Administration for Community Living

Affordable Care Act Training

Managed Long-Term Services and Supports 101

May 29, 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. During the question-and-answer session, please press star 1 on your touch-tone phone.

Today's conference is being recorded. If you have any objections, you may disconnect at this time. Now I would like to turn the conference 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.

I work in the Office of Policy Analysis and Development at the Administration for Community Living, a new agency under the U.S. Department of Health and Human Services which brings together the Administration on Aging, the Administration for Intellectual and Developmental Disabilities and the Office on Disability.

We thank you for joining us for this month's Webinar which is our latest in a series of Webinars 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 series is designed to provide you with the tools that you need to participate in ACA-related efforts in your area such as accountable care organizations, the community-based care transition program, state integration programs for people who are dual-eligibles, health homes and more.

So the past two years have seen a rapid expansion of interest in capitation and other managed models when it comes to Medicare and long-term services and support so today we begin what will be a multi-Webinar series looking at managed long-term services and support.

Today we're going to sort of take the 30,000-foot view and present a broad overview of managed long-term services and support including looking at where we are now with regard to managed long-term services and supports and where we are headed, why all of this change is happening now, the vehicles for the changes that are occurring in states, opportunities and challenges for home and community-based services within managed long-term services and supports programs and how you can get engaged in the process in your state.

Co-presenting with me today is my colleague from the Administration for Community Living Shawn Terrell. Before we begin though, we have a few housekeeping announcements.

First of all if you have not yet done so, please do use the link included in your e-mail 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 when you have them through chat.

If you don't have access to the link that we e-mailed you, you can also go to www.webex.com and click on the attend-a-meeting button at the top of the page, then you'll enter our meeting number which is 661740484. Again that's 661740484 for our meeting number and the passcode is aoawebinar and that's all one word.

If you have problems getting into WebEx, we invite you to call WebEx technical support at 1-866-569-3239. Again that Web number for WebEx technical support is 1-866-569-3239.

As (Ashley) mentioned, all participants 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 that I mentioned earlier.

You can enter your questions. We will sort through them and answer them as best we can when we take breaks for questions and in addition after we wrap up, we'll offer you a chance to ask your questions through the audio line. When that time comes, (Ashley) will give you instructions as to how to queue-up to ask your 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 e-mail them to us at affordablecareact@aoa.hhs.gov. Again that's affordablecareact@aoa.hhs.gov.

As (Ashley) also mentioned, we are recording this Webinar. We will post the recording, slides and transcript of this Webinar on our Website as soon as possible, hopefully by late next week.

If you would like to get a copy of the slides sooner than that, please do e-mail us at the e-mail address I just mentioned, affordablecareact@aoa.hhs.gov so with that, why don't we go ahead and get started today?

So first we really wanted to start this Webinar really at the very beginning in talking about what is managed care so when we're talking about managed care, we're talking about a way of not only paying for but also delivering healthcare and/or long-term services and support which we may refer to you as LTSS going forward throughout the Webinar.

And when we talk about long-term services and supports during the course of this Webinar, we're really talking about both institutional long-term care in nursing facilities and the like as well as home and community-based services so we're talking about both when we use the term long-term services and supports.

` So within managed care generally a payer gives a managed-care organization also called an MCO a set or capitated monthly payment per enrolled member which the managed-care organization then uses to provide services and supports to its members.

These managed-care organizations generally provided an array of services to its members through an established network of contracted providers. Some of you may be familiar with these through managed care or options that may be offered by your employer or through work that you're doing right now.

And in general when we're talking about this, you know, certainly costs are lower to a consumer when they stay within network in terms of providers but they can depending on the model of managed care can use providers outside of the network but generally they will come at a higher cost to the member.

Managed-care organizations assume and manage some or all of the financial risk for their members so whether or not someone needs more services than, you know, is covered by sort of the set monthly payment that they get per member or less, they're generally still getting the same rate.

So they're assuming some of that financial risk for their members and as such they have a financial incentive to keep members healthy and to coordinate their members' care. Okay so when we're talking about Medicaid-managed care, it's general taken three forms.

The first firm is generally a comprehensive risk-based capitation. Under this form of Medicaid-managed care, a state Medicaid agency pays just like we talked about before a per-member per-month rate or premium to a managed-care organization to provide a comprehensive set of services for its members.

There's also non-comprehensive managed care in some state Medicaid programs and under that a state Medicaid agency pays a managed-care organization to provide only certain types of services.

For example they may provide only behavioral health services so again that's non-comprehensive and then the final form that Medicaid-managed care has taken is something called primary care case management.

Under this, state Medicaid agencies pay certain primary-care providers a monthly fee in order to provide care management or care coordination for

their members. Okay, so that's a little bit about managed care in general both sort of generally and under Medicaid. Now let's talk a little bit about managed long-term services and supports.

So under this, a payer and again typically when we're talking about managed long-term services and supports and we're going to sort of get to the context of all of this, you know, where we are now and where we're going in a few slides but we're generally talking about - these programs are typically happening - under state Medicaid programs.

So when we talk about the payer, we're typically talking about the state Medicaid agency, contracts with a managed-care organization to coordinate and provide long-term services and supports.

This may include both home and community-based services and institutional care. In some programs, institutional care has been carved out which means it's not necessarily part of the program but often it includes both and certainly what we're seeing going forward in a lot of the models that states are proposing both of these types of long-term services and supports are included.

