

***Administration for Community Living
Affordable Care Act Webinar
Managed Long-Term Services and Supports: Engaging in the Stakeholder
Process (Part 2)
July 24, 2012
2:00-3:30 pm Eastern***

Coordinator: Welcome and thank you all for holding. At this time all parties will be in a listen-only mode until the question-and-answer portion of the call. The call is being recorded. If anyone has an objection, you may disconnect your line at this time. I would now like to turn the call over to Marisa Scala-Foley. Thank you very much, you may begin.

Marisa Scala-Foley: Thank you so much Michele, good afternoon everyone, good morning to folks who are joining us on the West Coast and in Hawaii and Alaska. As Michele mentioned, my name is Marisa Scala-Foley.

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

We do 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, on people with disabilities and on the aging and disability network.

Our Webinar series is designed to provide aging and disability organizations with the tools that you need to participate in ACA-related efforts in your area such as accountable care organizations, state integration for dual eligibles, health homes and more.

Last month we started a conversation about the topic of stakeholder engagement as it relates to the move toward managed long-term services and supports in many states. We talked about how you can get involved in the process and the kinds of questions you should be asking as you review your state's proposal and as your state may be moving forward in implementation.

This month we're going to continue that conversation looking at the important topics of stakeholder involvement, civil rights, appeals and grievances, oversight and monitoring and financing so before I introduce our speakers, we do have a few housekeeping announcements.

If you have not yet done so, please do use the link included in your e-mail confirmation to get on to 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 the chat function within WebEx.

If you don't have access to the e-mail link - the link we e-mailed you - you can also go to www.webex.com, click on the attend a meeting button at the top of the page and then enter the meeting number which is 663237084 with a passcode of aoawebinar and that's all one word, aoawebinar and again the meeting number is 663237084.

If you have any problems getting into WebEx, please contact WebEx's technical support at 1-866-569-3239. Again that's 1-866-569-3239. As

Michele mentioned, all participants are in listen-only; however, we do welcome your questions throughout the course of the Webinar. There are two ways that you can ask your questions.

First as I mentioned before is through the Web using the chat function in WebEx. You can enter your questions. We'll sort through them and answer them as best we can when we break for questions. In addition after our presenters wrap up, we will offer you a chance to ask your questions through the audio line.

When that time comes, Michele will give you instructions as to how to queue-up to ask the question and as always if you think of any questions after the Webinar or have any questions you'd like us to follow-up on, we invite you to e-mail them to us at affordablecareact@aoa.hhs.gov.

As Michele 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 early next week and once again we are thrilled to be joined by a terrific panel of speakers who also presented to us last month and let me introduce them all in turn.

First, Mary Lou Breslin has been a disability rights law and policy advocate for over 35 years. In 1979 she cofounded the Disability Rights Education and Defense Fund, a leading national disability rights law and policy center and presently serves as a Senior Policy Advisory with DREDF directing the organization's special projects.

Most recently her work has focused on improving access to healthcare for people with disabilities. Georgia Burke is a Directing Attorney in the Oakland, California office of the National Senior Citizens Law Center.

Currently her work focuses on national and state advocacy around programs affecting people dually eligible for Medicare and Medicaid.

She also advocates to improve language access for Medicare beneficiaries with limited proficiency in English and finally Silvia Yee is a Senior Staff Attorney also as the Disability Rights Education and Defense Fund where her work has included projects to increase physical and programmatic accessibility and disability awareness in the delivery of healthcare services and litigation involving federal disability rights laws.

So with that, I will turn things over to Mary Lou to kick things off. Oh actually, no I won't. I apologize. First I wanted to do a little bit of stage-setting before I turn things over to our presenters and we wanted to make sure everyone was on the same page as we talk about managed long-term services and supports.

When we're talking about MLTSS as we'll abbreviate it for the purposes of this session, we're talking about a payer which is typically the state Medicaid agency contracting with a managed-care organization or an MCO to coordinate and provide long-term services and supports.

Managed long-term services and supports may cover both home and community-based services as well as institutional care and it may serve different populations, older adults, people with physical disabilities and/or people with developmental or intellectual disabilities or behavioral health needs.

So why are we spending - we've now this is our third Webinar - where we're talking about managed long-term services and supports and why are we doing this and the reason why we're doing this and where we're headed is that as

you may know the interest in managed long-term services and supports is growing rapidly.

I was actually at a briefing here in Washington, D.C. where someone from CMS talked about a conversation they'd had with a Medicaid director in a large state and they expected really not to see much of a fee-for-service presence in their state Medicaid program within the next three to five years.

So really interest in managed long-term services and supports is growing at an extremely quick pace. One example of this is the financial alignment initiative which is being run through the Center for Medicare and Medicaid's services, Medicare and Medicaid coordination office often known as the duals office.

Twenty-six states have submitted proposals to CMS in order to better align Medicare and Medicaid in their state and really to integrate care so to integrate the acute care side with the long-term services and supports side which is more often covered under Medicaid.

Other states are moving toward managed long-term services and supports through an 1115 demonstration waiver process. Whether it's through the dual financial alignment initiative or through an 1115 demonstrative waiver, both processes now regard what is called ongoing and meaningful stakeholder engagement both throughout proposal development as well as during the implementation processes.

And stakeholders can include beneficiaries and their families, beneficiary advocates, consumer organizations, providers, plans and more and we can't overemphasize the fact that it's critical for you all who are on this Webinar and for others in your state to get engaged in this process in order to ensure

that consumers and their families' needs are met and their rights are protected throughout this process.

In another meeting I was in recently, they talked about really that we need to get engaged in order to get the system that we all want to have so the stakeholder engagement is really critical to this process and that's what we're going to spend the bulk of our time talking about today so with that, I will now turn things over to Mary Lou Breslin to present the content of this Webinar.

Mary Lou Breslin: Thanks very much, Marisa. As Marisa mentioned, the National Senior Citizens Law Center and Disability Rights Education Defense Fund (DREDF) have developed a Web-based resource entitled long-term services and supports in a managed-care environment and advocacy toolkit and we'll provide a link at the end of the presentation today for you to be able to reach that toolkit.

But we want to just mention that it covers 15 topics. We covered a number of those topics during the last ACL Webinar and we're going to be covering six of the 15 topics today and again these include stakeholder involvement, appeals and grievances, civil rights, state and federal oversight and monitoring, quality measures and financing.

Okay, I'm going to just begin by talking about or reiterating and stating again what Marisa just mentioned which is the important role of stakeholder involvements in the roll-out of managed care for people with disabilities and seniors and that will include long-term services and supports and home and community-based services in certain states.

