

***Administration for Community Living  
Affordable Care Act Webinar  
Managed Long-Term Services and Supports: Engaging in the Stakeholder  
Process  
June 27, 2012  
2:00-3:30 pm Eastern***

Coordinator: Welcome and thank you for standing by. At this time all participants are in a listen-only mode until the question-and-answer session of today's conference. At that time you may press star 1 on your touch tone phone to ask a question. I'd also like to inform all parties that today's conference is being recorded. If you have any objections you may disconnect at this time. And I would now like to turn the call over to Ms. Marisa Scala-Foley. Thank you ma'am, you may begin.

Marisa Scala-Foley: Good afternoon everyone. Good morning to those of you on the West Coast and in Hawaii and Alaska. My name is Marisa Scala-Foley and I work in the Office of Policy Analysis and Development at the Administration for Community Living which is a new agency under the U.S. Department of Health and Human Services that brings together the Administration on Aging, the Administration for Intellectual and Developmental Disabilities, and the Office on Disability.

Thank you so much for joining us for our webinar this month. It's our latest in a series of webinars that are focused on the Patient Protection and Affordable

Care Act also known as the Affordable Care Act or the ACA and its impact on older adults, people with disabilities, and the aging and disability networks.

This webinar series is designed to provide our networks with the tools that you need in order to participate in ACA-related efforts in your area such as accountable care organizations, the community-based care transition program, state care integration for dual eligibles, health homes and more.

Today we continue our multi-webinar series looking at managed long-term services and supports. Last month we started with an overview of managed long-term services and supports and today we take a much closer look at the topic of stakeholder engagement. How you can get involved in the process and the kinds of questions you should be thinking about and asking as you review your state's proposal.

So before I introduce our speakers, we do have a couple of housekeeping announcements. If you have not yet done so, please use the link that was included in your email confirmation to get onto WebEx so that you can follow along with the slides so you can go through them and ask your questions when you have them through the chat function.

If you don't have access to the link we emailed you, you can also go to [www.webex.com](http://www.webex.com), click on the attend a meeting button at the top of the page and enter our meeting number which is 660857762 and the pass code is AOA webinar. Again that's 660857762 with a pass code of AOA webinar.

If you have problems getting into WebEx, you will need to contact WebEx technical support and you can do so at 1-866-569-3239. Again that's 1-866-569-3239.

As Angela mentioned all of you are in listen-only at this point. However we do welcome your questions throughout the course of the webinar. There are two ways that you can ask your questions. First is through the web using the chat function in WebEx. Enter your questions, we'll sort through them, and answer them as best we can when we do the question-and-answer period at the end of the webinar.

In addition after our panel of presenters wrap up, we'll offer you a chance to ask your questions through the audio line. When that time comes Angela will give you instructions as to how to queue up to ask questions. And if you think of any questions after the webinar or have any questions you'd like us to follow up on, you can email them to us at [affordablecareact@aoa.hhs.gov](mailto:affordablecareact@aoa.hhs.gov). Again that's [affordablecareact@aoa.hhs.gov](mailto:affordablecareact@aoa.hhs.gov).

As Angela also mentioned we are recording this webinar. We will post the recording, slides, and a transcript of this webinar on our Web site as soon as possible hopefully by early next week.

So let me introduce our wonderful panel of speakers today who will be exploring this topic of stakeholder engagement with us. First is Mary Lou Breslin. Mary Lou has been a disability rights law and policy advocate for over 35 years. In 1979 she co-founded the Disability Rights Education and Defense Fund, a leading disability rights law and policy center, and presently serves as a Senior Policy Advisor with DREDF directing the organization's special projects. Most recently her work has focused on improving access to health care for people with disabilities.

Next on our panel is Georgia Burke. Georgia is a directing attorney in the Oakland, California Office of the National Seniors Law Center. Currently her work focuses on national and state advocacy around programs affecting

people dually eligible for Medicare and Medicaid. She also advocates to improve language access for Medicare beneficiaries with limited proficiency in English.

And finally rounding out our trio is Silvia Ye who is a senior staff attorney at the Disability Rights Education and Defense Fund where her work has included projects to increase physical and programmatic accessibility and disability awareness in the delivery of health care services and litigation involving federal disability rights law.

So that is our panel of speakers. I'm just going to give a brief introduction and set the stage for them and provide a little bit of an introduction to managed long-term services and supports and then I will turn things over to the panel.

So just to get everybody on the same page, what we're talking about and what this series is designed to address is the topic of managed long-term services and supports. And when we talk about managed long-term services and supports, we're talking about a system in which a payer typically a state Medicaid agency contracts with a managed care organization or an MCO as you will see in the slides going forward to provide long-term services and supports and we abbreviate that often as LTSS.

These managed long-term services and supports programs may cover home and community-based services as well as institutional care and they may serve different populations including older adults, people with physical disabilities, and/or people with developmental and intellectual disabilities or behavioral needs.

So where things are going as I'm sure since given the interest in these calls and the preponderance of calls that are out there related to this topic as you

can imagine interest in managed long-term services and supports is growing extremely rapidly. An environmental scan that was done by Thomson Reuters for the Centers for Medicare & Medicaid Services showed at least 16 states that had managed long-term services and supports in all or part of their state and many other states are indicating interest in implementing managed long-term services and supports this year and in future years.

The main two ways in which states are moving toward this system of managed long-term services and supports include the financial alignment initiative which was launched by the Medicare-Medicaid Coordination Office under the Centers for Medicare & Medicaid Services. Twenty-six states have submitted proposals to CMS and some of which are still open for or some of which are still in their federal public comment period and we have a link to the spot where you can find if your state in fact did make a proposal and if you - if they're still open for public comment.

Other states are using the 11/15 demonstration waiver process through the Centers for Medicare & Medicaid Services to move toward managed long-term services and supports. But both of these processes now require ongoing and meaningful stakeholder engagement especially during the proposal development process, but also hopefully through the implementation processes as well.

And when we're talking about stakeholders, we're talking about beneficiaries and their families or consumers and their families, we're talking about advocates, we're talking about advocates, we're talking about consumer organizations, providers, plans, and more. And we can't over emphasize and this is why we're spending all of today and our webinar likely next month focusing on this stakeholder process. It's critical to get engaged in the process

now in order to ensure that consumers and their families needs are met and their rights are protected.

So with that, I will turn things over to our panel to talk about the terrific toolkit that they have developed that addresses long-term services and supports in a managed care environment.

