

Transcript for April 25th, 2018 Webinar: Independent Practice Associations: What are they? How do they work? And will they benefit me?

Please stand by for realtime captions.

Good afternoon everyone thank you for joining today's webinar. I am Erica, senior director of the National Association of States United for Aging and Disabilities. This webinar is presented through the Business Acumen center. Made possible by the Administration on Community Living. Shortly after today session you will be able to find the PowerPoint and recording of this webinar along with the archives of all the disability network webinars. There will be time for questions and answers at the end of the presentation. Please enter your questions in the Q&A box in the lower right-hand corner of your screen. Today speakers are Marvin Lindsey MSW and CADC the Chief Executive Officer at community behavioral healthcare Association and Ray DeNatale, executive director for the innovation resources for independence. Together today speakers will describe how their shared experiences help resolve common issues. Specifically, they will be providing an introduction, an overview of the basics of Independent practice Associations, and then the Illinois health practice Association will talk about their work followed by the work of the Advance of Greater New York, considerations for CBOs and then the Q&A. . To provide a very brief overview in which the gentleman will speak further, and Independent practice Association otherwise known as IPA is a network of providers who agree to participate in an Association to contract with managed-care plans. And it works through providers maintaining ownership of an authority over there is active organizations. Serving as a vehicle for negotiating and administering managed care contracts for its members and then IPA can also provide access to networking, resources, education and training that would otherwise be difficult to obtain. Some things to consider as we go through this discussion is that the national moved to managed care what for people with intellectual and developmental disabilities and various structures created to receive Medicaid, Medicare and third-party insurance funds and then contract with providers for service delivery in the eye pay is the means to better represent providers to these organizations but there are different IPAs for different reasons and Marvin and Ray will be able to speak further about those models. With that, I would like to hand over the microphone to Illinois.

Thank you Erica. This is Marvin Lindsey and as Erica said I am the Chief Executive Officer of the community behavioral healthcare Association and we are a trade Association of community-based mental health and substance use providers in Illinois. We have over 70 members and our association, and we are statewide. I would like to just start by talking about the current environment in Illinois. Currently, we have about seven managed-care organizations in Illinois. We have gradually gotten to this place over a period of time beginning in 2011. When he 122 of the hundred and two counties were mandated to take on managed care contracts. In 2015, managed-care also expanded to our most populated county, which is cook County. And took on a good number of lives they are. This past January, managed-care also began

providing long-term services and support. And in April over the other 80 counties were brought online. Most of those counties are in rural Illinois. In total we have about 3 million people that are on Medicaid, which is about 80% of our Medicaid enrollees. We're moving towards value-based payments in our state. We have 1115 waiver and we also have our managed care contracts call for each managed care organization to enter into value-based contracts with providers over a period of time. We also have going on in our state a state plan amendments for an integrated health -- there are a good number of states that intimate -- implemented health home so Illinois is late to the game. And then in our sober of this year, managed-care will also bring online the DCFS population or child welfare population of special needs children including children with SSI and the medically fragile children. One of the things I did want to talk about on this call is just how do we get to a place where we now have an IPA? And how do we start developing that? It started with our board of directors. Charged the staff with developing partnership with managed-care companies. In our state, you have some providers, very few that were entering into value-based payment arrangements. It was for a small number of people. Maybe 50 or 100 lives. And our members were not really satisfied with the fee for service environment in Illinois. It was low rates, a lot of unfunded services and so we were looking at some kind of way to really address this. One of the important consultants and us consulting about what we should do was health management Associates. And they were I think indispensable and honest being able to develop this IPA. And luckily at the same time, we had an RFP going out for a new managed contract. And also working with national health plans -- in developing their application. So we sat down with HMA and they explained an idea that they had towards developing a partnership with the health plan. And so we brought some of our leaders together from our association from different parts of this date, and we had this meeting, and what came out of it was both sides were looking ads a new way of doing business. For us it was a way to improve our system. The behavioral healthcare system and for Centene, they were looking for a way to address behavioral health care. The strategy that they had in Illinois was not working. And they were open about that. So we had a Townhall meeting. Over a period of about nine months. Where we put together a group of providers who formed an IT finance and operations and governance workgroup. And we started to build this structure with - which today is the IPA.