As Marisa said, both the duals demonstrations and the 1115 demonstration waivers now require states to engage in and this is the language that is appearing in the federal communications ongoing and meaningful stakeholder engagement through the proposal development stage as well as the implementation processes.

Of course I think the challenge as most of you on the call understand and are very, very well aware of. The challenge is to use this stakeholder engagement process in such a way that states consider seriously the input that's provided and that the process is structured to be ongoing, transparent and it serves as a mechanism for course correction.

Since the structure of the stakeholder process is left up to states, it's really up to us as advocates to call for specific strategies that best ensure an ongoing and purposeful process.

For those of you who've been involved in this process already through various mechanisms, I know they include listening sessions, workgroup meetings, public hearings, notices, comment periods and so on, you may have experienced a certain level of frustration that the process appears to stand as the outcome rather than informing the outcome.

We recognize this concern and that's why it's so important to find mechanisms to ensure that the process is as effective as possible and that represents all of our voices and our points of view.

Our toolkit recommends that advocates call for two permanent standing committees, a state advisory board and an advisory committee at the level of the MCO. At a minimum we've created infrastructure in which fundamental engagement with the process as well as oversight can potentially take place.

We also called for MCOs to host quarterly meetings with members to collect complaint information and provide a dynamic feedback process. I'll be talking just a little bit more about that later.

In a technical assistance brief, the Center for Healthcare Strategies makes a number of recommendations to states about how to meaningfully engage stakeholders. A number of organizations have done the same. The recommendations include being responsive to concerns raised.

The concern is raised repeatedly, states are urged to respond in writing either by changing their approach or by explaining in some detail why that approach cannot be changed so establishing and maintaining mechanisms in which this process can take place is really crucial.

Okay, I want to just pause for a moment here and introduce or re-introduce one of the people we introduced during the last ACL Webinar because she's somebody who possesses a great deal of experience and awareness about how MLTSS and HCBS work in the real world and various elements of the toolkit we're going to be talking about today very likely are going to affect her personally.

And let me just say that the case examples we're using throughout our presentations today are drawn from real people featured in case studies published by the Kaiser Family Foundation.

Okay, Ellen is a 42-year-old wheelchair walker-user. She has Medicare and Medicaid. She has diabetes, a thyroid condition, effects of a stroke and depression. She lived in a nursing home for seven years until 2010 because she was having difficulty performing basic activities with her hands.

She returned to her own home through money follows the person program but she's having some new and not terribly unexpected challenges including experiencing some mental health issues, inadequate transportation and some changes in needed home assistance and adaptations.

So just keep her in focus while we talk about the various consumer protections because she is the person that we're concerned about in terms of how the roll-out of MLTSS is going to play out. Okay, what are roles that stakeholders can play in this process? There's a number of potential roles.

For example, consumer and advocates can include - the roles can include - promoting beneficiary awareness of expectations for HCBS, advocating for an appropriate balance between medical MLTSS supports and translating consumer concerns into specific policy recommendations, actions, plans and goals.

Stakeholders should also contribute to the development of quality measures. After the demonstrations have been implemented, consumer involvement should extend into ongoing monitoring through representation in the various standing advisory groups at both the state and local plan levels that we just mentioned.

Okay, let's talk about the state, the idea of the state advisory board. The state stakeholder board we think must include Medicaid-eligible beneficiaries to advise on all aspects of the planning, implementation and operation of the managed care program.

And people with a range of LTSS service needs and their representatives and advocates have to be included in this process. Okay, what kind of

qualifications should stakeholders have and these are specifically - we're mentioning these qualifications - because we would hope that these boards that we're recommending do not represent only the medical side of the stakeholder calculus.

For example, in terms of qualifications, to participants possess relevant personal experience of have connections with advocacy organizations with the expertise to assist them to understand the relevant state and federal laws involved, understand the contracts and the guidance that's spelled out, CMS-stated MCO requirements and the ability to identify and recommend solutions to systemic problems within the MCOs.

Okay, let's just turn to the MCOs committee idea so how should the MCOs involve stakeholders? The advisor activity that we are recommending should obviously include seniors, younger people with disabilities, family of members enrolled in plans, people with a range of disabilities and people with a range of LTSS needs.

How does each MCO involve the stakeholders? The MCO is the standing consumer advisory committee of the MCO that we're recommending should have access to information regarding the MCO's policies and practices as well as grievance and quality measurement information.

It should advise the MCO on all policies and practices affecting the experience of care and it should make recommendations for changes in policies or practices that will be presented to the MCO's governing board.

So as you can see this is a serious endeavor that we're recommending that will provide feedback and input into the process that the MCO is using to implement the MLTSS process.

In addition to the advisory board, we really urge that every MCO convene meetings with its members at least quarterly to document fully grievances that have been raised to keep comprehensive minutes of member meetings that are made available to everyone and to provide responses to grievances that have been raised prior to the convening of the next member meeting.

The MCO should notify members at least 15 days prior to each meeting regarding the state and location of the meeting and offer to provide accommodations such as ASL interpreters, print materials in accessible formats and they should assist with transportation and let's just think about Ellen for a minute.

What would this process look like in relation to her? Would the process embrace her participation? Would she receive assistance and support that she might need to come to the meeting and to provide her perspectives? In the perfect world, we would certainly hope that she would be involved.

Okay, so just to reiterate, while many groups and organizations have been involved in some aspect of the stakeholder process in many states, really this process has only just begun.

Consumers and advocates have to be involved during implementation phase and indeed throughout the entire demonstration so this commitment can't be only for the short haul and it really has to be for the long haul. With that, I'll turn it over to Georgia.

Marisa Scala-Foley: Actually Mary Lou, before we turn things over to Georgia, we got a question in from Deborah that relates to the advisory committee and it's a great question so I wanted to pose it now.

She asks, you know, regarding the advisory committee how do you ensure that these advocates have enough experience to be speaking for a range of constituents, not just their own personal situation or a small group of individuals?

Mary Lou Breslin: Right, it's a great question and I think that our recommendation is that a wide range of people who are in - have different backgrounds - and different experiences be involved and that the personal experience that people bring to the process is really critical and the range of personal experience is very important.

So a broad group of people with these types of experience that really represent not only one slice of the MLTSS process but also but a broader perspective is important and the process of constituting the committees is really a function of working effectively in coalition with other organizations to acquire agreement from the state that in the MCOs that they'll agree to build this kind of a committee with this kind of diversity.

Marisa Scala-Foley: Okay, thank you. I think that's all the questions we have for right now.

Georgia Burke: Okay, well then I'll get moving on appeals. This is Georgia. Thanks, Mary Lou. Let's look at appeals particularly as they apply to long-term services and supports. The challenge here is really to protect existing appeal rights while making appeals also really easy to navigate which is easier said than done so how do you do this?

