PLEASE STAND BY FOR REALTIME CAPTIONS. >> Please stand by for realtime captions. >> Hello, and welcome to the Civil Rights Protections and Long-Term Services and Supports webinar. My name is Naisha, IMP operator for the call. At this time, all participants are in listen only mode. Later, we will conduct a question and answer session. I will now turn the call over to Elizabeth Priaulx, you may begin.

Hello. Thank you for joining us and I hope we will have uninformative car. Cash call. I want to explain how we are funding and sponsoring this call. It is an exciting program called the aging and disability partnership for manage long-term services and support. This is a program that has been funded by the administration for community living estate between national area National Disability Rights Network, Health Management Associates , national Senior citizens Law Center and Disability Rights Education and Defense Fund . These organizations have come together to leverage the aging and disability network infrastructure service capacity and expertise to ensure the delivery of efficient, high-quality service and support to older adults and persons with disabilities. Our team is providing training and technical assistance to ensure that aging and disability network plays a significant role in developing and implementing quality managed long-term services and support.

So, that is who we are. I him from the National Disability Rights Network , Elizabeth, and Silvia Yee is from the Disability Rights Education and Defense Fund , DREDF . So actually, Silvia Yee, what you describe DREDF Sure, thank you, Elizabeth. Hello. I am happy to be here and I also echo Elizabeth's wish for a productive webinar. DREDF is a national policy and Law Center dedicated to protecting and advancing disability civil and human rights. Our vision is a just world and all people live free of discrimination. Our constituents are people with disabilities of all ages and parents of children with disabilities. We have held that disability rights are civil rights and health care rights are disability rights. And I want to take a moment to tell everyone that my colleague, Mary Lou Breslin, is actually not going to be a presenter on this webinar . She will be helping us to answer some of the technical questions when we do so , when we take the questions that we can answer in this period. >> I thought I would deliver a beta switch, Mary Lou Breslin would be on if she could be. Thank you.

Absolutely. I want to describe the National Disability Rights Network. It is a membership organization for the federally mandated protection and advocacy , they go by names in every state, often disability rights in the name of your state . Very few are actually called protection and advocacy anymore, but that is the name under which they are federally mandated to provide legal services to people with developmental and full range of disabilities, any disability. We are also the membership association for the client assistance program which assists people with disabilities to access vocational rehabilitative services. Our mission is to support the capacity of the P&A and CAP system, the national network to advocate for the enactment and vigorous enforcement of laws protecting civil and human rights for people with disabilities.

Just a few housekeeping tips. This is been live captioned and if you are having any trouble with the captioning, please , I actually don't know what to do if you're having trouble with the captioning. But, it is been live captioned and operator, could you tell us how to get to you if you're having any troubles with that?

For any issues, you can press star zero on your touch tone phone which located to an operator.

Okay, great. We will be stopping periodically for questions which can be submitted through the chat function or on your computer , or on the phone through the operator. But, the operator will have to open up the lines, which we plan on doing mainly at the end of the call. And just so you know, a full transcript and audio of this will be posted on three different websites that you can see .

As an overview of the presentation, we are going to be going through some managed care basics and common concerns for persons with disabilities , some Medicaid managed care consumer protections, Medicare managed care, nondiscrimination provisions and the nondiscrimination provision and accessibility provisions of the ADA Section 508 for, but we have act, and the affordable care act. Without further delay, I am going to get started. The first section is a very basic section on managed care. There are three models of Medicaid managed care. The first, MCL, provides a package of services in exchange for a capitated payment for each enrollee.

Managed-care plans would enter into a comprehensive risk contract through which they agreed to provide certain services and incur loss if the cost of providing the services exceeds the capitated rights. They are required to provide at least three of the following services. Outpatient services, federally qualified health center services, nursing facility services and early periodic type gnosis and treatment, cash they also have to provide the whole range , laboratory services.

Then there are prepaid and amplitude replant, the PHPs, which like managed-care organizations see capitated payments and offer a comprehensive package and services. But, they do not have comprehended risk contracts. Finally, there is the primary care case managers, the PCCMs, they are the entity in which the primary care provider is paid a nominal, monthly, per-person fee to coordinate care for beneficiaries and receive a fee for service reimbursement for services provided. So, the first thing to find out if your state is what type of capitated managed care arrangement your state is pursuing.

The other important thing to note about managed-care is that the managed care contract that your estate signs is going to be the equivalent of yore, you know, state statute that is giving you all of your protections under Medicaid. You do have Medicaid protections but the managed care contract is a very important legal document that is

defining the scope of benefits within the health plan. And identifies the responsibilities of the health plan.

This is where you find issues , like little involvement in the managed-care plan be voluntary or mandatory through passive enrollment? [Indiscernible] networks will be very important issues for folks needing long-term services and support issues like, well they have a long transition time frame? Will providers be able to support their client through this transition , even if they are not in the existing managed-care plan? What the payment rates for the assisting providers might be during the transition time frame. These are some of the issues that we will talk about in the question and answer section. But, I am just trying to let folks know that the contract is very important and unfortunately, there is not much transparency that goes on. But, advocate should still try to be involved. We will also talk about issues like the plant care, you know, folks who are currently receiving Medicaid have to have a plan of care when they switch to the managed care arrangements, will they be using the existing plan of care during the transition over a full assessment? What will the process before any reductions, appeals , and those kinds of things?

The plan would also require data collection and monitoring. So, --

Elizabeth? I am sorry, we are getting a few comments that you are speaking a little bit close to your microphone and there is a little bit of static.

Oh, you know? I have a habit of eating the microphone. I have been told that before and I think I'm also going very fast. So I will hold the phone further away and try to speak a little bit slower.

Thank you.

