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Please stand by for realtime captions.

The -- thank you for holding. Your call will begin in 4 minutes. Thank you for your patience. And Silvia Yee if you were online as a participant press started zero and we will pull you into the preconference. Again, Silvia Yee , if you are in the conference press store --*zero0.

Thank you and welcome to the webinar. We are about to get started. This is the webinar on proposed Medicaid managed care roles and impact on seniors and people with disabilities.

This is a webinar hosted by the aging and disability partnership for manage long-term services and supports. I'll introduce the partnership in a moment but I want to introduce the speakers who will be sharing insight about the proposed rules. First up we will hear from Elizabeth Priaulx. She is the senior disability legal specialist at the National Disability Rights Network. Then we will hear from Silvia Yee. She is a staff attorney for Disability Rights Education and Defense Fund. And I'm Fay Gordon and I'm a staff attorney at justice in aging.

Some housekeeping before we jump into the substance. We would like the presentation to be informative and as interactive as possible. We will take five minutes of questions following each speaker. If you have additional questions we will have time for that in the discussion at the end of the presentation. We have scheduled this for an hour and a half and you will see the proposed agenda if you need to step around and do different things, go for it because we're not sure if we will use the full amount of time but we will leave five minutes of questions following each speaker to break it up. There are 2 ways to ask a question. You can use the chat box on your screen which you see in the bottom right corner. Type the question in that white. If you do not have access to a computer you may also ask questions by phone. When we open it up for questions you ask the operator and you can ask a question through the phone. There will be a transcript available following the webinar. There is a lot of detail in information and you are welcome to review it in the transcript.

As I mentioned this webinar is hosted by the aging and disability partnership. The partnership was established by the National Association of Area Agencies on Aging n4a as part of the administration of community living grant building the business capacity of aging and disability community-based network for managed long-term services and supports. It's a partnership between reorganization of states speaking today and we're joined by the health management Association.

A little bit about the purpose of this presentation. We're hoping we will be able to provide you with an overview of the specific areas in the rule that may impact community-based organizations in the aging and disability network. As I am sure you up heard this rule is proposing very significant changes to the way the federal government states and managed care

organizations work together to deliver managed long-term services and supports. While the rule is still a proposal and it is not final it will be quite a process until it becomes a final regulation. It's a clear indication of the direction of managed long-term services and supports delivery. Everything we outlined today may not end up in the final rule but we think it's a pretty clear sign of where CMS is moving with managed care. With that in mind we think it's important for the organizations on this call that deliver long-term services and supports an advocate and work with individuals who receive the services to understand the potential changes coming down the road. We also hope it will empower those of you who were eliciting -- listening to share your experience and insight throughout the comments process and more broadly we hope you understand the potential changes to the delivery system.

So we have packed agenda and I'm wrapping up with the slide so we can get into the detail. We will go over key areas listed here. Elizabeth will kick off talking about enrollment and disenrollment, coverage and continuation of benefits during an appeal and also the grievance process. Silvia will take it from there and will discuss accessibility and network standards. And then I will zero in on stakeholder engagement, medical loss ratio, beneficiary support system and general items and LTSS issues. So I will pass it over to Elizabeth to jump into the presentation.

Hello everyone and thanks for joining us. As Fay said there are many areas for comment and we're narrowing it down to just a few which we think are particularly imperative for seniors and people with disabilities to comment on. We're skipping to enrollment and disenrollment. And we will look at individuals with long-term needs. This is a very rich area for comments because people with disabilities and seniors have unique considerations when selecting a managed care plan. What it does is require states to develop an enrollment system and have consistent standards for both voluntary and mandatory managed care plans. What they have done is create some broad parameters that states must follow when developing their enrollment system. Part of these include 14 days for beneficiaries to make enrollment decisions.) Note, I have abbreviated beneficiaries because I was worried about running out of space on the slide so I hope I didn't insult anyone. 13 days for beneficiaries to make enrollment decisions. 14 days fee-for-service coverage while an individual is selecting a managed care plan. And for individuals who are in passive enrollment, states that either allow an individual a certain number of days to pick a plan and at the end of those days if the beneficiary has not picked a plan they automatically pick a plan for them, that's the type of passive enrollment, or whether the state -- they have special standards for states that use passive enrollment and that includes adequate information on implications of the plan decision. Also confirmation of plan enrollment within five days and a requirement to preserve the existing beneficiary provider relationships. There is also a new requirement for choice counseling for any new enrollee or enrollee changing plans. There is a new for cause disenrollment option and that is FN enrollee has to change because a long-term service and support provider is no longer in the network. And they do say you can only have one 90 day without cause disenrollment per enrollment period. You can have as many for cause enrollments as you need but only one 90 day without cause disenrollment per enrollment period.

