Transcript for May 24th, 2017 Webinar: What CBOs Need to Know: Managed Long-Term Services and Supports (MLTSS)

Welcome everyone this is Erica Anderson. I am the senior director for the business acumen grant and we are pleased to have you join us today for this month's webinar about what is needed to know about long-term management support. If you have any questions, please enter them into the comment box and we will have time for Q&A at the end.

I would like to present today's speakers; we have Camille Dobson the Deputy Director at the National Association of States United for Aging and Disabilities and Diane McComb, Liaison to State Associations at the American Network of Community Options and Resources (ANCOR); and Camille will kick us off with speaking about managed care.

Thank you so much, Erica. Good morning and good afternoon. I will do a quick overview of managed care basics before turning it over to Diane to dive into the specifics of managed care for long-term services and support.

For those of you, very basic, managed care in itself is a delivery system that states use to improve access quality and reduce the cost of Medicaid services. It is an optional way to deliver Medicaid benefits other than the default system which is currently fee for service. So in fee for service, provides the states contract directly with dividers. In the managed care setting, the state contract with managed care plans to arrange and deliver Medicaid services. In fee for service, providers are paid on a service by service basis based on the claims they submit to the state agency. In the managed care delivery system, the managed care plans are paid a set amount each month for every member that they serve, Medicaid member that they serve. Lastly in the area of quality, rather than trying to work with individual providers one by one to improve the quality of the services they deliver, the states require through their managed care plan contracts certain quality standards that they have to meet to improve the health and welfare of the beneficiaries they are serving.

So why are states interested in managed care and what is it they hope to achieve for managed care programs? The first really is accountability with the single entity. As mentioned before in a fee for service system the state contracts in the home and community-based setting, with at least thousands of individual providers, and it becomes very difficult to have a single point of accountability. Contractors managed-care plans allows the states to drive improvements and care coordination among health care providers and the plans have a better capacity to collect data and measure quality improvements in health and quality of life. In many cases a managed-care system can hold down the increases or growing increases in Medicaid spending.

The payments themselves allow the state to have a better predictability and be able to better know what they're Medicaid budget will look like year-to-year. That is primarily because of the way the health plans are paid a set amount per member multiplied by the number of members. States have a good idea of what they're Medicaid budget will be every year.

Last that not least it allows the health plans to fill in gaps that might of existed in the fee for service systems to make sure they are delivering the right kind of care is at the lowest cost setting and the right amount.

One of the benefits that managed-care plans typically offer to the Medicaid members is a nurse advice line to help alleviate or address healthcare concerns so that they are not going to the emergency room and for those of us who have

insurance or managed-care insurance in your personal life you know that a nurse advice line is one of those great value adds that you get by being part of the managed-care system.

I mentioned briefly how managed-care plans are paid and how that contributes to budget predictability this is a more detailed explanation and I will spend a little time on this because typically the concept around the way health plans are paid is a source of mystery to a lot of providers who don't work in the insurance space very often. So I will spend time talking about capitation payments and what those are and how state use them. A capitation payment is simply an amount per person that is paid to a health plan every month for all of the services that the plan is supposed to provide. We typically call it a per member per month amount or PMPM and in some cases you'll hear that term used by state Medicaid agency's actuary plan officials they will talk about a PMPM for a particular category and all they are talking about is the amount of money they are receiving for that particularly type of beneficiary per month.

That per member per month amount of the capitation payment should vary based upon the type of individual that is provided so typically states will have a set of capitation payments for children it based upon age for pregnant women or for older adults and for persons with disabilities. They can have a myriad of ways to pay health plans but the goal is to set that amount at just the right number so that it provides enough funding for the health plan to cover all the services that are provided not too much and not to the little, just the right amount, and that is a very complicated actuarial science that states use in computation with their actuary consultants.

So once the plans get that per member per month amount, and the capitation payment they are responsible for all of the services that come under the contract. That means the risk of spending too much or in some cases spending too little resides with the health plan now and not the state. If the amount that the plan receives for that person for the month is not calculated accurately and it is not enough money to cover the cost of the services provided the health plan basically loses money. They cannot go back and ask for more money for that purpose in most cases. Likewise, if the services cost less that particular month than what they were paid, the plan is able to keep that access funding so the goal is that based upon these different categories the funding is calculated just right for each group so that the plans get just enough to be able to provide services, cover administrative costs, and don't lose money and also do not make a large profit on Medicaid enrollees.