Basically, this slide is getting out why we are here. At least mandatory managed-care for individuals with disabilities, long-term care needs, mental health needs has been the exception. Except within the past 10 years or so. And, the reason for the increase is that the Center for Medicare and Medicaid services has made it easier to find long-term care, behavior health services, under a mandatory Medicaid managed care plan. Some of the ways in which I have done that is with the new affordable care act dual eligible demonstrations where states can apply, and I think something like 39 states applied, 13 are going forward . Sylvia will have more information on that later. The idea would be to serve dual eligibles, eligible for both Medicaid and Medicare, provide them both with their primary care, their behavioral health and long-term care needs, all through Medicaid managed care. This is what implications for people with disabilities, as they shall hear, 58% -- I am sorry, I am calling the individuals eligible for Medicaid and Medicare tools. -- duals, Please pardon the shortening. I don't mean any [Indiscernible] to anyone. 58% of duals have a serious mental illness or intellectual disability. And nearly 7% of 18 to 64-year-olds have an intellectual or developmental disability. That is one reason for

the big increase . Now, not all of the dual eligible demonstrations have to be managed-care, but a sickness again number of them will be . And so that is why it is added. The states are also using 1915 waivers, 1115 waiver demonstrations, 1396 , and different programs have been added over the years to expand the options for states to provide managed care to older persons and persons with disabilities, and to provide home and community-based services through these waivers.

So, I'm just going to go into a little bit more on why this is such a concern for people with disabilities. I don't mean to indicate that Medicaid managed care is automatically a bad thing. There are many pros to it. And, there will be more pros , the better advocates are common to the table and being part of the managed-care providers system and infrastructure systems.

But, some of the concerns to lay out and we will be discussing them or as a fellow long are the lack of experience with long-term support in behavioral health among the typical managed-care provider, which because there have been carveouts and fewer people with behavioral health and long-term care needs, accessing a managed-care program than a typical managed-care provider is more used to the primary and acute care services and has less experience. There are ways that the states can make up for this, which we will be talking about later.

There are provider incentives in some managed-care programs. Again, this can be limited to the contract, but you'll often hear about withholds, greater prior authorization , bonuses for providers, and they can create this incentives to serving people with disabilities. One common example would be providers in a managed-care system getting a bonus for the number of clients that they serve successfully , or the number of clients that they need. There might be requirements of, like, 15 min. for a well-child visit, which for a child with a developmental or intellectual disability would not work 15 min. would not work, because he might have to provide some accommodations, which would require a longer visit. In order to adequately meet the needs of a person with, say, an intellectual or developmental disability. >> Right there, there is an incentive not to serve that person because the managed-care agency is requiring a 15 min. visit and you'll go over. So, those are some of the disincentives. They are not obvious on their face, but when you come to know , they happen. Then, there is the performance measurement focus of , you know, the quality assurance. Most of the CMS performance measurement guidance focuses on acute care , whether, you know, the number of heart attacks, I am not an expert in them, but if you look at them, they are very rarely looking at quality of life issues that are so important to individuals with disabilities that have long-term care needs. Issues of whether persons are put into an institution or have access to the full range of services of the community , self-determination and autonomy over services, proper care coordination, and, you know, there might be care coordination on the medical level of, you know, follow ups with nurses. But, when we are talking about care coordination here, we are talking about coordination between the medical services and actual services in the community. Such as, accessible

transportation , respite care, some of the things that acute care does not only look at. >> And then, you have issues of inaccessible facilities and outreach materials and, like I said before, services and supports mapping consumer directed. Not purposefully, but because providers are, again, not as accustomed to providing services to folks with long-term care needs and may not be as familiar with the nonmedical model consumer directed approach.

A huge concern is limited access to specialists because of the restricted provider networks . Some of the areas where this gets tricky are durable medical equipment, nonmedical services, such as transportation, accessible transportation providers , respite providers, and another huge problem is hidden formularies and rates. So, it becomes difficult to identify which plan would be the best for you when you can't access the truck formularies and other -- drug formularies and other types of services in advance. And then, there are issues of misunderstandings of whether you have to go through the internal appeals process of the managed-care organization, spending a lot of time in that process. Sometimes without appropriate care. And, not following them Medicaid requirements that benefits are provided during the time in which you are appealing your services. So again, this is sort of the worst-case scenario, but it is important to know ahead of time so that when we look at our system for providing services in our overall infrastructure, we can make the changes necessary to eliminate some of these concerns.

So now, Silvia Yee is going to go over where we are in the states.

Elizabeth? Yes, I am. In terms of the state overview, I just thought it would be interesting to have a brief look at what states are doing and where they are. This is actually from the state Medicaid integration tracker , which is available online and is published by the national Association of State United for aging and disabilities.

So, when I say Medicaid integration, I'm speaking of it in a couple of ways. There is the integration of long-term support and services with the medical services, the providers and hospitals, and there is also the integration of Medicaid and Medicare. So, there are a number of states that are engaged in person just Medicaid managed long-term support and services. They want to put home and community-based services and long-term services and support within an integrated Medicaid plan. And those states are listed there. >> And I'm going to confess right now, well, it's not a confession, but I am Canadian and I actually have always had a slight amount of trouble with all of the acronyms for the states, so I'm not going to go ahead and read them. But, there are a number of them on here, and if you want to give the update, however, that this was published in May of 2012. So that a number of states have actually was drawn their tools -- duals bits. Six or seven of them. Arizona, Maryland , Minnesota, New Mexico, Oregon and Tennessee. And number of states have actually advanced and con ahead and signed memorandums of understanding states that they have gotten approval from the government to have integration , at least integration of Medicare

and Medicaid. So, that is California, Illinois, New York, Ohio, Virginia and Washington.

