A Two-Part Webinar/Teleconference Series on Managed Care and the Independent Living Movement - Part 1: Managed Care 101 presented by Merrill Friedman, Bill Henning and Suzanne Crisp on August 28, 2012

>> TIM FUCHs: Thank you, and good afternoon everyone. I'm with the NCIL here in Washington DC. I want to welcome you to the webinar on managed car. It's presented by the new opportunity community center, a national training assistance program of the independent living research utilization, ILRU in Houston. This webinar was organized and facilitated by the national council on independent living and support for the presentation provided by the U.S. department of education and RSA.

Today's call is being recorded so we can archive on our website. We will break several times during the presentation to answer your questions.

For those on the webinar, you can ask your questions in the public chat. That is the text box under the emote con on the webinar platform, or use the chat feature in the cart screen. I'm there in case you have questions.

And then for those on the phone, of course you can just press 7 during our Q&A breaks.

The materials for today's call including the PowerPoint presentation and an evaluation form, are on the training web page that was sent to you in the confirmation e-mail. If you can't find that link or you don't have those materials for any reason, just e-mail me at Tim at NCIL.ORG I have my e-mail open right now. If you don't have the PowerPoint or the eval link, let me know and I'll get it to you.

Please do take a minute after the call today to fill out the evaluation.

It's very easy to complete. It's very brief but really important to us. We take them seriously as we look to improve all our presentations

I have been thrilled because this has been a very popular call. I have seen registrations flooding in right up until just a few minutes ago

I know you didn't join to hear me talk about evaluations or emoticons, so to introduce our presenters for the calls this week.

Each presenter brings a unique perspective to the discussion and I'm really thrilled to have them with us. Bill Henning is with us from Boston, the executive director of the Boston center for independent living. Merrill Freedman is vice-president for advocacy. I wonder if any clls are going to adopt that, the vice-president for advocacy.

Merrill is also chair of the Michigan sclk, excuse me, vice-president for advocacy at Amerigroup, a managed care organization, and also with us today, this week, I should say, to moderate our discussion is Suzanne Crisp. In addition to being fantastic presenter and expert on Medicaid, Suzanne is the program design for Boston college. We have all had a lot of fun developing the presentation along with the folks at ILRU.

And I want to thank each of you for being with us this week and helping put this together. Let's get started.

I'm going to turn it over to Suzanne to begin.

>> SUZANNE CRISP: Thank you, Tim. It's always a pleasure for me to meet with my friends at the disability community.

Thanks for inviting me.

One of the hottest topics in long-term care services and support is managed care.

I guess a close second right now are Medicare and Medicaid eligible, they call them dual eligible. Today and Thursday we're going to be talking about managed care.

Managed care in its broadest sense is a service delivery system that coordinates and channels the use of the of services to achieve desired access, service and health outcomes while controlling costs.

We might ask ourselves why is this service delivery so attractive to Medicaid agencies.

Certainly our speakers will discuss this in more detail. But a few reasons why would be to reduce state budget deficits by controlling spending.

And to improve access to needed services by creating a coordinated network to eliminate gaps and reduce duplications.

Basically managed care organizations, or NCOs, can be large for profit organizations, like Amerigroup, or smaller not for profit groups like local providers, and they can be a combination of both for profit and nonprofit entities.

The state Medicaid agency selects the managed care organization, or managed care organizations , through a competitive bid process. They are paid on per member per month set fee, typically called a kap Taited rate, and typically are held at full risk or partial risk for providing services.

In other words, they are paid the per member per month rate, and they are expected to serve that individual in various settings then.

If they don't serve that individual within the various settings, then the managed care entity is at risk for additional financing of services.

The state typically defines what services are included in a healthcare plan, and there's quite a bit of diversity with this.

For example, some plans manage only the home and community based services.

Some manage home and community based services plus institutional services. For example, nursing facility services.

And some plans also include all of long-term care services and supports plus acute care services. Even some other plans serve the dual eligibles, Medicare and Medicaid enroll es then.

An our next slide we see that a recent report by true vine, formally Thompson Reuters, this report is very helpful to understand the growth of managed care. The link is attached here.

Don't link on that now, but after the session please look this report over.

It highlights all 16 states servicing Medicaid participants with a managed care delivery system. Particularly is note worthy that by 2014, a projected 26 states will be operating with managed care as opposed to fee for service traditional service delivery system. Knowing that half of our states will be managed care oriented, nl and ILRU developed this webinar to begin preparing the disability community with both the knowledge level and begin a dialogue about the role of centers for independent living in a managed care environment.

Today's session will focus on establishing a solid framework to understanding managed care. Thursday's session will focus on the role of centers for independent living.

There was a glossary that was sent out in the e-mail that Tim referenced. I believe it's dated Monday the 27th. This glossary was developed for you in order to keep track of all the new language and definitions that we are seeing that come from the world of managed care.

We're going to be, our format is going to be interviewing Merrill and Bill with a number of questions. Our format will be very informal.

There will be discussion back and forth between Bill and Merrill. So let's get started now.

On slide 3 is our first question. Merrill, I'd like to ask you, what is managed care and why are states adopting it?

>> MERRILL FRIEDMAN: Sure, thanks Suzanne. And good afternoon everyone. We're absolutely thrilled to be here and having this discussion on a larger scale. Fortunately for me and thanks to Tim, my cool and groovy title, I have actually had the opportunity to meet with a lot of the centers individually. But clearly there are many conversations to come.

Managed care, you did a great sort of textbook answer, which is always good for me to hear because I sometimes like forget what the bigger picture of managed care may be. It's really an approach to delivering and financing healthcare services. In the PowerPoint you will see some of this.

But it really is to generate some improvement around quality and access to the care and services, and ultimately either saving costs or rebalancing I know we have all heard a lot about rebalancing lately as well.

It really looks at that kind of financial risk and coverage that a managed care entity can provide to cover a range of defined healthcare services, which is the benefit design and inclusion of services that Suzanne was mentioning earlier.

Then that would be defined for a defined population. As we have seen in many of the states lately and the ones going forward, people, states really design their own. So it just is so different. And we always say if you are seen wen one Medicaid program you have seen one. That's because states are so basic and that would be back to the definition around getting an approach that helps to deliver and finance healthcare services for people with disabilities.

So when we really look at it now, we look at improving access to services and the coordination of those care and services.

There is a significant reliance on preventive and primary care, and that has really been the genesis and history of managed care.

Now its actually really has a different focus, with I we're really happy to be part of, which is bringing up the importance of what those services and support look like, how they are delivered, how people access them, how people choose them, how people direct them.

So really trying to change the face of what the reliance is.

And yeah, you know, definitely looking to eliminate all of that sort of duplicative services, the unnecessary services. A lot of people get multiple calls, let's say, from providers, or I have to go back for testing that they have already had, which, one, can be a nuisance, and two, can actually alter the results.

Not in their favor.

Then looking again at that collaboration between managed care and provider.

Then that kind of tees up a little bit of Thursday's conversation because we're really going to look at who are the providers now and talking about the role of the centers at that point as well.

>> BILL HENNING: We probably will integrate that into today's discussion a little bit.