And these managed long-term services and supports programs may serve different populations. They may serve older adults. They may serve people with physical disabilities and/or people with developmental or intellectual disabilities or behavioral health needs.

They may serve only one of those populations. They may serve multiple populations. It really varies, you know, depending on the state's program. All right, so now let me turn things over to Shawn to talk a little bit about what are the vehicles that are being used for some of these program changes that are leading to managed long-term services and supports.

Shawn Terrell: Okay, thanks. I'll be brief so there's a couple of different ways that this can happen now. Traditionally I'll start with the second bullet, it's a lot of them were done in 1915B authority which is the actual specific managed-care authority under the Social Security Act.

And what they did was so in 1915B is the managed-care authority and then 1915C are all of the waivers that exist in states although I'm sure you've heard of the (home opportunity) based waiver program.

That's the 1915C of the Social Security Act so states combine those. They combine the ability to do managed care as Marisa described and also to have this in a - to combine them - with all the HCBS services.

And then the other maybe a little more recent and certainly has increased and this is where most of it's happening or most of the newer applications now are coming in through the Section 1115 of the Social Security Act and we'll talk about this a little bit more in a few slides into it but it's a much more general and broad ability to waive things.

It's supposed to be really a demonstration authority to sort of test a new model of care so a lot of the states that are coming in are integrating medical care and HCBS into one big package whereas the sort of previous efforts have been mostly focused just on the HCBS services.

So those are the - that's sort of a new thing - so it's happening more under 1115 and that we'll talk again about how there's a lot of flexibility there and that can go in a lot of different directions.

The Affordable Care Act - the third bullet on this slide - is sort of integrating financial alignment demonstrations for people who are dually eligible which means they're eligible for both Medicare and Medicaid which is a surprising - it's not a huge number of people - but there's, you know, significant numbers there and tend to be fairly high cost.

And because of the way that the two programs are structured Medicare and Medicaid, it requires some real effort to integrate both the financing and the supports and services that people might need to stay living in the community.

So this is a real big effort and we're going to talk a little bit more about that as well but those are the three basic mechanisms for delivery of managed care within Medicare and Medicaid.

Marisa Scala-Foley: Okay, great, thank you Shawn so let's talk a little bit about context for all of this so first we're going to start by talking about where are we now? Generally our managed long-term services and supports experience is relatively limited as is our evidence base for these types of services so let's talk a little bit about what's happening right now.

There are 29 states operating what are called PACE programs, Programs for All-Inclusive Care for the Elderly but even despite this being in a majority of - these programs being in the majority - of states, they only serve - they've had relatively limited - enrollment, only about 200,000 people served nationwide.

When we're talking about PACE, it's been around since the 1970s. It serves individuals who are aged 55 or older who are certified by their state to need nursing home care but who are able to live safely in the community at the time when they enroll and who also live in a PACE service area. PACE providers are generally certified under both Medicare and Medicaid.

And they offer the continuum of care and services to seniors who have chronic care needs while trying to maintain their independence in their homes for as long as possible so they offer things like adult daycare, medical care, home health care, prescription drugs, social services, respite care and hospital and nursing home care when necessary so that's a little bit about PACE.

In terms of managed long-term services and supports programs within state Medicaid programs, based on an environmental scan that was done by Thompson Reuters for CMS' disabled and elderly health programs group.

We know that as of May 2012 there were 16 states that offered managed long-term services and supports programs. There were a total of 19 programs so three states - Minnesota, New York and Wisconsin - offer two programs.

Seven of these programs are statewide and we've got the states listed here for those programs so all 16 of those states - all 16 states - target seniors. Eleven of them target people with disabilities including eight of those serve people with developmental or intellectual disabilities and eight of those programs serve kids.

The enrollment in these programs range from a low of 200 people in Pennsylvania to a high of 400,000 in Texas. The number of managed-care contractors that are included as part of these programs varies from a low of one in Washington or Pennsylvania to a high of 18 in Michigan's mental health and developmental disabilities program.

The most recently added program was Delaware which started their managed long-term services and supports programs this year basically on January 1st of

2012. Ten of the programs that are offered by states have voluntary enrollment and nine have mandatory enrollment.

Finally 10 of these programs offer self-direction or participant direction to their members or to the program enrollees and this tends to reflect what a state generally offers in its Medicaid fee-for-service program so the state has offered participant direction before in its Medicaid fee-for-service program, then it will tend to offer it in its managed long-term services and supports program.

It's also important to note that this represents a relatively low - these programs - represent a relatively low percentage of total Medicaid long-term services and supports expenditures and again this is Fiscal 2009 data so it's a little bit old but it represented about 5% of Medicaid LTSS expenditures in Fiscal Year 2009.

Also important to note is that nine of these plans, you know, when we talk about things moving quickly when it comes to managed long-term services and supports in the states, nine of these states plan to expand their programs to new areas of the state or new populations in the coming months and years.

So that's a really brief snapshot about where we are right now when it comes to managed long-term services and supports so now let's talk a little bit about where things are headed.

As I mentioned earlier when we did the introduction to this Webinar, interest in managed long-term services and supports is growing rapidly. We've sort of seen it in some literature referred to as sort of a state stampede towards managed long-term services and supports and in a couple of slides we'll talk a little bit about why this is all happening right now.