So, some of the state that have given up on their duals bit, that is the integration of Medicare and Medicaid, it does not mean that they have actually given up on putting long-term support and services into managed-care. That is a different thing. So, this is very useful for seeing how much this trend of putting long-term support and services into managed-care and turn into managed-care is a way of delivering Medicare and Medicaid. How much that trend is really sweeping the country. So, I'm going to try back to Elizabeth to go over some of the Medicaid protections that are available. >> Writes. Now, I went very quickly through some of the concerns with Medicaid managed care . But the goal of this call was was to talk about the nondiscrimination requirements, and there are a number of safeguards in the Medicaid act regulations intended to ensure that enrollees obtain the necessary services and quality of care that they need. For example, managed-care organizations must ensure that services are accessible to the same extent as recipients not enrolled in the plan. And, the contracts must also prohibit discrimination on the basis of health status or the requirements for health status in enrollment, disenrollment and reenrollment. That is basically what this clause means here.

The states must also ensure that the capitated rates themselves are adequate to cover necessary services for individuals involved in the managed-care plan. States can't receive the federal Medicaid matching rate for services provided by MC always cash by the -- by the MCOs, unless the payments are made by what is called actuarially sound and all of you on the call are better able to talk about actuarial rates . But, as far as a general overview

discrimination requirements, and then there are some federal Medicaid act requirements which would still apply in the case of Medicaid managed care. In some of the major biggies are that medical assistance must be provided statewide and states must use reasonable standards for determining eligibility and the extent of medical assistance. Again, some of the biggies are the amount, duration and scope of services much -- must be sufficient to achieve their purpose. No discrimination based on condition for mandatory services, and that services are comparable among similar groups and medically and categorically needy groups. Now, this is getting more into I could discuss what medically and categorically needy are, but we are in a big rush. I just want people to know that the federal Medicaid requirements would apply here. And then, it is important to note that we just talked about many states are designing their Medicaid managed care through 1115 waivers , and so it is important to note here that some of these overarching federal nondiscrimination requirements in the Medicaid act our way -- are waived when you pursue a program under the 1115 demonstration. So, the waiver allows a waiver of statewide mass comparability and financial eligibility requirements . And if you go back to the previous slide, you would be able to match up what the requirements are. I said previous, the ones that are now waived. The good part about this are that states must seek an amendment that has to

be approved by the secretary of HHS. And, waivers are supposed to be for a limited time frame, I think three years or five years many of them, have gone on for demonstrations that never really expire. But, the important thing about the approval by the secretary of HHS is that they can make sure that, for example, all of the new requirements of the affordable care act and the other requirements down here will be met, which is that states must meet assurances to protect health and welfare, and that includes the adequacy of providers and all state licensing and certification requirements. And again, unfortunately, both state assurances are pretty much it, as far as the requirements for waivers, other than the federal requirements that are waived. So, here are some specific standards for managed-care organizations that were passed under the balanced budget act amendment. For example, managed-care organizations must allow emergency care without prior authorization. And while this is a major issue as far as what is emergency care, there is, by statute, a prudent layperson standard which has been upheld in numerous case laws. They have to provide adequate capacity of services and, again, this is where the rubber meets the road.

But, it is a statutory requirement. They have requirements for quality assessment and improvement . Certain types of data collection, and an external independent review. They have restrictions on marketing , primarily to ensure that folks do have proper information about the types of services provided and any limitations and formularies, for example. And, there are sanctions for noncompliance . So, some of the other ones are , with the exception of rural areas , individuals must be provided a choice of at least two managed-care organizations . And, they can have disenrollment for cause, or during the open enrollment , but, that provide somewhat of a legal hook for folks with disabilities who may be disenrolled for issues that are in fact a manifestation of their disability. And that would not be an appropriate cause. And there are specific reasons and if you requirements which we will go over a little bit later. And requirements to provide sufficient notice of services and information and types of providers and covered services. This is -- well, I won't think any comments here. >> This is a chart that was done by the national health Law program which has wonderful further resources on Medicaid managed care and legal requirements. But, most of it is self-explanatory, although I wanted to have Silvia go over the difference between legal rights under statute and rules and complaints based on the managed-care contracts.

Thanks, Elizabeth. I think , in general, for the public looking at the difference between fee-for-service and managed-care, the one that is most apparent to the beneficiary is that , under fee-for-service, I could go to any provider I need to go to. Any provider who will take Medicare or Medicaid. But, if I go to managed-care, I am locked into a particular provider network. However, a really key underlying difference , one that probably lawyers are deeply concerned with, and advocates, are that in fee-for-service, the complaints about the service are based on the statutes and rules, as Elizabeth said. When talking about managed-care taking over some of these public programs and services, the

contract was entered between the state and or the federal government and the managed-care organization becomes a critical source. -- Becomes a critical source of rights. And that is something that is of great concern because the contract is not necessarily going to be so publicly and readily available .

One example is that in those duals projects, the ones for individuals who are eligible for Medicare and Medicaid , CMS, the centers for Medicare and Medicaid services and a particular state and particular managed-care organization will be entering a three-way contract. And this is a new thing. And it will go into a lot of detail, more than the memorandums of understanding that have already been signed or will be signed . What a beneficiary is actually going to be entitled to, how they can work on the ground running need a service, those kinds of things will be set out in the three-way contract . But, despite considerable pressure, some advocates across the country , both CMS and a great majority of states have refused to make those three-way contracts public before they are actually signed.

And it is not necessarily that advocates need to know every single detail of a plan's proprietary, the way in which they do things, you know, their internal organization, but it is important for advocates to be able to see and have some input into the consumer rights as they are explained and flushed out in the three-way contracts. And that is something that I think we all , as advocates, continue to really have to advocate for. Given that there is a non-trans. Tape that continues now. Elizabeth? Oh, actually I am going to continue on with the next few slides. Oh, thank you.

So, I wanted to look a little bit at Medicare and the managed-care nondiscrimination requirements set out in Medicare. I'm actually going to go ahead and read this for anyone who is not using their computer. Or who is not using a screen reader. Plan sponsors may not discriminate based on race, ethnicity, national origin, religion, gender, age, mental or physical disability, health status, claims experience, medical history, genetic information, evidence of insurability or geographic location. I guess that long list is a sign of how much discrimination there can be. Plan sponsors may not target beneficiaries from higher income areas or state or otherwise imply that plans are available only to seniors rather than to all Medicare beneficiaries. Only special needs plans may limit enrollment to dual eligibles, institutionalized individuals or to individuals with severe or disabling chronic conditions and or may target items and services to corresponding categories of fisheries. Basic services and information must be made available to individuals with disabilities, upon request.