First you have to make sure that the rights are understood. Individuals need clear notices and they need to be clearly written and these notices have to give enough information to understand why a service has been denied, what service

has been denied and what steps are available if an individual disagrees with that denial.

People need prompt access to impartial decision-makers outside of a plan. They shouldn't be stuck in a plan in multiple appeal processes within a plan before they can get to somebody who is conflict-free.

When the issue is the cutoff or the reduction of existing services like for example personal care services, individuals need a continuation of these vital services while an appeal is pending and no matter how successful we are in simplifying the appeal system, people still need help in navigating it.

An ombudsman who understands how the system works, can explain to a doctor what information is needed to support an appeal for example and guide the individual through the process and it's absolutely necessary to have this kind of help especially for people who are frail, many of them having cognitive impairments besides.

So what should we all be advocating for in a managed-care system for appeals? First we need to look at substantive rights, rights that are found in the Medicaid statutes that have been clarified through lawsuits, regulations and guidance and two really central Medicaid rights are aid-paid pending and access to a fair hearing.

Aid-paid pending is the term used to describe the right to continue to receive services while an appeal about discontinuance or reduction is going through the appeals process. Aid-paid pending through be available through all levels of the appeal until there is a final resolution.

Aid-paid pending also must cover any service that an individual is currently receiving. One problem we see right now is that current Medicaid managed-care regulations allow the option of denying aid-paid pending if an authorization period has expired.

So if for example an MCO authorizes LTSS services for six-month periods and then looks at it and reauthorizes, aid-paid pending rights would not be there if services are reduced at the end of that six-month period and you'd want to try to make sure that your state isn't allowing that to happen.

Speedy access to an outside decision-maker also is a critical right. Most plans have one internal level of appeal but moving through that level sometimes is futile and simply slows access to an outside decision-maker.

Many states allow an individual to bypass the internal plan appeal and go straight to a fair hearing and really to do otherwise puts Medicaid beneficiaries who are in managed care at a disadvantage compared to Medicaid beneficiaries who are in fee-for-service and can go straight to a fair hearing. Then we really need to look at the notices themselves. Do service reductions trigger notices?

Do care plan decisions that are contrary to the wishes of the individual trigger the notice and as we think this through in the context of managed care with care teams, with all the members of the care team being paid by the MCO, how do you make sure that individuals understand that some options were considered and rejected and that the individual has the right to challenge those choices?

And then are notices designed to clearly state what was denied and why? Does the notice provide enough specific information about the decision, about why

it was made, about the legal authority for the decision so the individual can reasonably evaluate whether to appeal and has enough tools to know how to do it?

Are the notices written in legalese? Are they as they should be written at a fifth or sixth-grade level? Are the notices available in Spanish or in other languages? Is there a notice on the notice telling people how to obtain translations or where to call to get an oral translation if a written translation isn't available?

And what about alternate formats, Braille, large print, audiotapes and have the plans already collected information about individuals' needs for alternate format or translations and have they used that information when sending out this vital information to affected individuals so that they know to send a notice in Spanish or to send a notice in large print for example?

Also we need to look at the decision-makers both inside the MCO and outside at the appeals level. Are they people who understand LTSS issues including the importance of services that provide independence and help individuals to be part of the community?

Decision-makers trained to evaluate appeals through an entirely medical lens just won't do the job effectively and does the system include adequate support for individuals seeking to appeal plan decisions? Is there an ombudsman and is that function adequately funded relative to the number of individuals enrolled in the MCO?

Wisconsin for example, it's a state that funds an ombudsman program and it funds at a level that assures at least one advocate for every 2500 plan

enrollees. Now you should be thinking what is the appropriate number for the plans, what's the appropriate level of funding for plans in your state?

And then what about complaints that don't specifically involve reduction or denial of services, things that we would usually call grievances but instead have to do with how the services are delivered?

Is there a system whereby complaints are investigated and responded to in writing within specified timeframes? Are call center personnel trained to handle complaints as grievances rather than to just nod sympathetically and do nothing about them?

Are plan members given enough information to understand their rights to file a grievance? If a response to a grievance is unsatisfactory for an individual, what further redress does the individual have? Is that a dead end or are there other steps that can be taken?

And finally is all of this being monitored? Does the state collect data on appeals and grievances on how many are filed, on what actions the plan has taken, on how many plan decisions were reversed when an appeal went to an outside decision-maker?

And is this information available to stakeholder committees and to the public more generally so that they can be doing some evaluation of the plan? Are reversal rates considered in plan evaluations by the state and in ratings that are available to potential plan members perhaps on the Web?

So those are some of the questions. Let's look at Ellen and see how some of this might work or not work in her situation. As you'll recall she's a wheelchair and walker user and has multiple conditions.

She'd been in a nursing home for several years and now she really values her independence now that she's back in the community. Her personal care needs are fairly high particularly because her stroke had left her with very limited strength and use in her hands.

Now she just got a notice that her plan is reducing her care hours by 20 hours a month. Lately she's been experiencing a decline in her strength and she's really terrified that with the drop in hours for reasons she really doesn't understand at all she's going to end-up back in a nursing home.

So the notice she got was vague. It didn't let her know why she was facing this change. That shouldn't be. She needs aid-paid pending whether or not the plan decided to do this at the end of a periodic authorization period.

Ellen's condition is continuing regardless of any arbitrary authorization periods and Ellen clearly needs help getting through this. she's been losing sleep with worry and realizes that she's in no shape to put together an articulate appeal and she's confused about what information she needs to put it together.

Now an ombudsman could certainly help her understand the process and help her to prepare and it's also possible that an ombudsman could bring informal resolution without even needing to go to a fair hearing because Ellen reported that there was some confusion about her latest medical records and it really might be something as simple as straightening all that out and that's all that's really needed to get her back the hours that she depends on.

Let's look at another issue that Ellen has which is more in the line of a grievance. Ellen has concerns that the home health nurse that comes and visits her is talking with her personal care attendant outside of earshot.

Ellen's been promised a person-centered care program but she feels that she's being cut out and also she's really concerned that her privacy interests are being violated. She's asked the nurse to stop but the problem keeps going on.

Long-term services and supports are so personal and having control and being able to get resolution when problems arise are very critical and often as critical as the issue of the actual authorization services.

Ellen needs to have a grievance mechanism that ensures that her concerns are heard and also that protects her from any fear that she might have of reprisals by her caregivers if she raises her complaints to a higher level.

She needs to know that her concerns will be addressed in a timely manner and with respect and she needs to know in writing what the MCO's going to do to resolve her issues.

