

**August 23, 2017: From Mission to Fruition: Developing your Relationships with Payers**

Thank you everyone for participating in today's webinar. This webinar is presented through the business acumen center which is a part of the disability network business acumen grant. And it is made possible by the Administration for Community Living. And last month's presentation, are they buying what you're selling, a look at what health plans need from community-based organizations, the national health plan shared some insight into what health plans look for contracting with community-based organizations. During that session they shared high-level opportunities of these relationships. They shared that when the relationship between the community-based organization and health plan a strong, it can do a few things. It can help each organization fulfilling their mission to reach performance, regulatory, and quality goals and to learn about each other, find out where the strengths and gaps lie and as well be able to demonstrate that value through various things such as data and stories about the individuals you have in common. Ultimately, this works for hospitals and health plan providers and communities in particular best serve the people that you both are responsible for and care about. Today we will hear from two speakers, Lee Schulz who is the President and CEO of IndependenceFirst in Milwaukee, Wisconsin and Carrie Hobbs Guiden; and they will discuss their experience for working with health plans and share tips with how to improve relationships with payers. We will have time for questions and answers at the end but please leave your questions in the comment box in the lower right corner of the screen. And we will begin today's discussion with Lee speaking about his experience with IndependenceFirst in Milwaukee.

Hello, this is Lee. Thank you Erica and the business acumen center for doing this and welcome to everybody who is listening today. IndependenceFirst is one of eight independent living centers in Wisconsin. Our budget is about \$32 million, million dollars, about 105 in-house employees and 1600 personal care workers. As an ILC we provide the core services of information and referral, advocacy, independent living skills, training, peer support, and transitioning. In addition our center provides 16 additional services on a contract or fee-for-service basis. Those are the services that we or you could be contracted with and MCO. Personal care services benefits, assistive technology, demonstration center, and that includes home assessments, DME equipment reuse, sales, computer recycling and training, and our leadership program. IndependenceFirst service areas for counties entered around the city and suburbs of Milwaukee. I have been President for 31 years. During the past 15 years, we have had the opportunity to work with and contracts several MCOs and I served on an advisory committee with one of the largest healthcare providers in the country. My goal today is to highlight both the positive and a negative asked X of contracting with and MCO. Hopefully this information will help you decide if your organization can approach and MCO and work with it. Next slide please. So why would managed care organization want to work with you or why work with a managed care organization? It appears that health and long-term care may eventually be controlled by managed care organizations and that is surely true in Wisconsin. If not most of the country. We must learn to contract with them or we are just going to

disappear. On a positive note if we provide good services and contract wisely, the agency can in fact make money. Unlike government contracts where you can't keep the profit, you bill only what you spend and if you overspend, you lose, and if you understand you turn back the money. Managed care organizations are eligible to continue. I lost my monitor so I will continue. In some cases an organization may receive financial support from an MCO. To build or maintain infrastructure to start or continue services. Your agency can fill a gap in community services. The MCO may have no history in your community or the specific population that you serve. It would be costly for them to recruit and hire staff and to design the necessary support structure. Therefore, your organization is already known in the community and knows all about the community resources. Personal relationships are important and they do not develop overnight. It may be less expensive for the MCO to contract with you than to try to do it on their own. Or the state may require the MCO to use a third-party provider to avoid any real or perceived conflict of interest on their part. In some cases the MCO provider contracts shared risks which alleviate some of the burden on the MCO. For example, the contract may spell out that you will receive \$250 a month per individual to provide case management. And you need an RN, a couple social workers for program participants. An example would be you would be getting \$200,000 per person per month and you would have to figure out how expensive that plays out. If you lose money, it would not be a good contract. If you have a profit, that would be to your benefit.