What are some of the considerations that are important for our network? These are the things we're hoping you might want to comment on. One is 14 days sufficient for an individual or senior -- seniors are individuals, but an individual with a disability or senior can make a plan

selection. We know we have many more factors to look at than the general population. So we might need to check into specifically what kinds of providers are in that plan, any kind of utilization controls, these can take more time. For our network it's really imperative if we think that individuals might need more than 14 days to provide detailed comment on the specific scenarios that would lead and -- a potential enrollee to need those extra days. CMS has asked for comment. They have specifically said would 30 or 45 days be better? That is in the preamble to the rule. Another question you might have is they created a new for cause reason for individuals with long-term services and support needs and other other for cause reasons that a person with a disability or a senior might need? You want to look at all of the for cause reasons allowed in the plan and determine if there is an extra one. Are there other factors that states should be required to consider if they are doing passive enrollment? Again if you are going to comment on this you want to look at the various factors already allowed such as geographic region and there is a whole list. Because they have added the factor for states that develop a plan they are now required to have preservation of the provider beneficiary relationship and factor it in when helping one automatically assigning a plan. What are some examples that could be a determinant of whether or not you are preserving the provider beneficiary relationship? A comment might include examples of how that requirement should be implemented. For passive enrollment, I actually don't think I included this but there are three factors for passive enrollment. One of them is that an individual must receive adequate and appropriate information which explains the implications of making a plan. Actually, I did include that. One thing that people might want to comment on is what is adequate and appropriate information? About the implications of not making a plan selection. That is real quick on the enrollment and disenrollment section. Now we will move to coverage and continuation of benefits pending appeal.

The rule requires that states must ensure prior authorization periods support individuals with ongoing and chronic conditions or individuals who require long-term service support needs. This is a wonderful new edition. They also have to look -- it requires that states provide continuation of benefits without interruption until conclusion of a timely filed appeal. What you need to know what that is if the appeal is not filed within the 60 day or 90 day requirement, then you were not entitled to the continuation of benefits. As long as you filed a timely appeal, you are entitled to earn benefits until the conclusion of the appeal. That scenario is had a lot of litigation so it's wonderful. They made some changes to the medical necessity definition. Mostly to promote compliance with EPSDT because that's an area of great concern and they add to the medical necessity division that must look at the benefits of community living.

What are some considerations for comment in this section? We want to since so many of these changes deal with individuals with long-term services and support needs, we should consider actually actively supporting the inclusion of the new authorization standards and submit examples of how the new standards would be cost efficient. I suggest that because there is probably going to be significant backlash, there is a possibility there will be backlash to having new standards. It will be important to talk about how yes, it is more cost efficient to not have people with chronic conditions have to keep going and getting new doctors appointments every three months for something that will not change. And talk about how inefficient it does to have to meet the utilization requirements if you have a chronic condition. You also might want to talk about whether the criteria that states must ensure that service authorization standards are appropriate and do not disadvantage individuals that of ongoing chronic care conditions or need

long-term services and supports. Is this language strong enough to actually ensure that people would long-term service and support needs to have on interrupted benefits or if you can think of alternative language that would strengthen this, that would be something to comment on. Is more detail needed to help states identified the types of long-term services and supports necessary to facilitate the opportunity for individuals with disabilities to access the benefits of community living? Do we want more details in the rule so that requirement really comes to life?

Moving on to grievance and appeals. This is a huge section so I will go over the basics. One thing they did is change the definition when you can appeal, you can appeal on any action. And this has been a subject of a lot of litigation of what is an action? They are trying to clarify this by changing it to make it consistent with Medicare and some of the Medicare terms. Some beautiful things about the adverse benefit determination as it must include looking at medical necessity, the appropriateness of the benefits be effectiveness of the benefit and the healthcare setting. These are all factors that are so important and you might want to comments on why this is a positive change in must be included in the final rule. It requires states to create a formal grievance system that would address both grievances and appeals. Part of that formal system is that the plans have to require only one mandatory level of internal appeal. They can have as many internal appeal levels as they want but only one is mandatory to go through. And another thing is that beneficiaries can be required to go through this one level of internal appeal before being able to seek a state hearing. It sets a minimum of 60 calendar days for beneficiaries to request an appeal.

Grievances and appeals continued, plan must rule within 30 days of the filing of an appeal. And if it's an expedited request they must rule within 72 hours. This is a change from before and it was three calendar days. States can get an exception -- an extension of 14 days, not for expedited, it seven days. And the regular ruling within 30 days they can get a 14 day extension but they have to show and prove how the extension would benefit the beneficiary. Enrollees have the right to information relevant to claim for benefits, that is free of charge. That includes medical necessity criteria and any processes, strategies, or evidentiary issues and her's used in setting coverage limits. This is huge and right now it's very hard for people to access these kind of criteria that are considered proprietary. It allows plans to recoup the cost from beneficiaries if the enrollee receives the final adverse determination. CMS has recognized that right now there are some notices that say if you lose your appeal, you will be held responsible for all the cost of the appeal. This can have a chilling effect and scare people from filing appeals. CMS has said they will in the future develop guidance on potential language that plans might use to reduce the chance that it deters a beneficiary from seeking an appeal.

What are some considerations in the grievous -- grievance and appeals section? You want to address is 60 calendar days is sufficient for a beneficiary to request an appeal. There are some states that allow more than 60 calendar days. You would want to talk about the reasons why a beneficiary might have exceptions to being able to meet the 60 calendar day retirement -- requirements. As a rule stands the state should have a longer calendar period but the minimum is 60 days. You might want to suggest what kind of model language should be required on the notices that tell an individual if they lose their appeal they could be held responsible for the cost especially since CMS said they are coming out with future guidance so this is a good time to suggest the language. You might want to comment on how the requirement to exhaust the

internal appeal process prior to pursuing a state fair hearing potentially could cause an unnecessary burden on the ability of individuals with disabilities and seniors to get timely services. If you make that point of course, provide examples.

I'm now going to turn -- actually I'm going to take five minutes for questions. Particularly questions we might receive by telephone and I understand we might not be able to get through all the questions and five minutes. I encourage people to put the questions in the chat box. Our speakers will make an effort to answer the questions and make the answers available online in the same spot in which one would be able to go and hear the recorded webcasts. I hope that made sense. Operator can we see up there are questions on the line?