So those are some of the sort of issues that we see around appeals and I'm going to turn things over now to Silvia who's going to talk about civil rights and also some of the important issues of oversight and monitoring.

Marisa Scala-Foley: Georgia, we actually got a question that - we got a few questions - but one of which I'd like to take now. I think we may hold others for later but a question from Deborah who asks where would the conventional thinking be that the ombudsman would live? Would he or she be at the agency that handles managed care within the state or the state Medicaid agency or someplace else?

Georgia Burke: Well, our view particularly when we're talking about long-term services and supports is that the best place for an ombudsman would be a contract with an independent community-based organization that really has an understanding of the needs of consumers particularly with long-term services and supports.

So we would think that the ideal situation would be for it to live outside of the state agency per se but be contracted probably with the state healthcare agencies, whichever one generally oversees the Medicaid managed-care plans but that it be an independent, outside, non-governmental group.

Marisa Scala-Foley: Okay, thank you.

Silvia Yee: Hello, everyone. Thanks to Georgia and to Marisa. I will be covering two topics from the tool that like most of the other topics in the Webinar look especially at the kinds of protections that can be embedded in the system to try to ensure that the healthcare services and approaches to service delivery that we looked at in the last Webinar in June such as care continuity and patient-centered planning to ensure that those things are actually delivered.

So the two topics I'm looking at are civil rights and state and federal oversight and monitoring so in terms of civil rights, I'm looking primarily at the disability background and the sources of civil rights federally are that individual providers and managed-care organizations are subject to Title III of the Americans with Disabilities Act because they are public accommodations.

States and local government agencies are subject to Title II of the ADA as local government entities and the Affordable Care Act which is and remains law in the country restates that health programs or activities that receive

federal financial assistance are subject to federal anti-discrimination laws including Section 504 of the Rehabilitation Act of 1973.

So in terms of civil rights, the challenge is to preserve the use of relevant civil rights laws as a source of beneficiary rights and to retain access to courts as another forum for individual complaint and systemic protection purposes.

One thing that states can do and advocates can ask for is to ensure that beneficiaries are notified of their civil rights and that all stakeholders including providers, managed-care organizations - if we can go back to the last slide - managed-care organizations and the personnel involved with complaints or appeals are trained on civil rights laws and how to meet their legal obligations.

But we did cover civil rights somewhat in the last Webinar and we primarily covered it as a means of informing what beneficiaries can and should ask managed care to deliver.

So beneficiaries who are people with disabilities have certain rights under federal and state disability rights laws so those laws should and must be acknowledged by plans in their service contracts with the state or with CMS.

In this Webinar we're trying to focus a little more on the ways in which states and plans should be required to ensure that civil rights have a procedurally-protected place within managed-care systems so in terms of notice, we're talking about broad proactive notice.

Will the states and plans effectively notify all beneficiaries of their right to request effective communications, accessible provider offices, and reasonable accommodations and policy modifications when they receive healthcare

services? This can't just be a small sentence in regular print at the end of a 20-page-long notice.

Effective communication requires proactive planning and involvement on the part of the plans in the state and I think this is especially important for many individuals who have acquired disabilities late in their life who don't necessarily identify as a person with a disability or think of themselves as a member of the disability community.

They didn't grow up per se knowing their civil rights as people with disabilities. At the same time people who are acquiring disabilities later in life especially around hearing or vision, these are disabilities that affect their communication functions, they may not necessarily be identified as someone who's visually impaired or hearing impaired in their state Medicaid codes.

That's not something that they've had all their lives so and the second issue around notice is will enrollment in managed-care organizations curtail or affect the right to bring individual civil rights or class-action lawsuits?

Some managed-care organizations just as a standard part of membership of being a member in the plan for example restrict a beneficiary's right to bring malpractice lawsuits and they require individuals to undergo individual arbitration instead.

First of all, civil rights should not be curtailed in this way. An individual's right to be free of discrimination should not be restricted and equally important not beneficiary should have their legal options restricted in any way without clear notice about that and I would include restrictions on consumer and malpractice rights and this requirement of notice.

Again continuing on with civil rights looking at accessibility and integration, we covered these a little bit in the last Webinar but they're very important. Is the managed-care organization, are they getting to survey all of their provider networks for physical and programmatic accessibility?

Does a managed-care organization actually know the extent to which they have offices that are accessible, that people with mobility disabilities can enter? Do they know the degree to which their providers have height-adjustable exam tables or have made arrangement for ASL interpreters, the degree to which providers make alternative print formats available, etcetera?

Will the front-line office staff at the plan have access to this information and in turn will they be able to provide beneficiaries with that information so if someone calls in and says I have a mobility disability.

I'm looking for a gynecologist that has a height-adjustable exam table so when they actually - that is taking patients - and that is in my area. Will they receive the assistance they need to make an appointment with that provider and to find that provider?

Will managed-care organizations be trained in beneficiaries' rights to receive healthcare services in the most integrated setting in accordance with the Olmstead decision?

And will those managed-care plans participate in the states' Olmstead plan and agree to establish measureable goals around helping seniors and people with disabilities maintain homes and lives in the communities?

These aren't just auxiliary rights. They can't be ignored as long as good healthcare is delivered. These are an integral part of good healthcare. A

patient is not getting good healthcare if she or he doesn't know what a provider is asking, what the provider is doing or why and doesn't understand the prognosis and treatment described.

In the long-term services and supports context, plan and provider decisions about who should get what kind of LTSS service and when home and community-based services are warranted cannot be effectively made by a plan or its providers without a full understanding of the beneficiary's legal right to return to or remain in the community?

And civil rights implementation, will the state and managed-care organizations commit to proactive plans to identify and consistently meet the linguistic, cultural and accessibility needs of plan members who have characteristics linked to health disparities? This is broad.

Many populations and many population characteristics are linked to health disparities including limited English proficiency, deaf persons, lesbian/gay/bisexual/transgendered persons, etcetera.

Do the implementation plans include genuine benchmark goals, data collection and monitoring obligations and training for managed-care employees and all their contracting providers including the nursing homes, including the OT or PT services that could be provided in a home including adult day centers and including community-based providers?

There is always some aspect of accommodations, reasonable accommodations and policy modifications that a provider might not be used to. Even a provider that deals all the time with people with mobility impairments for example and is accessible in that way may not be aware of their obligations with regard to language access for example.

Systemic needs and viewing them through the lens of civil rights. Does the state or the managed-care organization prioritize hiring and retaining long-term services and supports providers that can meet racial, ethnic, disability or other underserved population needs and preferences?