So, there are different types of managed-care plans and I cover this only because there are some states in the country where their health plans that deliver Medicaid services are not called managed-care organizations. They use different names so I just briefly wanted to talk about how that comes about. As you may know, Medicaid statute, federal Medicaid statutes, requires states to cover certain services, or mandatory benefits listed here, hospital, clinic services family-planning, nursing facilities, physician lab, and transportation to medical services.

They also offer optional services. Now you and I would say that this list on the slide are not really optional services, those are core to the way individuals get their health care, but according to federal statute things like this prescription drugs, prescription care, these are all optional that the state can choose to offer or not, and obviously that leads you to understand that most states provide most of those optional services. The ones you typically do not see that Medicaid programs cover are only covered dental and chiropractic benefits typically dental and in particular is usually delivered to

children and the Medicaid for pregnant women but older adults and people with disabilities generally in most states do not have access to dental benefits.

So the way that a state figures out what kind of managed plan they are dealing with is what the scope of services are included in the contract. So if a plan is delivering, is responsible for hospital services, as well as three of those mandatory benefits you saw, lab, physician, clinic services, they would be considered a managed-care organization because they have the broadest scope of services. If a plan delivers inpatient services and three or less than three of the mandatory benefits, they are considered to be a limited benefit plan. They are considered pre-paid and a state for an example in Michigan has a large network of what they call PIHP's that are limited to a patient service and just a handful of the additional services. Last but not least, a plan that doesn't provide any inpatient services and only a couple of those, for example only dental, would be considered prepaid ambulatory health plans and would have much less scope of services they are responsible for. You can see in this chart on slide 10 the decreasing the scope of services from left to right of these health plans. The states pay these plans slightly differently and they in fact have different levels of oversight depending upon how extensive the scope of services provided are.

So, the bottom line is the reason we are talking about managed-care today, is that for most Medicaid beneficiaries, managed-care is the predominant delivery system. About 75% of all Medicaid beneficiaries enrolled in 2015 were enrolled in a health plan for some or all of their services. Most obviously, our children, pregnant women, and parents but they can include in many cases disabled and elderly adults as well as those receiving long-term services and support, or waiver services, in a number of states. In addition to what we call regular Medicaid, traditional Medicaid, virtually all of the 11 million adults receiving coverage has an expansion population under the affordable care act, are also in managed-care plans. So the growth over the last level years has been fueled by the addition of those low income adults that have gained coverage in the 22 expansion states. So today 39 states deliver some or all Medicaid benefits through either comprehensive or limited benefit health plans are so it is broad coverage across the country. Capitated health plan payments in 2015 is almost half of all Medicaid expenditures which is a really rapid growth in the last five or six years. 15 years ago, only 17% of Medicaid expenditures were for health plan payments and now almost half.

This map shows the penetration of managed-care across the country and all of the states colored have some sort of managed-care. So you can see with a few states are that don't have any capitated health plans of serving in any capacity there Medicaid beneficiary. The ones in blue use full benefit, broad benefit, health plans called MCOs and the states in the red have both comprehensive health plans as well as more limited heath plans and the few states in green just have limited benefit plans for certain services. So for North Carolina and Colorado is for behavioral health services as well as in Idaho.

So how does a state go about implementing managed-care? They have to do a couple of things or a number of things. They would have to design a program or structure their Medicaid programs so they determine what eligibility groups will be enrolled in manage care plans, they decide what services will be provided by the health plans and then where the health plans will operate. Some states have regional programs others have all of their beneficiaries in a particular eligibility group coverage no matter where they live in the state. So they start with that design. If they want to do managed-care programs they put this design together and CMS has to give approval to that design, to their request to move to managed-care because Medicaid managed care programs need waivers of the federal rules around treating all beneficiaries alike, having programs statewide and limiting beneficiaries to the providers that are in a particular planned network as opposed to being able to go to any Medicaid provider.

So I will touch this briefly because it is arcane and I welcome questions about this if you need more information. But there are several different ways that a state can secure authority from CMS to do their managed-care programs so those numbers at the bottom of this slide reference sections of the Social Security Act. Voluntary programs that state operate are under 1915 (a) authority, and states can use the state plan authority under 1932 (a), and then 1915 (b) or 1115 demonstration waivers those are authorized at the discretion of the Secretary, and tend to have additional requirements placed on the state as a condition for getting approval under those authorities.