This strategy is for working with an MCO and will vary on who initiates a contract. There may be a state requirement that the MCO contractor and the human service organization and in this case there would probably be your responsibility to seek out the MCO and show them what positive outcomes you can bring to them. There may not be a viable community resource that the MCO contracts with the community-based organization to develop that service. In that case, they would come to you to create a new service. The CBO may have a solid community reputation that the managed care organization can tag onto. Also, the community-based organization may be in a better position than the MCO to expand capacity. Over the last 15 years, our organization is contracted with about six different managed care organizations. And we have done this and brought our community reputation to the contract. We have a solid record of service and advocacy. Because of this, case managers and people having disabilities that were enrolled in the MCO's requested our services. Some CBOs are willing to share the risk and others are not. That really has to be a decision by your organization, your community-based organization whether you are willing to take that risk. There can be challenges. I would say legal contracting is the number one. The managed care organization may have a team of lawyers and a standard contract where the CBO might not have an attorney or familiarity with such contracts. I highly recommend that you take the time and spend the money to bring in legal assistance on a contract. Cash flow can be an issue during service or contract issues. We have seen managed care organizations change software and immediately we have billing problems. These problems are not easily fixed and can linger which causes problems unless you -- reserves are available. Another issue is turnover. Our experience has been that

several of the managed care organizations have had fairly high turnover. Of their staff. Turnover negatively impacts dispute resolution as the players keep changing and the facts need to be reviewed. A small community-based organization can suffer from mission creep. The managed care organizations and funds for services. The CBO or independent living center provides Board of homecare personal-care they managed care organization member. Than the managed care organization request that the CBO begin to provide that service in a group home or to become a group home service provider. This in turn can be exacerbated by a liability of insurance issues and in the case of an independent living center, not an appropriate service. But there is also opportunity. As an independent living center, community-based organization, our mission includes advocacy. Because of the size most CBOs have a team. The CBO may be able to educate or access the CBO lobbyist for issues that are mutually beneficial. The MCO may have local state and national connections compared to the local community-based organization. This influence may include networking with other CBOs across regions. And that is the conclusion of my presentation.

Very good. Thank you Lee. We would know turn to carry who will share insight and recommendations on how to engage health plans from the work that the the art Tennessee has done in their state.

Hi, I am Carrie Guyton and we are a statewide nonprofit advocacy organization. Primarily focused on people with intellectual and developmental disabilities and their families. As an advocacy organization we focus on individual advocacy for children and adults and that may include working with families who have students using special education services so we may attend IEP meetings with them if they are in the adult services system, we may help them with situations that come up with providers and we also help with Medicaid appeals and things of that nature. We also focus heavily on systems advocacy across our government departments to make sure that services and supports are in place for people with disabilities. We work heavily on public policy at the state and federal levels to make sure that laws reflect what people's intellectual intellectual and developmental disabilities and their families need to have meaningful lives in their communities. And then we also provide a lot of public awareness activities and training for people with disabilities, for families and for the community at large such as teachers and doctors and firefighters, police officers, things like that. And so given that we are or merely an advocacy organization our journey to getting involved with managed care organizations have been pretty unique. And I wanted to -- today share a little bit about the Tennessee healthcare landscape so you can understand what things are like in Tennessee's know you can see why we headed in the direction that we did. Learn a little bit about why we became interested in contact contracting with managed care organization how we acquired our knowledge to pursue those contracts what our process was for engaging with the MCOs and Tennessee and how we had to learn how to be flexible and shift gears and do some changes to our healthcare system here. Some of the challenges we face as we go through the process and some of the opportunities that we are looking at in the future. In Tennessee, we have been basically under managed care since 1994. Our entire TennCare operation is an 1115 waiver and