But there are many other states in addition to the ones that we talked about them on the last slide that have indicated interest in implementing managed long-term services and supports as early as this year and certainly growing as the years go by.

Most importantly in terms of, you know, an example, the duals financial alignment initiative that Shawn will get into talking a little bit more about in a couple of slides. Twenty-six states have posted draft proposals for public comment and these proposals seek to integrate services and supports for people who are dually-enrolled in both in Medicare and in Medicaid.

And 26 states have posted draft proposals for public comment and 11 of those states have submitted official proposals to CMS and we've got the list of those states that have at least as of the end of last week have sent their official proposals into CMS and are now in the federal public comment period and we'll talk more about that sort of stakeholder engagement piece of things toward the end of this Webinar.

But in terms of where we're headed, you know, this is very much where things are headed in most states is toward managed long-term services and supports and I was recently at a briefing where someone from CMS quoted a Medicaid director from a large state who said, you know, within two years we do not expect to have a significant fee-for-service presence in our Medicaid program.

So really this is where things are going which is part of the reason why we're doing this Webinar series right now and starting things off today with this 101 so with that I will turn things over to Shawn again to get into a little bit more

detail about the Medicaid integration as well as the dual-eligible integration and then we'll take a little break for any questions.

Shawn Terrell: Thanks, Marisa. Okay, so again as I mentioned earlier most states are using the 1115 authority, allows a great deal of flexibility and we all I'm sure know that flexibility can sort of cut both ways.

It could be from the perspective of community-based services - home community-based services - it could mean cutting or increasing HCBS depending on all kinds of factors, you know, including political issues and input processes which stakeholder input processes are a big deal now which is, you know, positive.

All that requires, you know, significant input and effective input and also the ability for people to be able to do that. Of course budget considerations are always a factor so we can move on to the next slide, Marisa.

So the Medicare and Medicaid Coordination Office - that's the MMCO acronym - so that has a - this is for dual-eligible - for people as I mentioned, people who are eligible for both Medicare and Medicaid has very broad authority to work with states to create these integrated programs and the flexibility is similar to what exists in 1115.

There are however and this is something to really pay attention to, if one of your states is doing this and we'll talk about how to find out if your state is involved in one of these dual-eligible integration models, states require - the ACA requires - strong stakeholder input processes.

And that both happens at the state level and then CMS also posts proposals as part of their stakeholder input process so as a stakeholder in your state you'll

have an opportunity to have input twice and ongoing ideally with the state so we'll talk a little bit more about that in a few minutes as well. Go to the next slide, please.

Marisa Scala-Foley: Okay, we've gotten just one question so far.

Shawn Terrell: Okay, yes.

Marisa Scala-Foley: Before we move onto that and we really just have one to answer right now and that question came from (Eric) who asked the question that I have a feeling a lot of people have.

I rattled off a lot of statistics about sort of the 16 states that are offering managed long-term services and supports programs right now and (Eric) asked if that Thompson Reuters data or that report, if that information is available online and the answer to that question is no.

It's forthcoming. It was recently presented at a National Health Policy Forum briefing. You can find the slides on the National Health Policy Forum site which shows some maps and some additional information that was included in that presentation.

But we expect it to be released soon and certainly, you know, if you e-mail us offline once that information does become publicly available, we are happy to send that to you so with that, I think that is all the questions we have right now so Shawn we did get a request that if you could speak up a little bit louder that would be great but I'll turn things back over to you.

Shawn Terrell: Okay, thanks, will do. Hopefully you can hear me a little better now so the next slide here is why now? Why do states want to do this and there's a lot of

reasons and of course a lot of it significantly has to do with sort of controlling costs. There's huge budget deficits. There's growth in Medicaid spending.

There's a sense of being unsustainable in terms of the spending where 6% of the people receiving Medicaid long-term services and supports within the Medicaid population account for almost half of the total Medicaid spending.

So there's a real incentive to try to, you know, create efficiencies and coordinate care as well as possible to try to sort of rein-in some of that growth so there's a lot of incentives for states to develop new service and delivery models.

Of course we mentioned the Medicare/Medicaid coordination office financial alignment models. There's medical home, health homes models out there that are now available for states to take advantage of which integrates all of the medical, you know, acute care and primary care services and HCBS home community-based services into a team-based approach.

And then of course in 2014 there's a Medicare expansion which means that everybody under 138% if you add-in there's a little extra amount above 133% but 138% of the federal poverty level would be eligible for Medicaid which is a large number of people who currently are uninsured and make-up a large percentage of the uninsured in this country.

So that's a big deal and so this is a huge effort now. I think well how can we do all this in a way that's coordinated, efficient and gives everybody the best shot at having the right kinds of services and supports.

And of course, you know, there's current system issues we know, the fee-for-services FFS incentives are obviously the incentive is to maximize from a

provider perspective maximize, you know, expensive or any service really. You get paid for the more you do, the more you get paid.

There's institutional bias. We are all aware of that, you know, in Medicaid you have a, you know, you're eligible for an institution but not necessarily for all the community-based services so that's an issue and of course, you know, the idea here is if you put all the services into one big package including all the institutional services that you, you know, you sort of change some of the incentives.

If a managed-care organization is at risk for all of the services, institutional services being the most expensive, the incentive then changes to try to keep people health and safe in the community. There's also inflexible service packages in many situations and the oversight incentive isn't as strong either.