Some states just have a regular managed-care programs and they would deliver state plan the benefits, as we talked about mandatory benefits like hospital clinic services, lab, radiology, therapy services. If the state wants to provide HCBS services through a managed-care program, then they need to pair the managed-care authority that I talked about in the prior slide with one of these authorities that give the states flexibility to provide home and community-based services, and those can run through the alphabet soup of 1915 (i's)- which I want to go into today that's a whole other presentation- but know that states need to have multiple authorities in order to be able to deliver the long-term services and support in a managed-care setting.

So once the state has a CMS approval- so you can see that I'm going in order- they designed a program and get CMS to agree then becomes the real implementation work of the state moving forward to a managed-care organization. The first thing they need to do is select health plans they want to contract with and many states do that through a competitive procurement where they put out and RFP, however there are still a number of states that will contract with any qualified plan in other words they will let all-comers who can meet the requirements that the state sets for participation in the program to participate. They have to write the MCO contract and Diane will talk about the importance of the managed-care contract, but it is probably the key piece of the program that drives the behavior and the activities of the health plan. Many states have legislative or legislation or administrative code requirements in the health plan contract. There are a number of federal requirements that CMS says health plans need to follow in, those need to be in the contract. Then there is a whole variety of discretionary activities that a state might put in their managed-care contract and the quality measures that the state has to follow or the way that a health plan deals with dividers or contracts with providers or provides care coordination and those contracts can range from a couple of hundred pages to several hundred almost 1000 pages and they are or they provided the real detail and back bone of the managed-care program.

I talked about the state set payment rates, they work with their actuaries. CMS does have guidelines for setting those actuarial rates and the state need to make sure that they and there's actuaries follow the rules because once we get to the bottom, CMS and after they have given the upfront approval has to approve at the backend the MCO contract and they have -- MCO and they have to approve the rates that the state has to pay the health plans in the state cannot draw federal Medicaid matching money for their managed-care program unless both the contract and the payment rates are approved by CMS. So CMS has an upfront role in improving the design broadly and then has a very specific role on the backend and before a state goes forward with the contract.

So that is the operational pieces. And there is upfront, what I call outward facing work with consumers and providers around education and training. It is critically important that the state engage regularly with their consumer groups that help consumers with provider groups to help them understand what is happening with the change in the system. This includes public meetings, making websites available, publishing questions and answers, doing mailings and regularly talking with providers to get them ready for the change.

The states are also required to make sure that the health plans are ready to go and they need to be able to do all the things in the contract that the state told them they need to do; which includes paying claims on time, running a customer service center, having care managers play in place and trained. There are a myriad of other activities but making sure that when the state is delegating the day-to-day management of the Medicaid programs to those plans that they can do it well and meet consumer provider needs.

Last but not least the states have to ensure their staff have the necessary skills, abilities and knowledge to do oversight of the managed care plans. One of the key things that the NASUAD staff talks about when we talk to states about this is that the states are still the owners of their Medicaid program. Managed care plans are simply tools that they are wielding to make their system and program more effective. So they need to maintain strong control and oversight of the activities of the plans are undertaking. That ranges from reporting requirements placed in the contract, to regular meetings, to again engaging with the public to make sure that they are getting broad feedback about how the system is going and continuing to make improvements as the program progresses as they learn what is working and what doesn't work.

So there are a lot of things health plans are required to do this is by no means on this slide extensive, but I definitely want to highlight what we think are some of the most critical things for you to know that the health plans are supposed to be doing. The first is to make sure that they have sufficient providers to provide access to services. And again the state is required by the federal government to ensure that there are enough providers to serve the types and numbers and beneficiaries in that are going to be in that health plan service area. They are required to coordinate care, in other words provide care coordination services for members with special needs or long-term services supports. They can provide care management to other individuals, but they are required by federal law to do that. They are required to measure and report to the state on the quality of care that they deliver. The state has a lot of flexibility in determining what those measures are but there is a mandatory measurement and reporting process for quality. They need to provide access to member services by phone, web, or email. Multiple ways for individuals to reach their health plan as quickly as possible. They are required to authorize when appropriate and pay providers in a timely way for the services they render as they take on that responsibility for the state. They must have an appeal process for this -- disagreements or where the member does not agree with the decision that the plan has made about either the types of services they are getting or how frequently they are getting them. A federally required streamlined rapid decision appeal process available for consumers.