>> MERRILL FRIEDMAN: I'm sure we will. Bill, do you want to add to that before I keep rambling?

>> BILL HENNING: I think one of the things that is really important to get out there is to reemphasize the context.

As Suzanne said, you know, projection is up to 26 states will have active managed care plans. Many already do in the private insurance market. Many already do for Medicaid populations exclusive of people with disabilities.

This is in some sense a tidal wave that e are not going to be able to get out of the way from I think that is really important. We're in a climate, as the trailer introducing this set, I think, on the alert, anyway.

You know, it may not be adequate just to say no to these plans. A lot of them got really tagged with a bad reputation in the '90s when they emerged, HMOs and what not.

But states are grasping, as is the federal government, at ways to control costs, to save money.

We have got, you know, ACA, the affordable care act upheld by the Supreme Court, that is with us. If the Republicans win the elect, though vowed to get rid of it. Even if that happens you still have a budget that will change Medicaid, that will change Medicare funding.

Health reform, health change is with us. Managed care is a very active response by governments to all of this totally dynamic situation.

So it doesn't mean we accept everything that is put out by the government or CMS or a provider, but it means to just say no may be to be saddled with a radically worse alternative too.

I don't want to link this in a totally negative context, but in the past advocates have said no no no, whether healthcare advocates, disability, elder advocates. I'm not sure that is a sufficient response. Or at best a holding action probably.

>> MERRILL FRIEDMAN: Right. I think, you're exactly right, and I think being able to leverage that dialogue and use managed care, so to speak, to ensure self direction, you know, eliminating institutional bias

I think there are ways to kind of open up avenues to some of the very important policy influences that the disability community is trying to have within healthcare, and use managed care as a vehicle to get there.

>> BILL HENNING: I would agree totally I think it's a period where active engagement and advocacy is essential

I think one of the things that a lot of activists are saying, if you want to be a disability rights activist in 2012, you better be a healthcare activist.

That doesn't mean there aren't other issues out there, ADA compliance, other formats, housing, but healthcare is so prominent.

And with the duals initiative and other areas where long-term services and supports or home and community based services as it's similarly known, get merged into these plans, what we think of as vital elements of independent living funded by Medicaid in the states may be part of the primary care system in certain ways.

And if we are not active, we can lose control and consumer direction will not exist. Conversely, as Merrill says, this can become a vehicle if we are strenuous in our advocacy, to advance that concept.

>> MERRILL FRIEDMAN: Right. You know, and I think, you know, somebody I was talking to recently said this is really now, you know, no longer a matter of, you know, a provider and accessing.

This is really about system and systems change. You know, we know that NCIL and the centers for independent living have been very involved in that, so it is now about systems change in healthcare.

So when you look at some of these private contracts, and we have seen both. We have seen a lot of work by the community that has been able to influence these contracts in a very positive way, and we have seen a lot of work by the community that has influenced in a positive way and the state has still gone and done something else.

So I think it's really hard because we don't always know what the outcome is going to be

I do believe as we get better at working together on this, we will continue to strengthen the overall influence. Because we talked about it in our planning sessions, that we all want community first. You know. Then being able to get the services that you need in the community. That really does make sense for managed care too and for the states from a financial perspective.

If we continue to forge forward with that being a large premise, again the state has to be receptive to it. So there's a lot of work around that. But going to some of these private managed care contracts, and I know, IBM, you referenced it, and I have always said it, that managed care has had a very crappy reputation over the years.

But it has changed. And I think that all managed care organizations are trying to sort of get to a level playing field and do more of the right thing, and to do that it does take a lot of influence from the disability community.

>> BILL HENNING: Yeah. I mean it's almost a secret, but in the independent living community, we know the value of home and community based services. It's almost second nature. I don't think a lot of us stop and think how much they are intrinsic to the philosophy we believe in, the advocacy we do.

But they are actually somewhat foreign to the primary medical, the an I cute care medical -- acute care medical world, the healthcare providers and managed care entities. If we can sell these things, you can promote community based services.

You know, if you look at personal assistance services, economically, they keep people out of an institutional setting, but they keep people active. They are consumer controlled, and they improve wellness, they improve health. Somebody with a significant physical disability, perhaps somebody with quadriplegia, needs active PAS to stay healthy.

We know that has to be upright, has to be out of bed. You don't, you have many complications with breathing, you get skin breakdown, far more expensive for the managed care entity if you have a skin breakdown.

Same thing if you can integrate active purchase and use of durable medical equipment. You will prevent many secondary conditions that are the bane of people with significant physical disabilities.

Same with, you know, community peer mental health services. If you can get somebody who has been isolated because of some form of significant and persistent mental illness as the industry labels it, get them some care which may happen through a peer relationship, not a professional, highly professional outside of the community relationship, you can start to address concerns such as CO P. D, ace as May, diabetes, things that Cal cause people significant mental illness when they are about 40 or 50 to become highly expensive, highly unhealthy, with a very high morbidity rate.

Studies will show people with schizophrenia die young, and there's ways to prevent that. There are opportunities for community support, how to interest grace Olmstead principles to how the healthcare plan operates, to innocencivize payments even to the provider for people staying out of a community instead of going into a nursing home.

>> MERRILL FRIEDMAN: Exactly. And part of that, I mean we can actually spend the next hour and a half on that last statement. Know, you keyed up there.

Part of this, because you mentioned provider piece of it I think that new managed care, I don't know, you know, really needs to embrace, you know, kind of a new provider system and a new provider network.

And we have addressed that in, you no e several states recently. And it's really not perfected yet. There are a lot of issues with it.

And it's going to continue to create a lot of fear and distrust of both states and managed care organizations as these things get hashed out around case management and care management and some other, you know, pieces to it. So there is a lot of work ahead to resolve some of these issues and to get more savvy with dealing with them from a managed care and center perspective

I think that is going to be a great platform to balanced relationships off of as we go and address these issues with the states together. But the other thing about managed care, kind of who it is and what it does, it has the ability to provide additional services. Because everybody is contently asking the question, well, you know, what can managed care do, how can they do it cheaper with the same amount of money or even less money.

Right? Being allotted. Or you know, some centers who have naturally in their states kind of created ADRC models and are doing a lot of this already, what is the benefit of utilizing managed care.

Some of it really is just the financial resources that come along with it, and some also comes with a very strong large network internally, you know, within their sort of intrinsic system to address overall healthcare needs of hospital contracting and specialist contracting and those things.

The other thing it does, it Yates an ability to really kind of utilize judgment on adding in services that reduce and mitigate risk for members and for the managed care organization.

So those are things like, you know, we would know, as do the centers, as does everybody, that if a person doesn't have electricity, goes back to what you were mentioning with housing.

If somebody doesn't have electricity and they have diabetes, that their insulin needs to be at a specific, you know, at a temperature for it to be effective, so we really have to ensure that there's power.

Right? You know, because it's long-term pitfalls of not having that for the person. Same thing that you said with ducubit pressure sores and skin breakdown, if somebody with asthma is constantly going to a hospital, we had a situation recently with that. We did a home visit and found out there were about six inches of dust around the house.