If you're at risk for all the service and supports and all the money, you almost have to pay attention to how well things are - how well you're doing - and where the money's going and is it being spent efficiently so those are some current system issues as well if you can change the slide.

So potential benefits mentioned a few but there are several. There's, you know, you could have more care coordination could be the result of all of this. You know, you might have a real strong integration - improved integration - between acute care and primary care and long-term services and supports that just doesn't exist right now.

You could possibly have more flexible benefit packages. You can have a lot of self direction could be very quickly developed for instance if people are interested in that. Flexible benefit packages might also include support in employment services for people across the board.

You could include a variety of community support interventions, could include peer supports for mental health, you know, share decision making for mental health, etcetera so all that is possible in this. There's this potential for accelerated rebalancing through global budgets.

If you again put all the money into one pot, both the institutional money say the nursing home money and all the home community-based services, it creates essentially a global budgeting situation for people which then again aligns incentives to increase the services that are based in the community not just because they're less expensive but also because they're more effective.

You improve community alignment through all the coordination. You can improve quality management as we talked about a minute ago. So that said, I think it's worth pointing out that there are significant challenges in this process. First of all there hasn't been a lot of experience.

For those of you in the states that - the 16 states - that have experience with long-term services and supports to some degree, you know, have a lot of experience with say the BC combos with HCBS, with home community-based services and managed care.

But this is a new world where we're now entering and putting all the services and supports, all the medical and acute and the primary-care services into the same pot along with the institutional services and that hasn't been done very much and there's not a lot of data on it so this is partly an experiment.

Many states are moving very quickly in this, you know, already many states are a couple of rounds into their proposal development so and developing contract terms.

Part of the reason for this Webinar I think is to impress upon people who may not be aware of all this that, you know, now if your state is involved in this to get engaged as early and often if you have an interest in how this goes so this is really important that people are really business and they're moving fast.

Another challenge is, you know, just transitioning beneficiaries from fee-for-service to capitated systems, that process of financial, you know, information systems, you know, kind of changes that have to happen are pretty massive.

Network adequacy is a big deal. How do you know that the services now that are going to be in the network are adequate to really meet the needs of everybody?

A lot of the large managed-care organizations that are likely to apply for these through the contracting process don't have a lot of experience working with people with disabilities and aren't really aware of the whole range of services that exist or that are necessary for community living.

And so there really is a strong need to really help everybody engaged in this process to understand what this is about from a home and community-based services perspective. Again what happens to existing community-based organizations and networks?

What if I've been, you know, you have really great services and there isn't a lot of, you know, they've never worked with a managed-care organization before so they don't have the ability to bill say in 15-minute increments or whatever the requirements are?

Does that mean they shouldn't be in the network or how can they sort of ramp-up and be effective on that end and still provide the good services that they've been providing in the community for so long?

And also the other key thing about that is that, you know, it's not just providing the good services. It's being embedded and integrated into a community-based network that just takes years and years of developing relationships with all the players and you just can't replace that overnight.

Another big issue, remedicalization of disability, you know, disability over the years has spent many, many years trying to, you know, remove itself from a medicalized approach to their services and supports. HCBS has really been - that's what that's been about - to a large degree.

If you have a managed-care company that's run from a medical perspective which most of the large ones are, let's face it and be honest about that that there's a likelihood that not understanding what HCBS is, they're going to look at through the medical lens which and that can create a lot of challenges for the legitimacy of some of the HCBS services that have been around for a long time and have a good track record.

So with that you, you know, remedicalization perhaps you also lose the folks on independence and community living and recovery and mental health so that's some of the challenges. I think there's more in those slides, go ahead Marisa. Okay, so meeting people's needs, person-centered planning, that's really a very much an HCBS concept, real person-centered planning.

There's patient centeredness written into the ACA. There's not a lot of clarity on that that means. There's a real strong understanding of what good person-centered planning and implementation of those plans really means in the

HCBS world and so that's a whole new learning thing that has to be developed among managed-care organizations.

Service authorizations, are they made by people who understand the services that they're authorizing? Do they have experience delivering the services, working with the population that needs those services? Again, a whole new world for a lot of people, for a lot of managed-care organizations that have not been involved in this.

All of this could add up to, you know, compounding existing issues like lack of affordable housing, just not even being on the list of ideas that oh, you know, housing's important. We need to talk to the local housing authorities.

We talked a minute - I think the features - we've talked a lot about that. Quality and oversight, you know, really paying attention to what's quality in HCBS? What does it really mean to live in a community, to have a community-based life and to have a life that's meaningful and purposeful for individuals? How do you measure that from a quality perspective?

What's quality of life for instance in all of this? These are all legitimate important questions that have to be brought to the table and dealt with early and last and absolutely not least because this is what's going to make I think a lot of this - the important HCBS stuff - persist through these plans and grow through these plans as meaningful consumer engagement and participation.

And we, you know, this happens all the time. People who work and, you know, we are all salaried, you know, and we have our paycheck and we go to meetings and we invite consumers to participate and a lot of times, you know, they have to take time off of their work and don't get paid to come to the meetings that we're all getting paid on.

So there's issues like that that are just important to think through like who are you inviting and what do they need to get their accessibility issues generally but also paying some stipends to make sure that they are and for a lot of people with disabilities particularly, you know, having a job at all is a big deal and often it's not a high-paying job.

