43% have at least one mental or cognitive impairment. As I'm sure all of you know, a lack of alignment between the programs can lead to fragmented care for people with both Medicare and Medicaid coverage which can not only reduce quality, but also raise costs.

CMS' Medicare-Medicaid Coordination Office which some of you may also know as dual's office is charged with improving quality, reducing costs, and improving the beneficiary experience for Medicare-Medicaid enrollees. And we are thrilled to have Edo Banach from that office with us today, but I'll give him a little more of an introduction in a minute.

Most, if not all, of you serve Medicare-Medicaid enrollees in some capacity everyday and today's webinar will offer you the opportunity not only to hear more about the work of the Medicare-Medicaid coordination office, but also more importantly to provide you input and ideas about how to better align the Medicare and Medicaid programs. And in fact we want most of this call to be devoted to discussion and your input and your ideas as to how we can work to improve the alignment between these two important programs.

So before I introduce Edo more formally, we have a couple of housekeeping announcements as always.

If you have not yet done so, please use the link included in your email confirmation to get onto WebEx so that you can not only follow along with

the slides as we go through them, but also ask your questions or provide comments when you have them through chat.

If you don't have access to the link that we emailed you, you can also go to www.webex.com. Again, that's www.webex.com. You can click on the Attend a Meeting button at the top right corner of the page and then enter the meeting number for this webinar which is 665431222. Again that's 665431222 and that will also get you into this webinar.

If you have any problems with getting into WebEx, we do invite you to call WebEx technical support at 1-866-569-3239. And that technical support number for WebEx again is 1-866-569-3239.

As Laurie mentioned, all the participants are in listen-only mode. However, we do welcome your questions and comments also throughout the course of this webinar.

There are two ways that you can ask your questions. First as I mentioned is through the web using the chat function in WebEx. Please enter your questions or comments, we'll sort through them and answer them as best we can when we go to the question-and-answer period after Edo presents.

The second way you can ask your questions is that after Edo is done, we'll also offer you a chance to ask your questions through the audio line. When that time comes, Laurie will give you instructions as to how to queue up to ask your questions.

If there are any questions that we can't answer during the course of this webinar, we'll follow up to make sure that we get your questions answered. And if you think of any questions after the webinar, you can also email them

to us at AffordableCareAct@AoA.hhs.gov. Again, that's AffordableCareAct@AoA.hhs.gov.

As Laurie mentioned, we are recording this webinar. We will post the slides that you're seeing on WebEx, the recording, and the transcript of this webinar on the AOA Web site on our health reform page as soon as possible likely by the end of next week.

If you would like to have a copy of the slides sooner than that, please email us at AffordableCareAct@AoA.hhs.gov and we'll be happy to send them to you if you need them sooner than when we can post them on our Web site.

So with that, I think we're all done with the housekeeping announcements. As I mentioned, we are thrilled to have with us today Edo Banach, who is in the program alignment group of the Federal Coordinated Health Care Office also known as the Medicare-Medicaid Coordination Office.

He previously was Associate General Counsel at the Visiting Nurse Service of New York and prior to that he was the Medicare Rights Center's General Counsel.

Edo also practiced health law at the firm of Latham & Watkins and clerked for US Judge John T. Nixon of the Federal District Court for the Middle District of Tennessee. And prior to attending law school, he worked for the New York City Department of Homeless Services in the Mayor's Office of Operations.

And with that, I will turn things over to Edo for the presentation.

Edo Banach: Well thank you so much, Marisa, and AOA for helping to pull this together and for inviting CMS, your sister agency, to present today. I'm honored to

present and especially honored because of the work that I've done in the past and having seen up close the great work that all of you do day in and day out to help older and disabled Americans access their healthcare.

We want your input to make sure that we have it right and that we're focusing all of our energies and that of our small office on the right areas in the alignment initiative and in everything that we do. So this is a very helpful opportunity for me to listen. I'm going to try to keep my talk to a minimum and then open the floor after Marisa does some housekeeping to some questions.

I wanted to give you first a little bit of background about the office and how it was created. Talk generally about that and then get into the alignment initiative itself. And for those of you following on the web, we're at Slide 3.

The dual eligibles before we get into our office. Who are they? They're approximately 9 million individuals who are eligible for both Medicare and Medicaid -- maybe a little more, maybe a little less at any given time -- more likely to have mental illnesses, have limitations in activities of daily living and multiple chronic conditions.

Few importantly are served by coordinated care models and even fewer are in integrated models that align Medicare and Medicaid. This is importantly obviously because of the individuals who we're dealing. It's also important because -- and now I'm on Slide 4 -- dual eligibility beneficiaries account for a disproportionate share of Medicare and Medicaid spending.