So, that is what is in the statute. And I took that from the Medicare marketing guidelines for Medicare advantage plans, Medicare advantage prescription drug plans and that is from chapter 3 of that guide, which is kind of the Medicare Bible for managed-care plans. So, managed-care and disability nondiscrimination. Managed-care has had a long-term presence in Medicare through Medicare advantage plans, through dual

special needs plans, chronic care special needs plans and institutionalized special needs plans.

The affordable care act and promotion of integrated services, as well as the financial crisis of the last few years, have really pushed states to think about managed-care for the Medicaid population with disabilities and chronic conditions. But, as Elizabeth mentioned earlier, a lot of managed-care orchestrations have little experience with long-term services and supports. Furthermore, they have little knowledge of federal and state disability discrimination laws. I mean, that nondiscrimination provisions and Medicaid and Medicare loss and the mentioning of them in handbook, it is not as though discrimination does not exist as a concept. But in general, for managed-care plans, little attention has been paid to getting actual policies and procedures in place on the ground , concerning reasonable accommodations and policy modifications, concerning effective communication. Concerning staff training, and ensuring that accessible provider networks are accessible. >> I mean, for the most part, managed-care staff are trained in how to deal with patients, not individuals with rights. I mean, Medicare, the federal government has far more direct control and oversight in Medicare. But, it is my opinion that the Health and Human Services office of civil rights does not really have a history of a proactive and systemic enforcement of disability nondiscrimination amongst even the Medicare managed-care organizations. And it does not mean that they don't investigate or take individual complaints against particular providers or even larger entities like the county or state .

If there is a clear violation of rights, they do take those complaints. If a provider simply refuses a patient, a Medicare patient, just because ASL interpretation is needed, for instance, something clear-cut. I personally do not know of any kind of HHS monitoring and enforcement of accessibility and reasonable accommodation from managed-care organizations and providers. This does not take place as a regular component of enforcing a planned contractual obligations.

So, we have had CMS complaints going in and it can take a very long time for something like a complaint, such as on behalf of one of our clients who is someone who has a visual impairment and does not get -- who just wanted accessible formats, alternative format from their plan. They wanted to get their statements in accessible formats. That seems to be very, very difficult to get. And it is difficult to get from his Medicare advantage plan and also difficult to get for other individuals who have original Medicare, fee-for-service Medicare, and you want CMS itself to provide them with alternative format . That is something that is on the ground , not happening. >> Just before I leave Medicare, I wanted to look at the intersections between Medicare and Medicaid. And, I think in general, we know of Medicare as not covering long-term care, and it doesn't. For the most part. But, when we get into Medicare advantage plans, when a managed-care organization is taking over Medicare, it is possible for them to offer some of the
additional components , many of which touch on long-term services and support. Vision, dental, nonemergency, personal or custodial care,

transportation. I mean, a Medicare plan could offer those things. So then you start coming into this environment of managed care and long-term services and support.

And a shout out to national Senior citizens Law Center and the Medicare rights Center for much of this Medicare material, which is very useful. One example of Medicare and Medicaid intersection, so, both Medicare and Medicaid cover durable medical equipment. But the Medicare coverage is limited to durable medical equipment used in the home. So, it has to be a wheelchair that is needed is deemed medically necessary in one's home. So, here is an issue for someone who is dual eligible. Medicaid is always a payer of last resort. And it is a timing issue.

Medicare usually does not use prior authorization. It reimburses after a service is given or products have been delivered. But, Medicaid will review a claim until after a Medicare denial. And the third factor is, and this is that suppliers want to know that they will be paid before they deliver . For example, in the case of a wheelchair , they want to know that they will be paid, not that Medicare , after they provide a wheelchair, may decide not to take the claim . In the Senate will have to rely on Medicaid to review the claim before they get paid. So, that's one example of how there is a complication that has always been and how Medicare and Medicaid interact.

Another example, I mean, I brought up the DME one, because for me and many people with disabilities, DME is critical to life in the community. To living as independently as possible in the community. So, that is a really important one for many people with disabilities. Another overlap is in the area of home health . This is an interesting one. Medicare home health does have the homebound requirement. But, that does not mean that the beneficiary has to actually be -- can only be confined to a bed. There is a requirement that the nursing services, skilled nursing services are required in the home.

But, a great case that was approved in January of this year , it was decided that the improvement standard is not required for Medicare home health services. That is, it's no longer -- it is supposed to be clear that a Medicare beneficiary can get home health services , even if they are not improving. It used to be thought that if you are not improving, you don't get those services. If it is just to maintain your help or prevent backsliding of functions, you don't get the services. That is no longer the case. >> One of the potential issues for duals is that just as in skilled nursing facilities, the quality of the service, providers may actually like it better if Medicare pays. There was a preference for Medicare. Medicare rates and payments. If this is the case, you will wind up with kind of a two-tiered layer of services. And, it would then be possible to get higher or better quality home medical care, at least in some instances, for people with disabilities who are dually eligible.

And the last one I wanted to cover, just because it is so interesting, I know it is not directly a managed long-term services and supports

issue, but I do think this issue is going to come up increasingly as plans, and often different managed-care plans take over Medicare and Medicaid components of care. So, for prescription drugs, drug categories, almost all drug categories , there are a lot of drug categories in Medicare but plans are not required to cover every drug in a category. They have to cover every category, but it can be some drugs in every category.

There is an exception. Over-the-counter drugs, etc. The issue for someone who is dual eligible is that if a drug is a covered part D drug , Medicaid will not pay it, even though specific Medicaid part D plan that a patient has has denied coverage. So, that can leave someone in a very tough situation. If the truck is not a covered part D truck, the duals can seek medical coverage. Let's save have a Medicaid plan that refuses to cover a specific name brand drug in a formulary category. And then the Medicaid plan refuses to cover it because it is a covered part D drug.