This first point is not exactly a civil right but it logically follows from the recognition that a managed-care plan or the larger healthcare system cannot possibly meet the accessibility and accommodation needs of beneficiaries unless key personnel including LTSS providers have such specialized capacities as additional languages, accessible equipment and varied cultural backgrounds?

Will the state administrative and internal plan staff who handle complaints and appeal processes receive ongoing training on the right to reasonable accommodations and policy modifications both in healthcare service delivery and in complaint appeal processes?

It is really critical to have complaint and appeal staff receiving civil rights training. If individual beneficiaries cannot even get the complaint staff to appreciate that A, beneficiaries have civil rights and B, those rights have been violated, then it would be impossible to get the front-line staffing providers to understand and take those rights seriously.

I'm going to reintroduce Victor quickly. Victor is someone again based on real people, all of our case examples who we introduced in our last Webinar and just to look at him again today briefly.

When Victor was 60 his legs were amputated after an infection and that was really his first major disability and impairment. He entered a nursing home at

that time and because he had limited savings and a disability, he qualified for Medicaid and Medicare.

Victor always wanted to return to the community and after three years, the Medicaid Money Follows the Person program helped Victor to find affordable housing, furnishings and community providers.

He currently lives in a senior living apartment complex and enjoys overall good health. He enjoys the freedom to set his own schedule in particular and he has a lot of social interactions with his church community.

Victor receives a few hours of tour and meal assistance each day and exercises daily to maintain his upper body strength and capacity to transfer independently. Right now he is 64 and he uses a power wheelchair.

He's actually pretty healthy though he takes more heart medication and he's also losing some of his vision so in Victor's case, a civil rights issue arises as he continues to receive health information. He gets letters from the state and letters from his plan and long-term services and supports related notices in standard print and now he can barely read them due to his worsening vision.

I think the next slide will have some of this information as well. His attendant is actually not reimbursed for reading to him and even if he were, Victor wishes to maintain his independence and the confidentiality of his personal health information.

So as you can see on the slide, is Victor first of all is he notified of his civil right to request alternate formats especially around large-font print? He can still actually - Victor's not someone who reads or understands Braille - but a large font is something he can negotiate and also potentially audio.

So he would like to maintain his independence and so he needs these alternate formats for his general and personal health information and the notices that he gets. Is Victor informed of his right to bring a complaint if his request for an alternate format is refused?

Is he given an appeal process or a complaint - is he provided with accommodations - during the appeal process? Do they understand that Victor has to be able to see all his information in order to prepare his case?

Is data kept on the complaint as a civil rights issue? It will be important to be able to go into the information provided by plans and by the state to figure out well how many civil rights complaints have been raised or is there really an issue with civil rights around alternate formats or around a failure to get information about accessible offices for example?

Could Victor and other beneficiaries who cannot get alternate formats bring a class action, ADA or Section 504 lawsuit? If Victor for example learns of other beneficiaries, a number of friends or other people who cannot get alternate formats?

Do they have the freedom? Are they restricted in any way from thinking about bringing a system-changing class action lawsuit so now switching to the next topic of state and federal oversight and monitoring.

Marisa Scala-Foley: Actually Silvia we got a question in from (Kristin) who asks how are managed-care organizations themselves being educated and monitored on these guidelines and requirements?

Silvia Yee: Right. This is - our thought in our toolkit - we had called for the states' contracts with managed-care organizations to very clearly specify lines of accountability. Managed-care organizations just on their own as private entities whether non-profit or profit are Title III. They are subject to Title III of the ADA.

They are supposed to be following disability rights laws but by formally entering the system, by taking over Medicaid functions for the state, then they also enter into the line of receiving federal funding.

There are entities above them. They're carrying out a government function by providing Medicaid and so the state and CMS above them should be the entities that monitor and provide oversight of the managed-care organizations and ensure that managed-care organizations are actually doing disability rights training and educating and monitoring their provider networks. Does that answer the question?

Marisa Scala-Foley: Yes, I think so. (Kristin), if not, let us know and also it's another great opportunity to promote the fact that your engagement in these efforts is really important in terms of making sure that contract - that implementation - happens in a way that protects, you know, the clients whom you serve, it protects their rights or the consumers whom you serve.

And also that these managed-care organizations are being educated and monitored on the guidelines that we're talking about today so really just to reinforce the message we've been trying to convey all along that your presence in this process is going to be critical to make sure that we get the system that we want for the people whom we serve.

Silvia Yee: Yes, that's again, here in California it's interesting how advocates have actually managed to influence some of the managed-care organizations even before all of this firm (foment) in the last few years was managed care and the interest in getting public beneficiaries into managed care.

There has - advocates here - have really been working with a number of managed-care organizations to convince them that you can't provide proper medical care unless you provide reasonable accommodations and know your disability rights.

And it had an influence here but now this is a much stronger additional hook and opportunity to impress upon managed-care organizations their need to understand disability rights laws. In terms of state and federal oversight and monitoring well, I mean, there's a tie-in.

The challenge is we have a number of interrelated federal, state and local agency responsibilities for distinct service areas and it makes it difficult to have clear lines of responsibility for oversight, for monitoring and for ensuring implementation.

What we can really advocate and try to do is to avoid unnecessary overlap, achieve efficiency, foster high levels of cooperation and maintain existing expertise. That's a very tall order.

One of the first things to ask is does the state identify and define the role of every state or local agency or department that has been or will be involved in the delivery of long-term services and supports?

So looking at the next slide, I mean, it's easy to just list off a bunch of agencies and personnel that are involved in LTSS. It's much harder to give clear lines of responsibility for specific service areas.

It's important to have - the state has to have - a plan with clear transitions and time periods. It has to have a plan to maintain, develop LTSS relations and expertise and if necessary to restructure and rehire.

Its counties have been involved in now responsibilities changing from counties or transitioning from counties to managed-care organizations, still what is a monitoring agency that will be looking at let's say home and community-based services when managed-care organizations become involved?

There has to be single lead responsibility and it has to be clear where the buck stops in terms of care coordination. Where do you go if you have a problem with accommodations? Where do you go when you have a billing dispute?

Where do you go if you have a problem with independent medical reviews or Medicaid Part D formulary problems, etcetera? That has to be spelled out in some way. It's not enough just to have a list of agencies involved. On the next slide, continuing with monitoring.

Does oversight include activities to quickly identify and resolve immediate and developing issues as well as data measures that are designed to monitor managed-care organization performance and beneficiary satisfaction over the long term? There will be complaints about immediate needs and individual especially urgent complaints need to be addressed quickly.

At the same time there has to be data kept to see when systemic issues are arising. If there are many individual medical reviews that are requested around a particular condition for a particular plan, this is a sign that there is a systemic issue developing in that long-term services and supports context.