So you really have to support that and want that kind of input as an entity and let's say a Medicaid agency wants to get some input on this. Thanks, that was a long slide, continue. Okay, is that me, Marisa?

Marisa Scala-Foley: No, I was just getting myself off mute.

Shawn Terrell: Okay, good. Thank you.

Marisa Scala-Foley: Okay, so we've talked a lot about stakeholder engagement or we've referred to it anyway throughout the course of this Webinar and part of the reason is as Shawn mentioned why we're doing this Webinar series is that we think there are very important opportunities for you all to have your voices heard in this process.

So we wanted to talk a little bit about how two of the main vehicles are dealing with stakeholder engagement as well as the ongoing engagement that we think will happen, you know, throughout the implementation process so first let's talk a little bit about the dual financial alignment initiative that we described earlier.

As Shawn mentioned, the Affordable Care Act required what's called ongoing and meaningful stakeholder engagement which could take throughout proposal and development and that stakeholder engagement could take the

form of meetings, work groups, focus groups as well as, you know, certainly Web postings of the proposals and so forth.

This ongoing engagement includes a 30-day stakeholder state-level public comment period so once a state completes or completed at this point its draft proposal, they were required to post it on their state Website for 30 days prior to submission to CMS.

In addition after submitting their proposal to CMS, there's an additional 30-day comment period after that point so it's posted on and we've included the Website on which the proposals that have been submitted to CMS where they are housed sort of for that public comment period, that additional 30-day public comment period.

In addition the initiative requires that stakeholder engagement continue throughout the course of the demonstration and when we're talking here about stakeholders we're talking about beneficiaries and their families, beneficiary advocates, consumer organizations, providers, plans and more so and again this process is going to very much vary by state.

Some states have had extremely as they've developed their financial alignment proposals have had extremely robust stakeholder engagement processes, lots of meetings, lots of opportunities for the public to submit its comments and to provide input and feedback.

Others have had a less robust process let's put it that way and, you know, certainly CMS wants to know about areas - about wants to know - you know, what the experience has been in your state with regard to that.

When it comes to 1115 waivers, there are new requirements as mandated by the Affordable Care Act Section 1020I that are related to providing opportunities for feedback into the review and approval process for state 1115 demonstration applications.

This went into effect very recently, just a little over a month ago and the requirements are very similar to what we saw under what I just described under the duals alignment initiative.

It includes standardized application elements which CMS will be putting out. It also includes again a state-level public input prior to submission to CMS as well as federal-level public input in a comment period on that front.

We've to links to places where you can find your state's applications that they have submitted as well as links to places where you can submit public comments on proposals that may have been submitted by your state included in their resources section and we'll get to that in a couple of minutes.

Okay, so ongoing engagement in the process, you know, as these demonstrations move forward, certainly the duals alignment initiative requires that there are continued opportunities for the public to provide input and feedback whether it's throughout the contracting process and through the implementation process.

You know, some of the state proposals that we've seen have proposed consumer advisory councils, regional councils in a state, you know, certainly one of the - looking at some of these proposals - this is very much meant to be an ongoing process that would take into account consumers' experiences with plans and so forth going forward so we think that there are going to be - there have been - opportunities to provide comment.

There will continue to be opportunities for you to get involved in this process and make your voices heard so we hope that at least today was meant to be a beginning step in getting sort of trying to level the play field knowledge-wise with regard to Medicaid long-term services and supports so that you can become more comfortable and get engaged in this process if you haven't been already so we've gotten a number of questions.

We're going to get to those in a minute. I just want to spend a little bit of time going through some of these resources and then we'll get to some of these questions. Okay, so resources generally on managed long-term services and supports. This first slide includes resources provided by CMS' Medicare and Medicaid coordination office.

We've got links here to the initial state demonstrations to integrate care for dual-eligible individuals, the 15 design contracts that were awarded by the Medicare/Medicaid coordination office last year as well as to the financial alignment initiative and the guidance that has come out in relation to that.

In addition the last link on this page is to what is called CMS' integrated-care resource center. This is the spot where CMS is posting the proposals that it receives for the financial alignment initiative for the 30-day federal-level public comment period.

So I recommend, you know, that's certainly the place to check to see whether or not your state has put forth a proposal and if it is still open for public comment so some additional resources related to managed long-term services and supports.

We have posted a link to registration if you're interested in learning more, you know, certainly we'll be continuing our series on managed long-term services and supports but others - lots of other organizations - are doing similar kinds of Webinars, meetings, conferences and so forth.

We've included a link to one that is being done by the Disability Rights Education and Defense Fund in a couple of weeks so that link is included here. We've also got a couple of links from the National Association for States United for Aging and Disabilities.

They recently launched a state Medicaid reform tracker which is a great place to check on, you know, sort of what's happening in your state on this front. They also in conjunction with AARP published a report called on the verge, the transformation of long-term services and supports which looks again broadly at this issue of managed long-term services and supports.

And we've included a link to the National PACE Association's list of PACE programs in the state since we talked about that a little bit earlier as one of the sort of forefathers or foremothers in all of this in terms of integrated care so some additional managed long-term services and supports resources.

The National Senior Citizens Law Center has put together a resource Website on the dual-eligible integrated-care demonstration. Not surprisingly the Kaiser Family Foundation has lots of resources related to Medicaid managed long-term services and supports as well as Medicaid-managed care in general, the alignment initiative and so forth.