I want to tell you a little bit about our IPA and Ray and his is different than ours. Our IPA is unusual in that it is a partnership of providers and national health plans. Centene. We have 29 owner investors. We have set out and offering about a month ago, and we got 26 providers that wanted to buy into this company. We had some other interest so we sent out another offering and received three more. Total we have 29 investors and they are statewide. They cover all parts of the state. We also have 42 contracted providers providers and let me explain the distant dust difference. They are not owners, they did not buy in, but they are part of the network. And they will benefit in some way of being bought in the IHPA network. The IPA that we have bought is 50% owned by providers, 50% owned by the managed care company Centene. Centene also brings to the table a managed service

organization, a MSO which is essential and really doing the work we are talking about doing as far as data analytics, processing claims and all of the things that typically we have no experience doing as providers. And it's also very expensive. My Association will also be is also part of the IPA. And we will be providing provider relations. So the provider owners have formed their own company which merged with Centene. And so we will be servicing and providing support and recruitment services to the provider community. The Illinois health practice alliance, that is the name of our IPA, it's mission is to create a statewide network to provide culturally appropriate behavior healthcare services. That is integrated with physical health services and meets the needs of different communities. Individuals and families with a focus on excellent customer experience, objectively measured through metrics that demonstrate improved health outcomes. Some of the goals of the IPA are to work together to transform practices and provide supports necessary to be successful. Align providers and allow opportunities to invest in sheer infrastructure. And speak with one voice through the state of Illinois and health plans to help create a sustainable behavioral health care health system of care across Illinois. And some of our value propositions that we have also spoken to providers about that we feel will come from this is a pretty the bowl reliable cash flow will be a reality. One of the things that has happened in our interest and I'm sure in the DD world to is that we are relying on the state to pay us. The IPA that we have formed will contract with the managed care companies and receive monies upfront, a capitated amount in order to provide the services. We also feel like a big proposition is the partnership and integration between behavioral and physical health providers will be incentivized and supported. So one of the things that is going to make this work is if providers are able to work together, and also be incentivized and paid for work that we had traditionally done but had not gotten paid for. Another one is to empower providers to have more ownership and ability to influence the behavioral health care system. I think out of all of them this is one of the biggest ones. Because you are talking about providers being able to sit at the table with managed-care companies and make decisions on things they traditionally have not had any input on, particularly around authorizations. How to be paid. Instead of payment. So this is huge. And that of course the data-driven culture will be promoted by sharing and utilization of actionable data that is benchmarked by provider organizations and across providers. And also pilots for owners, which we have a pilot going in next month that will be for the owners who will be out doing outreach and engagement service on hard to reach managed-care clients.

What are some of the commitments by owners? What has been important is for their attorneys to look over all the documents, the operating agreements, all of those are a lot of legal documents and legal talk that I think only lawyers understand. Also the financial peace, the the offering. It is surprisingly -- when we set out the offering and I talked to providers, the money was not the big issue. Either for smaller mid-side providers. They were more interest to do just having a seat at the table. Being able to be paid for services that they traditionally have not been paid for and to be incentivized. The other one is commitment and attending board committee trainings monthly

meetings. I think this is very important as we start up, because this is our first year. In the IPA. And it has been a lot of work. And I think there has to be a commitment to be engaged in all of the board meetings, the committee meetings, and all that. And enter into value-based contracts. That is one of the commitments that the owners have made. We are very new at this. Today is the 21st, 25th, and we closed on our IPA on the 23rd. That was two days ago. Our IPA is very new. And so when I talk about these next two items, the successes and challenges, I am really speaking about how we were able to get this up and running. And I think one of the successes has been an increased trust between providers and health plans. This was essential for even the first meeting to get started. Some of the managed care companies, Centene, they provided a good deal of money. We hope to get that out on the table. And we had to address that before we were able to move on. That was a huge issue around trust. Getting providers to buy into a new concept. Where they are relying on each other. This is new. Still have some providers in the same community that traditionally has been competitive. We are asking that to work together in order to better the system, to be able to access these incentive payments. And to be in a value-based payment arrangement. And building a partnership based on transparency. We have to know what the managed care companies are doing. And so far I have to say they have been very transparent. We have learned things about managed care that providers -- that they would never have learned and are still learning. And I think it is the same thing. The managed care companies have learned community providers are able to keep people out of unnecessary hospitalizations. Out of the emergency rooms, and keep them engaged in treatment. Some of the challenges have been getting all providers to understand the value-based payment arrangement. This is new. This is brand-new territory too many providers. Because we have been in a traditional fee-for-service environment for all of these years and now we are going to have to show outcomes. And be paid according to those outcomes. So there are different level of experience at the table and I think right now, part of our trainings have been towards that bringing people along. And working as one unit, helping providers to think beyond their own organization and that is a little tricky. Getting other managed-care companies to contract with the IPA. This is one that we have been approached by a couple of other managed-care companies about joining the IPA. We have told them that we wanted to get it up and running first. But you do have a couple other MCOs that are a little skeptical, because they are afraid that I am in bed with my competition and I think the other one that I have talked with us are seeing the value of having a ready-made network, being able to have an Emma so that is processing claims in providing trading and all that. The other one is work together in a different way where successes dependent on each other. I mentioned that. In the different level of expertise and cost provider. Lessons learned. These are very very early lessons learned. Providers of -- can partner of the terms are right. We have had many back and forth with the MCOs on different terms. And language. Would come from two different worlds and we have to understand each other what we were really saying. One good example is what they meant by care coordination and what we meant by care coordination was two completely different things. The other one is legacy issues must be addressed first. The money that providers world. And the legacy issues. We had