If there a lot of appeals around reduced in-home supports and services hours in a particular county or with a particular plan? That's another clear sign that a systemic issue is arising.

Looking at the next slide, some specific activities that the state can commit to in its oversight and monitoring. Secret (software) surveys of LTSS networks so actually having someone going in and seeing are they getting the home and community-based services that they are supposed to be getting?

Is the plan monitoring and coordinating if that isn't happening? Are there audits of managed-care operations and LTSS subcontracts? Is managed-care organization encounter data on LTSS reviewed and analyzed?

Is there a state-run dashboard that can track how well managed-care organizations provide timely access to home and community-based services over time and during critical care transition periods like a return back to one's home after a couple of weeks in the hospital?

Are there real-time state backups for critical individual LTSS services like personal assistance and these are just a few ideas and the critical point to get across is the state cannot just make its oversight and monitoring dependent upon getting sufficient funds or if funds are available.

Oversight is integral not only to determining if beneficiaries are receiving the LTSS services they need but also to defining over time what success actually means for this population and for these people.

It can't be just a number of ideas that they'll think about more when they get money and finally on the matter of accountability on the next slide, is information exchange with stakeholder groups and any individual ombudsman built-in to state oversight and monitoring?

Will the state provide the public with historical and ongoing from its monitoring and managed-care organization performance and quality in a timely and regularly-updated fashion and will federal information about plans providing Medicaid benefits be similarly available?

Transparency is a vital component of oversight and monitoring. The state will not hold the feet of managed care to the fire so to speak unless advocates and the voting public can hold states' feet to the fire in terms of healthcare quality and sustainability.

So I'm just going to end now with looking at Maria, another individual who we introduced during the last break. Maria is a Spanish speaker and she lives alone. She doesn't have access to much public transportation. Going into her timeline a little bit, when she was 82 her mobility was declining because of hip problems.

She needed help to stay at home safely and she couldn't do a lot of things like bathe without assistance. Sometimes she got depressed because her life was becoming more limited and more narrow in her activities.

Her daughter tried to organize the help Maria needed but it was difficult. Two years later at 84, Maria fell. She broke her shoulder and bruised some ribs. She was in the hospital in rehab for a couple of days but then returned to her home.

At 85 a year later she had a serious stroke resulting in some pretty substantial care needs and moved to a nursing home. Now she's 88 and Maria has been in the nursing home for three years. She has increasing dementia and is very frail but enjoys the people there and the activities and her daughter pretty well makes all her decisions.

So I'm going to move back a little bit in time and looking at when Maria was 85 and after she had the stroke. She and her daughter sought information about Maria's long-term services and supports options because they realized that it would be extremely difficult for Maria to return to her home.

In terms of accountability and oversight, what kind of agencies are going to oversee Maria and her daughter's receipt of current conflict-free information about home and community-based services, assisted living and nursing home options?

Where will they be able to get updated managed-care organization performance and quality data and managed-care organization monitoring of nursing home contractors? Is that going to be available online?

Where will they be able to get that from? Who will oversee how the hospitals and the medical and long-term services and supports providers will be paid during and after hospitalization?

And who will take the monitoring lead over coordination during this transition period when they're really trying to decide between the hospitalization is over, they're not sure whether Maria is going to be able to stay in her apartment, there might be a transition to a nursing home?

They're looking at home and community-based services. Who will coordinate paying providers during this time and coordinate care transitions during this time and finally who will oversee and ensure that Maria receives Spanish translation and written materials?

There will be a lot of front-line workers in this situation, lots of the independent enrollment broker, a community-based organization, different agencies, county mental health, a lot of different people will be involved on the front end on the ground.

Who will oversee all of this front-end work and monitor to ensure that the front-end folks are doing their job and potentially provide corrective information if the front-end folks are not doing that?

Who will help the front-end folks perform a course correction when mistakes are made and this is not at all a comment on the quality of front-end providers, it's just a reality. We're talking about thousands of people, a lot of transitions and mistakes will be made.

It's a matter of how those mistakes will be corrected and caught so thank you very much. That ends my two topics for this Webinar. I'm going to hand this over back to Mary Lou.

Mary Lou Breslin: Well, thanks very much Silvia. I want to just say a few words about quality measurement because it's such a central element, I mean, ensuring both access

as well as coordination and satisfactory experiences across the range of services and supports that individuals with disabilities require in the managed LTSS environment.

But I want to just begin first by saying that I suspect that many of you have not had to deal directly with development of quality measures or with perhaps even using them. Some of you will have had direct experience and will know a lot about them, will know sort of what the state of the art is.

But I would really urge and encourage everyone to take some ownership over this topic and not think that it has to be put in the hands of the researchers or the hands of specifically of experts.

Because there's so much input that's necessary from seniors and people with disabilities and advocates on this issue that even if it may be new to some of us, it's going to be one of the key elements that we use to determine whether or not the structures that we want to see in place are in fact in place and working.

So please know and believe that you should and can and must be involved in this process as it unfolds. I want to just begin by posing a few questions including well what is quality measurement and why is it important?

What are we supposed to be measuring? Are there any tools available and how can we as advocates be involved in developing meaningful measures and also ensuring that they're being used? Let's just start with what is quality measurement. There are of course a number of definitions.

This is just one to choose from. Quality measurement in this definitely is the mechanism whereby data and information about personal quality of life

outcomes, quality assurance processes and organizational quality improvement efforts are collected that promote quality at the individual provider and system levels.

At the person level, data is absolutely the best tool to understand progress toward person-centered goals and a desired quality of life outcome and it can help answer questions such as are mechanisms available to ensure that desired services are delivered?

Is progress being made toward achieving goals? Does the person have a feedback mechanism to report on progress or on any problems he or she might be experiencing? At the provider and system level, data is also essential and required to generate improvement in the service delivery processes and system.

That sort of total quality management approach is evident in this aspect of quality measures so why is quality measurement so important? Well there's a whole variety of reasons why we need quality data and these are just a few of them.

Data enables state oversight of the extent to which MCOs honor commitments to person-centered quality services for people with disabilities and seniors. Data encourages MCOs to focus on meeting stated needs of consumer and tracking outcomes against advocates and others tools to hold both plans and MCOs accountable.

Data helps consumers make informed choices when they have a choice among MCOs and when similar outcome measures are used across programs and services settings, data can be used by consumers to make choices and by

advocates and policy-makers to shift resources to programs and settings with better outcomes so what should be measured?

Well, person-centered outcome data such as quality, adequacy and impact of services should be measured. Quality of life and social participation should be measured and this includes elements such as autonomy, choice, meaningful relationships, privacy, dignity, many of the elements that we're familiar with from the person-centered approach.