So if you look at the left part of the slide, the total Medicare population, these are numbers from 2006 was 43 million; 21% of those people were dual eligibles, but the spending that they would account for is 36%, a

disproportionate amount of spending on the Medicare side. And the same is true and this is using 2007 numbers on the Medicaid side; 15% of the population, 39% of the costs.

So with that in mind and obviously with the care of the individuals at the top of the list, Congress created in Section 2602 of the Affordable Care Act this office which in statute is known as the Federal Coordinated Healthcare office, also known as the Dual's office, and now known as the Medicare/Medicaid Coordination office.

The purpose is to improve the quality, reduce costs, and improve the beneficiary experience with some very specific goals and legislation itself. Among them insuring dual eligibles have full access to the services to which they're entitled and improve the coordination between the federal government and the states, improve coordination within the federal government between the Medicaid and the Medicare sides, develop innovative care coordination and integration models, and eliminate financial misalignments that could lead to poor quality and cost shifting between states and the federal government or between different providers and we'll get into that.

Let me tell you a little bit about the different parts of our office before getting to the part that I'm in. Data analytics is the first. The goal here is to create a national and state profiles of dual eligibles, analyze the impact of eligibility pathways to better understand the beneficiary experience, and improve access to Medicare data for care coordination including timely A, B, and D data.

There was an informational bulletin that went out and there's a link to it on the slide. This is the first time and this is really responsive to what our office and this agency. We're hearing from states that they didn't have access to all of the information that they needed to on the Medicare side in order to truly

coordinate care for the population. That information is now being made available to states and that's a very big step forward.

There's also the models and demonstrations group within the office. Here among other things there's frequent partnership with the innovation center to test delivery system and payment reforms that improve quality, coordination, and cost effectiveness, care for dual eligibles.

Among those things that have recently been announced is a 15-state demonstration program to design new models for serving dual eligibles. Those awards have been made of 15 awards up to $1 million for 15 states to design programs that are going to better enable them to serve dual eligibles. And the planning is also underway for future projects that could include among other things a focus on nursing facilities, health homes, and dual eligible special needs plans. That's exciting work and really builds off of some of the other things that are in the Affordable Care Act.

Now, the alignment initiative and I'll spend the balance of my time talking about this and taking questions about this and any questions that you may have.

The program alignment group works to identify ways in which Medicare and Medicaid work now and think about ways in which they may be able to work better to serve individuals with Medicare and Medicaid. Also to keep in mind those who serve them, those who provide them, those who care for them. The entire network of folks who are out there who deal with Medicare and Medicaid.

And with this in mind, the office put out the alignment initiative in May and again we want to make sure comments on that initiative are due -- and if

Marisa could show the alignment initiative itself -- comments are due on July 11 or before.

This was published in the Federal Register and it goes through a number of different areas that we think might be areas where some regulatory and occasionally some legislative change might be necessary to address the goals outlined for the office by Congress and we're specifically seeking input in six areas. One is coordinated care; (2), fee for service benefits; (3), prescription drugs; (4) cost sharing; (5) enrollment, and (6) appeals.

Hopefully these issues are not new to you. They're merely based on a lot of the input that we've already received and I'll say a little bit about what we have in mind in the six areas and then again stop talking so I can hear from those of you out there who deal with these systems everyday.

In terms of coordinated care, it means a number of things. But one thing that it means is the ability to coordinate care through a care manager or some other way for individuals. There are few existing options within fee for service Medicare and that's something that we point out in the alignment initiative and that we seek comments on.

There's also low enrollment in models such as PACE that integrate or go a ways towards integrating care between the Medicare and Medicaid programs. Very few people are enrolled in PACE, however, there's great promise.

There are also special needs plans. Some of them fully integrated special needs plans, low enrollment in those as well. Good promise again to integrate Medicare and Medicaid.

So when we talk about coordinated care, we talk about currently what is available, what are options, and in the future what are some options that might help coordinate care and in fact also integrate it, and what are the barriers that exist.

To give some examples within the special needs plan world, there are these plans that have to have a contract. Next year all will have to have a contract with -- (we're) in 2013 -- all will have to have a contract with the states. However, there are still different rules. Let me point this out in the alignment initiative for models of care, and for marketing, for appeals, for audits.

So you still have the situation where the entities that are fully integrated do still have to follow different rules on the Medicare and the Medicaid side and this is not just a plan issue, it's also an issue obviously that impacts those who are getting care from that plan. So that's coordinated care.

Fee for service benefits, this is an issue that when I was with the Medicare Rights Center would come up all the time and now that I'm here at the Medicare-Medicaid Coordination office comes up all the time which is when we talk about fee for service benefits and the alignment issues that exist, we're not necessarily talking about the fact that Medicare covers one thing and Medicaid covers another. Those are differences and differences are okay - not okay - but not going to be the focus of the alignment initiative.

It's only when a difference causes some access to care issues or some problems for beneficiaries primarily that I think we're mostly focused on the issue, and I'll give you an example to make it concrete.