Georgia Burke: Thanks Marisa. This is Georgia Burke with the National Senior Citizens Law Center and in case any of you are not familiar with our organization, this is our mission statement: We advocate for low income older adults. And the folks at DREDF advocate for people with disabilities (unintelligible) their mission statement.

As Marisa noted states are turning increasingly to managed care to deliver Medicaid services including LTSS. Both the hardest and the most important part of Medicaid for seniors and persons with disabilities is the delivery of LTSS. But it's also an area where managed care companies have the least experience.

So because figuring out how to deliver LTSS in a managed care environment is very new in most states and because it's just so hard to get it right, DREDF and NSCLC have collaborated and we've developed a tool for advocates and for other stakeholders to identify key areas of consumer protections that are necessary for an effective delivery of LTSS and to start drilling down on the details.

We hope the toolkit will be helpful both in identifying areas where protections are needed and also in suggesting the kinds of concrete measures that are needed to ensure that those protections really happen.

So we've tried to get somewhat specific. The really in the weeds work needs to be done by local consumers and advocates and other stakeholders taking into account local resources and the design of state programs. Many of you on the call today are exactly the people who need to get involved.

What we're going to do today is introduce you to some of the issues addressed in the toolkit, some of the questions that need to be asked, and encourage you to look at the toolkit and at other resources that you can really arm yourself to be effective in advocating for the design of an LTSS program that serves and protects consumers.

In our toolkit we cover 15 areas but today -- and there they are up there ranging from infrastructure through oversight and quality measures -- but today we're going to cover a limited number and primarily raise questions actually more than even giving answers.

Specifically we're going to address five sets of topics: persons centered planning including self-direction and assessment, (unintelligible) continuity when someone joins a managed care plan in the beginning, provider choice and access including looking at access through the a civil rights lens, care transitions when moving through changes in levels of care especially after a hospital, and finally what kind of infrastructure needs to be in place at the plan level and independently to ensure that consumer rights are really effectuated.

Mary Lou's going to start us off and then we're going to switch around. Along the way we'll be introducing three hypothetical, but fairly typical individuals who are dually eligible for both Medicare and Medicaid and we'll introduce these folks as a way to kind of bring issues down to earth.

The individuals we're using are based on real dual eligibles who were profiled on the Kaiser Family Foundation Web site, but we've modified it a little bit to help us make our points. So it's a little bit like those made for TV movies that are based on real events, but switched a little bit. So anyway Mary Lou can you get us started?

Mary Lou Breslin: I can. Hi everybody and thanks Georgia. I just want to begin by reiterating that managed care organizations lack of LTSS experience in particular makes advocate and consumer involvement all the more critical. In the consumer protections that we presented a toolkit we think can be a starting point for ongoing advocacy. I realize that everyone's saying this over and over, but it really is one of the key points that we are interested in making.

In addition to introducing Ellen who is going to be one of our case examples and a proxy for how integration of LTSS into managed care might play out. I'm also going to be talking about three critical core consumer protection elements: person centered care planning, self-directed services and supports, and assessments. And these three overarching elements set the stage for ensuring that managed care organizations take appropriate steps to integrate LTSS effectively.

Okay let me just say a few words about our first example and we're calling her Ellen. Ellen is a 42-year-old wheelchair, walker user. She has diabetes, a thyroid condition, the effects of a stroke, and depression. She lived in a nursing home for about seven years until 2010 because she was having difficulty performing basic activities with her hands.

She was able to return to her own home through the Money Follows the Person Program. But challenges for her now are beginning to develop and they include mental health issues, transportation, changes in needed home



assistance, and adaptations. She has both Medicare and Medicaid. Okay keep her examples in mind as we go through the next set of topics.

And I want to just now turn to the concept of the person centered care planning. The basic concept of person centeredness I'm sure is very familiar to all of you. It has very deep philosophical, practical, and legal roots in the de-institutionalization movements of the 70s and 80s and it's now a core operational principle in many systems of service and support for people of all ages and disabilities.

By mandating the delivery of person centered LTSS , the Affordable Care Act and we're keeping our fingers crossed that we will have it after tomorrow signaled the importance of the concept. We stress person centeredness here in part because managed care organizations are generally unfamiliar with the concept and how central it is to really meaningful and effective LTSS and also because of concern that managed care organizations may overly medicalize the process for determining and providing services which could really turn the clock back.

Okay. What is person centered planning? The central precept of person centered planning is that the person receiving services or it can be a designated interested family member or friend is the primary expert in his or her own goals and needs. A person centered approach isn't limited to health status, but it also encompasses the values of independence, control, and autonomy. The person who's receiving LTSS must also have control who is included in the process and that individual defines the desired outcomes along with the preferred methods for achieving them. Most importantly we think specific delivery of LTSS should be customizable according to the needs and preferences of the individual.

However realistically for person centeredness to be more than an empty promise, it has to be embedded as a core operational value within the leadership agencies and organizations including CMS, states, MCOs, and must be accompanied also by sustenance standards. Marisa, can we do the next slide. Great thanks.

I know this must sound really rhetorical or even aspirational, but practically speaking advocates around the country have been working really hard to achieve this goal. But much, much more work remains to be done to ensure that agency leadership is aware of and has adopted these principles and that CMS and the states establish requirements for person centered planning for managed care organizations.

Okay. Let's talk a little bit now about some planning requirements. Advocates should engage in the process of promoting requirements by asking key questions and providing recommendations during the various public processes that are underway as well as independent of them.

There are a number of key challenges that CMS and states have to address and I'm going to just touch on four of those. One big fear is that LTSS will take a back seat to clinical care as its integration takes place. And either the lines blur between clinical and LTSS or equally as problematic LTSS is maintained in a separate silo with no coordination and as a second class component of care. Let's see the next slide, please.

So we should be asking several questions. Are all elements of clinical and community living supports fully integrated? Another challenge is that - for example another challenge is that clinical care stresses processes rather than outcomes. So shifting the model of care to include person centered goal setting for individuals who need LTSS will be a significant challenge. So we

have to ask are goals set along the scope of service and supports to achieve them.

Another key question is does the managed care organization monitor and incorporate feedback for quality improvement. I know this topic is of great interest to many of you and we think it will be covered in another webinar in this series.

And finally we need to ask does reimbursement rates adequately account for person centered planning. I know this is one of the more difficult questions that we're all looking at and trying to answer and we hope to be able to provide a little guidance on this as time goes on.

Okay. Let's take a look at some potential solutions here. One of the most important tools for ensuring meaningful person centeredness of LTSS is the person centered care plan. Creation of requirements for the plan presents many opportunities for CMS and the states to provide direction that will help answer a number of core questions.