They are required, starting this July and next month, to start spending at least 85% of their payments that they get from the state on services and quality activities and 50 percent or less on administrative activities like member services and provider relations, and frankly profit and taxes and insurance- all of those things that accompany has to do to be in business. And last but not least, they are required to take on the states, to share with the state, the responsibility to

minimize waste, fraud, and abuse on both on the member and provider sides, so that it is an active program integrity activity to make sure that federal Medicaid and state Medicaid dollars are not being wasted.

That is my overview of managed-care hopefully it sets the table for the contest around how managed-care works with Diane as she takes over to talk about the nuances and specificity of delivering long-term service supports in a managed-care setting.

Thank you so much that was a very helpful discussion. So what are managed long-term services and supports? These include both HCBS and institutional-based services by definition through capitated Medicaid managed care programs. The populations included are all of our populations considered to be special needs or vulnerable, seniors, individuals with the behavioral health needs and adults with physical or intellectual and developmental disability, and plans are covering medical services as well which provides the comprehensive delivery system to beneficiaries.

This map displays the disposition of the states with regard to MLTSS. I would like to note that while it is not reflected there is a CMS PACE like demonstration pilot underway in Pennsylvania by a disability CBO. The adult community autism program is managed by Key Stone Human Services and operates on a PACE like model where it receives the capitated rate from the state and manages most of the risk including acute and primary care for adults with autism and although it is a small program it is another model that can be added to the mix.

Why are states looking at managed long-term services and supports? In 2015 LTSS expenditures represented about 28% of all Medicaid expenditures, or $166 billion, and that is a lot of money. The services constitute the largest group of Medicaid services in the traditional fee for service system and it has resulted in a fragmentation of care and support for people who are supported in long-term services support system. States have a lot of motivation to get these costs under control and to serve people better.

Medicaid prioritizes this activity through a variety of strategies focused on the specific populations that we talked about with the goals of cost containment, increased access, improved outcomes, and improved population health. Ultimately the hope is to provide better services to people and the right amount at the right time so that they have meaningful outcomes in their lives.

Just to what Camille had mentioned in a lot of specificity for managed long-term services and support, basically the federal government establishes rules and criteria states must follow when they design and operate in a managed long-term service support system. There are rules for managed care that incorporate many of the tenants found in other long-term services and supports- the HCBS rule, the Olmstead decision, the ADA etc. All must be adhered to. Covers a significant portion of the cost at this point and approves contracts and grades between states and managed-care entities. So when this states set their rates, the federal government actually has to approve that first. Next slide.

The state government may establish the actual benefit package who is eligible for services, the contract provisions, and the rates management that is paid to administrative the program. They compensate the managed-care plans using a capitated rate, usually the per member per month rate, and they are the overseers of that process.

The MCOs administer the program according to the terms of the contract, and I cannot emphasize this enough if a provision is in the contract it will be met and if it is not in the contract, there is no obligation on the part of an MCO to do anything other than what is in the contract. MCOs measure their abilities to support the members and other quality metrics and the MCO actually establishes the contracts with providers, and in this instance we are talking of our disabilities CBO's community-based organizations that will deliver the services and support better in the state plan.

MCOs are also required to have a network that is sufficient to ensure access to services. They coordinate care for members who have special needs and use long-term services and the support. They must measure and report to the state the quality of their care, and they must provide access to member services by phone, web, email, so that individual beneficiaries are able to reach out to them and they authorized when appropriate and pay providers for a timely services. So they become the players rather than the states.

We will go to the next several slides talking about the CMS guidance to states for MLTSS. The state issued guidance in these areas and we can begin that.

Adequate planning and transition strategies. States should use a thoughtful plan said that gives enough time to outline its program. States that have an Incorporated disability populations into a managed-care framework are the ones that appear to have been the most successful in the ones who have taken a very protracted period of time to figure out how to do it. The states that have rushed forward quickly have had results that have been less satisfactory to individuals with disabilities from what we can tell. It is essential that at the time new expanded or reconfigured programs not only on the slide but also the solicitation consideration of stakeholder input and corporations of that input. It should not just be something for a meeting is held and they come together and they take minutes but every suggestion of stakeholders should be deliberated over and considered and that the state is not going to incorporate some of those changes they should be able to articulates. The last bullet is important for disability CBO's to be aware of; states will be expected to develop information technology systems data collection processes information health technology processes within their managed-care programs that would to celebrate the effective management of the program and this should include a CBO readiness as well because they have needed IT capacity to successfully move forward to a MLTSS structure.