Yes we will now begin the question-and-answer session. If you have a question press star and one. If you would like your question to be removed rest the #or hash key and there may be a brief delay. If you're using a speakerphone pick up the handset before pressing the numbers. To ask a question press star and then one and you have the opportunity to ask questions over the webinar if you prefer.

We do have one in the chat box. Asking is a more beneficial for beneficiaries to have longer times to file due to a lack of awareness on the part of members and also the confusion associated with the Medicaid program was

I think that would be definitely something to put in your comments because there are all sorts of reasons why a beneficiary whether they have a disability or they are senior, there are all kinds of reasons why they might need more time to file in the more examples of this that you can include in your comments the better. I see another question asking if the slides will be sent to participants? Actually anyone can go on after the session within a couple days and it will be made available on the website, either the network website or also on the three websites NDRN.org and the Justice for all website. I would wait a couple days but you will be able to access the full video and the transcript as well as any of these questions that we are not able to answer during the chat.

Also I think Charles sent the slides to those who are participating so participants get the bonus of getting the slides early. It's a reward for sitting through the webinar.

All right. Do we have any questions by phone?

If you would like to ask a question press star one on your telephone keypad. We have some questions. One moment please. The question is from Fred.

One thing that is a comment about the 14 days, you definitely need 30 days at least. Maybe not 45 days. That's a long stretch. People with TBI, traumatic brain injury are probably going to need a few more extra days and you are also dealing with whoever is helping them out to try and wrap their heads around all of this. Definitely at least 30 days. On this appeal process, where if you lose you have to pay the cost, does anyone know if any other appeals process that if you appeal something from a state or government agency that you have to pay for the cost of that? I have never heard of that.

I'm not up to date on the processes that other agencies use. But if that is unique to CMS or even if it is not that would be an area for comments. I don't think that would be something that CMS is flexible on because that's the current requirement already. The change would be if you could comment on if you have to do that, how do you have the notice provided in the way that it does not have a chilling effect?

You have any idea how much it might cost if you lose an appeal?

No, I don't. Any other questions by phone?

We have another question. One moment please. This comes from Sharon.

Your line is now open for your question. Please go ahead.

I would like to comment first on the previous question. Having to pay for services and any cost for appeal unfortunately are standard part of the Medicaid and commercial insurance business. If you don't win the appeal, you are required to make the payment. My question though is back to the issues around the grievance and appeals process as well as the 14 day minimum on voluntary versus other enrollment. Of these benefits going to be extended to everybody in the program or is it just restricted to people who are eligible and enrolled through long-term care services because I think that creates some dissension amongst the population in health plans and the states and up having to manage down to a much more granular level on benefits for different consumers enrolled in the health plan.

I'm not quite sure do you have any thoughts on that question?

I'm pretty sure the protection is extended to all Medicaid beneficiary so it's not just a distinction of the [Indiscernible] population.

Thank you.

And I want to add Stephanie said in the chat that the appeal is not actually the cost of the procedural cost but you are responsible for the cost of services that you obtained during the appeal process, the pending of the appeal if you lose. That's an important clarification.

Go ahead, Fay.

I was saying we need to hold on questions and move on to Sylvia's portion and get back to questions at the end.

Okay. Thank you everyone. Hopefully we will have more time for questions at the end, they are going to come up because there are so many levels of depth to the rule. I will be moving on to accessibility and accessibility crosses a number of sections in the rule because there are number of new proposals. When I say new I want to be clear that the accessibility requirements are not new in the sense that they are springing forth from the rule and have not existed before.

Accessibility laws state and federal have been around for decades. What the rule does is translate those laws which have always applied to providers and have always applied to plans and translate those laws and places them into the context of Medicaid managed care in specific ways. What the rule does and I will highlight three new proposed elements. One concerns informational formats. It will cover paper information, electronic information, and online information that is provided by the state and managed care organizations. It also looks at the contents of that information. Now the information that is provided by states and managed care organizations has to cover the accessibility of a provider network. Also the third new thing is looking at network adequacy. The states establishment of standards is supposed to include accessibility considerations. Accessibility in the sense of disability accessibility. The kind of accommodations and accessibility people with disabilities need to access health care services. To say again, there have always been standard non-discrimination contract requirements in the contracts that states enter with plans for Medicaid and in fact the federal government enters and plans for Medicare. Does have always been in there that managed care organizations are not to discriminate and to meet the requirements of federal law such as the Americans with Disabilities Act and the Rehabilitation Act. What the rule does this is translate those general requirements.

Looking at more detail into those three things. First accessibility in terms of information formats. The rule indicates the proposal that states and managed care organizations must provide information such as enrollee handbooks, provider directories, appealing grievance notices and other critical notice to enrollees and potential enrollees in a manner and format that may be easily understood and readily accessible. Readily accessible is defined now in the proposed rule in a way that actually seems to speak more about electronic information being fully accessible and it mentions specifically a number of World Wide Web standards that apply to electronic information. Whether it is delivered electronically or online at websites. In fact the rule makes clear that alternative formats and auxiliary aids and services must -- must also be provided and it's not just electronic information. A Medicaid enrollee or a plan enrollee requires information and if they want a provider directory or handbook, if they need that information in braille or large print or they need and assistant with sign language when they speak with a plan or with a provider, that has to be provided upon request and offered at no additional cost. Furthermore the taglines in non-English languages and in 18 fonts print are to be included in critical information. These are new changes and throughout the proposed rule there are clear references to the fact that were states and managed care organizations provide information to enrollees and potential enrollees in the public, that information has to be available in formats that people with disabilities can read independently for themselves and that's a critical change and one that many people in the disability community will welcome.