Here are just a few examples. How is the person centered plan created? Are goals identified? Are persons and providers identified? Who will be providing services and assistance? Is an option available to individuals to opt out of general requirements when appropriate? For example care provider training when this may not be necessary. And are conflict resolution requirements in place?

Okay. With respect to the written plan, we also need to ask if the requirements we just talked about translate into the care plan itself. For example does the plan foster support and support self-directed services to the maximum extent possible. We're going to talk more about self-direction in just a minute. Does

it document the scope of services and methods to achieve them? Does it include names and signatures of the people who are responsible individually and with an agency for implementation? And does it include a conflict resolution process? And these are important core questions to ask. There are a number of other questions to ask that are presented in our toolkit.

Okay. So let's just move on to self-direction. The principle of self-direction as everyone I'm sure is quite well aware is a close companion to person centeredness. Self-direction is a delivery mode through which a range of services and supports may be directly controlled by an individual of any age or disability with the help of representatives if desired. This would be family, close friends, and others.

Self-direction probably more than any other principle cuts through the historical paternalism of disability policy which is assumed that others will make decisions for us without our involvement.

Self-direction in the context of integrating LTSS into managed care stands as an important beacon in the overall person centered planning process and it has very specific meaning. For example services and supports are based on the individual's identified preferences and needs.

Mechanisms for self-direction include employer authority, budget authority, or both meaning that the individual or a designated family member or friend hires, trains, and fires personal care workers for example and maintains control over budgets established to purchase services, equipment, or other items that further the goals of the person centered plan.

Let's take a look at the central goals of self-direction and these are quite self-evident, but it's good to reiterate them. The goals are to maximize

independence, to ensure that the individual can live in the most integrated community-based setting, and to implement the desires and wishes of the individual.

So what are some challenges in relation to self-direction? And what happens to the concept of self-direction when managed care organizations integrate LTSS? Well self-direction is optional for most Medicaid programs now and managed care organizations integrating LTSS are required to preserve and enhance self-direction if it is already in place. So this is an important leverage point for advocates who are working with plans and with states to incorporate the concept of self-direction.

As LTSS becomes part of managed care, we also need to be asking questions about the incorporation of self-directed goals and implementation mechanisms. Let's just look at a couple of those.

For example does the person or their chosen representative retain employer control over hiring and firing for example? Does the person or the representative retain budget authority over say technology or home modifications? And additionally is risk taking permitted? Will the individual have the opportunity to identify specific issues that he or she wishes to be engaged with and will those activities be permitted?

Okay, let's move on to assessments. I'm touching on the assessment last in this section because it's very deeply intertwined with persons that are care planning and also with self-direction. An assessment is the mechanism used to collect information across multiple domains including social, functional, medical, behavioral, wellness, and prevention. And as managed LTSS rolls out states must develop and require MCOs to use uniform assessment tools

and processes which offers an important opportunity to establish protections and safeguards.

One way to think of assessments is as a solution that unifies the often disconnected worlds of clinical, social, behavioral, functional, and other services. And some basic questions we should be asking about what assessments include are, are services that are currently available and those needed but not currently available included? Is all the information relevant to living in community-based settings included? Are care needs assessed by agency without a conflicted interest? Are assessments conducted when people experience significant change or at least once every 12 months? And do they integrate clinical and LTSS home and community-based needs?

For the most part the LTSS assessments are not focusing on clinical needs, but it is very much worth considering having the two be unified in order to create a whole picture of the person's needs.

Okay, I'd like to at this point move on to our earlier example that I introduced about Ellen and I think what we will do here is move on actually to the second scenario rather than look at the first one.

So let's just look at how LTSS - the protections that we just talked about might affect her now. And let me just remind everybody that Ellen is a wheelchair user, she has been living in her own home for two years after having been in a nursing home for seven years, she's experiencing some new mental health and transportation, other challenges now. Let's just look at what steps might make sense to try to give Ellen some assistance here.

She's struggling to remain in her own home after moving from the nursing home at age 42. What sort of protections work for her at this point? Well first

an updated assessment is needed in order to identify her new functional environmental and social support needs. And an updated person centered plan is needed to identify her need for additional home care for example a voice activated telephone which she may need or additional peer support.

And we can see that three of the protections that we've been talking about are working. If in fact these are implemented are working to meet her current needs, but what's the outcome going to be? Let's just say for example the MCO denies her additional services and supports. Now the additional protections that allow the assessment and the person centered plan to be updated and to identify these new needs are the good news.

Now the level of uncertainty that we're confronting at this point is what to do about the fact that MCO denies the additional services and supports. Ellen has access to an appeal process and she decides to seek that appeal process and she also seeks the assistance of an ombuds person and Georgia is going to be talking about more about this in a minute. But let's just think about what the outcomes might be of this process and how important these consumer protections are in ensuring that Ellen does receive the services that she needs that have been identified through the assessment and also through the person centered plan. I'm going to leave the answer to the outcome question open for the moment and let's move on to the next area of consumer protection.

So this has just been a brief overview of the three important consumer protection tools that we've just mentioned. And now I'd like to actually pass this on to Georgia to continue with additional consumer protections.

Georgia Burke: Thanks, Mary Lou. I'm going to be talking about peer continuity and how we really protect a person centered process at the very beginning when

somebody's just joining a Medicaid managed care plan and particularly as in the case of many states when joining Medicaid managed care is mandatory.

So how do we make sure that there is not gaps and dislocations? But first I'd like to introduce another dual eligible and we're calling her Maria. She's a Spanish speaker, she's older. We created snapshots of Maria at various moments.

At 82 she's in relatively good health, but she's got hip problems that have really made her unstable and made it difficult for her to venture very far from her home. She needs help with bathing and with other daily activities and sometimes she gets very depressed because her life has become so much more limited. She's got a daughter who helps out and tries to manage her care and manage help, but she's finding it really difficult.

Two years later Maria has a fall. Fortunately it's not too bad. She breaks her shoulder, she's shaken up but she's only in the hospital and rehab for a few days, but then she needs to get back to her home. At 85 she has a really serious stroke, ends up with very high care needs and she's in a nursing home. And then we finally see her at 88 when she's been in the nursing home for a long time. She's really settled in. She likes it there.

So we'll look at Maria through some of these scenarios. Looking at care continuity, it's really a challenge to avoid disruption, to make transitions smooth, to prevent gaps for individuals entering managed care and this takes time. It varies depending on the individual on what their prior care picture was and what the resources are in the new plan. But we think it takes - we think that a full 12-month care transition should be allowed. Most people won't need that long. Limiting care transition period to 60 days or to 90 days or even



six months can be just too short given the complex array of conditions and providers that many people using LTSS have.