With regard to stakeholder engagement states are required to provide a structure to an engage routinely and an implementation of MLTSS. This must include across disability representation, as well as community, provider and advocacy groups in order to maintain a meaningful input and the planning and operation. States must have a formal process in the ongoing education that stakeholders prior to during and after implementation. States must require their contractors to do the same so MCO's should also be required by state to convene a local regional member advisory committee that is able to provide feedback on how the implementation of managed long-term services and supports is going. Again this last bullet is important. MCOs must provide support to enable state holders to put participate in

transportation interpreters and personal care assistance and they are also allowed to compensate stakeholders as appropriate.

The enhanced provision of home and community-based services are required by CMS to deliver services that are consistent with the federal and local rules, including ADA and did the Supreme Court Olmstead decision. States are encouraged to include in their benefit supports to enable work force participation, such as peer support services as appropriate and as desired by the person. States are required that noninstitutional long-term services and supports are provided in settings consistent with the CMS home and community-based setting requirements as defined in regulation and guidance regarding the 1915 c, i, and k provisions.

Alignment with payment and structures and the goals. Rates must support the goals and objectives of the MLTSS Programs. Payment structure should provide incentives to HCBS services, so what does that mean? States must design the payment structures so that they are supporting the rules and regulations and the goals of this program. That means that we are a country that has gotten behind in all of our laws the presumptive competence of individuals with disabilities to work in a competitive setting; it is incumbent upon us to provide rates that support and incentivize that. The managed-care entities should also be held accountable through a performance based incentives and or penalties in the way the contract is constructed. On an ongoing basis states are required to validate payment structures and make changes necessary to support goals and their programs. Again payment structure should be encouraging delivery of HCBS as opposed to institutional services where appropriate and even though both institutional or not institutional services are included in managed-care calculation rates. We should be providing plans with the flexibility to offer lower-cost noninstitutional services for but should beneficiaries to aid in the rebalancing of the aggregate for states to move away from institutional setting.

Support for beneficiaries. Those of you familiar with the typical long-term services and supports will note that we are now referring to individuals with disabilities that are supported in these services as beneficiaries because they are part of the health insurance plan. They must be offered a conflict free education of what the services include. They must be offered enrollment and disenrollment in assistance and advocacy that is accessible outgoing and consumer friendly. Again in simple terms a person who may have any need for accommodation to understand what is before them and what their choices are must be given additional assistance if needed so that they are able to fully understand the choosing of a managed-care company and the choosing of providers etc. The support is more readily accepted and trusted we find, from an independent and conflict free source, in terms that are not new to disability CBO's and they must also be looking at the ability to do similar and switch to another MCO or go back to a fee for service payment if the termination of a provider results in the disruption of their services either residential services or employment services.

Person centeredness. All managed long-term services and support entities and CBO's must engage in person centered practices as defined in the HCBS role. This includes active participation by the beneficiary in the service planning and delivery process including the setting of meetings and the choosing of individuals who might be part of their team as by their preference so if a team wants to have a meeting at nine in the morning but the individual is employed and unable to participate at that hour the meeting should take place at the time that the individual being supported is able to participate. There needs to be meaningful choices of service alternatives and the opportunities to self direct community services with assurances of appropriate reports as desired by the individual. Person centered practices include

identifying what is important to the person and what makes that person satisfied content comforted fulfilled and happy in their life and also must identify what is important for the person and what is important for the person is what is needed to protect the person's health and safety and what is important to make the person a valued and contributing member of their community. This definition I think puts it on a page where we are focusing on the individual the beneficiary being at the core and in control of the service planning process. All MLTSS programs must require the implementation and use of a person with needs assessment service planning service coordination policies and protocols and states must require MCOs to use a standardized person centered and date approved instrument to assess the participants physical psychosocial and functional needs. This must include such elements as health status and treatment needs social employment and transportation needs and preferences. Personal goals preferences for care backup plans and when caregivers are not available a formal support network and approved instrument must be capable of producing similar estimates results from one MCO to the other. The use of an interdisciplinary team of professionals and nonprofessionals includes individuals who have chosen were chosen by the process and the professionals and nonprofessionals involved in the planning and decision-making processes must have adequate knowledge training at an expertise around community living. Participants must be permitted to include individuals of their choosing with a service providers and the CMS process up except the ability to choose which team members should serve as the lead and main point of contact. Disability CBO's on this call this is an opportunity to develop the expertise within the disability world regarding person centered practices to share that knowledge as a valued member of the community.