The Center for Health Care Strategies also has similar lengthy list of resources on this topic. We talked a lot about 1115 demonstration waivers throughout

the course of this presentation. We have provided a number of resources related to that.

First is a link to the your state Medicaid director letter that provides guidance on the revised review processes and the transparency requirements for Section 1115 demonstrations, what we talked about a few slides ago.

We've included a link to the database of CMS Medicaid waivers and demonstrations as well as something new called the CMS idea factory which is a place where you could post comments on some of the 1115s that have been submitted by states.

In addition, it's also worth noting although we don't have a direct link to it yet because it is not yet live, CMS is working with a contractor on a Website that will provide guidance on and very consumer-friendly guidance on managed long-term services and supports.

So look for that in the coming weeks and months and with any luck once that's released, we're hoping through this Webinar series to sort of provide a tour of that site with our colleagues from CMS.

Okay, really generally as we always include with some general resources related to the Affordable Care Act the first link is to our health reform Webpage which is where we store our Webinar recordings, transcripts and slides. You can find all of those for our previous Webinars that we've offered over the past year and a half now.

We've also got some resources on here, a fact sheet, a link to a fact sheet on the Affordable Care Act for Americans with Disabilities, to the Health and Human Services healthcare reform Website, to the Affordable Care Act, a

place where you can look-up the Affordable Care Act text as well as a blog that talks about disability disparities in the healthcare law.

So to wrap things up before we get to some of the questions that you all have posted, we will continue this series on managed long-term services and supports throughout the summer and potentially likely even into the fall.

We don't have a June date because we're working on recruiting speakers for this Website. We plan on getting into - this has been as I mentioned a very sort of 30,000-foot view of all of this - and we're really just talking very generally about managed long-term services and supports and some of you have some really very terrific specific questions.

So we'll delve into some of those both on the sort of the consumer experience side of things with regard to managed long-term services and supports as well as the more of the business side in terms of contracting and so forth and also hopefully take a look at state experiences with managed long-term services and supports and how consumer groups have come together to form coalitions and really engage in the stakeholder process.

So please do watch your e-mail in early to mid-June for more registration information on that and finally before we get to the questions and comments that have come in through chat and before we turn things over to (Ashley) to open up the audio lines, we do invite you to submit if you think of a question, you know, an hour from now or, you know, two days from now, we invite you to e-mail those to us at affordablecareact@aoa.hhs.gov.

Also if you have suggestions for future Webinar topics, we invite you to give those particularly as it relates to managed long-term services and supports we

invite you to send those to us as well and again that's affordablecareact@aoa.hhs.gov.

Okay, (Ashley) if I could ask you to let folks on the line know how they can queue-up to ask audio questions, we would love to get those and in the meantime we'll take a look through the chat questions.

Coordinator: We will now begin the question-and-answer session. If you would like to ask a question, please press star 1. Please unmute your phone and record your name clearly when prompted. Your name is required to introduce your question. To withdraw your request, press star 2. One moment, please, for your first question.

Marisa Scala-Foley: Okay, while we're waiting for questions to come in, Shawn I think actually this question may be more up your alley. We got a question in from (Amy) who asks can you please talk about carve-outs and explain what that means exactly and perhaps provide an example related to intellectual or developmental disabilities.

Shawn Terrell: Sure, okay, so carve-out just means that if you take the entire set of services and supports for a given group of people, for multiple groups of people, say you have developmental disabilities and you have aging, right, in a managed-care model that you're trying to build.

And a carve-out would say well, we don't, you know, develop people with intellectual and developmental disabilities are, you know, really strongly against this for instance so we're going to not include that population in the overall managed-care structure and to keep them sort of fee-for-service as it is now and that would be a carve-out.

Another example is a carve-out for mental health which has been going on for quite some time actually like 20 years or a long time, mental health has had carve-outs where they've basically contracted for all the mental health services to a separate contractor to sort of and the carve-out could also still be a managed care model but it's carved-out of the larger managed-care plans.

And just as a standalone managed by a particular specialty managed-care organization of which there are several in the mental health or the real health world so those are examples of carve-outs. It's specifically taking out a larger managed-care scheme.

Marisa Scala-Foley: Okay, I'm sort of scrolling through the questions. We got another question in from (Ed) who asks what role do you envision the ADRCs, the Aging and Disability Resource Centers can play in this integration, you know, including options counseling and so forth?

We think that there are a lot of opportunities for aging and disability resource centers as well as other community-based organizations such as centers for independent living and others to play in managed care, managed long-term services and supports models that are being integrated in the states.

You know, and certainly it relates to a lot of the different functions whether it's system entry, providing information and assistance doing functional and financial eligibility assessments and providing options counseling so that people can use their resources wisely and not go into institution long-term care prematurely.

Some other areas where ADRCs and other community-based organizations can be part of this through person-centered needs assessments and person-centered planning to develop, monitor and modify person-centered plans.

So that they can offer access to services that are both cost-effective and participant-directed, helping people to apply for Medicaid in many situations as well as care management and service activation and linkages to health promotion and disease prevention programs such as a chronic disease self-management program, diabetes self-management, fall prevention, caregiver support programs and the like.

In addition, transitions management can be another place where area agencies on aging, aging and disability resource centers, centers for independent living, other community-based organizations can play a role in managed long-term services and supports models. Shawn, I don't know if you wanted to add anything there.