DME, durable medical equipment, there are different standards for getting wheelchairs or canes or other DME under Medicare and Medicaid. The issue

though as far as we could see and the issue I think that disturbed me when I was on the outside is that you could have a situation where -- and I'll give you a concrete example -- an individual who is say 21 has been on Medicaid for a few years or a number of years and is suddenly eligible for Medicare through disability. So they've reached the end of the 24-month waiting period. They get Medicare and the impact of getting a new program should be that whatever coverage you have has now been enhanced.

In the DME world, it doesn't always mean that and so when I gave one of these talks at a conference recently and a woman came up to me afterwards and she laid out the scenario for me. Her son who was 21 and was now receiving Medicare coverage in addition to Medicaid had a shower chair covered by Medicaid and a wheelchair covered by Medicaid. When he became eligible for Medicare, the Medicaid agency said, "Well, we can't cover these things anymore. We need the Medicare agency" and it's really a contractor of Medicare "to say whether this is covered or not covered by them before we can be in a position to continue covering it."

Needless to say, this caused some delay for the family, for the individual, something that he was getting and was getting maintained by the state he was not getting and not getting maintained by the state. It took a bit of intervention and the two programs worked a little better going forward, at least for that individual. But that is not a unique situation. It's a situation that we're looking at where the issue is again not what the benefits are, but it's how seamlessly the two work together.

The same is true in the home health context depending on the state. Again, issue was not what the coverage or the benefits are, the issue was how the two programs work together. And so that's an example of some of the things that we're looking at in the fee for service context.

Also, a nursing home transfer issue; situations where individuals are in nursing homes and are transferred to hospitals and back to nursing homes. We want to make sure that those transfers are being made for medical purposes not for any cost shifting or any other reasons, and that's something we're going to be focusing on as well.

Cost sharing is another - I'm going to skip over the prescription drugs area not because it's not important, but just because I have a little more to say about cost sharing and appeals and enrollment. In terms of cost sharing one issue that comes up and comes up a lot is the issue of Medicare savings programs and the extent to which folks who have one of them QMB can be billed for the balance, 20% co-insurance that some providers would ordinarily bill individuals.

And the answer is no. It's not allowed. Those with QMB cannot be balance billed and that's something that we intend to clarify and that is something that's on the alignment initiative as well.

The whole area of crossover claims on the front end and bad debt payments on the backend is an area that we're looking at that is how providers are to be made whole or what options there may be for individuals to receive help paying the co-insurance fees are all related issues and issues that we're very much looking at it.

In terms of enrollment, this is something again that's not new to most of the people in the room. How people get on and stay on Medicare savings programs and Medicaid in different states, looming differences in changes that are going to come in 2014 and so we're very focused on those issues and then

also recertification. Again, it's just not how people get the benefit, but it's how people remain on it.

Going in and out of Medicaid creates complexity not only for the individuals themselves, but also for the providers who serve them and for the plans and indeed for the states and the federal government as well. That's another thing that we're looking at.

In terms of appeals, you know, this is an area where there are different systems in Medicare and Medicaid. Lots of these differences though are actually in the statute and so the issue is for any integrated system, how does one provide an integrated system given the two different sets of rules for Medicare and Medicaid? When an individual is receiving care from an integrated entity what set of rules apply and how is the individual to navigate the system? How is the provider to navigate the system? And so that's another area that is in the alignment initiative and that we're very much looking at it.

Again, I just want to say I can't say enough how this is a great opportunity for us. We know all of you are going to read the alignment initiative, but we hope that some of you will consider providing written comments to that and if there are a million different things going on, we understand. This is an opportunity for us to get any feedback that you might have the alignment initiative or some of the issues that I discussed.

And again, I wanted to thank you so much for this opportunity and I look forward to -- after Marisa does some housekeeping and gives you other information -- I look forward to remaining on the line and answering any questions you may have. Thank you.

Marisa Scala-Foley: All right. Thank you so much, Edo, for that terrific overview of not only the work of your office, but also more specifically the important work that you're doing with regard to the alignment initiative.

As I mentioned, we want to allow lots of time on this call for all of you who are on the phone and on the web to provide your feedback, to ask you questions, and so forth and we've gotten a few in through chat.

Before we go ahead and take those, I just wanted to quickly run through some of the additional researches that we've provided. This is by no means an exhaustive list of resources on any of these topics. We just wanted to provide a few resources in each area on the web where you can certainly learn more about the issues that we've been discussing today in the area of resources related to Medicare and Medicaid enrollees.

We've got a link to the Medicare-Medicaid Coordination Office's Web site as well as links to the Kaiser Family Foundation's Medicare and Medicaid dual enrollees resources.