to get that out of the way first before we were able to move on. And objective facilitator. They can see both sides of the issue and be able to make decisions, important decisions and keeping everybody's eyes on the goals. It's a time-consuming process. We did it in a very short amount of time over a period of about nine or 10 months. We have put all of this together. But if we were to do it I think one of the lessons learned would be to get to the business of financial models early in the process. The other one would be the value of different skills and competencies to the table and I mentioned a little bit about that. In terms of what MCOs bring to the table and what providers do.

I think you, and I will be here for questions after Ray gets through his presentation.

Thank you Marvin. For now we will go to Ray to talk about an overview of the work --

Good morning everybody. My name is Ray DeNatale. I am the executive director for -- innovative resources for independence. And I wanted to talk to a little bit today about AGN way, Advance of Greater New York and what that is and -- and a few other topics. Let's talk about -- Advance of Greater New York is an entity that represents about 52 50 small to medium size agencies supporting people with I/DD. We wanted to secure an advantageous position with MCOs and the greater New York region. State and national on IPS and are thinking has evolved based on the additional discussions and information. But to go back a little further, some seven years ago at one of our provider association meetings, the assistant secretary for health in New York State and the office of people with developmental disabilities budget director came to that Association and said New York is going to move to managed-care for all services for people with intellectual and developmental disabilities and just to be clear when we are talking about all services we don't only mean all waiver services at all services to include medical services, behavioral behavioral health services, dental services services for I/DD in our state that is to say all services and when that happened, he said something that was quite shocking to us, to teach insurance companies how to teach insurance companies how to -- group of small to midsize agencies major large agencies. That are in the greater New York City area that if we do not been together so we can be represented that these managed-care organizations. Somewhat off-balance if it were to only go who can't really have the capacity to implement such anyone small or medium-sized agency. So it's important to note that that seven years ago in New York State we were moving towards managed care. And that is very critical to this discussion. One of the other things that had to come before we got into managed-care is CMS told New York State that they agree with us that we had to have conflict free case management and they put a time limit to New York State's head and said you need to implement this by a certain date and that date is this July 18. So as a process to get to conflict free care coordination and in consideration of our state moving to managed-care for the I/DD population organizations called care organization that were made up of providers of services to the I/DD population were formed across the state and right now there are I believe ten of those care coordination organization three of which are

in the greater New York area. One of those is what is referred to on my slide number 19 advance care alliance of New York and its relationship with AGNY. It's important others New York State looked at the various initiatives taken that process strongly slowly conflict free care coordination in a facility that would allow those facilities to become the managed-care organizations so in our state effective July 1, these care coordination organizations will be implemented, and they will be implemented under the facility of a -- then they on their own or in combination with other insurance companies will get to that point -- will create an ability to be a managed care organization and one managed-care comes into play they will receive the per member month rate for the constituents within that MCL and provide support to individuals through the providers as they are in the state for the delivery of services.