So the person was really just never having the ability to kind of get past that. So the managed care organization can pay for house keeping at that point. Really because then the person is feeling better and not going to the hospital. Back at work if that is where they want to be or raising their family.

You know, we had a gentleman on dialysis who was really lashing out, very young, and lashing out at the folks that provide dialysis services.

You know, long story short, he was getting kicked out of most centers where in fact, you know, the managed care organization ended up paying for somebody to be there with him and actually for a while a security guard. But until that gentleman could actually process and get to where he was going by himself, he built relationships with the people at the dialysis centers and worked through the things he needed to work through.

Those are just some smaller examples of where a managed care organization via owning the risk for that makes decisions to ensure, you know, really be able to tap into the prevention piece and ensure that the person, you know, is then being able to continue to self direct.

>> MERRILL FRIEDMAN: Yeah, I think the more you can push things like this and sell it from an economic standpoint. Although never surrender the independent living or human justice element. Because if it's ever proven not economic, we still want to push these things.

>> MERRILL FRIEDMAN: Exactly.

>> BILL HENNING: Maybe Merrill's board doesn't want to hear that but the rest of us sure do. You can push things such as home modifications, housing search potentially, peer mentoring is part Massachusetts duals initiative, will be funding options counseling for nursing home diversion.

You know, standard ILC services, you may be able to get in there.

It's in everybody's best interest for these things. And part of the risk is don't be overwhelmed by the complexity of health insurance plans. This might be jumping a little bit ahead to Thursday, but I often worry people say, well, health insurance plans are complex. And they certainly are. There's no doubt about it.

But that is where you makes alliances with healthcare advocates. I think that is a tremendous essential allegiance that we have to have. There are health care advocates in every state with the legal services attorneys who can help wade through these things.

Then there are overshrouded really by what we believe in. Consumer direction, integration, consumer involvement, choice, living in the community.

It's there to be pushed. Doesn't mean it's all easy, but it's there to be pushed from an advocacy platform.

>> MERRILL FRIEDMAN: Absolutely. And it's the other thing that drives the reduction of healthcare disparate. Yes, Suzanne, are we too long on question one?

>> SUZANNE CRISP: No. Think we have a lot of questions so I'd like to get to those. Just by way of summary, sounds like half of the nation is going to be involved in some sort of a managed care service delivery system overthe next two years.

So it's here to stay. So now that we know that it's coming and it's going to be here, it's here or it's coming to our state soon, how do we grapple with that then? Sounds like managed care got off to kind of a rough start in the '90s and early 2000s.

But what I hear you all saying is that there's a new managed care out there that emphasizes personal assistance services and prevention, and it also –

>> MERRILL FRIEDMAN: It doesn't, it can, we have to advocate to steer it in those directions.

>> SUZANNE CRISP: Okay, so that is part of our role then to make sure that it does include this. It also includes flexible services then. So it's sounding like we have learned a lot from our mistakes then.

>> MERRILL FRIEDMAN: There's plenty more to learn. I think that is what brought a lot of people on the phone will feel as well because it's just, every time you go to a new state , and the state puts in, you know, different requirements, it's going to change the tenor, you know, of how that works.

And so yeah, there's just, there's still plenty more to learn.

>> BILL HENNING: And there are plenty of risk. We can get to that in a subsequent section here actually.

>> MERRILL FRIEDMAN: Yes.

>> SUZANNE CRISP: Tim, if we can go to questions. I see that we have a lot of questions.

>> Yep. Wes, if you can get the instructions for asking questions on the telephone, I'll start out with a couple questions we received over the web.

>> The line is open for your questions. If you have a question or comment, please press 7 or Q on the telephone keypad.

>> Thanks. So while we're waiting for folks to queue up on the phone, let me start the first question from the image center.

They are wondering if we can talk a little bit about managed care and how that relates to services for people with mental health labels.

>> BILL HENNING: Sure. I think that managed care is being targeted for people with disabilities. It's not necessarily distinguishing about any one disability versus another.

There have been some movements by some groups to exclude people in managed kairs in certain waivers, especially DDI, but a very small subset.

Managed care is very active in the state I'm in, in Massachusetts, in some levels for people with mental illness.

A lot of it may be some basic elements like, oh, somebody calls you to remind you to take your prescriptions. They coach you or whatever. But you can expand it. And I think this is where there's a real important element, to peer models, recovery models that assist people to regain a life, break out of some of the traditional models of service and treatment.

Not to exclude them if that is what works for people, but not entirely medication based or psychiatric in patient based, to really take advantage of community based services.

You know, it's there. It's evolving. I don't know if that is enough of an answer. I don't know, Merrill, if you want to add to that.

>> MERRILL FRIEDMAN: I'd be happy to I think there are a couple of things in response. Some states continue to carve out behavioral health from the overall managed care system.

And so you will have managed care providers not unlike Amerigroup, but then you will have another managed care provider that is responsible for providing the behavioral or mental health services.

Then you have to integrate and coordinate and communicate between the two managed care organizations and really ensure that the person stays at the center of that and is continuing to direct their mental health services. That is one way to do it.

The other system is like at Amerigroup we, our behavioral health is integrated. So we don't ever carve out in the states where we don't have to. And we do it intrinsic elan and internally. Because really they always say you can't really treat somebody's head in one place and the body in another.

The medication, you know, assurances and effects are part of that. The recovery model should be part of one's overall being and wellness.

So you know, that is the other way to do it.

Centers can really look and I think Bill was mentioning as well, really be increasing utilization of peer support specialists. It may be, unless I was scattered at the time that you asked the question, Tim, was about the center's role in this as well?

If that is the case , I mean, I'm curious to know if centers want to employ peer specialists eventually to really continue to have that cross-disability presence in their communities.

>> BILL HENNING: Yeah, and there also are certified peer specialists in the mental health community who may go in various places, go flew a certified training on working as a peer for somebody with significant mental illness that can help people access the health system, who may have lots of fears too.

That is a good thing to get from treatment, so many people have bad experiences with mental health. They go to the emergency room with, you know, in a separate place away from everybody else. They may go with a severe stomach problem, they immediately get asked are you taking your meds, have you been going to your counselor, and the person will say, I'm here representing a serious physical issue, I want treatment for that.

So there's this real alienation from the system. So if we're proactive in advocating, you can maybe improve some of these systems. One of the things to ask, is the them good status quo.

>> MERRILL FRIEDMAN: That would definitely be one of the questions to ask I think you're right.

You know, the other thing is housing between, you know, kind of supportive housing and just, you know, housing where the person wants to live and receive behavioral health services and supports within that house, their supportive employment for people that want to get back into the work force and still need peer specialists or support possibly, even job coaching on the job.

There are many similarities as we build long-term services and supports models for people with disabilities that we keep in mind recovery and people with significant mental illness.

>> BILL HENNING: One of the things I would emphasize, we discussed this in our preparation for this. If we don't satisfactorily answer a question, you can through this system ask us a question, we can follow up later with more information or experts I know some outstanding folks, mental health advocates who can in fact answer the question better than I did and would be happy to put anybody in touch with them.