The link to the alignment initiative in the Federal Register in the body of the slides, I've also sent it to all participants through chat in WebEx as I know we've kind of scrolled through it rather quickly. We want to give you also a chance to take a look at it offline and read it a little more in depth so that you can hopefully provide comments before the end of the comment period. So that link is in here as well.

As always, we've provided a few resources on the Affordable Care Act through AOA's own health reform page which is where all of our webinar recordings, transcripts, and slides are stored as well as other resources related to different federal initiatives on the Affordable Care Act. We've got a link to

healthcare.gov as well as to the Affordable Care Act text and related information if you want a little light reading.

Our next training we will continue our series in the dog days of August taking a look at medication management tools and resources. This is certainly a critical issue with regard to care transitions and care coordinations not only for duals, but for all people with Medicare as well as those with Medicaid. So we invite you to join us. We have not yet finalized the date for that, but we will certainly send out an email to everyone in August with registration information.

And as always if you have comments or questions or stories or suggestions for future webinar topics, we invite you to send them to us at AoA at our email address which is AffordableCareAct@AoA.hhs.gov.

So enough talking from me. We want to now hear from you. We've gotten some questions in via chat, but I wanted to toss things back to Laurie so she can let you all know how to queue up on the audio line, and then we'll go into some of the chat comments and questions.

Coordinator: Thank you, Marisa. To ask a question, you press star 1 and record your name. Your name is required to introduce your question. To withdraw a request, you press star 2. One moment while we wait for that.

Marisa Scala-Foley: All right. Well while we're waiting for those to come in, we've gotten some comments and questions. So let me sort of walk through those a little bit.

The first one Edo comes from (Cedar) who brings up the issue of finding providers. I know this is one that you all have heard about before because I've

been in sessions with you where this has come up. But she wants to know what can be done with regard or do you have any plans with regard to the issue of beneficiaries having a harder time finding providers who accept Medicare as well as Medicare and Medicaid.

Edo Banach: Thanks for the question. I think it's a key question. I think one of the most important things that we're looking at is in whatever model is created or exists to serve duals, you have to make sure that there are enough providers to serve them. Otherwise, we really haven't done much.

And one thing I'll say is a lot of the things that I talked about do address that issue though not directly. So for example when one talks about the QMBissue. The issue there is the payment of co-insurance for providers also for beneficiaries. We're tackling that issue with the coordination of benefits issue primarily because it is a network access issue. In other words, you want to make sure that there are enough providers who are paid appropriately who are willing to serve people with both Medicare and Medicaid.

We don't want to have situations where there are more and more providers who are dropping out of the Medicaid program or indeed the Medicare program. So that's one thing I'm absolutely focused on making sure that we're abreast of the payment discussions that are going on.

And also in the new models that we've been discussing that the talk about integration, there's a promise there too to create a network of available providers for individuals who have agreed to provide care to those individuals. And so we want to make sure that we address it through the existing system to make sure that there are enough individuals whether they're in cities or in rural areas or in frontier areas to serve the population, and that we address a lot of the coordination of benefits issue. And then too we want to make sure also

that in any new models we take into account the existence of enough people to serve the population.

Marisa Scala-Foley: Okay, great. We got a question in from Eddie who asks how the alignment process will interface with the exchanges that are currently being developed in many states.

Edo Banach: Thank you, Eddie. It's a good question. One of the things that we're looking at as part of the alignment process although it's not sort of explicitly there is the future need for alignment. So here we're talking about the alignment of Medicare and Medicaid for people who have both.

Come 2014 we're going to be talking about some issues that relate to what happens if somebody has Medicare or is on the exchange and Medicare is on the exchange and then gets Medicaid and how did those three programs now interact and what information flows from where to where. So it's the same concept. We're out a couple of years. We're doing all of the thinking that we need to do for then.

In terms of what we published in the alignment, it's mostly focused on the current misalignments and the current need and we think we have an opportunity thinking forward to ahead of time address a lot of issues that may exist between the three programs. So it's a very good question and again work is absolutely underway to think about how all three programs work together.

Marisa Scala-Foley: Okay, great. Let's do one more comment or question in from chat and then we'll see if folks have queued up on the audio line.

So a comment in from MacKenzie who says one way to help bridge and better align Medicare and Medicaid would be to allow SNP information to be put on

the Medicare plan finder. She says this would help with prescription drug screenings and enrollment issues so that area agencies on aging, SHIPs, and others can help assist in terms of sharing responsibility and educating about these plans in helping to reach these folks. I don't know if you have any comment on that, Edo.

Edo Banach: Well thank you. I will definitely send it along to folks here and we'll make sure that that comment goes to the right place.

Marisa Scala-Foley: Okay great. So Laurie, do we have any questions on the audio line?

Coordinator: I have no questions at this time. Again if you'd like to ask a question or make a comment, press star 1 and record your name.