In terms of the information format change, here are considerations for the disability network to think about. How will this benefits beneficiaries with disabilities and functional limitations to need all tiller -- alternative formats and auxiliary aids and services? Do you know of individuals who have inquired difficulties getting these in the past? If you think this will have a positive impact or any other kind of impact it's an opportunity to comment on that. How will community-based organizations within managed-care networks meet their own information requirement obligations? For example as a community-based organization as an LTSS provider within the managed-care network. Is your website going to be accessible? If you have clients who need alternative formats and auxiliary aids and services, how will you meet those obligations? And

finally another consideration is what other critical information to potential enrollees need? I draw attention to this because enrollees in their proposed rule, they get a larger list of information that must be made available to them in alternative formats. The potential enrollees have a smaller list. They have to have enough information to make a choice between plans and they have to be able to understand what managed-care is and what enrollment means. For many people with disabilities and people who are older, details really matter. Let's say for instance the plan has a drug formulary, if there is a difference between how specific drugs are covered amongst the choice of plans, that is something you want to know before you make a choice of plan. What is the process how you obtained your TME is an example. These are details and another one is for people with mobility disabilities, what is the policy on transportation? Medically necessary transportation or normal transportation. These are policies and procedures and coverage issues that may seem to be very detailed but a very important to some particular beneficiaries. Having that information in an alternate format you can read for yourself can be a critical issue. That's another area to comment on if that's something you have information on.

From the rule looking at the contents of the information, provider directories now must include under the proposal information about whether the provider's office or facility is accessible for -- for people with physical disabilities including offices, exam rooms, and equipment. And buy equipment it would be a reference to say height adjustable tables that people with mobility disabilities or strength disabilities or little people need to effectively transfer onto an exam table to get a complete examination. Or an accessible weight scale. This is a new obligation that the rule recognizes as necessary the Koch managed-care organizations are increasingly providing services through Medicaid to persons with disabilities who cannot meaningfully access the full scope of service at a provider's office without accommodations. This is something very interesting for the rule to recognize and for CMS to recognize. That accessibility makes a difference to the quality and healthcare that Medicaid enrollees receive.

In terms of the contents of the information here are some critical considerations for the aging and disability network. Since this information is not required in directories, how will states and managed-care organizations -- I'm sorry. And went backwards instead of forwards. How will states and managed-care organizations find out that structural and physical accessibility of the healthcare professional network -- how will they find out whether the providers are accessible and how will they ensure that providers are consistently assessed? Do you have ideas how that can happen? I will say there have been surveys and research looking into how providers assess their own offices. The front office staff responding to questions for example, and these tend to be quite erroneous. It's not because of any evil intention. It simply because people are not trained to recognize the types of barriers that prevent people with disabilities from getting inability -- in a building. They don't necessarily think about if they don't need it themselves at the elevator has braille signage. There are things they don't think about when they go to work that would stop someone with a wheelchair from getting in. Those are common issues around accessibility that are not recognized necessarily when people answer questions about their own offices. How can information about reasonable accommodations and effective communication best be collected accurately and in the detail required by enrollees with disabilities? In terms of the directories, how will updated information be collected? What is the best way to ensure -- and shore and maintain accuracy? This is an interesting thing about how the rule is written. The proposed rule a peer to recognize there is a need for nonphysical accommodations such as auxiliary aids and

services, something as simple as someone at your request reading a form to you or providing that form to you in an alternate format or an audible format. The rule is written appears to be limited with enrollees with physical disabilities so for any of you work with people with mental disabilities who need accommodations, what is the impact of that? It's definitely something to think about. And also comment on it if you have experience with it.

I want to move on to looking at network capacity from an accessibility viewpoint. In terms of the overall approach, the state is supposed to establish standards for MCO network capacity and ensure the standards are met. The standards are supposed to consider physical accessibility, reasonable accommodation, culturally competent communications, and accessible equipment. There is a deliberate intention as well to ensure there are sufficient and adequate healthcare professionals and this includes LTSS providers within the managed-care network for enrollees with disabilities and for limited English proficient individuals. All these individuals need to have sufficient access to service.

What are the things that the aging and disability network should be thinking about? First is to think about what would be the impact on long-term support and service providers of network standards that extend beyond structural accessibility to accommodations, communication and equipment? This is something that long-term service providers have not had to think about -- federal and state disability access laws to apply. They apply to providers including LTSS providers including [Indiscernible] facilities and others who provide services in the home. We provide anyone who provide services to the public. They apply to healthcare providers. What is it -- thinking about how these apply to yourself or a community-based organization, these are new requirements for you to think about and thinking about how to meet your, and managed-care organizations assist the LTSS providers and the networks to meet their obligations? How can those community-based organizations who have accessibility knowledge and expertise work with managed-care organizations to achieve greater overall network accessibility? Finally what are effective ways for states to monitor and enforce how managed-care organization provider networks meet physical accessibility and accommodation standards?