You can well have two different categories. I know here in California, the state has agreed that it is going to be possible for people who are in a Medicare advantage plan, at least for some time plan to stay in a managed-care plan, but they have to join a Medicaid -- they have to join one of the states plan for their long-term services and supports. And it can be a different plan. It used to be that the state, for a while, they said it had to be a match. No, it does not have to be a match. It does not have to be the same parent company. One managed-care organization is taking care of your Medicare services and one managed-care company is taking care of your long-term services and supports. Your Medicaid services. And in theory, it's taking care of any additional share of cost that a person might have or any additional co-pays.

How those things are going to interact when it comes down to two different plans , which appeal process governance, or will simultaneous appeals need to be taken? These are open questions and are difficult things to answer and part of why this is such a puzzle as managed-care takes over. The goal is integration, but on the ground, we are not necessarily going to see that for a long time, if ever.

Just very quickly, this is a slide that looks at the private Medicare health plan appeals process. And I just put this in because if it turns out that some Medicare managed care organizations to include some element of long-term services and support as plan benefits and a beneficiary thinks those elements are desirable , this is the Medicare process which is not the same as a Medicaid process in the state. There are six levels. You have to go through the managed-care organization first before getting to an independent review entity, let's say eventually get into administrative law judge before going to that review before going to judicial review. >> Okay. So I think, let's see, we are going back to Elizabeth to look at the next slide.

Just, just for a word, Silvia and I were not quite sure where to put this slide because it is a word about long-term care services and supports to quality standards. A big issue for advocates for persons with disabilities and seniors is that the existing quality standards do not necessarily capture the needs of persons with -- they capture much more acute care needs and acute care quality them long-term care quality. >> And there is an effort by CMS to develop quality standards . One of them, just recently came out, it states using 1115 demonstrations or 1915 (b) waivers for long-term services and support and it does get at some of long-term care quality issues, like consumer directed services, promotion of autonomy, what it means to coordinate, not just traditional medical services, but community services and medical services together.

And so, this is well worth looking at, and I have given you the site . There is also the national quality forum which is developed preliminary quality measures for CMS for managed long-term care services and supports programs, specifically those developed for duals under the CMS duals integration program. They have already sent that on to CMS and you can access that there. And Sylvia's group, the Disability Rights Education and Defense Fund has developed long-term outcomes measures. So, we really encourage all those who are going to be providing long-term care services to look at the quality measures and to provide input to CMS on how well it fits at identifying the service needs of folks accessing long-term care.

So now, back to Silvia.

Thanks, Elizabeth. We might thought it would be a good point to see if there are any questions. From anyone who is listening. I noticed that the chat has been fairly quiet and so we are happy to see if there are any questions . Operator? Thank you. >> We will now begin the question and answer session. If you have a question, please press star then one under touchtone phone. If you wish to be removed, please press the pound sign or hash key. If you are using a speakerphone, you may need to pick up your handset first before pressing the numbers. Once again, if you have a question or comment, that if star then one under touchtone phone. We are now awaiting any questions.

[Pause]

Our first question is Debra Docker, please go ahead with your question.

Hi, thanks, ladies for doing this. I am from disability rights California and have been living this issue of the duals integration and managed care for a couple of years. And, it is something that is on my mind today, is the effect of the rates on civil rights. That is, how the rates are constructed as to whether or not they incentivize or de-incentivize noninstitutional care . For instance, in California, the blended rate, and this is capitated managed care, is based on where the person lives, in addition -- I don't mean geographically , to be brief about it, nursing homes will get more money the more people they have.

I mean, managed-care plans will get more money the more people they have a nursing homes. And so I'm wondering if other people have dealt with this, whether CMS has shown any interest in this issue. It seems completely anti- homestead to me. >> That is an excellent question. I know that one of the recommendations that advocates have been making is that in the managed-care contracts, there should be a requirement that prior to, and this is addressing reduction in services, but specifically they were addressing transition services. And, I forget which stated was, but, specifically said that prior to any reduction in a person's individualized care plan, they will consider the homestead impact and whether it might need to unnecessary instant cash [Indiscernible]. I don't know how you could look at that in the rates context without an actual lawsuit. But, it does seem like some of the provisions that require a provider sufficiency would include, you know, ensuring that rates are sufficient, but this is a different issue , looking at the impact on integration.

We will get to that later, because of course in the affordable care act it specifically says that plans must comply with the Americans with disabilities act. But, I would be interested in others.

Yeah, that is a great question, Debra. And in a way, getting to the root of it, of the abstract answer is, well, they have nothing to do with one another. Civil rights continue, they apply, managed-care just has to meet them, the state just has to meet them. Homestead exists and the rates are what they are. But, that does -- the reality of it, you could see the same thing in education. You know, IDE a exist, the rights are there, the due process rights are there. What about those schools who basically seem to have very little money to execute quality , special education? I mean, obviously there is an interaction. But, I think you have to be a really targeted case and a case with a cold note updated to make that direction. To say that this states rates to manage carrying and how they're working, how these institutionalization rates and reimbursement rates for those in the community are working together is violating the ADA or violating section 504. You know, it is not impossible, but I think you have to be a very specific case supported by a lot of data.

Well, thank you. But I can bet this is something we need to push back on before it happens.

Yes.

Right.

It is not a done deal, yet. I mean, it is very old-fashioned thinking that ties the level of care with the location of Kerry and nearest the discrepancy between, you know, what the state of California is going to pay for somebody in a nursing home versus what they are willing to pay for somebody getting equivalent or better care at home. There is a huge gap there, and I feel like as a public policy argument, if one of the reasons for doing this is to lower the rates of people who are -- not

money rates, but lower the number of people institutionalized because, you know, play our state's medical team, managed-care plans will do that. But to me, that flies in the face of constructing a rate which incentivizes , to some degree, having people in institutions.