>> All right, thanks Bill. I'm going start off with you on this next one then we'll go back to the phones.

So the next question comes from Melvin townsman. And Melvin asks, in states which include home and community based services for managed care but exclude nursing homes in managed care, what is done the prevent managed care organizations from quote/unquote dumping a high need or high cost consumers into nursing homes if they are not responsible for the cost of institutional care?

>> BILL HENNING: I don't know what each state does I know that that is a pressing concern. In New York state right now where they are trying to exclude the nursing home benefit from the managed care package.

You know, sounds counter intuitive at the start. Why would we want nursing home coverage? Because we don't want people to be excluded and just dumped out of the managed care scenario into a nursing home, which will reduce the cost as it's paid for by the separate fee for service I think it's just advocating as we normally would to either get that into managed care and to look at ways to prevent dumping, which would go into some of the more complicated features, possibly, of health insurance plan.

What are the quality measures, what is the oversight, what kind of reviews are done for outcome measures, does it have an ombuds person program, things of that nature. It's really getting to, you know, really getting to the nitty-gritty of this. Intensive advocate issue. And that is a potential serious problem, of course. It's a potentially serious problem without managed care as well.

>> SUZANNE CRISP: Bill, this is Suzanne. Would you say as part of the centers for independent living, to advocate for home and institutional services, plus institutional with managed care organizations just to prevent the quote dumping.

>> BILL HENNING: Yeah. If you have the nursing home separate on the outside from this, there is a high risk of dumping.

Within the insurance plan too, you could ask for a payment structure that incentivizes keeping people who are deemed nursing home eligible, whatever that criteria may be in a state, if they remain in the community, the managed care organization may get a higher payment than if that person is placed in a nursing home to give further incentive to keep the person living in the community.

>> MERRILL FRIEDMAN: All I can do is agree. Because as a managed care, you know, organization, we would prefer nursing facilities to be included because then it does make sense and it's much easier for the service coordinators from the centers, from the CMACs, from the managed care organization to work to ensure that we're continuing to not rely on nursing facility placement for anything. And if people are in the nursing home, the ability to get them out more quickly, you know, is amplified if in fact they are included.

>> BILL HENNING: Absolutely.

>> Thank you, Merrill. Let's go to the phone. Let's try to take two questions from the phone and see about the time. I want to be fair and make sure we have time to get through the rest of the presentation.

>> OPERATOR: First question comes from Kelly grown. Kelly, the floor is you. If I don't remember phone is muted sh please unmute your phone.

>> Hi. Yes, Kelly green. We're from Florida where the governor has refused to accept any federal money for long-term services and support.

We feel it's going to be very difficult to work with the managed care providers here in Florida. However, I do have a couple of questions.

It appears that the managed care providers have failed in many areas to comply with the ADA, such as failure to provide effective communication, such as interpreters, failure to provide physical access as far as many of the providers' offices are concerned, restaurants, entries, entranceways, and also failure to provide accessible examining tables and diagnostic equipment.

Now, several of these managed care companies have indicated an interest in contracting with centers for independent living in Florida.

But my concern is when we're taking money from them to provide services like case management or respite care or whatever it might be, how are we going to be able to advocate on behalf of our consumers without risking the loss of those contracts.

Seems we have to walk a very tight tightrope. I'm wondering how we should handle that.

>> MERRILL FRIEDMAN: This is Merrill. I don't mind responding. You know, I would personally say rock on and do what you do best.

Because your role is to really advocate, and good managed care organizations are going to be appreciating that advocacy work.

The thing is we would want whole heartedly our providers to be accessible or to ensure that, you know, there's accessibility within it.

We have talked to many of the centers, and I know that the other managed care plans have I hear where you are coming from in terms of want to go have those contracts as a provider for a center but still wanting to advocate.

Part of, you know, what you can look at doing with those managed care organizations is being part of that provider training.

You know, so that you're out there, you know, kind of checking out the provider offices, offering up accessible providers for the managed care organizations to get into their network. So if they don't have a good balance, that they should get them, that you're the ones in there with the managed care organizations ensuring the training for those providers across, you know, all spectrums and areas of expertise.

So I think you can easily, really you can continue to advocate for people with disabilities and also provide services. Because the best way to ensure that the services that people are getting meet their needs and are preferred by them is if you guys are completely in the mix on multiple levels.

>> Kelly: We have found they are not interested, at least one or two that we have spoken with in depth, and they do not seem to be interested in receiving any training, even though it make it be provided no cost to them.

>> BILL HENNING: That might be a situation where you break off the relations I think you have to make that judgment. It's pretty easy to sit here on the phone and say this is what you should do or shouldn't do. Because each situation is particular to your location.

If they are that obstinate and you can identify thoses of people are being defind equal services, and there's a disparty because exam tables aren't accessible, which is common through outthe country, maybe you engage in advocacy, whether to seek regulatory requirements through state public health, whether to file lawsuit and engage in protest, whatever

I do think, you know, in Massachusetts we have got it stated that the managed care organizations for the duals should be accessible.

That is the easy part.

Getting that to play out in practice is going to be the challenge because the managed care organization contracts with health providers once removed who aren't accessible. And we can say don't go to that managed care organization, but the provider still is inaccessible whether it's fee for service or managed care.

Any number of targets. May be the provider, separate from the managed care entity, and maybe the state can require access, maybe a federal lawsuit. It's a very enter twined system and there are many targets.

>> SUZANNE CRISP: Merrill, I have a question. Is there another level this a center for independent living can go to,

I thought it was kind of the corporate party line to listen to advocates and invite them into the mix. Sounds like on a local level maybe that is not happening.

>> MERRILL FRIEDMAN: You know, I'll be real careful because I don't want to speak for other managed care organizations when I say this.

But it is, there are several things. I mean, I know at Amerigroup, I mean, we wouldn't even be where we are today if we didn't have input from stakeholders, advocates and consumers in all aspects of what we do.

The states are actually mandating it in many states. Not all. As well, you know, to ensure that managed care organizations don't go the other way and not engage, you know, advocates at the table.

If in fact you're getting turned away and the managed care organization is not listening and does not want training and people do not have access to a full and equitable exam, let's say, from that perspective, I would actually call the state.

>> BILL HENNING: The other option, if the state is not being responsive and you have a situation in Florida where they don't want any federal monies to boost Medicaid under health reform, I presume, you can go to CMS, centers for Medicare and Medicaid services, who oversees the use of Medicaid and Medicare money.

There is energy and momentum to require compliance with the ADA.

It's the federal architectural access board is convening a group to develop standards for medical equipment to become accessible.

CMS just signed on to the plan in this state requiring ADA compliance. So there is that fallback too.

At this point we have reasonable Alis at CMS. Doesn't mean we agree on everything, but they tend to be with appropriate inquiries and some pressure responsive. You know, in an advocacy picture, there's many avenues to pursue.

It's not going to be all lumped in at CMS or the state or the MCO.

>> MERRILL FRIEDMAN: Right, there are multiple I agree with you, IBM. CMS has been very supportive of this. And there are new regulations coming out for DM or MDE, for the medical diagnostic equipment

I know I submitted public comments in support of accessible MDE I think we all have to be out there doing that.