Shawn Terrell: I would just say just a couple of things. I think that and I don't want to get too far in front of what managed-care organizations might be looking for but it might be worth thinking about how the services that you provide could both be packaged in groups or unbundled and sort of made available individually like just options counseling.

It depends on the managed-care organization that sort of ends-up getting a contract and what they're looking for and how they want to start to pay for some of the services. A lot of managed-care companies may want to have all their eligibility stuff in-house and not, you know, sort of contract that out.

So as an example so I think that really thinking about being as flexible as you can around the services you provide and maybe even start talking to some of the larger managed-care companies or some of the ones that might be operating in your state now about what kinds of services they may want to

purchase and how to make what you do sort of fit that sort of value-added approach and again being flexible might be important.

Marisa Scala-Foley: Okay, (Ashley) have we gotten any questions in through the audio line?

Coordinator: I am showing a question and it comes from (Linda). Your line is open.

(Linda): Hi. I have a question. I wanted to know, I know you were going to talk about dual services but what if somebody is on Medicare only? Right now we have a state program that's called CHOICE and I don't know whether it's like the PACE you were speaking of and right now that served my needs.

But there is a possibility that they might try to dissolve that down the road and I'm on Medicare only so what do you do? Are there any plans in the long-term care area for people that have Medicare only that need help every day, not just post-surgical?

Marisa Scala-Foley: Shawn, do you have any...

Shawn Terrell: Well, there's, I mean, Medicare has been around, I mean, Medicare - they call them special needs plans - have been around for awhile and so there is the ability to do Medicare-only managed care and that may be something that if your state hasn't looked into that can look into that or just maintain the Medicare fee-for-service system that exists now.

I don't know if you're in - you mentioned the program but I don't know if it might be a PACE program - you mentioned it might be a PACE program, you know, if that's going to go away, that would be a challenge for Medicare only.

So again this is one of these things where you got to really get a clearer picture where the state's going with these, with their plans and how, you know, your situation can be affected by that and, you know, join in and try to make some real - make it clear - that this is not, you know, it's not really going to work if there's nothing and if all you need is fee-for-service Medicare, that may be enough.

(Linda): Well, I don't really know what you mean when you say that because right now the only time Medicare gets involved is if you're post-surgical but during that short period of time you're almost like under house arrest because it's so limited as to when you can leave your house.

And right now I'm on CHOICE Home Care Services of Indiana which I can, you know, I can come and go as I please and it's not based on a medical model. It's more based on an independent living model so that's why I'm really concerned about what they're going to do with this because Medicare's so restrictive whenever you do get services from them when you're post-surgical or something.

Shawn Terrell: I see, okay, so yes, where - I don't know enough about the service - that you referred to that...

(Linda): The CHOICE program?

Shawn Terrell: Yes, where that - what the funding is - for that.

(Linda): It's funded by the State of Indiana.

(Linda): It's a state-only program so it's not Medicare or Medicaid?

(Linda): It's a state-funded only program and if you're non-Medicaid-eligible then you can receive services from CHOICE and that CHOICE money also helps some people meet their match in order to receive their home care services if they are on Medicaid but it's for home care services only.

So, you know, and I know they're trying to dissolve it already so that's why I didn't know what was going to happen when we got into the Affordable Healthcare Act if they didn't include those people that didn't have Medicaid, I was afraid I was not going to have any services.

Shawn Terrell: I see, yes, I really think the most important thing you could do is get really involved as much as you, you know, have time for into exactly what the state's plans are around these supports to make it...

(Linda): Well, I know they're trying to get rid of CHOICE as it is now. They're trying. We're fighting back for them not to do that and I don't know what's going to happen when the Affordable Healthcare Act kicks in.

But if you have - I don't know where you guys are located - but if you have any influence at the federal level with the Affordable Healthcare Act, could you please mention that there's people out there with disabilities that are only eligible for Medicare and not Medicaid at all? I receive absolutely no Medicaid.

Shawn Terrell: Thank you. We'll take that down and try to make sure we think through that for sure.

(Linda): And see what they might want to do with those of us that are in that category. That would really be greatly appreciated.

Shawn Terrell: You bet. Okay, thanks again.

(Linda): Great, thank you.

Marisa Scala-Foley: Okay, we got a question - let's take another chat question - and then we'll again go back to the audio lines. A question from (Karen) who asks with regard to the 1115 waivers, if the state submitted a proposal prior to April 27th, do the requirements still stand? Shawn, I know you've been pretty involved on this front, you know, in working with CMS. Do you want to comment on that?

Shawn Terrell: Yes, my understanding is technical if it's submitted prior to April 27th before the 1115 regulations took effect for stakeholder input that the state is not required to fulfill that and so and, you know, I think some states knew that and wanted to come in early so, you know, it certainly is less of a burden on their end.

However, I think though the spirit, I mean, there's nothing, you know, enforceable around this but it certainly is consistent. The spirit of this is to get - make sure - that people are aware and have input into the design of these things and that there's also a kind of a recognition that it really can't work if people - if it's not designed around - the needs that people have.

And it could really backfire so I think although it's not - you can't require it - it's worth bringing that reg to the state's awareness and really trying to advocate for some real input based on that. It's in the best interest of everybody involved including the state.

Marisa Scala-Foley: Okay, (Ashley) do we have any additional questions through the audio line?