Marisa Scala-Foley: Okay. So we got another question in from - we'll keep going with chat and then we will see if anybody else has queued up on the audio line. And if you've asked your question through chat and want to try it through the audio line, you're more than welcome to do that as well.

We've gotten some questions in just in general on chat in terms of, you know, who covers things first and how is this benefit covered and this benefit covered. I just wanted to sort of make a general announcement that we understand that these are extremely important questions and we do want to make sure that they are answered. We will do a lot of that offline because this webinar is not really designed to provide information about coordination of benefits.

It's more to talk about this particular alignment initiative and get your comments on how these two programs can be better aligned rather than providing basic information about the coordination of benefits between the

two. So we will follow up with you if you've asked a question about sort of who covers what and what's covered first. We're happy to point you toward resources that can answer those questions, but we're going to do that offline with you all. We'll make sure those questions get answered.

So we got a question in from Anna who says some, you know, organizations within the aging network are looking at chronic disease and the Stanford Chronic Disease Self-Management Program. Do you see any possibilities for embedding this type of program in some of the care coordination models that you all are looking at? And I don't know whether that may have come up in the demonstrations that you all are doing, Edo.

Edo Banach: Thank you. Thank you, Anna. That's a great question and a great point. You know, without necessarily endorsing any particular chronic disease management program we do think that there's great promise here.

When you think about it, I said a lot about integrated care and obviously our agency talks a lot about better health and better care and lower costs to improvements. So there's a promise inherent (in) an integrated plan itself.

There's also the promise inherent in programs whether they be through a managed care fee for service or otherwise that manage chronic diseases. If one could manage chronic diseases particularly well for duals or indeed for pre-duals, then that very well might be a great place to focus some of our attention. And it's something that we've been thinking about and talking about, but again yes absolutely chronic disease management programs in their various names have been very much a part of what we've thinking about.

Marisa Scala-Foley: Okay. Laurie, any questions on the audio line?

Coordinator: One moment. We have one question from Mary Cabot. Your line's open.

(Mary): Yes. My question is to what do you attribute the low enrollment figures for PACE and for Medicare special needs plans and what does CMS intend to do to encourage increased enrollment?

Edo Banach: Well, it's tough. You know, different people have different reasons for why the enrollment is low and I think those two programs are different.

PACE is a very specialized program. There is an age cutoff. One has to be older than 55 and nursing home eligible so that's a restrictive - right off the bat I think you're restricted in the number of duals who might be eligible and in terms of special needs plans.

There's a lot of competition in the market there, but one option in terms of what we're going to do about it, I think there are conversations going on right now about that. I think it's premature to say exactly what, but I think the key is to take a look at eligibility for the programs and certainly to make sure that the programs are as good as they can be to make sure that more people want to go and receive their care and have their care coordinated by those entities. That's a very important part of it and address any things that prevent those plans from being as good as they can be as well.

Those are some initial things that I think that we can do and certainly there's a lot of thinking going on about what more can be done.

Marisa Scala-Foley: Any other questions on the audio line, Laurie?

Coordinator: I do. Can you give me just a moment?

Marisa Scala-Foley: Sure. We'll take one more from chat while that person's queuing up. We got a question in from Elizabeth who asks or who makes a comment. If you considered requiring state Medicaid offices to provide Medicare with daily data updates, their agency has found that this is a very pressing problem for them since they have a lot of people who fall through cuts when Medicaid can't find them necessarily as duals.

Edo Banach: That's another great point. You know, we focused initially on making sure that the states have all the Medicare data and that's the initiative I talked about; A, B, and D data timely (unintelligible) timely as possible A, B, and D data to the states and I think yes. The second part of that would be to make sure that Medicare has all the Medicaid data.

We focused on the Medicare process first and the Medicaid process I think follows. The goal is to make sure that both the state and the federal government have a full picture, so yes.

Marisa Scala-Foley: Okay. Laurie, did you have a question through the audio line?

Coordinator: Sorry. One more question is from Sister Welch. Your line's open.

Sister Welch: Hi. My name is Sister Welch and I'm from Rhode Island, so I know a little bit about what's been going on in the State of Rhode Island. But I've also been a recipient of Medicare and Medicaid for the last two years due to hip surgery. So I'm a patient and resident as well as a nurse.

But I'm concerned about the effect of this trying to do these programs when we have a very structured Medicare provider and a very structured DHSTEA provider group. And I'm trying to analyze the budget implications of these two and I'm trying to figure out to do this. Is there a timeline for this process?

Edo Banach: There's no set timeline for the office. The office was created as part of the Affordable Care Act in terms of the alignment work and some of the things that we suggest. These are the things that we're suggesting now, and there is no set timeframe for addressing all these things.

We understand that there are state budgetary issues, certainly federal budgetary issues, and we're going to have to be working within that world. But some of these issues are going to be addressable in the short term and some are going to take a lot longer.