that is pretty important in the sense that we operate under managed care and we have a lot of exceptions to what would be traditionally allowed within CMS rules. Basic health care has been around in managed care since 1994. In 2007 they added behavioral health to the managed care system and then in 2010 we added long-term services and support which is basically what you will call traditional waiver services. To managed care and that was for physical disabilities and for people who are elderly and then as of July 2016, we also moved to long-term services and supports for people with intellectual and developmental disabilities under managed care when that had traditionally been provided outside of the managed care system and had been administered through one of our government departments. We just made that shift a little over a year ago and that has been a pretty interesting transition for the entire state. Part of the reason we became interested in contracting with MCO is we were looking for a new source of revenue. Our organization is heavily dependent on state contracts. The state contracts were tied to some lawsuits in Tennessee around our developmental centers and those lawsuits have been settled and our developmental centers have closed and so when you're looking at the potential loss of state funding, and having to downsize your organization, you start to look for other ways to bring in income that could help keep your organization moving. And so that's why one of the primary reasons we started looking at contracting with MCO's. Also an opportunity to pioneer a new business. The new employment and community first choices program that is the long-term services included some advocacy services that are pretty unique and so we wanted to look at the possibility of becoming involved in that. And then with the shift in the long-term services and supports from our state agency which was the department of intellectual and departmental disabilities to managed care that was illuminating the need for independent support coordination as a service in many of our local chapters provide independent support coordination and so trying to look for ways to support them to move to a new business model. And have opportunities for sustainability. And while all of this was going on and we were looking at these possibilities we have the opportunity to apply for technical assistance grant through the Administration on Community Living to help us learn how to contract with MCOs and other health providers through the creation of provider networks. And so that was perfect timing because it gave us some of the tools we need to move forward into the uncharted territory. And so through our participation in the community Administration on Community Living grant which was for two years, we learn how to speak the language of a managed care organization. They call things benefits packages, they call services benefits. We have to shoot -- shift our language. Understand how our managed-care organized -- operates in we learned about capitated rates and they get a certain amount for each person and they have to make all of the services and supports within a certain amount of money so how to leverage that knowledge to possibly do some negotiating for contracts. One of the things that they drove home during the grant period was knowing the true cost of the benefit that you are proposing to provide. If you're in a negotiating situation you don't take what they are few cooker Lee mentioned that a little bit. They have attorneys, contract language, and you don't always think that you have any negotiating power but you don't necessarily have to accept what they offer. You

need to become -- be able to cover your costs. It doesn't do any good to enter into a contract to provide services if you lose money. It needs to be mutually beneficial. It was helpful to know some of that information so that if we were in that situation we would be able to negotiate appropriate rates. And then we also learned about how to get in front of the right people, how to make those contacts, and the other thing was really focusing on your areas of expertise. I believe Lee mentioned this also. Watching that mission creep. You don't want to just start writing every service possible even if and MCO approach as you to do that because you really want to stick with what you are good at, what works for you and your organization because otherwise, you might risk putting your reputation in a bad position if you are not good at what you are doing. You may not be able to know that your cost to something if you have never done it before. Really understanding what you're good at which for us and most of our local chapters is that social services aspect of the work that some of the managed care organizations have had to take over.

And so our initial idea when we walked into this and try to get involved with the managed care organization as we wanted to create a provider network where the our Tennessee would be the primary contractor with the MCOs but we would have to a network of community-based organizations that were providing the direct services so we weren't stepping out of our mission in terms of providing some of the direct services that our local chapters would be able to do and possibly other small providers as well that were interested in working with us. Possibly her centers for independent living which are very small compared to least chapter and some of the other organizations and so they would be able to have that -- a benefit for the MCO is that they would have only one organization to do that and we are used to being a pass-through and doing administrative work for other organizations to make their life easier. That was fitting within things we are ready did. It would increase efficiency and referrals and coordination for the managed care organization because they only had to go to one entity. We would have people as part of this network that would be scattered across the state, and they would be able to work thrust in that way and it would consolidate those administrative activities for not only the MCO but for our local chapters. The way the MCOs are set up in Tennessee is we do have three MCOs that cover the entire state. You have to just be able to work with those but we don't have any local MCOs. All through our TennCare Medicaid agency that we were focusing on initially. And so one of the things we wanted to do to try to develop those relationships is start at the top and that would talk -- start with TennCare since you were the ones who held the major contract with the major -- contract in our state and that is United healthcare, blue care, and a mirror group. And we shared with them our idea to provide local community-based organizations I could provide direct services and they were very supportive of the idea and provided us with the people we needed to get into contact with at the MCO so we could pitch our ideas to them. And so in preparation for these meetings with the managed care organizations we created a one-page overview of the our Tennessee and a one-page overview of our network concepts and they would have something to look at and something to keep after the meeting. We scheduled meetings with the individual MCOs, blue