It is important to understand that, because Advance of Greater New York is one third equal partner with two other entities that form advance care alliance of New York. But as much as we are one third partner to advance care alliance of New York, it is only one care coordination organization or soon to be managed care organization that we needed to negotiate with. And when we recognize that and we recognize that individual agencies would not be in the strong position to negotiate with these managed-care organizations on their own, we started to look into an IPA for AGNY. We talked about what an IP is and you are getting a little bit of an idea of why developing an IPA. Marvin's description of his IPA and what we are trying to do here in New York with AGNY is an perfect example of two distinct goalposts on either side of the field. Marvin's is operating, it is in conjunction with and MCO. Ours is under contemplation, we do have a set of bylaws but we are not we haven't started yet the managed care organization to begin to negotiate with. In our minds, our view is much more focused on the notion of who should be part of it IPA, what are the standards for that IPA, how do people who are interested in being members, do they be assessed against those standards, and what is the role of the IPA in terms of helping any of those members maintain or reach those standards in order to be part of the IPA? And when on slide 20, the last bullet where it says thinking has evolved based on additional discussion of information, you might have listened to what I said and say we want to create this very high and person-centered high standards IPA so that we can negotiate for the best rates because we are delivering the best services and we really strengthen our standards in doing that. But that's a good example of learning and our thinking evolving as a result of learning. The implication of that is if you do that, than the number of people all, number of agencies that are part of the IPA are likely to be less based on a stricter criteria and as a result, the very reason at least in our case for negotiating efforts with the managed care organization might be reduced because of the lesser number of members of the IPA. So we learned that we had to somewhat temper our standards for membership in our IPA. So the standards of practice. Performance improvement using these standards. Whether our provider network is adequate. That would in sent and MCO, ACO or health went to contract with the IPA. We have some 50 individual members all of which for the most part are providers that are authorized under the office of people with developmental disabilities to provide waiver like

services. But what about people and behavioral health? Should they be part of our IPA? What about people who are providing direct medical services? Should they be part of our IPA? This is part of the discussion we are having right now. We haven't answered that question. Albeit we do believe that the most eclectic we could be would result in and MCO providing a better contract because it would be more from their perspective of a one-stop shop. We looked at things like the range of provider types, depth of services, overall, overall size, the fiscal stability. We needed to define our member expectations and performance criteria. Let's talk about member expectations for a minute. Marvin talked about for lack of a better term two groups of providers. The owners and the providers. I think they were contracted providers. That has been a discussion that we have had with our group as well. That is to say are we going to identify a criteria where people in the IPA who put in some fiscal support will have the opportunity to reap the benefits of the outcomes of the IPA and also have the risk associated with not meeting them. And that group of people would be different than just the providers who we refer to as the downstream providers, who would be responsible primarily for the delivery of service. So we are looking in that direction as well. So how would one create IPA standards of practice?

Again, I think it's really important to see the differences between Marvin's presentation and mine as Marvin's is providing information about a relationship of provider associations with a managed care organization to form this IPA and we are talking about developing an IPA for individual agencies that provide I/DD services in the state of and that is significantly different. We would look at social determinants of health for people with I/DD. Housing, employment, friendships, social relationships. We might use the Council on quality and leadership through the personal outcome measures and we have contemplated that. Whether the members meet basic regulatory standards. Whether the members promote and what they do to ensure that their activities in the service they provide are based on person-centered thinking and actions. So the result of that was to form an IPA committee, to survey a member of existing IPAs which is how Marvin and I got together. To create a first draft of standards. And to create an approach to determine network adequate -- accuracy and that's where we are today. Slide 24, you will see proposed IPA provider standards for AGNY. Providers will maintain basic regulatory standards. Provider is in good standing with relevant state oversight bodies and that is OPWDD, office of people with developmental disabilities. SCD, state education, OC after OCFS, children and family services, Department of health, and DOL, Department of Labor. What I think would be interesting is it says here good standing shall mean at any given point the agency must be fully authorized to provide services approved from the governing and/or office agency and where agency are required, in accordance with state to find guidelines and time frames. I will read you what the first part of that was before we made modification. Providers in good standing under those agencies that I just described where it says be fully authorized to provide services approved from the government and/or related agency were corrective actions are required such actions shall be approved I the governing state agency so you can see it's a little tighter there, and agencies not under any operational restrictions

OPWDD early alert status. We first put those up and we modified them to the one that is on the slide presentation because of our recognition of having to be a little bit more open to providers and therefore reducing some of the standards. Next one providers will have an individualized high quality person-centered approach which emphasizes participation in community and social activities. And it says for OPWDD agencies, AGNY IPA members meet the spirit of the national core indicators. What we said initially was providers will have an individualized person-centered approach which emphasizes participation in the community and social activities including how much time is spent with people not paid to be with the individuals. For OPWDD agencies must utilize personal outcome measures and goal identification and development and agency standard for members to meet indicators. You see their that we have modified our thinking in light of what we have learned from Marvin and other IPAs across our United States. And then when it came to fiscal sustainability, the agency shall remain a growing concern. Maintain a positive net asset position, standards of -- standard accounting ratios liquid unrestricted assets, debts service a quick ratio, and then consideration should also be given to the activities of the entity at a point in time. That would have impact on ratios but name -- may not suggest fiscal instability.