Medicare and Medicaid were created, as you all know, in 1965 and it's been this long that some of these issues have been festering. So we don't expect that we're going to fix all them overnight.

Sister Welch: The whole division of the home health aid group and the home care group because that's different concepts in our state, and I'm trying to put the, you know, both groups together into one group and I'm still having difficulty. But I'll watch it and keep in touch with you.

Edo Banach: Thank you. And you bring up a good point which is, you know, and let me say something about this. Having been in a home health world, there is a Medicare home health benefit and in some states there's a more robust Medicaid home health benefit that includes personal care. And yes, I think we need to keep in mind that there are sometimes different providers that serve Medicaid and that Medicare and that's certainly something that we're thinking about and talking about. So thank you.

Marisa Scala-Foley: Okay. Let's take - oh. Go ahead, Laurie. Did you have another one?

Coordinator: No. I was just going to say I have no other questions at this time.

Marisa Scala-Foley: Okay. Well, we'll give folks another couple of minutes and we'll take some more questions and comments that have come in through chat.

And the next two questions actually have to do with again how the alignment initiative fits in with different other programs and demonstrations authorized by the Affordable Care Act. And the first one Edo is what is the linkage between the coordination that you're discussing, and the alignment initiative, and the community-based care transition program that's authorized through Section 3026 of the Affordable Care Act?

Edo Banach: All right. There's no inherent connection between other than that the agency is dealing with both at the same time between the other initiatives and the Affordable Care Act and the alignment initiative.

The alignment initiative is this office is the Medicare and Medicaid coordination office's effort to communicate with stakeholders about some of the things that we think may need to be addressed. At the same time obviously, we are having conversations with the individuals who are running the various initiatives and various things that are going on within the agency whether we're talking about health homes, or we're talking about the community-based issue, or we talking about any of the other number of initiatives that were in the Affordable Care Act.

There are constant conversations between our group and other groups to make sure that we're all on the same page. This, the alignment initiative, is an opportunity to get feedback on some of the things that our office is going to be doing. But certainly to the extent that you have feedback that spans what our office is doing and what other offices may be doing to the extent that they

relate to dual eligible that would be appropriate to be in comments and we welcome those.

Marisa Scala-Foley: Okay. We got a question in from Terri who asks as your alignment analysis and planning happen, how is your office addressing the issues that legislative action might preclude or close off some of the good ideas that may come up?

Edo Banach: That's another very good question. The Affordable Care Act itself recognized in Section 2602 charged our office with addressing some of the regulatory barriers. But also said as part of every year's budget that our office is to submit -- and the agency in fact -- submits some legislative proposals to Congress that might be necessary.

So if you look at the alignment initiatives, there are a lot of issues at the end in the appeals section that talk about some very specific rules. At least some of those rules are in legislation, so that would be an example of something that's only fully addressable through legislative action. And again, Congress has invited our office to submit legislative proposals as part of every year's budget and we intend to do that.

Marisa Scala-Foley: Okay. We got a question -- I just need to scroll up for a second there -- from Lisa who asks what role does your office think that community-based organizations can play in order to proactively address coordination for people with Medicare and Medicaid in their communities and their states?

Edo Banach: That's, you know, community-based organizations are gong to be our key to coordinating care and to addressing some of the problems that have been outlined between Medicare and Medicaid. We don't think that this is

something that's fully addressable through some entity, you know, swooping and "coordinating care" for the population.

This is an issue that is going to have to rely on the network that exists supplemented as well, but through the network that exists to care for the population. There are some very specific networks who are already in place whether the AAAs or the ships or other entities who are as you know I'm preaching to the choir day in and day out helping individuals. And also the provider network that exists who's serving this population very much is going to be a part of or have to be a part of the solutions going forward.

Marisa Scala-Foley: And Edo, we've got this question in from a couple of folks who have asked if you could tell us who the 15 states were who received the awards with regard to the demonstration programs or the design programs and some examples of the types of things that they are proposing or that they propose.

Edo Banach: Sure. Not the expert, but I'll give you a high level summary. The states are -- and this is by the way on our Web site, you'll find a lot more information about a number of the things that I've been talking about and that's http://www.cms.gov/medicare-medicaid-coordination -- but I'll read through the states.

They are: California, Colorado, Connecticut, Massachusetts, Michigan, Minnesota, New York, North Carolina, Oklahoma, Oregon, South Carolina, Tennessee, Vermont, Washington State, and Wisconsin.

And remember these are planning grants, so they did make initial proposals with some information in there. But we're in the middle of the planning process and the approach is that the states have been very different. There's some commonality, but very different. Some states are relying on capitated

managed care, and some folks are relying on managed fee for service, and some states have a different approach. So the states have had a number of approaches that they proposed on the front end and now they're in the middle of the planning process to determine exactly how this is going to unfold and we'll see how that goes.