care, a mirror mirror group, and United healthcare and some more more receptive than others we had to meet them where they were at. When managed care organization really seem to be able to see the benefit of the combined administrative, having less paperwork on their part, being able to work for one organization where is the other MCOs seemed a little less intrigued by the idea and didn't seem to see that value. We left things where was at with the idea of going back to them and then pursuing things with the MCO that was more interested. In the process of sharing our idea we were working under the concept of the new employment and community first choices program as a backdrop for the discussion. I mentioned that early on but that started in July 2016 so 16 so that whole year prior is where the MCOs had their focus. And so we were trying to convince them that this would be a good way to keep small local providers and keep that small town feel that our net system has here in Tennessee for providing long-term services and support but to lessen their paperwork and make their life easier rather than having potentially 50 contracts, they could have one contract with us and we would be able to maintain the administrative. That was our backdrop for them and we really try to focus on the benefits to the MCO by looking at that piece of it, that it would be less paperwork, only have to deal with one organization, they would keep the small town feel of the individual providers without the extra effort and that would increase their potential to it make money on this program.

We quickly realized after these meetings that even though there was interest and some MCOs having more interest than others, but but their biggest priority was getting ACF choices off the ground. And so they didn't want to dedicate the time to figure out how to make the community network work within their system and how to do the paperwork and deal with contracting and technically you can't have subcontracts within and MCO when you have a contract with the MCO trying to work on that language, even though they know it is done, so we sort of set that aside, because we really wanted to focus on getting a contract with the MCO. Again, meeting them where they are at what we changed our direction and trust focused on becoming an individual contractor with the MCO. Exactly what Lee has done and for certain benefits under the new program. And so prior to them actively soliciting providers for some of the services, we drafted and submitted a detailed proposal to each MCO and to TennCare for the services that we wanted to contract for and why we were the most qualified. And again for us, we focused on the specific benefits that were our expertise. And so they were things like counseling around alternative conservatorship and conservatorship. Health insurance form counseling. Peer to peer support community and systems navigation. All of those things that have that advocacy type flavor to it that we already do through some of our other contracts. And so this would be an additional source of revenue to do things that were comfortable for us and that stayed within our mission. And so some of the challenges we faced of course was putting that network project on hold so we could meet the immediate needs of the MCOs and TennCare which is our Medicaid provider agency. And then completing the process to become Medicaid providers. We didn't have a Medicaid number. It wasn't for us just direct contracting with the MCOs, we also had to be approved through TennCare so we needed to do that, credentials through the MCOs and three of them and their processes are little different.

It is a little more time intensive than having to keep up just with the regular contracts that we had with this date. And then their requirements and processes because everyone is a little different. And then again being part of a new program that is experiencing it's own growing pains that comes with any new project that is started.

But we have had some opportunities in this process and so getting the support of TennCare has helped the ark Tennessee become recognized as a valuable stakeholder in this entire rollout so they are not looking at us only from the advocacy person active but also as a legitimate provider. Where able to provide where two different hats and provide two different sources of input for them. By starting those conversations with the MCOs early, it really really open the doors for us to become -- be the first approved provider of the specific services and one of the few that has a contract for services in the date. And then we have also been included in the ongoing development and improvement of the ECF choices program. We are part of the stakeholder group for leadership groups to try to make some of those improvements that are necessary to make this program work. And by being involved with the MCOs through ECF we hope that it will make it easier to pitch our network concept to them in the future. I think as they are seeing developing be provider network for the state program has been a challenge for them. Keeping up with all the small providers has been a challenge for them and I do think there will be a way for us to bring that concept back in the future. And then the one other thing I wanted to add before I conclude is that just by being in on the front-end of this ECF program at least we have that foot in the door for the MCOs in general and so if the network concept never works specifically for the ECF choices program we do know that there are other things going on within the MCO on the healthcare side. Bundled payments for certain types of surgeries like hip replacement and the replacement where the MCO is risk possible for not only the actual medical service and also responsible for the patients transition back to the community. After they have the surgery possibly going to a nursing home for rehab and having to go home for outpatient rehab and what types of support does that patient need in place to make that happen. So by being part of that administration and community living grant we learned that some of those other things that are happening through the centers for Medicare and Medicaid services, and through the managed care organizations that we might be able to tap into in the future. And because we have this relationship with them through this current program, that will will help us be able to access those other opportunities in the future. Thank you.