The reality is if you're getting turned away and people do not have access to their services they have a right to have access to, I would try all avenues

I think CMS, state, managed care plans, state associations if they are helpful, I would go just about everywhere. And anything that we can do to support you in that, we will. I mean, I have to, you know –

>> Kelly: I don't think ALKA is very interested in listening. That has been my experience.

>> Hmm.

>> Okay. Let's go back to the presentation. We have a lot to get through in the next 30 minutes. I'm going go on to slide 6 here. If you all will come with me.

We'll continue the discussion. If you have a question waiting, I apologize. We will get to it.

If you tipped typed one in the webinar, we do have it. We will get to them as we can.

We will be breaking twice more for questions as we proceed. Thanks.

>> SUZANNE CRISP: Thanks. Bill, I'd like to ask you, what concerns do advocates have about managed care, and do you have some strategies to reduce our eliminate those concerns.

>> BILL HENNING: Obviously we have heard some concerns already, and I wouldn't try to minimize them at all.

You know, I think one of the big concerns is whether the managed care entity understands disability, understands recovery or independent living, and will in consequence try to minimize support for the services.

You know, Merrill and I were talking about how valuable home and community based services can be, and with a strong advocacy perspective, you may be able to get them included in a plan.

Conversely, without that, absent that, they may not exist and you'll have in some cases managed long-term services and supports without a full understanding. And the risk of that can be that they give short shrift to them for short-term savings.

All right, somebody gets 40 hours a week of personal assistant services.

Gee, I bet they can get by with 31, 30 hours a week, and they try and save that money and it has dire consequences for somebody who has a very fragile support system set up. So that is a real risk.

Always trying to cut costs, cut corners, not invest in the long-term services and supports. That is probably one of the biggest concerns. It was mentioned nursing homes services aren't in the package, then there can be dumping. That is a real real concern

I think that just not having the cultural competency, not complying with the ADA, not understanding how you would invest in services.

One of the things that becomes a big concern is that state governments, federal government may be looking for immediate savings from these plans. You know, stockholders for a huge company may be looking for profits from a plan.

If you are investing in a long-term services and support system, it can take some time to accrue positive economic results tied into positive integration.

You may have to upload a lot of personal assistance services. You may want to buy somebody that second backup wheelchair, another power chair, which would be expensive. You may need to start paying for interpreters.

You know, ASL or English second language for folks in medical situations so they get the proper care. So that is a real risk, is that the finances get tightened around this or the provider doesn't understand some of the disability issues.

And we're worried about that in this state. I'm sure everyone is really worried about that. You know, it's a fragile package.

You know, in that they are not measuring the right things. They are not measuring integration, ability to live independently in the community, things of that nature.

>> #S: Merrill, do you have something to say about the concerns of advocates?

> MERRILL FRIEDMAN: I mean, I –

>> SUZANNE CRISP: Yes?

>> MERRILL FRIEDMAN: I think, Bill, you listed clearly the more significant ones.

Cutting costs and corners is typically what we always hear.

It goes back to how, you know, does managed care realize it can come in for the same and do less and increase access and all the things that kind of get laid out as states roll into this.

So the onus is on the managed care organization to, you know, ensure that we really do, you know, when there are really good, and I know Suzanne is eventually going to ask us what makes a really good ACS program, right?

That is kind of what we are talking about now, and that does include, when you have the ability to, you know , liberate folks from nursing homes into the community, when you have the ability to eliminate the duplication, then you don't need to cut costs and corners to do what is right. It goes back to having really strong plans.

And I will say, I'll kind of digress a minute, there is a lot of increased oversight these days that was never there back in the '90s, you know, when things were not great

I will of course always say this, that there are human oids that work at managed care organizations, so still there are some things that aren't perfect by any stretch of the imagination within any corporate entity like that or any entity.

But there is oversight and monitoring now by the state and by the feds around care and services plans. Provider networks, critical incident.

>> BILL HENNING: Huge.

>> MERRILL FRIEDMAN: Right. Reintegration. When we talk about not only used to be just whoa, you know, we had several, 147 nursing facility transitions. Okay, but six months later are people still out in the community? And if they have been out in the community for six months, now what are they doing? Are they self directing, are they working, are they included in the community.

Are they, you know, going to school, you know, are they getting support to raise their families. Some of these things are all starting to change on what that oversight and interactive –

>> BILL HENNING: And the outcome measures. Provider networks is huge.

A real risk would be that you have over the years, the consumer has knit a very fragile but reasonably effective system for them tapping into a variety of specialists, for instance, or developed a strong relationship with a behavioral health provider.

Then a managed care entity comes in and says no, you have to use or network.

And there are risks if that is really steadfast, you can't opt out of the system.

You know, you may not hit it off with your new mental health provider, and that can be catastrophic. You may lose your physical therapists or neurologyists for somebody else who may know your health intimately and in a very positive way.

Those are some of the risks. The risks very specific to switching healthcare providers or insurance mechanisms that lots of people face but that are most acute for people who are highly medically involved.

Not all people with disabilities are, of course, but if that is who is in a plan, those are some of the real risks. You know, can you get the services you need. That would be a risk as well

>> MERRILL FRIEDMAN: Exactly.

>> BILL HENNING: Geographically, transportationwise, whatever.

>> MERRILL FRIEDMAN: That is where I was going to go.

When we talk about that and you talked about, you know, ADA compliance and accessibility, there's accessibility of transportation.

Can people get to and from services in rural areas. You know, and in city areas

I can't tell you the number of places in New York, for instance, that you can't get to unless you can actually walk upstairs.

That really isn't a reasonable expectation for some people at this point I think that whole accessibility conversation has to really change.

Oversight and accountability for the managed care organization.

One of the things that always makes me feel better at Amerigroup no matter how bad a day can be is that I hear consistently from our executives that, you know, the more accountability there is, the actual, the easier this really is.

So managed care organizations are very comfortable with that level of accountability and oversight to ensure that the future of long-term care services and supports and people's independent living options are not marginalized, they are only increased. And we can do that through the accountability measures and rebalancing

I would say in terms of cultural competency both from disability literacy and then multi cultural and ethnic and language.

I mean, it is written in the contract to ensure provider training is done

I know within Amerigroup there is a lot of training. But really a lot of this has to extend to provided. The best way to have a really solid provider network so people can access their services, and actually access them with people that they want to see and are helpful, is to really educate providers on what people's capabilities are, what people's resources are in the community, what the benefits look like

I can't tell you how many providers that you can talk to that really don't know what community resources exist, what centers for independent living, what their bandwidth is and can be.

You know, and really what people want. It's that paradigm shift that we continue to get into in the healthcare industry and we're making progress, but we have to keep getting there, is getting healthcare, you know, professionals, if you will, to quit caring for people.

To some extent they are always going to care. But to really switch to really asking people, you know, what do you want? What do you want to do? What services do you want? How much of this do you want to direct? What supports can we give you.

Really kind of changing from that paternalism to an outlook of independence.

>> SUZANNE CRISP: Uh-huh.