Marisa Scala-Foley: Okay great. We got a question in from Katherine who says, you know, she's a legal services attorney who's seen many individuals who are duly eligible lose their Medicaid benefit because they purchased a Medicare Part C plan, and she wants to know is this something that you're looking at or is this something that was addressed by the Affordable Care Act?

Edo Banach: I need to know a little bit more from Katherine about exactly how this is happening that folks are losing Medicaid because they're enrolling in Medicare Part C and would welcome an email from Katherine to me. My information is in the Federal Register notice.

It shouldn't be that someone just because they're enrolling in a Medicare advantage plan is losing Medicaid. So I'm assuming that there might be more to the scenario, and I'd be happy to clarify.

Marisa Scala-Foley: Okay great. Laurie, have we gotten anymore people queuing up in the audio line?

Coordinator: I have no questions at this time.

Marisa Scala-Foley: All right. Well, we still have some more. We're plowing through the ones in chat. So let's keep going with that and if certainly if anyone has questions they'd like to ask over the audio line, we would welcome those as well.

We got a comment or a question in from Marcia who talks about the important roles of SHIPs that many of them are trying on their own to build a stronger relationship with state Medicaid agencies and not surprisingly some are more successful than others in building those relationships. How is your office involved in terms of fostering some of those relationships between state SHIPs and state Medicaid agencies?

Edo Banach: Well, our office is certainly supporting efforts that are underway within the agency and other parts of the agency. We have frequent calls with the SHIP folks here at CMS and we do have -- I talked about the 15 states -- we do have a whole part of our office which is dedicated to supporting states and working with states, both the states that receive the planning grants and states that did not receive planning grants.

So we are working as a resource for states and other stakeholders and certainly do support better communication between states and the various stakeholders that they need to coordinate in order to make this a more seamless relationship between Medicare and Medicaid.

Marisa Scala-Foley: Okay. Let me go through and see if we have anything else that we need to answer right now. Laurie, while I'm sort of scrolling up through our chat can you let us know if there are any other questions that have come in through the audio line?

Coordinator: I have no questions. Again, if you'd like to ask a question press star 1 and record your name.

Marisa Scala-Foley: Okay. We got a question in from Eddie who asks how will this alignment initiative interface with efforts to build 2703 process focused on behavioral health clients?

Edo Banach: Again, you know, the alignment initiative is sort of an overarching plan and an indication of some of the things that we intend to work on. It will not hinder our work in any particular area. But certainly Eddie if you have some feedback about the 2703 process, ways in which you think we might want to work on that we would welcome that, you know, those comments.

Behavioral health is an area that we've been very focused on. There were a lot of areas that didn't necessarily make it into the alignment initiatives as it was published, but we do and have been working on specifically behavioral health issues every since we were created. And those are very important to our leadership, very important to me so if there are specific ways that you think we need to be working on those issues, please. We welcome your feedback.

Marisa Scala-Foley: Okay. We got a question or comment in from Susan who says that they are very concerned that in all of this that patient choice is maintained whether it's, you know, with regard to enrollment or choice of clinicians. Particularly in terms of behavioral health clients as well as choice of treatment and so forth, how is your office dealing with these issues of choice when it comes to alignment between the two programs?

Edo Banach: Well choice is paramount and it's choice not just in the abstract, but it's informed choice. We want to make sure that the beneficiary protections -- whether we're talking about fee for service, or we talking about capitated models, or we're talking about any other model -- that information should be accessible, understandable in a language that someone speaks in a way that they can understand so that they can make an informed decision.

And I want to emphasize again, we've been doing a lot of thinking about this issue and it's something that's right at the top of the list in terms of what

we're focused on. We want to make sure that there are adequate and more than adequate consumer protections in place choice is crucial and it's again not just a theoretical choice, but it's informed choice and we have been working diligently on that. And again, all these areas are areas that we would welcome your feedback and specific feedback about the various areas. But choice and informed choice are the most key and paramount in (sort) of building blocks in a lot of the things that we've been working on.

Marisa Scala-Foley: Okay.

Coordinator: I do have one question.

Marisa Scala-Foley: Great.

Coordinator: It's from Ernest. Your line is open.

Ernest: One of the big problems that states have had in coordinating care between Medicare and Medicaid is the inability to mandate enrollment (into) managed care for Medicare participants. So in your legislative initiatives that you're putting together, what are putting together that gives the state flexibility to mandate that enrollment when they mandate it for a Medicaid recipient?

Edo Banach: Well, there are no plans to do something like that. We are aware that the states are focused on this issue. There are some states I know of that do have plans to mandate enrollments. There is a process whereby states make requests of the federal government and there are ways for those requests to be granted currently without our office. But we've been very involved especially with the 15 states, but with the other states as well thinking about what models they're thinking about.