The other large subject I will do with is looking quickly and network capacity and I know I'm coming close to the end of my time or I have passed it. The rules overall approach to network capacity establishes states as the overall -- overarching responsibility agency that will both establish network capacity standards, monitor MCOs, and enforce the standards. The rule establishes time distance standards as the fundamental means of network adequacy for medical providers, including mental and behavioral health providers. By time distance I made the managed-care organization has to have a network within a certain time or proximity to enrollees in the plan. The approach to LTSS network capacity is a little bit different. The rules is time distance of -- apply where enrollees traveled to the providers and standards other than the time distance where providers traveled to the enrollees home. CMS establishes a number of additional elements for states to consider when establishing both time distance and other standards and the one I went into in considerable detail earlier was the accessibility consideration.

For the aging and disability network is to think about include how is your state monitored and enforced managed-care network adequacy in the past? Is this going to be a big change for them and would these changes proposed in the rule for network adequacy meet the needs of Medicaid

eligible seniors and people with disabilities? What are other ways that LTSS network adequacy can be measures -- measured if providers go to when enrollees home? What if the provider does travel to provider homes? What is the impact on provider availability? Does the division make sense? What are the kinds of significant changes in an LTSS network that could trigger managed-care organization notices to enrollees? The examples given in the rule our medical changes. For example, if a managed-care organization network stops contracting with the hospital network or a critical children's hospital or treatment center, what are significant changes in the LTSS network that should trigger questions about the managed-care organization network capacity? And finally is CMS involvement in network capacity sufficient to support all of these changes in the proposed rule? I will stop there for a moment and ask the operator if there are questions over the phone. Also I will ask Elizabeth to join me in answering questions and see if there are any other questions as well.

If you have a question press star and one on your telephone keypad now.

While we're gathering the phone questions or was it question about whether or not these protections are disincentives for providers to contract with managed-care organizations? Any thoughts on whether providers may shy away from these provisions?

I think that's a very good question to ask and I think it may be a distinction amongst providers as well. For many community-based organizations to of been specializing in providing LTSS to people with disabilities and seniors, I think there is a sense that this is what we do. We want to continue to provide the services. We serve the Medicaid population. We will do what it takes to be in the network. Medical providers it is possible it will have an impact although I do think it's very interesting that the proposed rule also -- I can go into another section that talks a little bit more about state enforcement. There is another section that indicates that we believed that the obligation for the state plan to provide access and delivery of services without discrimination is necessary to ensure that services are provided consistent with the best interest of beneficiaries. It also talks about how they want to include that in the fee for service network as well, a newer provision. The fee for service one will not be as explicit about physical accessibility or accommodations but it does talk about non-discrimination. The point behind that is it states also have to hold fee-for-service Medicaid providers to non-discrimination standards, that should include ADA and Rehabilitation Act. That provides more of a level playing field for providers. They have always been under these obligations. At least if you are in a managed-care organization, the network might actually help you figure out what those obligations are and meet them.

To we have any questions from the phone.

I am seeing no questions at this time.

There is another question in the chat box and just to be cautious of time we will move forward in the presentation and I see there are questions in the chat box so please continue to send those on and we will have answers on all these questions in 10 to 15 minutes at the conclusion of the presentations. Silvia, I will just keep going with the presentation.

And if I can answer questions in the chat box I will do so as well.

Perfect. Wonderful. We will switch gears again in the final pieces of the presentation we will start off with stakeholder engagement. Stakeholder engagement comes up and 2 key pieces and long-term services and supports in this rule. CMS emphasizes the value of engaging with stakeholders particularly in designing and implementing oversight of any new managed long-term services and support delivery systems. Where do the stakeholders fit in the picture? The states will be required to set up a state level -- level stakeholder group so there will be us the group to work on design implementation oversight. And again we see stakeholders in a requirement of managed-care organizations who provide long-term services and supports will be required to establish a member advisory committee. Many MCOs already have these committees that this is a requirement for all of them moving forward. I want to note on both of these requirements the state level stakeholder engagement group and the plan level advisory committee, the information is very general. CMS is intentional about keeping a general particularly at the state level group. They want states to have flexibility in determining the composition and structure of their state level stakeholders. So that's it in the rule but a few considerations as we think about implications for the network. First of all CMS wants us to comment on what are the different responsibilities that stakeholder group should be and how frequently the group should be and the general approach to a stakeholder group. Feel free to weigh in on that. I would recommend thinking about this and even more detail. Particularly how can states [Indiscernible] be part of the process? What types of supports to consumers, family members, caregivers, and community-based organizations need to fully participate in any stakeholder process wax we need to think about this in detail. Such as [Indiscernible] assistance for members who are participating in these groups. Meals, reimbursement, materials in advance of meetings and this is the level of detail we don't currently see in the rule that we know is necessary to meet these good ideas a reality. Many of us who are working in states that already have some level of stakeholder engagement with either transition team managing long-term service and support so with their dual-eligible demonstration projects, we can weigh in on those experiences and think about what works in that process and what guidance states and managed-care organizations could receive to help make the process run more smoothly. Last of all we should think about the transparency of information needed for an effective stakeholder process. What type of materials to stakeholders need an advance of stakeholder meetings, after stakeholder meetings in the way of notes and minutes and what types of formats do people need to effectively participate in any stakeholder process?