For those who are not on the computer, Mike Oxford has also written into the chat line that in Kansas they have performance measures and the managed-care organization contracts. Marketing folks out of nursing facilities is incentivized. So they get an extra bump in the contract payment if the transition folks out. And so, that raises again the quality measures and the importance of having performance measures that are oriented toward civil rights and homestead. And then linking those performance measures to actual dollars in the contract.

Right. The contract had already been approved by CMS?

No.

Because that seems like the place to pressure would be on CMS to not approve the contract because , you know, you try to make the argument that it incentivizes institutionalization and bring up the Fisher case and things like that.

Thank you, Debra.

One of the things that have done is asked if anybody on the call had had a similar experience. So if you have, piping because this is a way of helping each other grapple with these issues occurring in every state. So, I don't know if I mentioned this before, but everything that is written in the chat will be saved for us, so if we don't have time to answer all of your questions, or if you are shy and you want to put in your question later or you want to respond to Dr. was a brilliant idea, during or after the call, it will be captured.

Also, Sylvia and I will be answering any questions in the chapter we don't get to . So, I just wanted to make that clear. Operator, do we have other questions?

We do. Our next question is from Nancy [Indiscernible last name]. Go ahead with your question or comment. >> Hi, thank you. It is helpful to know that we are going to need to look at contracts and try to get them . One of the other things that we have been doing is looking at , we have an 1115 waiver that will go into effect on January 1. It integrated managed-care behavioral health and physical health for the first time in many, many years. For our Medicaid program. And, the CMS issued [Indiscernible] specific terms and conditions which seemed to have a basis for a lot of rates for people . So my question is, in addition to the specific terms and conditions, it sounds like it is necessary that we get a hold of the contracts coming here in New Mexico, we are going to have for managed-care entities providing services. So, I need to get all four contracts.

Yeah. Each contract will be different. And thank you for mentioning the 1915. Yes, they do have specific terms and conditions and the transparency of that, I mean, CMS has set up a requirement that if a state is applying for a 1915 waiver now, there are transparency requirements. But, if you have an existing one and you are applying for an amendment, those new transparency requirements don't necessarily apply. So that is something to watch out for as low. On the ground, it also comes down to, they are the right computer but who is monitoring and managing and enforcing them?

That sounds like something we may end up having to do. So, it sounds that we need to get all four contracts.

I needed to know. I was hoping that, and there we go. And the second question, one of my colleagues is on the phone as well, but the dual insurance of Medicaid and Medicare, how does one get a denial before one can try to force Medicaid to pay? Is that getting a written denial from Medicare? Apparently it requires magical acts on the heart of the Advocate.

Oh. That's interesting. Or rather very discouraging. Yes, I think it is useless to get the written denial . Well, they give you these summaries every three months. Of the services that they did Summit and were or were not paid for. At the very least, there should be that summary. I think that it is fast and I am sorry that I am not more or not at all in Medicare expert. But, I do believe in generally good to read something written about that denial , that you did not get it. And then you send -- yeah, I think that is necessary. As opposed to just, they told me on the phone. >> So the question is, how to get something in writing and what you're saying is the summary that a person gets every three months maybe the only written statement that Medicare is denying payment ?

Yeah, possibly. I hope that it is, as opposed to just continue summary of services that they actually paid for. You know, I will find out more about and try to include them with the chat questions. That will be published after.

Okay. And for those of you on the phone, Mike Oxford has added another bit. He was talking about how -- I have to scroll up to the beginning to see the beginning of that and I'm having trouble doing that. He was talking about how you can engage in private contracts with the managed-care organizations to long-term community-based providers and develop these private contracts and say that they are able to provide the extra long-term care services that the acute care providers aren't necessarily skilled in providing. And, if you would like information about, you know, some suggestions for ensuring things like quality, adequacy of providers and equality transition services and what to put in your contracts, there is a great publication , and I'll try to type it in here, but it is by the Kaiser family foundation and it is called the summary of insights from experts for successful transitions from fee-for-service to capitated managed care. And that publication goes into

some of the suggestions similar to what Mike Oxford was just saying. For example, to include in your plan that managed-care organizations have to contract with existing community-based providers in order to ensure appropriate long-term care services are available. Or, have to allow people to maintain their long-term care provider for the first three years of transition until enough providers with that level of skill have joined the managed-care networks, for example. And so, this is a great application to look at. I'll type it into the chat function, but it has some good suggestions for what to look for when to review the contracts. And unfortunately, Nancy has to review four of them. But your up for the challenge . Do we have any more oh, go ahead. >> I am wondering if we should try to cover this last part of our sites quickly and then get back to the questions.

Right. Again, you can put them into the chat function and we will take them shortly. Okay, so you are on for the next part, Silvia.

I just wanted to go over federal disability rights laws and managed-care. I think some of this will be very familiar to some of you and not so familiar to others. But primarily, I'm just looking at ADA and section 504 of the rehabilitation act. Just looking at a managed entity. A private , for-profit or managed-care entity, ADA, title III applies to the operations of private duties that are considered public accommodations. They apply to 12 listed categories and one of them is a professional office of a health care provider, hospital or other services establishment.

So initially, you might be able to argue that, well, a managed care organization is not the office of a health care provider and is not a national hospital. Sure, some of them actually own the hospitals or the clinics and employ the doctors but not all of them. I think it is pretty undeniable that managed-care entities affect commerce in terms of healthcare providers and hospitals. They are in the stream. They received -- we are talking about entities that receive Medicare and Medicaid money , and that managed to survive because they provide a service. So, they provide a service to the public and it is a healthcare related service. Even if it is not an actual affect a Medicaid service. And in any event, with managed-care organizations , getting into Medicaid and Medicare, they are increasing the getting into character ordination, which -- care coordination, which is, they are the entities defined in care coordination. That is one of the reasons that states are turning to managed-care organizations. One of the stated reasons is that managed-care will help Medicaid and Medicare beneficiaries to coordinate their services. To coordinate all of the different needs and serves as and treatments that they have in their life . It will provide an extra service that is needed. And if that is the case, then they are providing healthcare in and of themselves. I think there's no question to think of them as to understand as being covered by title III. Increasingly so, given the increasing role of managed-care organizations in the public programs.