So during this transition the individual ought to be allowed to go to their provider out of network and that provider if they're not joining the network should be able to be paid at least the prior rate that they were paid when the individual was seeing them before joining managed care.

So what to look out for in these contexts? People think mostly about transition protections in terms of primary care physicians and specialists, but DME providers, physical therapy, and other LTSS providers are equally important. California for example recently transitioned seniors and persons with disabilities who were Medicaid only into managed care and CMS let them exclude medical equipment suppliers from transition protections and it caused a lot of problems for people who experienced disruption in being able to get the continuous durable medical equipment needs that they had.

What constitutes a satisfactory transition? For example if a Chinese-speaking beneficiary has a provider who speaks her language, she should have transition rights until a Chinese-speaking provider with whom she's comfortable is available within the plan.

What the plan does when the plan - what does the plan do to encourage providers to join the network? The best person centered network is really one that builds its network around the needs of the existing networks of its members. The network should be around the members rather than the members squeezing into the network.

And is the plan working with trusted community providers even if those providers may not have maybe the billing procedures - the billing software

that the network wants? Does the network accommodate the needs of these providers who are so central to the people who are joining the plan?

Transitions aren't just about providers, but they're also about services. Again we tend mostly to think of this in terms of medical services like a scheduled operation or someone who's moving into managed care in the middle of chemotherapy. But it's also important that there be transition protection for hours of personal care services or continuing medical supplies and for other LTSS supports.

And then finally, is there a safety net for people who's needs simply cannot be served through the managed care system? So looking at some of these questions and some of these principles let's look at our two dual eligibles. Let's look at Ellen and also at Maria.

Now Ellen needs frequent adjustments to her wheelchair. Her supplier has worked with her over several years and she actually sees him more frequently than she sees any of her doctors. Her supplier is not part of the new planned network. So it's important that Ellen's relationship not be disrupted until the plan can either convince the supplier to join the network or she transfers over to a new supplier that she's really comfortable working with.

And then there's Maria. Let's look at her while she was still at home. She was struggling with depression, but she found help in a small community-based mental health program. She works with peers who share her same language and culture and it's really helped her immensely, but the community organization is bare bones. It doesn't have a lot of electronic records capability. The MCO really needs to be able to be required to work with Maria's provider to find ways around those technology limits if they are the only barrier to joining the network.

And then let's assume that Maria is joining the MCO after she's been living in a nursing home for several years. Moving would be incredibly disruptive and difficult for Maria, but the nursing home is unwilling to join the MCO network.

This is really an important point. It's imperative that there be protections in place for people like Maria either a single case agreement for as long as she wishes to stay so that the nursing home is not part of the network, but that the MCO will pay the nursing home just for Maria. Or if that won't work that there be an exemption from her for joining the MCO altogether. No beneficiary should be required to move from her home just because she switched to a managed care program. Now I'll turn things over to Silvia. She's going to talk about benefits packages and provider choice.

Silvia Yee:

Thanks, Georgia. I'm just going to take a minute to introduce another case -- another person in our -- as we're looking at individuals. Victor is 60. His legs were amputated after an infection. Well, I'm sorry. Victor's not 60, but his legs were amputated when he was 60 after an infection. Victor then entered a nursing home and his quite low savings and his disability qualified him for Medicaid and Medicare at that time.

Victor always wanted to return to the community and after three years in the nursing home, the Medicaid Money Follows the Person Program helped Victor to find affordable housing, furnishings, and community providers. Right now he lives in a senior living apartment complex. His health overall is pretty good. He really enjoys the freedom to set his own schedule, to make his own meals when he wishes, and also engages in a lot of social interactions with his church community.

Victor receives a few hours of chore and meal assistance each day and he exercises daily to maintain his upper body strength and his capacity to transfer independently.

Now he's 64. He uses a power wheelchair. He takes some heart medication and he's beginning to lose some of his vision. Okay just keep Victor in mind as we move on to a discussion about the tools.

The three specific topics on the tool that I'll be looking at are home and community-based benefits package, provider choice and access, and civil rights. And I think these three topics are very much linked to the overall umbrella of independence in the community.

We are starting from the base assumption that most adults regardless of their age and their functional impairment level would prefer to live as independently as possible in their communities rather than in an institution and Medicaid is a primary source of long-term services and supports for low income persons.

These three topics especially provider choice and access and civil rights are where health care intersects with this desire to be independent in the community. So first I wanted to look briefly at the home and community-based services benefit package - the opportunities and challenges in that.

Just before I begin, I just want to make the point I think it's often been discussed that having rights on paper means very little without a real means of monitoring, getting data, making complaints, appeal of rights, independent assistance and advice (unintelligible) and I think that's absolutely true. But it is also equally true that it is much harder to complain about or appeal a right that has never been acknowledged or is ever put down on paper.

In terms of the benefit package, it's important to get rights in there. To ask questions and get rights in the package that you can actually appeal later and (unintelligible) care organizations have not traditionally worked in the area of long-term services and supports. This is new and this something we as advocates really need to press on.

One of the big opportunities around managed care organizations taking over is that they will have an incentive to re-balance away from an (unintelligible) towards costly and restrictive institutional care toward increasing LTSS and especially home and community-based services. But they won't have that incentive unless they are responsible for the full range of services.

In terms of home and community-based services, if two organizations are taking long-term supports and services there is a real need for their benefit packages to include certain things and these are key questions to ask. Is the benefit package going to provide services in sufficient amount, duration, and scope to achieve the purpose of the service and without such arbitrary limits as wait lists or enrollment caps or geographic limitations?

If services critical home and community-based services are included in a benefits package, it's harder to apply arbitrary limits. So there shouldn't be a wait list or an enrollment cap on the services that are included in a benefit package. Members in a managed care organization should not be subject to arbitrary limits like that.

Does the benefit package cover expenses that arise from the care transitions and changes in functional level that many beneficiaries commonly experience - moving expenses, home modifications, the kinds of things that are needed

when there is a change in one's health status or a temporary stay in a nursing home, etcetera?

Keeping this in mind and going back to Victor. Here's a situation with Victor. So he joins a managed care organization. His state decides that dual eligible beneficiaries will be placed into managed care and he transitions to a managed care organization and that's fine.

Then his power wheelchair requires repair or replacement. The managed care organization contracts with one particular durable medical equipment provider. That provider proposes solutions for the chair that require Victor to forego his chair for a period of weeks and as a replacement offers only a manual wheelchair which severely limits Victor's mobility.