What we first talked about was maintain a surplus or positive net asset position. Maintain standard accounting ratios and those are the ones we listed there. Consideration should be given to the activities of the entity had a point in time, if the agency was involved with office change or government funding other than multiple PPA's, these would have an impact on the ratios that may not suggest fiscal instability. Here's an example, you are getting a trend here that we had tighter more restrictive requirements that have become a little more loose as we learned a little further. Finally, on this page, providers will maintain adequate governance in accordance with our funders, not-for-profit revitalization act and the state of New York. Pretty broad. What we said originally, providers will maintain adequate governance, they would have bylaws that would note board composition committees officers regular meetings, level of regularity of operational issues presented to the board and all that was drawn down from or drawn down to what we just discussed saying that with respect to our funders that we are maintaining adequate governance according to in our case OPWDD the statewide not-for-profit revitalization act in the state of New York. In summary, our IPA is not in place, albeit that we do have an approved set of bylaws and we have six initial members of the IPA. That IPA will not come into effect until such time as the care coordination organizations that begin July 1, 2018. Has the authority under article 44 license or through a collaboration with an existing insurance company to be a managed care organization and under that rubric, then this IPA would be designed to negotiate for the number of providers in our IPA. It would be our intention and strictly my opinion, I don't represent the full board's opinion that I think we will get to a point where we will have a small number of owners that will put up some money and then enjoy the benefits and except the curses of getting the risk associated with the IPA. And we will wait for the start of managed care in our New York State. The one piece that I would say is that like Marvin, the state is moving on identifying value -based payments

structures for I/DD services, so it's really easy to see if you went to the hospital for a urinary tract infection that you got medication and you didn't have a return to the doctor or hospital within 30 days on the basis of that, get a value-based payment but it is not so easy to say your two individuals, one is an individual with good capacity one has a job, and one is successful and not in -- and somebody who is on a gurney who has the ability to move solely for eating purposes and that person maintaining his health. And trying to define value-based payment structures to address both of those an equal rates, equal weights on the success of either of those two individuals is a challenge and we are working on the. Like Marvin's, just this year the OPWDD services have now come under New York State 1115 waiver which will give us access to a lot more flexibility and hopefully give us a lot more opportunity to test a variety of options so that by the plan date of 2020 when managed care for the I/DD population is started only on a voluntary basis many of the questions from a behavioral health perspective in Illinois by Marvin and his group will be answered for the I/DD population here in New York State.

And that is it.

Very good thank you. We have a couple questions coming in and everybody in the queue please remember you can enter your questions in the lower right-hand corner of the screen. As we start to go into those please advance the slides. Marvin and Ray, you did an excellent job of describing the work you are doing. Between the two of you, if you were to give advice to organizations that are thinking about pursuing an IPA model, in addition to some of these high level tips you have given, within both of your presentations, what else would you advise?

My first thought is what is happening in your state with respect to managed care for the I/DD population? Is it there yet? Is a coming? What has happened with other organizations other than the one you might be connected to with respect to that process? It is my belief that managed care for the I/DD population will be a reality in both dates and as a result of that getting your finger on the pulse of your state in terms of where you are in the process and beginning to answer some of the questions that Marvin's group did and ours is doing is critical. You want to have those things answered and feel comfortable with your position way before you are required to so that when that requirement comes you will know what to do. Marvin?

I totally agree with you, Ray. Our ours is a lot different than yours in terms of behavioral healthcare.

Our world is a lot different than yours. In terms of behavioral health care. But I know we have experience in working with managed-care companies. So I think really developing those relationships right now with managed-care companies, at least talking with them about what kind of ideas they have for the DD population will be essential. One of the things that really happened in managed-care and you probably know this is things change so much. And they are not the same according to each managed-care company. I think it's going to be essential to understanding where they are at in their strategy. Like I said, with

the managed-care companies in Illinois and I think across the country, the behavioral health care is just not working. Their strategy was to try to reduce the cost of behavioral healthcare. And when they reduce the cost of behavioral health care what they saw was healthcare, physical health care went sky high. Went up. And we could have told them that. But the reality of it is when you aren't trying to provide those community -- or to have people have access to those community services that it does reduce cost.