>> MERRILL FRIEDMAN: And self direction. That is a big paradigm shift.

Managed care companies, providers, specialists have to come around.

It is the influence of the advocacy community that is really moving the needle on that.

>> SUZANNE CRISP: Good. The last part of our question here is how can we ensure managed care program operates with with integrity. We have already talked about this.

Certainly the involvement of the center of independent living in both the design and management of the managed care offering.

Advocacy.

Certainly the offering of training to staff.

Supporting the disability community and independent living.

Reviewing for ADA compliance and ensuring that we have accessible HCDS, home and community based service programs from the Olmstead perspective.

Then educate providers on existing resources and educate everyone on closer listening.

Is there anything else that you would add to that list?

>> BILL HENNING: Yeah, I mean it's just being engaged. Having three and five-way conversations, which is easy to throw out there.

But there is a discussion between consumers, enrollees with advocates, with level legal services attorneys, with the managed care organization, with CMS state officials, state legislators.

>> (Participants speaking at the same time).

>> BILL HENNING: Congress persons. It sounds daunting and sometimes it is, but that is what is at stake. That is part of the game.

You may not be able to perfect it, you may not be able to do all of it, but there is not much option from trying to be at as many of these tables as you can and threading them together in some way.

Easier said than done.

Get a good ombuds person program or consumer advisory committee.

Check out those components and look at the outcome measures which gets daunting, but that is where you look up with all lies in the healthcare communities who are very familiar with these things and the technical elements.

>> MERRILL FRIEDMAN: Yeah, and I think we have to somehow demedicalize a healthcare system that is still going to be able to address chronic and complex conditions, and not lose sight of some of the very very significant, you know, healthcare issues that people want to receive services for.

But yet look beyond it.

When we look at some of these global waivers, these 1 115s that are being submitted now, really have to address both of those.

But it's starting to incorporate employment, housing, and so many other components, so it's demedicalizing a system that still does need to address. Some whether accessibility through ADA, cultural competency, outcomes, but we need to be sure we addressing some people who have significant and complex chronic conditions.

>> SUZANNE CRISP: Merrill, I'm intrigued by what you said about the demedicalization of managed care organizations.

Since they are so rooted in the medical model and to a large degree have experience with acute care. Can you or Bill think of any ways to actually perform this demedicalization other than actual physical surgery?

>> MERRILL FRIEDMAN: I was start to go have scary nightmare movies, you know, exorsism I would say from a grassroots approach it is going to take the continued movement of the independent living community to educate managed care organizations I think that, I have to –

>> BILL HENNING: And government officials.

>> MERRILL FRIEDMAN: And government officials I think CMS is really starting to get this too, which is why we see some of these waivers changing. HCL, Henry clay Bayh, there are people at the federal level that are looking

I think there's a policy component where we all need to influence policy.

Because really that is what is going to drive contracts. But it is learning, I think if you look at a company like Amerigroup over the last several years , it's engaging with people with disabilities that had everybody kind of turn around going, oh, goodness, what were we thinking.

>> BILL HENNING: Yeah.

>> MERRILL FRIEDMAN: So now if we do get a request for somebody who likes to swim and uses, you know, augmented communication device, it's not a matter of like not swimming because the communication device isn't waterproof, it's a matter of getting a waterproof one.

If somebody lives out in frontier land and they need a wheelchair that can go over rocks and craters and things, an its a matter of looking, well, that is the right wheelchair, and yeah, you need another power wheelchair for going into the community and to dinner and taking kids to school

I think it's a matter of communicating and being very very visible at the table with some of these conversations. Go ahead, Bill.

>> BILL HENNING: Yeah, and empowering people. And the phrases that is used so much it's almost a u feminism, person centered.

We know it as consumer directed services in healthcare. From my experience where we have been effective in this state, those times we have been influsing the shape of managed care as it is designed, it's when we create forums for people to speak about wanting control of their own care and services and letting them put it in their own terms.

It may be, as Merrill said, I need a waterproof augmentative communication device. When I say I need a new cushion for my electric wheelchair, I need it because if I don't, I am going to get skin breakdown and might cost you $100,000 for for the surgery and rehab or 200,000.

It's using our terminology and repeating it. Our perspective.

>> Yes yes. Can you repeat that, please?

>> SUZANNE CRISP: Can we go to questions now, Tim

>> Tim: We sure can. Let's start on the phone this time. Wes?

>> OPERATOR: Again the phone is open for questions. If you have a question, please press 7 or Q on the telephone keypad f first question comes from Billy rich. The floor is yours.

Billie, if your phone is muted, please unmute your phone.

>> Tim: Wes, let's go to the next question.

>> OPERATOR: For question or comment, please press 7 on your keypad.

Okay, Billie Rich, go ahead.

>> Are you there?

>> SUZANNE CRISP: Yes.

>> Tim: We can hear you.

>> Hang on.

>> Calling from North Carolina. We are already experiencing the managed care, well, specifically in western North Carolina where smokey mountain has become the managed care.

One of my concerns, and it continues to be a problem, is that consumers are losing services.

There's no appeal process associated with this. And that is the managed care is the one that will be taking the services via the state mandate through a waiver called innovation of waiver (breaking up). Do you have any comments on any of that information?

>> BILL HENNING: Sounds dreadful.

>> MERRILL FRIEDMAN: It does. >> It's already happening here. As a matter of fact, the case managers lost their job July 1 of this year, as mandated because of the innovations coming down from the managed care entity.

This is what we are experiencing now. And as a (breaking up) intake has increased.

We have little means to provide services because we are able to go through Medicaid supply. It has to go through the managed care entity.

>> MERRILL FRIEDMAN: I'm catching every other word because I feel very bad. This was sounding dreadful from every other word.

I don't know what the words are I think, you said you're from North Carolina

I think that is a PCCM model, which is a little different than what a lot of other states are going towards.

But because I can't capture all the words, I'm hesitant to answer at least on line. I'm happy to talk with you.

>> I picked up the phone. Can you hear me better?

>> MERRILL FRIEDMAN: Very much.

>> It was because it's a speaker. You called it a what, a what kind of model?

>> MERRILL FRIEDMAN: It's a different kind of engine, but I don't know if that even plays into what you're saying because I couldn't hear you. Sorry to ask you to re-do it.

>> Okay. Basically on July 1 the target case managers was removed from the services being provided for people with special needs, the IBD in particular.>> Okay

>> With that, the managed care is now being provided through the LME.

There's two in this area right now that have become the managed care entities.

What is happening is that the consumers upon their birthday will be losing services based on a model that the state of North Carolina has come up with, actually it's the model that has come up with an innovations waiver that has to do with cab, Medicaid services, called 1915 B.

So if I have an individual in a level 4 home and he does not meet the criteria that the state or managed care interest ty has come up with, they will lose those services. Will no longer be able to have what a level four provides. It will knock them down to level 3.

These are ICSMR individuals, people who are at risk for being in institutions.

And people have already lost services by the dozens if not hundreds

I just didn't know like if it's advocate concerns about managed care, it's already happening. We are already having issues to go on.