In addition, Victor's senior living complex requires residents to be independently mobile and maintain a certain functional level and his personal assistance hours do not cover chores outside of his apartment. Right now it's (unintelligible) assistance and some other home chores.

So for Victor in this situation, it's important for him to have a Medicaid benefits package from the managed care organization that covers DME and also covers a wide variety of circumstances commonly encountered by people with disabilities who use wheelchairs and other DME. For instance he should be able to have access to a durable medical equipment of equivalent functional capacity.

The manual chair perhaps someone has (unintelligible) it as well. He has upper body strength, he can get himself around in his apartment with a manual wheelchair. That might be true but it's a very, very short sighted assessment. It fails to understand that Victor is independent, that he prefers to do his own

shopping, that he needs to be in the community. It fails to understand his social needs and that's something that needs to be addressed within the benefit package as well.

This also raises issues around a managed care infrastructure that Georgia will address later, but it's important to have people at the managed care organization that understand the implications of this durable medical equipment contractor's decision to offer a replacement that is only a manual wheelchair. So these are all - it's also an example of how these buckets interact. It's difficult to suggest work on the level of one. As advocates we're going to be looking at how individual situations raise many protections at once, many of these topics at once. If we can go on to the next slide.

The issue of provider choice and access and the big challenge here is what has been discussed already. Managed care organizations need to develop and be held accountable for a long-term services and support provider network that can meet the varying needs and preferences of a large and very diverse number of seniors and people with disabilities.

This raises a need for CMS and the states to develop readiness criteria and network standards specifically for LTSS providers. The general ones just won't do and managed care organizations don't have experience with providing LTSS.

Also there's a need for a comprehensive assessment of LTSS needs and capacity at the local and state level to determine such key elements as community health needs, disparities, a network of existing providers, gaps and barriers and the need for transition planning.

Our hope is that -- the ideal for this transition is that it doesn't just -- it's not just about treading water or losing ground, but that it can actually lead to improved services and a real community assessment is necessary for that. Moving on to the next slide.

So some of the key questions that advocates will need to ask and be involved in answering are will the managed care organizations provider network include a sufficient range and variety of LTSS service providers such as center-based adult day health care, personal assistance workers, home health providers, occupational therapy, physical therapists, speech therapists, and skilled nursing facilities. The whole range.

Another question is how can the managed care organization continue to cultivate and further develop important community-based service organizations that already serve particular sub groups of dual eligible beneficiaries? There are many community-based organizations that are already in touch with people who are dually eligible and other low-income seniors and people with disabilities - independent living centers, recovery learning communities, aging services, access points, vision or hearing loss orientation organizations, etcetera.

And this is a really, really critical point. Managed care organizations need to really get in at the ground level to be figuring out who is working in their community, what organizations are out there that are providing services and providing good services often very effective services. As Georgia pointed out, they may not be the ones who have the most sophisticated billing systems or administrative systems in place but they are the ones that are trusted, that know what they're doing and are doing good work. And the managed care organization has to be motivated to get into the trenches and figure out what's working and who's doing the work.



Will the managed care organization honor or implement a beneficiaries right to hire or train, supervise and fire the personal assistance workers of his or her choice even in the event of possible conflicts with qualification standards either existing or new ones? And how can managed care organizations and states be held to an accurately assessed baseline level of beneficiary access to long-term supports and services over time?

Long-term supports and services are being provided in the community. They should be a baseline and there must be a way to measure that so that when and as managed care organizations take over LTSS they at the very least maintain that level. They don't cut back on the hours, they don't put additional limitations on the LTSS available in the community. Going on the next slide.

I'm just going to cover primarily the first one at this point. Do applicable standards and contract language reward managed care organizations for increasing their home and community-based services capacity especially with regard to providers who have language capacities such as American Sign Language or Mandarin, an in-house physical or programmatic accessibility or who work in rural areas? These have traditionally been difficult areas to ensure especially home and community-based services and where managed care organization manage to increase their capacity, they should be rewarded for doing so in these areas. Okay.

I'm just going to run quickly the information on the slide and I wanted to go on to the next slide - the last one about provider choice and access. I think many states do especially those who have a history of working with managed care organizations. Many states do have standards that are applicable to the provider network that managed care organization provider network and

there's an issue for ensuring - how to ensure those general standards remain applicable to the LTSS network as well.

Often these networks have information - have requirements around the choice of available and appropriately experienced providers for every category of service in the benefits package. Time and travel distance standards, the availability and limitations of public transportation options including paratransit and the number of providers who are actively accepting employment or patients. So these are the kinds of general standards that we really need to be applied as well to an LTSS service network.

Really managed care organizations are faced with two challenges. One is building an LTSS network from the ground up or incorporating and helping to build an existing LTSS network.

The second is to ensure that their typical provider network of primary care providers and specialists is equipped and ready and sufficient to handle an influx of people with disabilities and seniors who have chronic conditions.

So turning back to Victor to the scenario that it could be happening with many (or) it could be common for many. Since leaving the nursing home Victor has maintained a strong preference for hiring and training personal assistance workers that are from his own church community.

The state and managed care organization has instituted broad certification and additional training standards related to personal assistance workers and Victor is not particularly interested in those standards for his workers and his current personal assistance worker is not interested in taking those certification standards either. This is someone who Victor knows, an individual who might

not be doing personal assistance work at all except for the fact that he knows and is connected to Victor.

So in that event you have something of a conflict between a general certification standard and Victor's choice over who his personal assistance worker is and that's one scenario.

Another is that Victor is losing more and more of his vision and he's beginning to think that he would like to use at least some aspects of the care coordination services that are offered by his managed care organization. However he doesn't really want to reveal all of his personal medical information to his personal assistance worker who is also a peer in his social circle and at his church. That should be, you know, in our opinion that should be Victor's option. Victor as the employer should be to decide if his personal assistance worker is part of his care coordination team or not.

Going on to the very last topic that I'll be covering on civil rights. People participating in getting health care services should have equally effective services regardless of disability and that is a requirement of the Americans with Disabilities Act. Also the Affordable Care Act itself clearly incorporates existing federal civil rights acts such as Section 504 of the Rehabilitation Act and Title VI. So those apply to health care services that have federal dollars.

Some other groups that we have listed on the slide, we are talking about age, sexual orientation, gender identity, linguistic needs, cultural, racial background. Some of those groups do not actually enjoy current federal protections, but some HHS -- some health and human services proposals or enacted regulations actually have included -- mention those groups. And there is certainly nothing to stop state and managed care organizations from having wide non-discrimination provisions.