Family and caregiver data such as adequacy of supports, stress concerns, financial impacts can be measured. In addition health functioning and diagnostic data can be measured. Cost, incident reporting and complaint data can also be measured through a quality measurement process.

So are tools currently available to measure quality outcomes in the MLTSS environment? What is true is that home and community-based services are non-medical and they operate in a different framework than the health system in performance measures.

And as a consequence measures in HCBS are really in the early stages of development compared with clinical services and settings. As a result, thus far no quality measures have been validated for use nationally.

For example the widely-used quality measure set such as the healthcare effectiveness data and information set and the consumer assessment of healthcare providers and systems sets do not take into account or include targeted measures that reflect the person-centered measures required to evaluate outcomes in the managed LTSS environment.

The Center for Healthcare Strategies released a report in November 2010 that identified the top 10 mileposts for reaching effective managed long-term supports and services delivery and the report stressed that performance measurement is not possible without LTSS-focused measures that stress individual consumer outcomes.

So having said that, are there tools available even though we know none have been validated for national use so against this backdrop, what's the answer to the question? Well, the answer is that yes, there are some tools that are available. States really do not have to start from scratch to develop these tools.

Instruments are already in use and in some cases they've been validated for specific settings, not for national use but for specific situations in which they're being used and some states have created tools using models created by the Council on Quality and Leadership.

And these models contain many of the key questions that would likely be pressed into service in developing a quality measure in the managed LTSS environment so how can we be involved in this process when it appears to be sort of in the realm of the academics and the researchers?

Well, in light of the important role that these quality measures are going to play in ensuring and preserving beneficiary rights, we think that people with disabilities of all ages who use LTSS and HCBS are really one of the best resources particularly on our own experiences and outcomes of services that are required and that we must be key participants as states develop quality measures.

There are a number of venues and structured opportunities for providing input including as we mentioned earlier the idea of making this information

available and participating through the state and MCO advisory boards and stakeholder forums.

Specifically advocates and consumers should urge for specific principles related to development of quality measures such as broadening the definition of standardized quality measures because data actually can be aggregated on items that are personally defined rather than standardized in the traditional sense.

We should also be urging states to structure contracts with MCOs with a requirement for uniform valid and reliable reporting and evaluation through the use of personal outcome measures.

We should be maintaining suggesting that uniform metrics are maintained throughout the state and across MCOs and make sure that clinical, functional and personal outcomes are integrated.

This of course is a significant challenge but it certainly is one that we need to be at the table and participating in discussions to make this a reality. Okay, again let me just that I really urge people not to be flummoxed by the requirement for quality measures they need to be involved in developing good tools for use at the state level.

We need to be at the table during these discussions. Let me just wrap up this section by bringing us back to Ellen and what does quality measurement have to with her? Well, first this is really all about her.

Her experience as someone who receives LTSS and HCBS has to be measured in order to determine how she perceives her quality of life and whether or not

she thinks she's making progress toward or has reached the goals she's defined for herself.

And in addition she has important experience and qualifications as a consumer to be a valuable resource to advisory committees as they advocate for quality measurement and determine what are the questions that should be asked to collect the needed information?

And let me just end by saying that developing authentic and reliable quality measurement tools in the LTSS environment is really going to take time and collaboration but it must not be a hurdle that states and MCOs use as a reason to avoid the necessary work or as an excuse to sidestep the process so we all need to stay engaged as this piece of the process unfolds.

Okay, I'm going to actually stop at this point and turn this over to Georgia for the final section.

Georgia Burke: Thanks, Mary Lou. Behind all that we've been talking about is of course the matter of money. Both the payment structures to the MCOs and the payments that the MCOs make to their providers need to be structured in ways that incentivize good care and that also support rebalancing so more people can stay in the community longer.

But we all know that savings and state budgets also are a big motivator for the move to managed care and we need to recognize that. I think one thing we really need to remember is that this is largely new territory in most states, bringing this population into managed care and incorporating all of their services including LTSS under one umbrella.

So the answer on how we structure payments will likely really be a work in progress that needs fine-tuning along the way but from the start there should be some risk adjusters based on diagnoses but also on functional limitations and what's really important is there should be a move away from basing payments on where an individual resides.

Plans shouldn't be paid more for residents of nursing homes compared to those living in the community or if there is some differential rate, it shouldn't reflect the full differential between nursing homes and community care because if you do that then there's no real incentive whatsoever to keep people living in their homes.

Also there should be some bonus payment or transition payment, something that needs to be part of the design in order to encourage plans to transition people back into the community and to recognize that there really are additional costs when you do transition somebody.

Some states have tried different models. In Arizona the state pays plans a blended rate that incorporates nursing home and community-based costs but over time it gradually tilts to a greater percent of community-based costs so basically that blended rate kind of starts shrinking and thus will only work well for the plans if they move more people into the community.

In Minnesota plans get a bonus for residents that they move from nursing homes back into the community so what should we as advocates be looking for? Is the rate setting based on diagnosis?

Are functional limitations also looked at because functional limits more than the cause of those limits are really the predictor of what the long-term services

and supports costs are going to be and care setting like the nursing home really shouldn't be a primary factor in setting reimbursement costs.

Also are there risk corridors or reinsurance provisions to protect against extreme costs of outliers? Is there some good monitoring of how these costs are going built-in to the system so that these measures - these risk corridors and all - can be tweaked over time?

How does the payment structure incentivize moves out of institutions? Are there bonuses or is there some other payment structure that gives plans something extra when they move people into the community?

And what about rewarding quality? Is the state asking individuals about their quality of life and their integration into the community, some of these questions that Mary Lou was just talking about as part of the evaluation?

And if those questions are being asked, do the responses translate into quality payments for plans? Do plans get rewarded if they're doing well and not rewarded if they don't and is there a requirement that savings be achieved through quality improvements and not through squeezing rates that the plans pay to their network providers?

And we all know that some of the best MCOs are non-profits and community-based so we need to look at whether the payment structure adversely affects these entities and makes them less likely to participate in demonstrations or in Medicaid managed care more generally.

Is too much capital required? Is there too much risk that is being undertaken that these smaller, non-national, not-for-profit groups might not be able to

absorb so those are some of the questions and let's look at Maria and see how this kind of broad issue of financing really addresses individual needs.

If we look at Maria when she was 82 and she was living at home and her big issues were that she didn't have much public transportation and her mobility was declining and she needed to stay home safely but she couldn't do a lot of things and sometimes got depressed because her life had become so much more limited.

Maria needs personal care services but just as important, she needs some social contact. She needs trips to a senior center or adult day health and if an MCO does nothing more than keep her out of a nursing home, it's really not doing its job.