We're just waiting to see how many lawsuits the state is going to be up against with this.

Don't know if you have any comments on what is already happening here.

>> SUZANNE CRISP: I know Merrill wants to respond. Sounds like they changed their eligibility criteria. I would suspect that in order to do that, they would either have to go through a legislate promulgation or some public notice about that

I would hope that she could talk more with the state about understanding that change.

>>En. to s to use that as their leg to stand on, stating they don't have an appeals process, they weren't notified of these changes ahead of time, and they did do a partial information letter to inform.

But base it was moving to the innovation in managed care, it was being mandated. The state adopted and that was it.

And upon the appeals process, it's very slow and not necessarily effective.

>> Hmm.

>> Anyway.

>> I'm not as familiar with North Carolina I would just be hesitant to misguide you at all I would be curious as to, you know, are they recessing folks and starting again under this? Or people are, I mean, I just don't know enough except to be dangerous because I'm not there

I do think if there's no appeals process, if there's an om budsman or person to connect with and find out some reasonable path to get some history and find on you how people are not going to lose services and wind up institutionalized.

Or with increased chronic, some acuity, your omom buzzman, CMS, reach out and get dug in on that conversation.

That is why Bill and I and Suzanne have kind of referenced, the states really do create their state plan. So all of the conversations that are happening in concert with the affordable care act, with global, everything happens at the state level.

So really embedding yourself in that dialogue with the om budsman, with the stakeholder engagement that states are really adopting in terms of getting input, and find out what the process is going to be so that people aren't without services.

>> BILL HENNING: Yeah, as I said, this is dreadful, frightening to hear this.

This potentially can happen elsewhere and it speaks to the point of getting engaged.

That is the team of thing that can happen under the guise of managed care. So that is something to be most watchful of and to fight.

You said will there be lawsuits, I hope there are. It's conceivable. It's an Olmstead lawsuit if it's services in the least restrictive setting no longer exist.

But even if you don't have managed care, that is somewhat on the horizon anyway if you have radical budget cuts to Medicaid.

>> Right.

>> BILL HENNING: Block grants that may reduce funding for Medicaid by 20 percent, and state innovation isn't going to make up that 20 percent. It's political huii, those who say that. You don't get 20 percent savings.

>> Exactly. This was when the states were charged with cleaning up their debt. This is when this started happening

I almost feel like this was a scheme back before the states were charged. Because there were things put in place that was a model that was tested out that was not an appropriate model for a rural area such as where we were. But there were things being tested out and they adopted this because it did save money.

However, it's not a blanket program that covers everything.

There's so many things and people falling through the cracks.

That is why we took this webinar, to see what else can we do other than encourage people to sue. (Chuckles).

>> BILL HENNING: Protest, agitate.

>> Say that again?

>> BILL HENNING: Get out into the streets on it. Not just sue. Put a face behind any lawsuit.

>> A face behind the lawsuit.

>> BILL HENNING: Yeah, the lawsuits are settled in a political context, a public context I would go to CMS.

I don't know if there are allies in state legislature, coming, whatever. I'm not totally familiar with North Carolina landscape.

Healthcare advocates as well, some strong healthcare advocates in North Carolina

I know we have had that in my state and some other states, Ohio, some good matching with healthcare and disability advocates.

It may not be perfect, but the coalescing is important, there may be senior advocates as well.

>> Thank you for your help.

>> BILL HENNING: Good luck.

>> SUZANNE CRISP: Do you want to move to questions or do you want to have our panelists talk about the last question?

>> Tim: Let's quickly go through the last questions. We have a lot of questions in the queue. Maybe if we can quickly do this last section. Then we'll break and spend the remainder of the call today trying to get through as many of those questions as we can.

>> SUZANNE CRISP: Okay, all right. Our last question has to do with quality and outcomes of managed care situation.

I'd like for each of you all, Merrill and Bill, to describe what the perfect long-term managed care organization would look like.

>> BILL HENNING: Okay.

>> MERRILL FRIEDMAN: (Chuckles).

>> BILL HENNING: I mean there are so many, there are many facets to it.

One of them, something that has adequate benefits. You know, halleluia if you get it. I understand that is a fantasy in some states.

You want adequate benefits that give prime si to long-term support, primarily community based. You want assessment in a person's home that plays heavily on the consumer or the consumer's support system, family support in many instances.

That is broad on the assessment. May include vocational assessment.

It then integrates services to the best degree possible, giving priority to community based services in lieu of medical wherever possible.

It may save money. In some instances it will not. But you want to utilize the community services, DME, PAS, peer support, home mods, things of that nature. Then you want to be able to have adequate oversight for when there are glitches, consumer advisory board, ombudsman roles.

You want measurements and outcomes that track things such as independent living that aren't just traditional outcomes from Medicare that play to a medical model. You want adequate financing so that the provider isn't trying to cut costs.

And because when that happens, we know who is going to carry the brunt of the burden, the consumer right at the start.

In most instances, if not immediately down the road. You know, that is part of it.

Merrill, what else do you guys do? You must have the perfect program, right?

>> MERRILL FRIEDMAN: (Chuckles). Oh, god. Nice way to end it, Bill. We have behaved the whole time! I mean, I would say, I can correct and correct and correct.

It's kind of Bill's list is obviously very like mine I think coordinating services and supports across the entire continuum and array, it just has to be loaded early on with the benefit design. Get in early, the managed care organizations too in terms of filling up what that benefit package is going to look like and having the appropriate fiscal resources.

The state has to be able, you know, to really make it viable.

We have seen in too many instances where it's not viable, then you can say, oh, managed care looks bad, then the state looks bad.

Really what Bill said, the individual really carries the burden of that failure.

It's not acceptable at this point. There are enough lessons learned

I think the perfect LTS program will incorporate the lessons learned from other states.

The ability to provide smooth transitions in care and services. Because we know that people just change every day. And so it has to be fluid and flexible enough to be responsive to the person and what they are choosing and what they need, and be really responsible to personal preference and choice.

And just continue to acknowledge through that resiliency kind of, you know, how to really manage your own resources. When I say your own resources, it means the person is hopefully under self direction, that of the managed care organization

It has to promote independence, recovery, community inclusion, enhance all the home and community based services, inclueing teeing up Thursday's conversation, increasing capacity of the centers.

I don't know, I can keep going I think suz Anne said quickly.

It's really just a very very comprehensive model that builds on independence and self-sufficiency, personal responsibility, and people, you know, with disabilities being able to be in the community working, raising families. That is a good program.

>> SUZANNE CRISP: Good. Quite helpful. That ends our formal questions today.

Tim, if we want to go back to questions from the audience, that would be great.

>> Tim: Sure, I'm going start with a question for you Suzanne, Megan Burk, and if others know, please chime in.

If we're aware how many of the states with managed services include nursing homes.

>> SUZANNE CRISP: We have the capability of finding that out but I don't know offhand. It will take me a while.

I'm going to use the truven report that I had made reference to I believe that we will be able to include that I know just in my studies, the majority of states do include nursing home and it is not a carve out. Merrill, do you have a sense of that?