Just a brief overview and now we will jump to the medical loss ratio and I will refer to this as MLR. You have probably heard about this because the MLR is a big component of the rule and its receiving a lot of attention in different health policy forums because it is a significant change. For those of us in the aging and disability network there is one component of the MLR that impacts long-term services and supports in particular. Before I go to that I will do a brief overview of an MLR. It measures the share of healthcare premium dollars that are spent on medical benefits compared to the overall company expenses and if you put the medical benefits in the numerator and overall cost and the denominator, the overall cost them process and the denominator and the medical loss ratio is that number of medical benefits to overall cost and that ratio should be 85% of dollars spent on medical benefits. The tricky piece to long-term services and support is what actually counts as a medical expense? Those of us who have been in

managed-care states there's been a shift to managed-care for long-term services and supports there's been a lot of discussion about whether certain long-term services and support activities are considered medical help activities or if they may be considered more administrative activities. If they are administrative activities they are in the denominator. So CMS is attempting to clarify some of the confusion and the rule says the existing definition of what constitutes medical activities which CMS calls the healthcare quality activity is broad enough to include long-term services and support activity. CMS sees three activities they say are under the umbrella and those are service coordination, case management, and [Indiscernible] community integration. Basically CMS is saying the current definition of the healthcare quality activity is broad enough to include these three LTSS activities. And as background my current definition that healthcare quality activity or medical activity in the numerator is any activity that improves healthcare quality, increases likelihood of desired outcomes, and are grounded in evidence-based practices.

So this is kind of tricky stuff and when we think about this what are some of the considerations for the network? It's a two-step question. First you need to figure out if the existing definition of a healthcare quality activity really works on the ground and second is that definition broad enough to encompass long-term care and activities? If you look at how CMS broadly defines long-term service activities for the MLR they say at service coordination, case management, and community integration support. And DAG and disability network need to think about the activities and services we provide. If a managed-care organization is paying for services they want them included as a healthcare quality activities so do these activities fall into those buckets of service coordination, case management, and community integration support? If they do, how can we explain how they do. If they don't, what additional clarity do we need?

Moving to the beneficiary support system, you have probably heard of this and well and many of the activities in the beneficiary support system encompass services your organization may currently provide. The basic concept here is all states will be required to develop a system that offers choice counseling and then for states that also have managed long-term service supports this is similar to offer for additional components. I want to clarify that CMS in this rule are not expecting states to devote the whole new consumer assistance network overall new consumer assistance agencies. They are looking for states to [Indiscernible] on their existing network and demonstrate how the network works together as a beneficiary support system. The rule notes that the choice counseling concept in the beneficiary support system is similar to the SHIP system which we know is the state health insurance program. The rule does clarify that any of the services that the system provides must be accessible and information must be available in multiple formats. I want to say in reviewing the rule I did not find a lot of information on how the system will be funded. CMS said the caution be a minimum burden on the states. States will be permitted to draw on and expand on existing resources. This is a question right now. Moving on to other things for us to think about in aging and disability network. It's an intense section so please bear with me. There are 2 slides on considerations and questions. The first questions is the part of the system requirements is the system has to provide training to managed-care organizations on the available network of community-based services. The system has to go out to the managed-care organizations and told him here is a network of community-based organizations in your region. Here is what you should know about them. It's a very good goal. The idea is to have a more integrated coordinated system once the managed-care organizations

know more about community-based services. That is all that it says so as a network we should be thinking about what types of information the managed-care organization needs and how the training should be conducted and what effective training is constituted of? In the cost estimate section the rule estimates minimal cost for producing the training materials. I think they estimate about two or three hours so we should think about whether affected training would actually require significantly more effort. Next on the section on choice counseling, the choice counselors here are described as enrollment brokers and from those of us in LTSS states we know states have enrollment brokers with private contracts who actually enroll individuals and plans. There is also a network of consumer assistant entities like the SHIPs will provide choice counseling services. We may look for greater clarity on the -- on how the entities will work together in the benefit support system. That is a prohibition on counselors to having a financial organization as a contracted provider. Someone said you are losing your voice, I hope folks can hear me. I will try to speak more clearly. Thank you for noting that. Last among one of the thornier issues is the issue of a choice of an entity that has choice counseling and also assists individuals with appeals at the state fair hearing level. In general CMS does not want to allow an entity funded by Medicaid to assist with both but CMS is proposing an exception if an entity refused non-Medicaid funding. That they can use the non-Medicaid dollars for that state they are hearing assistance and provide a firewall between the Medicaid side and the non-Medicaid side, then they may allow for that exception and they are seeking comments on that part.

What are some questions we should think about? As you can tell there is a lot of emphasis on conflict of interest. In the exception I just explain for entities who use their non-Medicaid dollars for earned beneficiary representation and assistants and also service choice counselors, the solution is a firewall. The network should think about existing firewalls and their experience with firewalls and what kind of guidance we need to build this firewall. If your organization is working through conflict free case management requirements you probably know about firewall requirements. In your experience with firewalls will be very informative and helpful here. The next piece under conflict of interest is prohibition on community-based organizations with the managed-care contract from serving as a choice counselor. Think about what this could mean for your organization. Then we have section on questions about training and as I mentioned earlier there is an emphasis on training the managed-care organization to understand the community of services network. So thinking about what type of training should be provided to the managed-care organization to better facilitate coordination and integration. And finally as the state develops its system this will only be effective if beneficiaries are aware of its availability. What kind of outreach is necessary and specifically how can we conduct effective outreach to people with disabilities and older adults?