So the financial incentives need to be there to encourage plans to help Maria to get out of her apartment and participate in her community and her community happens to be Spanish-speaking.

Quality evaluations by individuals and their families and not just forms in English but evaluations that are available to people who speak other languages as well must be an element in plan payments.

There's a real risk here that plans will just be incentivized to do the absolute minimum to keep people out of nursing homes. Money talks and innovative financial incentives are needed to make sure that person-centered planning really turns out to be more than just a slogan.

Let's look at Victor. Victor had been in a nursing home for three years after his amputation. Let's assume that he's in a managed care organization while

he's in the nursing home and getting him re-established in the community, it's really going to take some doing.

There's going to be up-front costs to get his living arrangements in place and with his increasing vision issues, he's going to need a lot of help in the beginning getting oriented to his new surroundings, getting help he needs, establishing the patterns that allow him to get back to his life in the community so there's going to be a lot of case management costs as well.

So getting Victor out of the nursing home is much more likely to happen if his MCO gets financial rewards for doing this, special payments or bonuses, payment structures that are based maybe on how many people a plan manages to serve in the community.

All of these are options that could work to make Victor's transition really happen so those are a couple of examples. Finally I just want to emphasize just as Mary Lou emphasized with evaluation that sometimes that seems like an area where there's experts and advocates find it a little difficult to get their toe in the water.

I think the same thing is true with finances. Most of us aren't numbers people. That's why we're in law or social sciences or health but we really need to pay attention to the financial structure of MCO payments because if the money doesn't work then the consumer protections, the network access and all the rest of it isn't going to work either.

So that's the end of our presentation. Our contact information follows and I'll turn it back to Marisa to walk you through some of the resources that are available and particularly urge you once more to look at our tool which goes into what we talked about today in more detail. Thanks very much.

Marisa Scala-Foley: All right, thank you so much Mary Lou, Silvia and Georgia for a terrific presentation. We've gotten - first I want to really quickly because we only have a few minutes left so we can end at 3:30 - I wanted to quickly walk through some of the resources that we've included as part of these slides.

First is the toolkit that our presenters today have been referring to, their toolkit on long-term services and supports beneficiary protections in a managed-care environment.

We did get a question earlier that asked, you know, is there an entity that can review state of MCO contracts or, you know, is there an assessment tool that could be used to analyze the contracts if advocates can get a hold of it themselves?

You know, I would encourage you to look at this toolkit as sort of a way, a lens through which you can view some of these contracts and some of the implementation that may be happening in your states.

It's a tremendous resource as front and we've only gotten, you know, we sort of have been limited to 90 minutes per Webinar so really we haven't been able to go into nearly as much depth as the toolkit that NSCLC and DREDF have put together on this so we really encourage you to explore that as well as the Website on which that toolkit is housed.

We've included some other resources, the National Association of States United for Aging and Disabilities has a state Medicaid reform tracker. There are also several Kaiser Family Foundation resources that we've included in the resources list as well as the Center for Healthcare Strategies.

In addition CMS has resources that they have put together that describe the initiative that are targeting people who are dually-eligible for Medicare and Medicaid and the integrated care resource center where you can look to see if your state submitted a proposal to CMS for the duals financial alignment initiative.

Finally we've also included some resources on 1115 demonstration waivers since that's another mechanism through that states are using to move toward managed long-term services and support systems.

There's a database there of CMS and Medicaid waivers and demonstrations as well as a place where you can post comments on 1115s that are submitted by states as we've also included some general resources on the Affordable Care Act as well including a link to where these Webinars are housed, where the recordings, transcripts and slides will be stored.

And that brings us actually before I turn things back over to Michele to open things up for questions, I just wanted to briefly talk about our next training.

We're looking at - while it's not specifically on managed long-term services and supports - it does look at this issue of managed care in general and look at accountable care organizations and the relationships that they have with community-based organizations or could have with community-based organizations.

We're targeting this for August. Please do watch your e-mail for registration information so with that Michele, maybe you can let people know how they can queue-up on the audio line in the remaining five minutes that we have.

Coordinator: Thank you. If you would like to ask a question, please press star 1 on your touch-tone phone. Please unmute your phone and record your name when prompted so I may introduce you prior to your question. Once again star 1 for your questions.

Marisa Scala-Foley: And while we're giving everybody a few seconds to sort of queue-up, we did a question that where can we access the previous Webinars? I did point you toward our Website. Also if you go to www.aoa.gov, you'll see a button on the right-hand side of the screen that says health reform and the aging network. If you click on that button, you'll be brought to the page where we house all of these Webinars.

We will post the recording, slides and transcript from this Webinar there likely by early next week and if you would like the slides sooner than that, please do e-mail us at affordablecareact@aoa.hhs.gov. Again that's affordablecareact@aoa.hhs.gov. Okay, Michele, have we had anyone queue-up to ask a question?

Coordinator: We do have a question. Denise, your line is open.

(Denise): My question was just answered. Thank you.

Coordinator: And once again star 1 if you would like to ask a question.

Marisa Scala-Foley: Okay, we did get a question earlier. I'm scrolling back through the chat and while we give folks a chance from Judy who asks how quality measurement might relate to a state's determination of need criteria for the purposes of managed long-term services and supports? Mary Lou, I don't know if you want to take a crack at that question.

Mary Lou Breslin: I don't actually think I know the answer to that question. Perhaps Georgia does.

Georgia Burke: We're passing the ball here.

Marisa Scala-Foley: We can also get back to her too if you'd like more time to think about it.

Georgia Burke: That's really a tough one because part of the issue is quality measurement when you're talking about a population that has high needs and some of the traditional quality measures don't always take into account the high needs that you typically with a duals population so I think it's an interesting question. I'm not sure we have an answer but it's certainly one we should be keeping in mind as we're looking at quality measurement.

Marisa Scala-Foley: Michele, anybody else on the audio line?

Coordinator: No ma'am, we have no questions.

Marisa Scala-Foley: Okay, well we are actually just about at the end of our time anyway so with that I will again thank our panel of speakers for a terrific presentation and really a lens through which that all of us can use to take a look at these proposals that states have developed and are moving forward with in many cases and thank you all in the audience for your questions.

If you think of any additional questions or if you have suggestions for future Webinar topics particularly related to managed long-term services and supports, we do want to hear from you so please do e-mail us and I've mentioned this before but our e-mail address is affordablecareact@aoa.hhs.gov.

We do want these Webinars to be as useful to you as possible so we very much welcome your suggestions and thank you all for joining us today and we look forward to having you with us on future Webinars. Thank you.

Coordinator: That does conclude today's conference. Thank you all for joining. You may disconnect your lines at this time.

END