The fact of health care reform and the restructuring of programs especially on such a large scale gives advocates a new opportunity to make real on the ground rights that have existed on paper for a long time. For example patients with disabilities and seniors with various functional impairments have a right to be notified of, to request, and to receive reasonable accommodations and policy modifications that are needed to get an equal opportunity to receive effective health care.

The large scale incorporation of managed care into Medicaid service delivery on the one hand can be seen as just another bureaucratic layer, but on the other hand it also provides additional resources and infrastructure for practically figuring out to ensure that people with disabilities really get the accommodations that they need.

And Olmstead is classic. A very important 1999 decision from the Supreme Court that talks about how people with disabilities can't be segregated, can't be made to stay in institutions to receive the health care services that they need. And since managed care organizations are now part of the picture of health care delivery, they also need to be part of finding the solutions that will make Olmstead real. Going on to the next slide.

So here's a question for advocates to ask, does the managed care organization survey its provider network for physical and programmatic accessibility including accessible exam tables and weight scales? Does the survey look at the kinds of policy accommodations that providers know about and provide such as extended appointment times or sign language interpreters or alternative print formats?

Another question is do plan beneficiaries have access to information about the accessibility of provider sites? It's very important for many beneficiaries to know whether they can go to a particular office, whether they will have the equipment that's needed, whether if they request sign language the provider will know what they're talking about, will the managed care organization participate in the state's Olmstead plan, participate in the Olmstead committee if it exists and have its own plan as a managed care organization for delivering health care services and long-term services and supports in the most integrated setting?

On the next slide, I'm just actually going to - I'll just go to the first one. Will the state and the managed care organization commits to an affirmative plan, benchmark goals, and monitoring obligations concerning the delivery of accessible health care for all beneficiaries and effective communication for limited English proficiency individuals including training for the managed care organization employees and all contracting providers?

And the last point concerns the need for gathering data because it's so hard to really track disparities and discrimination and actually remediating these situations without data.

So the last slide is looking at Victor again and just a couple of scenarios. Victor undergoes a relatively minor cardiac event. He is taking heart medication. Maybe that was brought on having to use that manual wheelchair, but anyway leaves him with a weakened left arm that may or may not be permanent. It's unclear. But at this point the weakened left arm impacts on his ability to independently transfer and it also impacts on his desire to continue seeing a primary care provider who is right now around the corner from his home, but who does not have an accessible weight scale. Victor has transferred himself before when seeing that provider.

Secondly, Victor's also experiencing some issues related to increasing blood pressure and a rising risk of Type II diabetes. He would like to educate himself about both of these conditions and what he can do to reduce his risk, but he cannot read standard print health care information due to his vision loss.

So Victor may or may not consider himself a person with a disability and he very likely does not self-identify with the Disability Civil Rights Movement since he gained his primary disability at 60 years of age. These are his clear preferences to be able to read health information for himself and to be able to see a provider that has accessible equipment. But he may not think of these as his rights.

The managed care organization and the state must really do outreach and make people aware of what they can ask for and help people to understand that they can press the first person they talk to about this. The front person at the provider office simply doesn't know what he's talking about. If Victor goes to the plan, if he goes to customer service, if he asks different providers they should know about his right to reasonable accommodations. And it is a matter of civil rights and it is also a matter of effective service and that is the goal of this whole operation. So thank you. That concludes my part of this and I'm going to hand it back to Georgia for the rest of the discussion.

Georgia Burke: Thank you Silvia. I'm going to take us through care transitions and then look a little bit at infrastructure requirements and that'll wrap us up for the day. There's really nothing static about health needs.

An illness or a hospitalization or a fall can all bring significant changes and needs and at these times of transitions someone who was living independently can suddenly need a whole new array of supports and services.

For others who may have had significant needs already and had depended on a carefully constructed collection of supports, they might find that what they had is no longer enough. And there's a real danger at these critical junctures that because of poor planning people will end up in institutions and just get stuck there losing the independence that they've fought so hard to maintain. So it's critical that there be early and effective transition planning to allow people a safe return to community settings after they've been in a hospital or a skilled nursing facility.

So what are the issues? Our assessments after an event like this full and timely ideally early in a hospital stay. What systems are setup to make sure that those assessments really happen? What measurables are tracked to make sure that the plans are meeting their obligations? Are individuals given all of their choices, all their post-discharge options? And are their choices honored or are they just given what seems fast and easy or are they really given every position that might be available to them?

More importantly are there systems in place to ensure that all the needed supports are ready right when the individual needs them so that the individual can safely return to the community as soon as the need for hospitalization or skilled nursing ends?

And what about protections against losing your place in an adult health program for example? Or losing your assisted living apartment because you haven't been able to pay the rent while you are in skilled nursing? Does the

plan have provisions to pay providers so that individuals don't lose the chance to return to the services that they already had during a hospitalization?

And if a change in health status means that a home has to be modified to remain safe or if assisted living is a newly appropriate option for the individual, does the plan have methods to fill in to cover the expenses around the home modification or around the move?

And then finally on the flip side what about people who are stuck in institutions and want to get out like Victor used to be? Can an MCO demonstrate that it has a plan to identify the Victors in their membership and that it has a strategy for giving them an opportunity to move back to community settings?

So let's think about some of these transition rights in the context of Maria. Now she was pretty luck with her fall and only had a few days in the hospital in rehab, but her arm is immobilized and there's a lot more that she can't do for herself at least for awhile. This is back when she was home. She needs more personal care hours and she needs occupational therapy and some home health.

So is a plan setup to get her assessed quickly -- and remember she needs to be assessed in Spanish -- and to get everything in place so that she can quickly and safely return home?

And then there's Ellen. Let's say she ends up in the hospital and skilled nursing for a longer illness for over six weeks. Meanwhile her caregiver doesn't get paid. The caregiver that she's carefully trained and chosen and who is an integral part of her person centered care plan. What provisions are being made by her MCO to ensure that she gets to keep this carefully trained



caregiver. Are there any provisions to pay the caregiver all or some of her wages while Ellen is recovering.

Finally I want to touch on another more kind of global issue. Basically a couple of structural things. We've talked about all of the protections that we think are really critical to long-term supports and services. What underlying structures are needed so that these protections really happen?

First and it may seem obvious and we've touched on it already, but MCOs really need to have long-term support and service expertise embedded in their organizations and in a way that gives LTSS (concerns) equal weight with medical issues. We need the expertise at the operational level, the people who are making care decisions, people who are reviewing exceptions and appeals. And you also need it at the very senior level in management, the people who are really guiding how the entire MCO is structured.