Comprehensive integrated service package. MCOs must provide and coordinate the provision of all physical and behavioral health services as well as long-term services and supports and they must assure that the disciplines receive those services in the amount of duration scope and manner as identified through the person centered plan and this is critical and something that disability CBO's have knowledge of and the ability to provide some of that knowledge to the partners. Service packages should be broad enough to support people and their families are caregivers in receipt of all services based on the services articulated they must not be reduced modified or terminated unless an up-to-date assessment has been made and the should ensure that services are included to support people as they transition between settings such as a hospital that back to the individual's room following the hospital and so on. Next slide please.

Plans which have an adequate network of qualified providers to meet the needs of their enrollees and they must meet state licensing, credentialing, and certification requirements, which is sufficient to provide adequate services. For states transitioning from fee for service to MLTSS, states should encourage or require through contract provisions the incorporation of existing LTSS providers to the extent possible and the state should provide or require MCOs to provide and traditional LTS providers with assistance and educational opportunities to better understand information technology billing systems operation and to assist them in making the transition to managed long-term services and support successfully. Again the last bullet is very important for disability CBO's because state must provide support through it traditional providers following traditional CBO's and may have a lack of understanding of the needed technology, the billing, billing is going to occur instead of just with the state, three managed-care companies and assistance operation to secure a successful transition with managed long-term services and support. Instead terms of the contract language around the continuity or notion of care for this transition provides for minimum qualifications and prevention requirements and states are expected to develop plans to support providers in this transition to minimize the disruption to the folks who are supported during this time.

States must establish state bars to ensure participants health and welfare and that it is ensured in the MLTSS system. We know people with disabilities and I'll elderly are at greater risk for abuse neglect and exploitation as well as health disparities. Robust health and welfare protections and monitoring our clinical and these should include a statement of beneficiary rights and responsibilities, health and welfare assurances, critical incident management system for reporting what is known to all entities involved and strong appeals process or individuals and disability CBO's and individuals including fair hearing protections which are already part of the rule for Medicaid programs and it allows for the continuation of services while appeals are pending and simply put if a service is discontinued based upon the decision by the MCO an appeal is filed, there is an obligation for those services to continue until the appeal is resolved.

Examples of participants protection that are somewhat common and emerging in the disability sector. Individuals have a right to be supported in the most integrated settings available they have the right to fair compensation; and the right to own property; access to a human rights committee meaning that if any right protected by the system is abridged by a disabilities DDL or an MCO and that must be taken before the CBO's human rights committee to determine whether or not it is appropriate and is there a plan for mitigation to return that right to the individual, and what is the process to engaging to do so. There needs to be a right to presumptive competency. People supported are in the full range of competencies rather than making the assumption that an individual cannot work in a competitive heading we are to make the assumption the individual can and it is then up to us to figure out how that can work before a decision is made that the individual cannot. There is a right to be free from excessive medications and regular review of medications to modify behavior. A right to freedom from abuse neglect and exploitation, and a right to privacy. States need to establish MCO contracts must reflect the statement of the participants rights so everyone is on the same page about this to ensure that participants are advised of their rights and provided with whatever additional support is necessary so they understand their rights as well as their responsibilities. Managed long-term services and support for disciplines retained Medicare hearing rights as mentioned prior slide, as long as they are participating in Medicaid program they must also have access to the appeals and grievance system and states must assist beneficiaries in understanding what those hearing rights are so that they are not just left hanging out there if they have an issue.

Quality. A big issue obviously; states are expected to use the existing quality system for waivers and managed-care to create their managed long-term service and support quality framework. Comprehensive quality strategy to take into consideration the whole package of acute care, behavioral health as well as LTSS needs; individuals to provide a framework for states to incorporate that focus on quality. They are expected to maintain the highest level in all of the operations and services so that they are integrated and the design and implementation of quality improvement strategies must be transparent and appropriately tailored so that everyone state or managed-care organizations disability CBO's and especially individuals with disabilities should be able to understand the steps taken that the state is taking to define quality. States contractors or MCO's must measure key experience and quality of life indicators for beneficiaries and they must be specific to the needs of the beneficiaries and the data has to be collected using best practices for reaching individuals with disabilities. For example, a mail survey which might typically be very successful for the general population is not necessarily going to be successful for individuals with disabilities and they have done much better on a face to face interview if it is warranted and you will get good quality data.