Marvin to your point, I agree. Part of the reason why I personally believe that managed care can work the I/DD population in my mind is largely based on the way managed-care originally was designed for medical services. And the notion there was to have a high degree of connect Tivoli between the providers of medical services to coordinate those services with other life-support which in the I/DD population likely also in the behavioral health population has some pretty significant interrelationships between medical and other services to ensure that the services are delivered in the most efficient and successful way. And I believe that will happen. What does that mean for emerging -- emerging states? If there are states that are contemplating it, be at the table and advocate for the managed-care organizations to be operated by I/DD agencies or by a group of I/DD agencies that form an agency to run a managed care organization. White? Because they don't have the same fiscal responsibilities as an insurance company. They will know the population inside out, and they will be able to address more of the person-centered mindset and social determinate criteria than an insurance company will. And in OPWDD case, they actually made that as their criteria. The first goal is to have those managed-care organizations be from conglomerate or groups of organizations that support the I/DD population. That would be another recommendation I would have.

Great, thank you. One question that came in is what was the approximate MSO function as a percentage of the total revenue? Looking at cost information. What is the approximate cost of the MSO functions. MCO.

I understand what he is asking. The MSO is going to be -- and our IPA is going to be owned by Centene. It is a product that they are going to use across the state. I am in DC right now talking with my Florida counterpart, and they are in the process of developing the same type of IPA. They will also have access to this MSO management service orders -- management service organization and the cost will be a fee for the IPA to the MSO. If another managed-care company joins the IPA, they will also pay a fee to work with the MSO and that will also bring down the cost of what the IPA is paying towards the MSO.

In the world of acronym canoe spell out again what the MSO stands for?

Managed -- management service organization.

I think its an important question to ask the person if they were talking about MSO or MCO. Because Marvin answered it exactly that way as MSO. MSO has -- almost like a TPI. Third-party administrator role

for the IPA or the managed care organization to manage the back office stuff at a per per per -- per person or -- if he meant MCO, managed care organization that is a bigger significant question because what it is saying is if we move to managed care what is the cost of the organization to create this managed care organization across a particular state and what is the actual cost against what we are getting paid now. I will tell you my answer to those questions that I've heard. A low of three to a high of 7%. I've heard other people talk numbers even higher as 10 but I don't think that is accurate. In our state have actually talked about 3%, 3% to 5%. I will say will say between 3% and 7%.

For those of you who are skeptical out there and I believe there are 67 people, at, at least 66 that are skeptical. You have to figure out whatever you are states cost are take 7% out of that and what that basically means is the remainder is what goes to services. When you add the notion and I still think it can work. I believe there is some opportunity for flexibility. I/DD support services. Managed-care can do that. But what you have to consider is for the sake of discussion your talking about 93%. You are not going to get the value of 93%, you only get the value of 93% if you made the value-based standards that were set. You need to speak to your state and need to understand your I/DD office in that state in terms of what they are thinking to get a handle about that. The value-based payments are going to be set where you hit all your value-based payment you will get 93% in my examples. If you don't hit the mall you will get less than 93%.

Very good. As of right now we don't have any other questions in the queue. Before we closeout are there any final words of wisdom that you would give to the audience?

I think if you are looking at your system, and you are not satisfied with the way things have been going on over the years, this may be an opportunity that you may want to look at. We are right in the middle of bonds right now. We don't know how it's going to end up. I would love to come back here in here and say this is what happens. But we are looking at the first year as being kind of a learning experience. And that's how we were able to sell it to our providers. But our providers are really they really understand that the system that they were in was not working for them. And so I think that's the question that anybody who get into this must ask.

My comment would be I'm not sure how those 60 people who are on there whether they are executives or not come up but to the asked tent that you have the ability to take time away from your support to people with I/DD to be part of those conversations at any level in your state, do it. There is a reason why AGNY was crafted by six people of which I am one. We thought that when this managed care service delivery model was going to be in place we wanted to make sure we have an Association that would represent our needs and we wanted to have an IPA it was created that we could negotiate really well not only with our own managed care organization with the others that are in the state. -- without something terribly. Do get involved, be involved.

Very good, thank you. If you could advance the slides please. Before we close I wanted to share an update on the stories in the field contest that we released earlier this spring. The stories from the field contest was intended to draw on some of your successes in the field of organizations that a been improving or implementing various we are pleased to have received more responses than what we expected. And so we are still reviewing those submissions and we will be planning to provide an update to and about the winners and make. So if you submitted and are on the line, thank you for those submissions. If we are always looking for stories even outside of the contest so look for more information coming soon. Marvin and Ray, I want to thank both of you for all of your time and your information today. And we do certainly look forward to touching base in the future to hear about your continued success.

Thank you.

Thank you everyone. Have a great afternoon. Goodbye. [Event Concluded]