For most MCOs we can't expect that this expertise already is there. For the most part their history has been managing medical services and it's been managing those services to populations where seniors and persons with disability have mostly been carved out. They've been dealing with general Medicare populations or with children and their parents and (Medicaid).

Because MCOs generally are coming from this medical model, it's incredibly important that consumers and their families and advocates get actively involved in shaping these models. The hard fought games of the independent living movement and the benefits of the recovery model in mental health just to name a few, they're not always an easy fit with managed care. But they need to be there if these programs are really going to work for consumers.

So stakeholder involvement particularly by LTSS users themselves and by their family needs to be continuing and it needs to be built into the system. Not just at the planning stage, not just in initial work groups but also long-term in plan governance and in ongoing advisory committees.

Applying this to Ellen and Maria, let's look at Ellen for example. She's someone for whom independent living constants are critical and she needs a managed care organization that understands that. But more importantly for her, she's really a good example of someone who could bring real world experience to a plan advisory committee. She could do a lot more than any outside consultant in terms of helping the plan to understand the needs of its members.

And then let's look at Maria. When she was home, she didn't have huge medical issues but her life would have gone downhill fast if she hadn't got personal care services, if she hadn't been given opportunities to socialize, get counseling, get out of her house and deal with her depression. And MCO if it had a heavily medical bias would not have been able to provide the person centered assistance that she needed.

And the last structural issue I wanted to address is really something outside of the plan, but we think is absolutely critical in any state that's putting LTSS under managed care and that's an ombudsman office. An independent conflict free trusted office preferably housed in a community-based organization with extensive experience in LTSS.

So what would be the role of the ombudsman and what kinds of qualifications would you be looking for? You'd want an ombudsman that had authority to help consumers to navigate the system, to help with appeals, to troubleshoot, to identify systemic problems. Can we have the next slide.

An ombudsman might also be tasked with providing assistance with enrollment, but it wouldn't necessarily have to go that way if there were other organizations who were tasked with that and sufficiently funded. To work well and ombudsman needs channel setup to state, to decision makers in the state regulatory authorities and also to senior people within the plans.

Wisconsin is a good example of a state that has functioning ombuds program. The contractor for its disability rights in Wisconsin, they have regular meetings with the state, they have high level people in the plans that they can all. And the result is that many issues that are brought to the attention of the ombudsman get addressed quickly and often there isn't a need to go many layers through the exceptions and appeals process because it's easy to get resolution informally.

Ombudspersons in Wisconsin also have been very good at being able to spot systemic problems. They also write reports on the functioning of the MCO. These are public reports that help both the state and consumers to be looking at quality issues.

And of course for any (unintelligible) program to work it needs to be funded and it needs to be adequately funded. One of the things we've seen on the dual demonstration projects is proposals from the state is some of the states are saying well we think an ombuds program would be a good idea, but we want to make it dependent only on whether the federal government gives us the funding to do it. We think that it's a critical element and that it should be funded and there should be a commitment to fund it whether or not there's federal money involved.

So let's look at Ellen and Maria. Ellen's in a situation now where her upper body strength has decreased. She needs a different wheelchair, but her current wheelchair is only two years old and her plan says that's too soon to get a replacement. But she rightly is concerned that her situation has changed and she needs a different one so she wants to appeal, but she really doesn't know how to do it. So this is a case where an ombuds could really help her put together her case and let her know what kind of information she needs to collect.

And then there's Maria. Let's say that when she broke her shoulder she was stuck in the hospital because the plan had an (unintelligible) and she can't really go home until the additional help she needs gets lined up. So she really needs some troubleshooting and this is really a, you know, short-term high need thing where it needs to be dealt with right away. So she turns to the ombudsman office. And it turns out that the ombuds have seen five or six complaints about the same problem in the next few weeks.

So something's broken down and the ombuds reports this to the state and to the plan and the state steps in and requires the plan to modify the procedures so that timely assessments get back on track. These are the kinds of things that an ombuds program could be helpful with.

So we covered a lot of ground here and that's pretty much the end of our presentation. Our contact information is here and I'm going to turn things over to Marisa to finish up and deal with some questions. Thanks everyone.

Marisa Scala-Foley: Well thank you so much, Georgia, Mary Lou, and Silvia for your presentations. I think you've given us all a lot to think about in terms of engaging in the process and the kinds of questions people need to be asking as

they review proposals and as their states go through their implementation and processes.

So we've had several questions through chat and we'll get to them in a couple of minutes, but as we always do with these webinars we conclude with a list of resources that can be helpful to you as you embark on this process or continue in this process for many of you within your state.

So we have several slides that deal with resources related to managed long-term services and supports. I'm just going to highlight a few of them. First is the toolkit upon which this webinar was based and you've got the link for that and the toolkit is on long-term services and supports, beneficiary protections in a managed care environment.

And Georgia, Mary Lou, and Silver were only able to really touch these topics. There's a lot more detail within the toolkit so we very much encourage you to visit and take a closer look at the additional questions that are there.

There are also as I mentioned before - there were 26 states that have made proposal to the CMS Medicare/Medicaid Coordination Office with regard to integrating care for people who are duly eligible for Medicare and Medicaid. We've got links of this slide to the places where these proposals are posted and you can check to see (1) whether or not your state did submit a proposal and (2) if it is still open, if it is still in its federal public comment period.

We've got resources similarly where you can post comments on if your state has submitted an 1115 demonstration waiver on this slide. And again this is probably great point as I'm sure people are trying to write down resources. We will post these slides on our Web site next week. However if you like the slides sooner, you can certainly email at [affordcareact@aoa.hhs.gov](mailto:affordcareact@aoa.hhs.gov). Again

that's [affordablecareact@aoa.hhs.gov](mailto:affordablecareact@aoa.hhs.gov) so people aren't trying to frantically write down long URLs and all of this.

Just a few general resources related to the Affordable Care Act. You'll see first on this list is where we store our webinar recordings, transcripts, and slides. We've been doing the series now for 1-1/2 sol we've got lots other for you to take advantage of and we highly encourage you to visit the site and take a look at those.

Our next training we hope to continue our work with our partners at DREDF and NSCLC and take a continual look at stakeholder engagement and consumer protections. We're still working on a date for July so please do watch your email early next month for registration information. So with that I think Angela if you could give people instructions as to how they can queue up to ask questions through the audio line and then while we wait for people to queue up, we'll take some of the questions that have come in through chat in the sort of 10 minutes that we have left.