We have one more slide, 2 more slides and one more section and that's the general brown bag section of additional long-term services and support pieces. So we will do that and then we will get to question and discussion. You are wondering how to CMS defined long-term services and support in the rule since this is a big piece of what we're talking about. They do it broadly and they are intentional about that. They don't want a definition that is too limiting so they are not listing out specific services that fall under long-term services and supports. As Elizabeth mentioned there's been discussion on long-term services as medically necessary service and there is a little bit of lack of clarity. As we know managed-care organizations use the definition of a medically necessary service to decide whether or not they will provide those services, and

whether or not the services necessary. That definition is usually detailed and written out under the managed-care contract. In this role CMS is proposing that states the managed-care organizations work out their definitions and contract negotiations that the definition of a medically necessary service must include the opportunity for individuals receiving LTSS service to have access to benefits and community living. It's kind of a medically necessary requirement that if you think about that language, opportunity for access to community living it's not a very clear directive how much community-based services are medically necessary services. So there's a little clarity on capitation rates the rule requires managed-care organization rates be sufficient to pay for care coordination and care continuity. It does not go into detail beyond that. There is a requirement that service plans be developed within Rowley participation and be in compliance with existing person centered planning requirements. I combined our consideration slide with our pieces on the rule. I would think about the vagueness in the medically necessary definition whether that needs to be clarified and whether we need more clarity in the definition of long-term services and supports? I am going to wrap up the substance of the presentation and I have our email addresses listed here and we can answer questions following the presentation but it sounds like we have questions in the chat box and I know there were some questions left over from Elizabeth so if you don't mind opening up the phone line for questions and we can get started with the chat box questions. Silvia and Elizabeth, are there any we should dive in right away?

I was looking for questions that address what you were talking about and there are some questions that address different sections that Silvia has done a good job answering in the chat box. I don't know Silvia if that is something you want to answer orally as well?

I think there might be a couple of the recent ones that raise a conflict of in-flight issue, I think there was one about providers who must provide consumers they have a choice of any [Indiscernible] provider in the community and I'm not sure if that was meant to be a question of around conflict of interest or not?

Interesting. I am looking at that. If someone can remember in the rule a clear directive that advises the choice counselors about how they will advise beneficiaries about different providers. I know currently in managed-care states the brokers have to have access to a provider directory in order to answer questions about different providers in the network. I imagine that would continue but from what I remember the rule did not get into that level of detail.

There are some questions that dealt with the enrollment and disenrollment. One was from Charles who says he's wondering if a beneficiary expresses interest in a plan is there an auto enrollment requirement or can someone switch to go fee-for-service and that would entirely depend on your state. He mentioned some of the requirements in the rule that would affect that but some states of managed-care plans and fee-for-service plans. For the purpose of this rule there are requirements for states that do have passive enrollment, they have to consider certain factors such as certain factors in choosing a provider like they have to seek to assign beneficiaries to plans that preserve the a fishing provider beneficiary relationship and a half to ensure that adequate and appropriate information is provided to beneficiaries explaining the implications of not making a plan selection. And they have to provide 14 days of fee-for-service

coverage while an individual is choosing a managed care plan. It doesn't directly answer your question because that depends on the state but those are some factors.

We can go to questions over the phone if you would like to take those. We have Sharon.

My question is related to any provisions in the proposed rule about financing some of these changes. My concern is that we are dealing with states that are already facing very tight budgets on their Medicaid dollars in funding and as MCOs and states continue to contract for services for long-term care and Medicaid services, that the potential exists and something we saw with Medicare advantage when the rates dropped a couple years ago was that health plans are going to withdraw from participation in the program's leaving consumers high and dry in some cases. How should we approach that issue as we respond to the proposed rule or have you heard any feedback from states and managed-care plans about their reaction to the proposed rule?

Hello Sharon. One quick thought and that I would like to hear from Silvia and Elizabeth on their perspective gives. As far as what CMS proposes for funding the rule there isn't a section in the rule where they have a cost estimate on the states burden for each component of the proposal. I don't have the page numbers off the top of my head the acronym Ford I think is called IRC and a blinking of what it stands for but they go through every section in detail how much personal support it would cost to implement each portion. As I said, for example on training managed-care organization, that estimate is pretty low so what it would take to actually do effective training so exactly what you detailed, the fact there are significant expectations here and it will take [Indiscernible] to make this work. I am not sure what the plan is. I think it will be part of the general federal state match process but I really don't know enough about the funding. My other thing I will say is I have not heard directly from states what their responses. I'm sure that information is available on their websites as they put together their resources. And Elizabeth and Silvia ?

Elizabeth do you have anything?

No.

I don't have -- no state has come to me for advice either. Implants have not either. I think it will depend -- my thought on this is a rule is trying to affect a cultural shift which is probably pretty necessary given that there has been a major shift to Medicaid managed care. This is a new way of doing things. We're talking about a population that does have very specific needs, and people, because population is a generic word but people have clear needs in order to receive healthcare. That is what this is about. Trying to keep people healthy and helping them stay out of hospitals and maintain their lives in the community. Because it's such a major change, how CMS will implement and work it as it goes forward, it may take place over time and maybe that is why they are giving such flexibility. Caring California, the state -- here in California, the state engages in a facility psych review. There is a requirement that they survey their provider offices. They do this and have done this for years. The fact they have to make that information real and in a database, states actually have to figure out -- let me back up a little bit. Prior to doing it now the information is there. Now there is a greater responsibility to make sure it is kept up-to-date and in the directories in a real way that is useful to enrollees and potential enrollees. The cost is

not so significant as for a state which never thought about accessibility at all and hasn't paid attention to it. Overtime hopefully you bring everything up to level so that people are served effectively. And that's something that comments can reflect as well, your thoughts on how that approach can work.