Coordinator: I am showing no further questions at this time.

Marisa Scala-Foley: Okay, we did get, let's see, we got a couple more questions in through chat, just bear with me as I sort of scroll through some of these so we got a question from (Dale) who asks for the states that have managed long-term services and supports, who do the care managers who do the assessments and the care plans work for, independent agencies or insurance companies?

You know, it really varies depending on the program and depending on the state. In some instance, you know, and depending on the plan, in some instances they may be employees of the managed-care organization.

In other situations, the managed-care organization may contract out some of those services with other agencies or community-based organizations to provide care management to do assessments and so forth. It really does vary. Shawn, do you want to add anything on that?

Shawn Terrell: Yes, there's a principle around sort of care management that you really and this is peppered throughout some of the regulations from CMS that you want it to be conflict-of-interest-free as much as possible.

Like for instance you really don't want the care manager working for an agency that also provides services that the care manager might be, you know, providing assessment and referral for. The incentive of course is to provide sort of refer people to the agency services as opposed to any of the other competitors for instance.

And so there is definitely going to be in any state that comes in with a - you know, care management is going to be part of any plan - to look at the conflict-of-interest issue around that.

And so I would strongly again if you're engaged in the state input process to pay attention to that and ask those questions is this what's the incentive for the care manager in terms of where that person may, you know, have some interest in sending an individual in terms of services and supports?

And the other thing that's also important is that if the care manager is also authorizing services which may be the case, it's the same question. What's the incentive for the care manager about authorizing these services in terms of just - it's just incentive - it does not mean that the person is acting on it.

It just has to be - the incentive has to be there - and if it's there that it's actually managed well and that's where a lot of work and scrutiny has to be put into to pay attention to what those issues are and how it's being managed in a way that is supportive of the best interests of beneficiaries of people receiving the services.

Marisa Scala-Foley: Okay, (Ashley) did any additional questions come in?

Coordinator: I still am showing no further questions.

Marisa Scala-Foley: Okay, we've gotten a number of questions that have asked for very specific data on savings and so forth and I am going to suggest that we're more than happy to provide any research that we know of on the questions that you've asked with regard to savings and so forth.

We're going to do that offline so as not to get into sort of signing-off lists and I don't know that you necessarily have all of the lists of different studies right here in front of us that we can necessarily pinpoint right now.

So please do know that we have seen your questions on that front and we will try to respond to those offline as quickly as possible with some of the data such as it exists on this front so let's see, I'm just going to scroll through one more time to see if there's anything else that we can necessarily answer right now. Just bear with me for a second.

Oh, okay, so great question in from (Scott) who asks what role does ACL have or the Administration for Community Living have in reviewing 1115 waiver applications submitted to CMS, you know, and is there a formal role between or sort of a formal partnership between CMS and the Administration for Community Living or the Administration on Aging?

You know, certainly we've been working very closely with CMS on issues related to managed long-term services and supports going forward including the 1115 process on all of this. Shawn, do you want to talk any more about that?

Shawn Terrell: Well, yes, just to yes, we have a close relationship where we work very closely than we have been. All of our members of the agency's project ACL have ongoing strong relationships with CMS and so we, you know, we're in a kind of the ACL.

We kind of try to take a focus of the, you know, what's really best in the end for people who actually are receiving and, you know, the services as a result of all this and I think that's been - that a nice, a good - it's a relatively new role in the Department I think.

And I think that we have that to offer and these like Webinars like this and the questions that you're asking are really important for us to understand what's going on and what the issues are from your perspective out there.

And, you know, we do take that and try to, you know, make sure that that as much as possible is understood and heard across the Department including CMS so hopefully you'll continue to do - bring in good questions - and continue to participate in these things because it helps us and hopefully it's of some assistance to you as well.

Marisa Scala-Foley: Okay, (Ashley) any additional questions that have come in?

Coordinator: I still am showing no questions.

Marisa Scala-Foley: Okay, so we got a question in from (Romaine) who asks about sort of generalized experience with incorporating HCBS in managed care and that's a great segue into talking a little bit about sort of what we intend to look at going forward in this Webinar series. We are hoping to do a sort of a more detailed look at sort of managed care and HCBS as part of this Webinar series going forward.

We also invite you, we had included a link in the managed long-term services and supports section of the resource section of these slides that was a link to a Webinar that's going to be done on June 11th by our colleagues at the disability rights - hold on, I'm trying, just trying to put that back up here - so the disability rights, education and defense fund that's going to talk a little bit more about this issue of HCBS and what needs to be included and what's being done on the advocacy front on that.

So we would encourage you to register there as just stay tuned for what we - this Webinar series - going forward. With that I believe (Ashley), anything else that has come in on the audio line?

Coordinator: I still am showing no further questions.

Marisa Scala-Foley: Okay. With that, we've caught up with most of the questions that we actually can answer today via chat so we think you very much for joining us today and again if you have any additional questions or if you think of a question, you know, a day from now or, you know, a week from now, we invite you to e-mail us at affordablecareact@aoa.hhs.gov.

And also if you have suggestions for future Webinar topics, we want this Webinar series to be as useful to you as possible so we welcome your suggestions particularly as it relates to managed long-term services and supports so thank you again for joining us and we look forward to having you with us on future Webinars.

Coordinator: Thank you for participating in today's conference call. You may disconnect at this time.

END