Coordinator: Okay. Thank you. And at this time if anyone would like to ask a question, please star 1 on your phone. Unmute your phone and record your name clearly when prompted. Again for any questions, please press star 1. And it'll take just a moment for customers to come through.

Marisa Scala-Foley: Okay. So while we're waiting for questions to come through on the audio line let's try to take some of the ones that have come in through chat. First is a question from Amy who, you know, asked on what you've said in the presentation asks, you know, suggests that managed care organizations could and should contract with community-based organizations for some of the services that they are providing. How can they go about advocating for that?

Mary Lou Breslin: Well this is Mary Lou. I can jump in and offer an example. We're working with a managed care organization in our area called Alameda Alliance and they have - this is not to say they're going to get this right, but they have proactively reached out to the community to bring in representatives from organizations that are providing very significant services to very broad populations who might be involved in LTSS and managed care and are conducting a scan of the organizations that are providing those kinds of services. So between the scan and the regular meetings of representatives from those organizations that plan is looking to develop a mechanism for contracting with the organizations that provide services that would be part of the LTSS package so.

And I mean I think our recommendation is that unfortunately you really have to get into this at the plan level with the plans that are going to be taking over the LTSS functions and really advocate very persuasively that they must bring the community organizations together to talk about what services are available and to find ways to develop contracts and interactions with those organizations.

Marisa Scala-Foley: And again that's a really great reminder Mary Lou of what this was all about and that is really to encourage people and strongly encourage people to get involved now not only in the proposal phase, but also during the implementation and contracting phase with your state as well as with the managed care organizations with which your state may be contracting. So it's really an important opportunity to make sure that those kinds of things happen. So Angela have we gotten any questions through the audio line?

Coordinator: I do. I have a question from Susan. Go ahead, your line is open.

Susan: Hi. I have just a little bit more of a comment than a question and thank you for highlighting some key and very important areas of focus for people to consider when managed care is moving into LTSS. I just wanted to briefly share a little different perspective based on my experience working for a managed care organization in Minnesota.

The MCOs, I'll just refer them to as MCOs -- managed care organizations -- have been responsible for managing the LTSS care for dual eligibles 65 plus for about two decades now. And I certainly understand the concern of managed care being medically focused, but there are some additional benefits that can come out of a health plan structure.

For instance our program offers a lot of preventative programs: tobacco cessation, health coaching, a free gym membership, and specialized fitness classes geared towards seniors that aren't covered in the Fee for Service Program. Our care coordinators are nurses and social workers and they work in a multi-disciplinary team work so medical and psychosocial needs are both addressed.

I really think that the medical community is catching on to the fact that you can't only address the medical side of a person's needs and that the likelihood of improving a medical condition really relies on psychosocial needs first being met.

In Minnesota most managed care organizations contract with community-based agencies and they contract with the county, social services, and public health departments to do care coordination in addition to care systems. So there's not a lot of lack of LTSS expertise. I know that's not the case in every state, but I think we need to consider that there are states that do have this



experience and states that don't have it are oftentimes consulting with the states who have been doing it like Minnesota.

So lastly I want to reinforce a comment one speaker made which was that it's important to keep in mind that managed care organizations managing LTSS for dual eligibles are required to comply with state and federal requirements. Medicare's network adequacy requirements are extensive and the state has additional requirements that provide many safeguards.

I understand the trepidation many people have about managed care and the best advice I can give to anyone moving in that direction is to work with your state to be part of the feedback process and make sure that there protections in the contracts such as requiring person centered assessments and care or requiring multi-disciplinary teams. At the end of the day we all have the same goal of helping maintain their dependence while achieving the highest quality of life possible. Thanks for the opportunity to comment.

Marisa Scala-Foley: Great. Thank you for that. It is important to remember that there are states that have gone before who have some experience in this area in which there may be some models to look to in terms of how things can be done and pitfalls to avoid. So thank you for that reminder. Angela, any - actually let's take another question from chat before we move back to the audio line in the 5 minutes that we have left.

And that's a question we got from Alice who Georgia was asking about ombudsman. You mentioned sort of having adequate levels of funding and she wonders if there's sort of a - what might constitute an adequate level of funding? Is there sort of a rule of thumb based on the number of members in a particular program? And it's fine to say if you want to answer that offline.

Georgia Burke: Yes. I'm not sure that there is. It really would depend a lot on how things we setup in the state. I think - actually the Wisconsin model. You can look at that. They're contract is actually available online and I think they have one full-time attorney and then some additional individuals who are non-attorney staff who work on the issue. But Wisconsin, you know, is a smaller program in a smaller state so obviously it would really depend on staff. But I don't think - the short answer is I don't think there really is a rule of thumb right now.

Marisa Scala-Foley: Okay, thank you. Angela do we have any more questions from the audio line?

Coordinator: I haven't had any questions show up on the phones, but again star 1 if you'd like to ask a question.

Silvia Yee: Could I raise one -- this is Silvia and I thought -- I just wanted to raise one additional point about opportunities for advocacy. Mary Lou raised the advocacy at the plan level and of course there is the chance to try to effect that three-way contract between CMS, and the state, and the plan. I think also for those states and there are some that require the move to managed care to be legislated in some way. This is an opportunity to try to influence the legislation and I think the legislation is always going to be bending to what CMS actually approves.

But to the extent that the legislation will actually have some kind of consumer protection that goes above the project I think that the state would be held to it and bringing a real live story to your state legislature about how important the community-based organization is or how important it is to understand the needs of beneficiaries - psycho social needs, it is potentially getting a companion in your legislature on your side.

Marisa Scala-Foley: Okay. Angela did we get anymore questions through the audio line?

Coordinator: I do not have any questions on the phone at this time.

Marisa Scala-Foley: All right. Well as luck would have it or that's perfect timing because we are just about out of time for today. Again I want to thank our presents today: Mary Lou Breslin and Silvia Yee with the Disability Rights Education and Defense Fund and Georgia Burke with the National Senior Citizens Law Center. Thank you so much for a terrific presentation. And thanks to all of you who have been on the phone and on the web for your terrific questions and for your participation today.

We hope to - if you think of any additional questions or if you have any suggestions for future webinar topics particularly related to managed long-term services and supports we do want to hear from you. So definitely email us at [affordablecareact@aoa.hhs.gov](mailto:affordablecareact@aoa.hhs.gov). We do want these webinars to be as useful to you as possible so we welcome your suggestions. Thanks so much for joining us today. We look forward to having you with us on future webinars. So with that, I think we're concluded for today.

Coordinator: And that does conclude today's conference. Thank you for participating. You may disconnect at this time.

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