I have thoughts on the question. I think you are right that there might be some backlash against certain provisions so related to the requirements around prior authorization and medical necessity and clarification of what an appeal is I think it will be important for the long-term services of the community to provide comments that talk about cost efficiencies because I am sure CMS will hear from a lot of the plan saying this will be cost in efficient and I will not participate. One of the things you might comment on is actually you can be more cost efficient to not have individuals going to the doctor every quarter to get a prescription because the fact that treatment may lack -- lapses a result in a treatment lapses because someone has to get a new directive, then treatment costs could escalate which could mean more costs and see examples how prior authorization has resulted in exacerbation and a disruption of treatment that is cost more money. Those were the kind of things that you should comment on as well as the issues around accessibility and if more people can access providers than that increases -- that wouldn't really work. My point is we really have to submit these comments because they will be hearing that don't support some of these changes.

Are there any other questions on the phone?

We have another question from Colleen.

Hello. Thank you. I wrote this down but it's hard to write it all. I get concerned whether attendant services are really being handled with an understanding of what someone with a disability need so I'm going to use an example of an extreme case. There is a guy who works in my office as an intern. Is quadriplegic and on a ventilator. He gets attendant service through Medicaid and he has nurses. He doesn't have nurses around the clock, he only has them for 12 hours of the day. The other 4 hours he has to get someone else to do that. The other thing that happens is that his nurses are not allowed to drive for him so he has to find someone else who can drive for him and doesn't have the money to pay them so we tried to get help out. I am wondering and thinking this through and thinking out loud, if attendant services under LTSS are considered medically necessary, they should truly reflect all the need someone with a disability has in order to live in the community. You can't give only a little bit of what someone needs especially and this is not a ridiculous example, my husband was on a ventilator and needed 24/7. If we had use the Medicaid service he would not have gotten everything he needed except for his great wife. You know what I am saying. This is a worry and is not clearly articulated always or not clearly responded to by the Medicaid program, whether through an MCO or not what the true deeds are of someone with a disability who lives in the community.

That's exactly what I was trying to get it when I was talking about how people might want to identify if there are other factors or more detail that the state that should be required in the role so people can identify the types of medically necessary services that to quote from the rules would facilitate opportunities for people to benefiting community living. Like you said, what

does it mean and what's required for accessing benefits? If they have utilization controls, how might that directly impact somebody's ability to access the community?

I feel like we make it very difficult for people with disabilities to use the system or use it better because there are very strict things about what is medical and what is not and driving is considered not apparently it's just,. It is not an informed program and it sounds like the effort is to make an informed and I'm happy to comment to try to get it to be a more sensible system that really understands what the needs of disabled people are.

Colleen, the rule has some discussion on long-term services and supports and there is an attempt and CMS came out with these principles in 2013 the rules try to put some principles and infuse them into -- community-based services and says all manage LTSS programs must be implemented consistent with the Americans with Disabilities Act in the Supreme Court Olmstead decision. Then they point Than they .2 a proposed section 438 43813 43813O as something to put in there to try to deal with this concern which I think is the heart of what you are getting it too. Maybe that is something for you to zero on in your comments because yours is an experience of someone in the community and that is especially what CMS needs to hear from people who know what it is to be in the community, live in the community, and what is necessary. That social needs are important as medical.

They are critical. They won't let you be driven to the movies or to the grocery store and that kind of silly business. The other thing is can you guys send the proposed rule and some of these other things? I get confused by this myself sometimes and I want to make sure I do a good job making comments. Can you send us a link or something so I can read the proposed rule we're looking at here today?

We could add the link to the online version of this.

That would be great. Thank you.

I'm showing no further questions.

David asks their RCD PA services for Medicaid eligibles in New York State that have approved services by MCOs such as taking -- I think what he is saying is the state can be creative in how they deliver services in the state plan. That wasn't really a question.

It does raise the underlying issue with the rule which is that states establish their Medicaid programs and this rule sets up parameters of that program and the federal government is contributing money. The rule also preserves state flexibility in many instances. That's an area for comments. If there are critical areas that you think the state needs to be clear about meeting changes or directing changes in some way that you think states need assistance in altering the program are going in a certain direction. That is something more to comment on.

One thing to clarify. There were some questions I realize we never shared when the comments are due. CMS is excepting comments through July 27 that 5:00 p.m. Eastern so by the end of this month on the proposed rule. We have information on our website and as Elizabeth mentioned we

will have this presentation posted for additional resources and we are working on a guide specific to this presentation that will have useful information shared in the presentation. I don't know Elizabeth if it's possible to send it out. I think we have the email addresses.

As we do. And that would go to the question of it would be helpful to have citations and we should have said this from the beginning and I forgot. We will have a guide that accompanies the webinar so that the directions to access the webinar afterwards will be on the websites as well as the network. If you follow directions to get to the recording we're calling it a guide to long-term services and supports provisions in the proposed rule and I can forward that out to folks who formally registered. I think we have the emails. Thank you for reminding us to mention that. We are much more -- we will include the citations in more detail.

I think with that it's almost on the half-hour and you've all been wonderful. I think we're good to close and we appreciate the dialogue and encourage you to weigh in and participate in the process.

Thank you.

It's great to have an interactive webinar.

Thank you. Have a wonderful afternoon.

Goodbye all.

Thank you ladies and gentlemen. This concludes the conference and thank you for -- for participating in you may now disconnect.