But again to reiterate, there is authority in place right now for states to request the ability to mandate the enrollment of any particular population into a particular model within Medicaid currently and we've been very involved in talking to our friends on the Medicaid side about how that's playing out in different states.

Ernest: Yes that's easy. I'm talking about the Medicare side.

Edo Banach: Mandated enrollment into managed care on the Medicare side?

Ernest: Right. In other words, it doesn't do any good to mandate enrollment of a dual on the Medicaid side if all your primary care decisions are done on Medicare side. So unless you can mandate them both in under the same managed care organization, your ability to coordinate care is very limited.

Edo Banach: Fair enough. But, you know, again I go back to the conversation we had before about choice and there is the right on the Medicare side to make a decision on the consumer side about where they choose to receive their care. It's certainly an area that we've been talking about as well, but that is the policy on the Medicare side.

Ernest: And there's no intent to go forward with any legislative initiatives to look at giving states even some demonstration capacity? Maybe not making it a broad, you know, allowance under legislation but allowing some limited demonstration.

Edo Banach: There are a lot of conversations about a lot of things, but nothing along those lines that I'm aware of in terms of legislation. But this is obviously a very fluid time and there are a lot of discussions going on at this date in the federal level, but at this time again choice is key on the Medicare side.

Ernest: Okay.

Marisa Scala-Foley: Laurie, anyone else on the audio line?

Coordinator: I have no further questions at this time.

Marisa Scala-Foley: Okay. I think we've gotten, you know, some of you have contacted us via chat with some questions about sort of specific clients. We're happy to follow up with you offline about some of those questions as well rather than try to answer that on this webinar. But we did get a couple of other questions or comments and I'd like to pose to Edo.

Pam talks about Medicaid waiver programs that Medicaid waiver programs have proved themselves to be, you know, cost effective and person centered. Are there any of the demonstration models that you all are funding right now in terms of the planning phase that look at collaboration between a Medicaid waiver program and acute care? Sort of going beyond the medical model and integrating the social model as well. I don't know if that's a question you want to answer Edo or maybe it's a webinar for another day with others on your staff, you know, once these states are moving more in this direction.

Edo Banach: Yes, I would say the latter. I think it's a key point, but one I think it would be better for the process to play out a little bit more and then we could speak to the question a little more intelligently.

Marisa Scala-Foley: All right. Shantelle asks a question with regard to is your office looking at alignment with statewide Medicaid managed care overhauls? And this may again be an issue related to some of the demonstration models that you all are looking at right now in the states you funded.

Edo Banach: Yes. The alignment initiative is not again - we're not considering it in a vacuum. Obviously, there are these demos going on and various other things going on throughout the agency and at the state level and we're going to be communicating with the folks who are responsible for those different areas to make sure that we're all on the same page. And this may again be another opportunity to come back and talk in more detail as these things, you know, become clarified over the next few months.

Marisa Scala-Foley: All right. Laurie, any final questions through the audio line?

Coordinator: I have no questions.

Marisa Scala-Foley: All right. The remainder of the questions that have come in through chat have been a lot of questions related to information about how Medicare and Medicaid currently interact when it comes to client benefits. What we're going to try to do since we're really trying to focus in this webinar specifically on the alignment initiative, we will answer those questions offline certainly with input from our friends in the Medicare/Medicaid coordination office.

You know, we do certainly invite you to not only ask your questions to us after the webinar has concluded at AffordableCareAct@AoA.hhs.gov, but as Edo mentioned certainly their office wants to hear from you all with regard to comments/suggestions about how their office can work to better align these two programs. They certainly value the experience that you all have in working with clients who are duly eligible. So we do invite you to submit those comments and suggestions to the Medicare-Medicaid Coordination Office. I believe the Federal Register announcement -- and we provided that link to you all in the slides has -- has Edo's email address in it where you can send those comments.

You can also send them generally to their office's mailbox at MedicareMedicaidCoordination@cms.hhs.gov. We're got that up on the screen here in WebEx. And again that's MedicareMedicaidCoordination@cms.hhs.gov.

As I mentioned, we'll post the slides and the recording, and the transcript from this webinar on our Web site on the health reform page within the next week or so. So we invite you to take a look at that and we'll certainly keep you posted on when that is posted. If you need our slides ahead of time, we invite you to email us at AffordableCareAct@AoA.hhs.gov.

We thank you all for participating and certainly want to thank Edo for his time and for a wonderful overview of the important work that their office is engaged in and for taking your comments and questions and so forth.

Edo Banach: Thank you very much.

Marisa Scala-Foley: So with that Laurie unless -- last call -- anything else through the audio line?

Coordinator: I have no questions.

Marisa Scala-Foley: All right. Well thank you all very much. We invite you to join us again in August when we take a look at medication management. Thanks so much for being with us today.

Coordinator: This concludes today's conference. We thank you for your participation. You may disconnect your lines at this time. Have a great day.

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