When we look at the guiding principles for managed long-term services and support that have been espoused by many outstanding national organizations that support and advocate for people with disabilities, there is a host of them, but there is a thread that runs throughout to them and everyone would agree that when starting a change a systems change

for managed long-term services and supports. When those first stakeholder meetings are convened, it is very advisable to establish guiding principles at the onset of the planning process and the way to move through the thorny issues for different stakeholders with different priorities. MLTSS must address the diverse needs of all beneficiaries but do so individualized basis, so this is a list that's a good place to start that conversation. Information must be understandable that all people, including communication technologies, most appropriate to the person, sign language interpreters, card services, video signing, voice descriptions on the website so that people who are blind can understand and working age enrollees with disabilities must receive the supports necessary to obtain competitive employment. There needs to be meaningful alternatives to meet their needs during periods of time for that where they are not employed and this includes all eligible individuals in the transition including those with state institutions and/or nursing facilities and a means to resolve wait list including the needs of individuals who are underserved.

Maintaining a robust and diverse network engaging eligibility individuals in the transition eligibility resulting in choices in the most appropriate integrated setting and coordinating primary and specialty health services for what someone might require. One of the things that runs through these national organizations guiding principles that we see is the reflecting of the needs for disability MLTSS recurring throughout the lifespan. Birth to death services provided by disability CBO's and there needs to be a recognition that people move through various stages of life, various stages of illness and wellness, and that the support needs to fluctuate and the payment to provide those needs to fluctuate to accommodate the changing needs of individuals with disabilities throughout the lifespan.

With that said let's go to the next slide.

I would like to talk about this topic to bring us back to center about what people with disabilities tell us. What we design collectively as managed long-term service and supports should be responsive to people with disabilities. In 2012 HSRI published the results of the survey of people with disabilities about what they wanted and needed in a long term services and supports systems and they were pretty simple. People with disabilities say they want to be safe, want to be supported to be independent. They wanted to live where they choose; live with people they love; if you can imagine going through life without those opportunities; and they want real jobs, not make up jobs; they want to be employed competitively. If we look at a system and design it so that we can accomplish these things for individuals in long-term services and support, I think we will come far to meet the mandate that we have, not only by CMS but also people with disabilities. So with that I don't know if we have time for questions but that has concluded my portion of the presentation.

Thank you Diane, this is Erica Anderson again with NASUAD; if you can go to the next slide please. We might have time for maybe one or two questions, but before we do that I want to thank everybody for attending today. This work is being funded through the Administration for Community Living and forming the basis for our business acumen center where we are working hard to provide resources and information that will help community based organizations and integrated care organizations work well together. We do ask that you visit NASUAD.org to see our resource center. We do still have the environmental scan and needs assessment survey open through May 31st, and we ask you all to please complete that survey; we want your information and this will guide our work and it really tells us what it is you need, so it is critical that we hear your voice. Our next webinar will be June 28 from 12:30 to 1:30 PM Eastern Time. We do have a

couple of questions that came in and the first, is the current waiver program going to remain in place or will managed-care be in place of the waivered program, and Camille this could be a good question for you.

Yes, so no, the waiver depends on the approach that the state takes to deliver their programs but primarily the state keeps their waiver programs in place and the health plan delivers those services that are authorized through the waiver so there are a couple of states that have moved to an 1115 demonstration and in those cases they have closed down there waivers and have made those services demonstration services, but in the end of the plan does not change the scope of services provided; the state controls that.

Thank you. The second question that has come in, is what does CMS say about defining what constitutes a sufficient number of providers?

Not much; that is a state decision; CMS simply requires it in the new regulations that the state set network adequacy standards for certain types of providers in the acute care world, and for the MLTSS programs that they set standards both for services where the consumer travels to a service, as well as for those services delivered in someone's home; and states are taking a multitude of approaches about it, CMS basically reacts to what the state puts forward and if they have some reasonable approach for it CMS has been flexible with specifics.

All right, thank you. Since we have less than one minute left I am not going to take any additional questions but we will do a review of the questions that have come in and do a response on the website as possible and feasible. Again, thank you all for joining us today, please visit NASUAD.org; the slides and recording of the PowerPoint of this session will be available by the end of this week or very early next. Thank you all and we will see you next month.

[Event Concluded]