So, primary responsibilities under title III. You are liable under title III if you fail to make reasonable accommodations and policy modifications so, these are the kinds of requests that a beneficiary can make , as simple as. A managed care organization in saying, I need a doctor who is accessible. I need to know that before I go to the office that I can get in the door. Then I can be examined on a table, or I need to know that I need my managed-care plan handbook and accessible format and large font or on a desk. Those are reasonable accommodations, requests from members . Policy modifications, an example would be, I need a provider who can help me undress . Who will just stick me in a room and tell me that this is -- that I just need to get myself ready. So, those are all examples of kinds of healthcare accommodations and policy modifications. And managed-care organizations are responsible for providing auxiliary aids to the services. For effective communication. And I already mentioned, some of those alternative formats , ASL, American sign language translation, captioned videos. A lot of managed-care organizations provide instructional videos on their websites. Those need to be captioned. And, that is a responsibility of a managed-care organization itself. And finally, the readily achievable removal of architectural barriers. The stairs. The putting in elevators and doorways are wide enough. We -- waiting rooms that have enough space for people using mobility devices to turn around in. It's worth pointing out that readily achievable -- the obligation under title III with regards to architectural barriers is lower than the obligation under title II. It is what an entity can readily achieve. But I also want to point out that a managed-care organization , in general, is an entity that has greater resources than an individual provider's office. So, perhaps it is the case that the single practitioner who speaks a rare Asian language and practices in Chinatown and has an office of a small flight of stairs, maybe he or she is practicing on a shoestring for all touristic reasons, wanting to serve a particular clientele and does not have the resources to readily -- that removal of barriers from his or her office is not readily achievable. But, the provider network of which they are a part, the managed-care organization to whom not providing is critical because he or she speaks that rare Asian language has more resources. And, we have always tried to argue that the managed-care entity has to be judged on its own level of resources and responsibility, not at the level of the individual provider. But, at its level, as a much larger managed-care entity.

Going on to the next slide. I am looking at ADA title 2. And while an entity can be both subject to ADA title 1 and title 2. But, when a public accommodation, a public or privately owned managed-care organization contracts with a state entity, and they are doing so to provide an eight or benefit of service to the state or local government, the government entity must ensure that the contractual functions are carried out in compliance with title to of the ADA. So here, the higher obligations of the state to apply and the main argument is that Medicaid, including long-term services and supports and home and community-based services, Medicaid does not lose its character as an aid benefit or service to the state, merely because the state chooses to implement its functions through contractual

arrangements with managed-care organizations. We would argue strongly that this remains an obligation to the state. But at the same time, it does not and that it directly makes the managed-care organization itself responsible to title II levels or standards.

Going on to the last one. I'm looking at section 504 of the rehabilitation act of 1973. The scope of coverage here is everyone who takes federal financial assistance, and it has been clearly established in case law in virtually every circuit. That's Medicare and Medicaid services are financial assistance and they should be federal financial assistance whether they are provided to an individual provider or a provider group , a nonprofit managed-care organization or a for-profit one, and their federal financial assistance when they go to the state Medicaid agencies. The main obligation here is that anyone who receives federal financial assistance cannot provide any aid , benefit or service that denies people with disabilities the opportunity to participate in or benefit from Medicaid . That affords people with disabilities an opportunity to participate in or benefit from health care services that are not equal to that afforded others or provides people with disabilities and eight, benefit or service that is not as susceptible as those provided to others.

I wanted to point out another section that frankly haven't actually been litigated, as far as I can tell. And I have always kept an eye on this section. It is in section 504 ended his federal financial aid recipients are also prohibited from using methods of administration that have the purpose or effect of defeating or substantially impairing accomplishment of the object is of the recipients program for activity with respect to handicapped persons.

And I think it is relevant, as I see some of the very complex contractual arrangements and subcontracting layers of additional subcontracts are being entered into, a lot of this is been undertaken with a stated purpose of integrating and coordinating care for people with disabilities, whatever category they fall into. Dual Medicaid beneficiary Medicare . And yet, the line responsibility seems to be stretching, farther and farther from the hand that gives out the door to the actual entity on the ground that is supposed to be providing the service.

Unless there are really clear lines of responsibility, who is finally responsible for coordinating ? For ensuring that nobody slips through the cracks? They service isn't forgotten or not administered or not pay for -- or not paid for? It seems to me that we have a method of administrating Medicaid and Medicare that is increasingly complex and that ultimately, in many ways and in many circumstances could defeat the purpose of providing integrated coordinated care . And this is theoretical. This is one of my series and thoughts. But it's something I want to really keep in mind. Because if it does not apply in the incredibly complex world of healthcare services, this is where I think it comes up. So, I'm going to turn it back over.

Unfortunately, we only have about seven more minutes but this is a really written provision so I'm going to go through it quickly and then we can take questions. The affordable care act also has a nondiscrimination provision and it creates a new authority to prohibit discrimination against individuals with disabilities applying for health insurance and accessing healthcare services. This is huge. I mean, you guys should be jumping out of your seats. Not only that, it specifically states that it is individually enforceable . Oh, I'm going to go back.