>> MERRILL FRIEDMAN: I'm actually scanning. I know actually which graph it is in the report. I'm scanning I want right now to see if we can find it before the call is up.

>> BILL HENNING: For people who may have come late, the value of having nursing home in the benefits package is so that people don't get get dumped into nursing homes and not use community based service.

If somebody is just on they may wonder why this is here.

>> Tim, thanks Bill James moody asks, in regards to managed care, does in mean that centers won't be able to do as much advocacy but it will be focused on case management I know you touched on that, but can you address that quickly?

>> BILL HENNING: I don't think it means that at all. Think there's over 500 centers in the country, each one has its own unique culture, style, priorities.

You know, sometimes there's attention, if you are providing services and getting paid, how do you bark at or bite the hand that feeds you t. There's a so fist ty case to it.

You set up firewalls and figure out what is po. If you don't think you can advocate, if you don't think, if it's going to compromise you, I would say, you know, stick to the advocates

I think you can balance it both ways. If a managed care organization or the state is screwing people with disabilities, I think your integrity calls into question you don't continue to provide a low level of services while people are being screwed, you have to take that stand.

It can be done both ways.

Many states, Main many ILCs operate personal assistance programs and advocate fervently with the states or with Medicaid departments for better programs, better funding. Sometimes it creates issues and you deal with it as it comes on.

But it's the perpetual juggling. ILCs are set up to provide as core service various services and systemic advocacy I think it's just a balancing act. But it's not either-or.

If somebody tells me it's either-or, then I'm really not wanting to provide services with them actually.

>> Tim: Uh-huh. Good.

Let's go to the phone and we'll take a few questions from the phone. Then I'll continue with questions that have come in.

>> OPERATOR: Again, the floor is open for questions. Please press 7 on the keypad for a question. No further questions from the phone.

>> Tim. Thanks, Wes. We'll continue then.

Next question comes from Jessica layman. Jessica is looking for tips or examples on how provider training has been done successfully in terms of ADA access and long-term services supports.

>> MERRILL FRIEDMAN: I can respond kind of what we have seen that actually has been successful from a managed care perspective.

Then Bill, you know, jump in here. But we have worked with centers and done some joint provider training. So we're setting up systems now and the states, for a long time, services and supports to be sure we're partnered with the centers to do our provider training.

And that includes, you know, accessing, you know, kind of going into provider sites and assessing accessibility. Never easy to say.

Talking about kind of doing provider training around healthcare disspart, disability literacy, even people first line.

All encompassing, getting providers really engage. Whatever you guys, the centers can do, and we'll talk about this on Thursday, to get yourself kind of carved into that model, that would be great.

Before it was us, if you will, doing it. And while we think we know a teeny little bit, it's just not the same. So I think –

>> BILL HENNING: Not even close to being the same.

>> MERRILL FRIEDMAN: Exactly. There's nothing going to be better than having the centers the at the table to do that.

>> BILL HENNING: I think there's a strong interrelationship, and this goes back to a question we just heard, can you provide services and advocate.

Part of the basis for successful training is that the provider wants it because they know they need it because it's essential to their compliance with all the standards that may be laid out.

If you set a context over the course of a year, let's say where ADA accessibility is important that you want interpreters for deaf people. You have had public meetings let's say where deaf consumers speak about the importance of ASL interpreters competent in medical terminology, you then offer a training, there's a receptivity, you have laid the ground work, tilled the soil, whatever analogy you want to make

I think that is where it becomes successful. We have done that with some providers.

We have some lawsuits in with some major healthcare providers in Boston. And one of the frustrations has been that they haven't used to the degree we would like some of the consumer based models of training.

It's been some outside entities that use people with disabilities that aren't quite as intensive than what come from the independent living center.

Doesn't mean it's bad, just maybe deficient I think you have to aggressively insert yourself I think we know it.

One caution in medical arena, ADA compliance is pretty complex.

There are some great resources out there

I know Greta has one, Jessica in California, there's a group access living has been doing some of this in Chicago, BCIL, a number of other places.

It's real important to get it right.

It's not just if the doorway is wide enough to get into. That is important. But how do you make an exam table accessible, what does it take to make bathrooms accessible.

A lot about procedures that has to be accessible. It's bringing it home with consumers telling their stories.

To the degree someone can fes up and be personal, the better.

That is very hard when talking about personal medical interactions. I respect that.

>> MERRILL FRIEDMAN: Even knowing how to use video relays services, you know, in any kind of exam There's a fact to that and how can we do that at the choice and direction of the member.

You know, the other thing is people with psychiatric disabilities if they are going to sit in a waiting room, if they have an anxiety disorder a sitting in a waiting room crowded and loud and people running around, are they going to stay for the two hours because you are running late, probably not.

There's going to be a lot more to the concept of accessibility going forward than can you get in the door

>> BILL HENNING: Scheduling is critical. If someone uses attendant services, you don't schedule for a 7 a.m. exam if at all possible.

>> MERRILL FRIEDMAN: Right.

>> BILL HENNING: Transportation service doesn't start until ten in the morning, whatever, all those kinds of situations.

>> MERRILL FRIEDMAN: Correct.

>> SUZANNE CRISP: Let me put in a plug, I think we're drawing close to the time.

Let me put in a plug for Thursday's session. We're going to be talking about the involvement of the centers for independent living with managed care services and support.

About training. About why CILs should become involved with managed care, what capacity must they have to operate a managed care environment, and the administrative and financial capacity that CILs would have to operate in a mrgd care environment.

So this is just been too much for words actually I have been taking a lot of nodes I was going to summarize but I don't think I have that capacity.

So thanks to both of our speakers. You were just marvelous

I can't wait for Thursday to come so we can hear more and learn more.

>> BILL HENNING: I'd like to look at some of the questions we weren't able to answer and maybe meld some answers into the presentation on Thursday around that as well.

>> MERRILL FRIEDMAN: Absolutely. Or at least get some answered, especially state specific answered we may not be able to address, start generating some dialogue off-line on that.

>> BILL HENNING: I saw quite a few pop up and we didn't get to everyone. So that will be useful.

>> Tim: I have those collected and that is exactly what I was going to suggest. Thanks for saying that, Bill

I already have these collated. I'll share these with you and we'll develop some answers.

To the folks we didn't get to your questions, we have them. Thank you for your patience. We'll get you written responses

Of course whether we take time on Thursday or whether it's a roll of new questions, we are going to be back with you on Thursday.

We'll leave as much time as possible for questions on that call as well.

We're at 4:32, so I really regret that we have to stop. I want to thank you our presenters, IBM, Merrill, Suzanne, tremendous job.

Connection information for Thursday is the same. So you don't have to hunt for it.

I want to remind you to please fill out the evaluation form.

There is a separate evaluation for Thursday's call. So I really do want to encourage you to fill out the evaluation here today.

If you are on the webinar, that is slide 10. That is a live link. So feel free to click and it will take you to the evaluation.

If you are on the phone or can't see the webinar screen, that is valuable on the training page that was sent in the confirmation.

Same place where you got the connection information for today's call. Thank you again for being with us.

We'll talk to you at the same time on Thursday afternoon. Bye-bye.