And it basically applies to the civil rights act, age discrimination act, and 504, and health program or activity but it goes beyond 504, because not only does it apply to any entity receiving federal financial assistance, it applies to any entity administered by an executive agency or any entity established under title I of the affordable care act, which basically makes it apply to the healthcare marketplace or exchange. So, if anything is going to make you happy, if this slide. And, some of the areas where this would apply , it requires a little bit of understanding of the difference between the healthcare marketplace, which they used to call exchanges, and folks who are eligible for Medicaid. >> The way that it works is you go to the marketplace and marketplace has an online system or you could call or use a mail system , but most people would be using the online system to determine whether you are eligible for health care. And they will look at whether you are eligible for CHIP, Medicaid, private insurance or subsidies and credits. And the way it reads is that if you have a disability or are medically fragile, you are automatically eligible for Medicaid and don't have to go through the healthcare marketplace. The reason this is so important is because the healthcare marketplace has, you know, benchmark benefits. And while they have to provide certain essential health benefits , the benefits will be, you know, if you are in the Medicaid expansion population, your eligible for alternative benefits, and then even if you go through and end up with a plan under the healthcare marketplace, you might end up paying for it. Whereas with Medicaid, you would not have to and have more entitlements.

So if anything, call, all of us as advocates have to make sure that there is a good system for when somebody applies to identifying whether they have a disability. The reason I bring it up in this antidiscrimination context is that if somebody has identified as having a disability, this provides more opportunities for folks to do and ensure that individuals receive services in accessible formats, for example , and are in plans that are accessible . So, all of this goes together. I am not sure I am seeing it perfectly. But, some advocates have been suggesting that if they know somebody has a disability because they figured it out in the application process, that they can automatically be aware to provide services to them in accessible formats. Also, where this becomes so important is that a lot of people will be accessing a call center to help them identify him whether they are eligible for Medicaid, CHIP, tax credits or a plan. And the call centers will need to have experience communicating with and supporting individuals with disabilities . And, we have experience with call

centers before, and CHIP programs, and we have heard from P&As and others that these programs did not always have a lot of experience serving folks with , in particular, communication or intellectual and developmental disabilities. So, here is another chance to set up a call center which is sufficiently trained . Toward that end, CMS has already put out guidelines for what I call center should do to ensure accessibility , and it is going to require a lot of monitoring on your part to see that these services are met. And, all of the things that Silvia talked about under the ADA and ensuring accessibility under ADA would apply to these call centers and to the healthcare marketplace as well.

I do want to point out, and I'll also put it here in the chat function, that the national health Law program, I am always talking about them, but they put out a great publication called ensuring accessibility for people with disabilities in the marketplace. And it is a bulleted three-page list of all of the things that you can do . And it goes to the hotlines and it goes through, you know, title III basic access issues. So, I will put that link up and I encourage folks who want to make sure that they are doing the monitoring of nondiscrimination that you have that list . I don't know, Silvia, whether we should go through these next two slides . You do have some important points about data and some missed opportunities, or we could go straight to questions for the last three straight to questions for the last 3 min. What do you think, Silvia? >> That is a really hard one. I will make a brief plug for data collection because I think that is important and something that state advocates could really press for. Under the nondiscrimination provision and the ACA, it says the secretary shall not take into account average assistance ashcan it mentions people's disabilities. The thing is, the secretary can't take into account or can't be criticized for not taking in to account problems that he does not know about. And, it seems it has been very, very hard to get fed and state entities, federal and state entities, to capture disability status information.

Questions exist that have been tested that get people and information about disability status in an intelligent and reliable way. But, the questions and applications and surveys, etc., all of this material being pushed out by federal and state agencies, we are not getting those questions being used. If we get anything, it is just a question of do you have a disability or do you have a disability or are you using nursing home services? The kinds of questions that are not going to capture who has a disability does not manage to properly identify them and therefore cannot trace problems that people with disabilities are having in the delivery of services. This is true both for the exchange and public programs. It seems like such a geeky thing to be interested in data collection but it is a critical civil rights issue. I just want to put a plug and I'm happy to take as many questions as possible in the remaining time. >> I just want to answer one question that came up here because it is related to what I just said. Somebody said, if you have any disability, you could be tracked into Medicaid as opposed to the health marketplace? That is a big issue for states and what is going to happen is there has not really been much CMS guidance on what

constitutes medically fragile or disabled for purposes of determining whether you get put into Medicaid. But, there has been lots of attempts by CMS to collect guidance on this, and, you know, issues like, well you need to just have one limitation of a major life function or should it be the Social Security definition of disability, which is much, much stricter . And these things are still up in the air. But, I think it is something to watch and something to weigh into and , Silvia, do you know whether that is going to be -- I think it is going to be determined by CMS and not the states. Do you know whether that is correct?

The data collection?

No, the definition of disability. As far as I know, we are waiting for CMS to make that determination and it would not be done by the states. >> .com I think, I'm not sure. I'm not sure about that one, actually. And I will just say that right now. Another chat question I am going to memorialize.

Right, right. But, it is my inclination that it has to be done by CMS while you're still waiting but that will be huge. But, I don't see any other questions on the chat function. Operator, can we open up the lines were any questions that are waiting?

As a reminder, ladies and gentlemen, for any questions, it is*one on -- it is star one unretouched home phone. -- On your touch tone phone. Once again, for questions or comments, that is still star one on your touchtone phone.

I can only take that as evidence that we have left you so satisfied that you cannot think of anymore. But, in any event, we will hold it open just a little bit longer , knowing your time and you guys all have to leave, and lots of things to do. But, in the chat, if you want to type something in , as Elizabeth had said, we will get to those and publish the chat with our answers at the same time as we put up this webinar and the slides.

And, thank you all for joining us. Please check back to the chat where we answer some of the questions and put some information on. For anyone that you know who would be interested that has not been able to join, remember that it will be available within 10 days on the three websites listed at the front, or you could always contact Silvia or myself and we will put our e-mail addresses down in the chat function right now.

Thank you.

Thank you, ladies and gentlemen. This concludes today's conference. Thank you all for participating. You may now disconnect.

Judy Telge says: If your state is in process of begining MC, advocates and providers should ask for opportunity to provide input to those contracts

Judy Telge says: Helped State in Texas create a 'dashboard' of what needed to be in contracts for benefit and protection of pwd.

[Event Concluded]