Very good, thank you. We now have time for questions. For either Carrie or Lee. We have some that have come through the system already and if there are any new questions that come in and if you want to ask a specific speaker, please indicate their name, otherwise we will ask the the group as a whole. We will start with either Carrie or Lee, feel free to answer to any of the questions as we asked them. The first question was can for-profit companies offer survey contract with a CBL. I'm wondering if they're asking if for-profit companies can be a CBL possibly.

This is Lee. My reaction would be for sure. The MCOs are probably for-profit. So I would think they could contract. We happen to be a nonprofit so that is my experience, but I don't why that be possible.

This is Carrie. I would echo the same thing that Lee said. When we were part of that grant, a lot of the information that we got from the technical assistance experts did indicate that there are -- that community-based organization is that broad oversight term that they use for organizations that are providing services in a specific community so they could be for-profit or nonprofit.

Thank you. And again, this webinar is a follow-up to last month's webinar where a health plan presented their perspective and during the presentation if you participated, they shared that getting the contract is sometimes the easiest part of the process. After that it is maintaining and really continuing that relationship. With that as a backdrop, the next question is how do you receive referrals from the MCO once you are contracted? You have the contract, but some CBOs find they are not being utilized yet.

Lee did you want to start or did you want me to?

I can. I think it goes down to the the reputation you have any community either the consumers or want the service and requested and/or the staff of the MCO are aware of your organization and your reputation and they are going to want to use you. Clearly after you have done the contract it is important to know that people on the ground, not just the folks who read the contracts. So anything you can do as far as marketing to them, having coffee, invite them into see your organization and the services you do, but the folks who are developing the plans for their customers, those are the ones that eventually you want to connect with.

This is Carrie. I would again echo with -- what Lee said. In our particular situation, the services we are currently contractor for our long-term services and support. What they call their support coordinators within the MCOs. That send us the referrals. And because our services are what I would call NISH services. Niche services. Things like personal assistance and employment are much more common than the services we provide. But it is important for not only us as an organization to market ourselves to people who are receiving employment and community first services. And know that our services are available. We are know who we are what we are about and why they would choose us over another one. In theory, it is the individual receiving services that makes the choice, but in absence of them having any preference that support coordinator is usually the one that will guide them one way or the other so it really is important to make sure that your name is out there and people recognize who you are and what you are about.

This is Lee. I'm going to add to that. You may initially just contract for one service. In our case we do personal care services and that's what our initial contracts were with most of our CBOs, but we also really have some expertise with facility assessment and assistive

technology. I have some staff that really specialize in that area. So once you have developed a relationship with the CBO, then you can approach them on other services that you might want to sell to them. Just because you have a small contract doesn't mean it can't expand.

Thank you. The next question takes up a little bit earlier into the process and more about how do you get started? If you want to work with a managed care organization, where'd you go to find the application to become a provider, information about what their expectations or credentialing process is, and so forth.

I don't think there is any -- you can't just go to a website and download an application. You could possibly, but I don't think you will get anywhere. For us, it was a get good try to find somebody that knows somebody so we started where our relationship is strong and it happens to be strong with TennCare and so we used them as our -- to gauge to get connected to the right people to have those face-to-face meetings. It really starts with having conversations. It does not there with an application and credentialing and all of that. That comes after the meetings, after the relationship has started, and then they will give it you or tell you where to go find it. And they will walk you through the process. I would say that once we have that connection with the MCOs and they knew that we were interested, we got a lot of support from them in getting through the process to make sure that we were credentialed and that everything was done appropriately.

This is Lee. I will add to that. It's really going to vary by's date. By state. Contracts are probably being authorized or coming through the state entity so a contact with your state Department of Health services or CMS or whoever it is, that would probably be initial knowledge of what is coming and who to talk to. Ed that I would definitely suggest that you identify organizations in your state or around the country similar to yours that have worked with MCOs and ask them who and how to approach.

In your experience so far are you finding that MCOs require accreditations for CBOs?

This is Lee. And our case, no. I guess it would depend on the service. That they are contracting because in some situations, people may have to be licensed.

This is Carrie. Originally and again I can only speak from our experience in Tennessee and with the employment community first choices program. They started out initially with one thing, providers, or what they would call preferred providers to be certified by the CQ L, accounting quality leadership or certified by [ Indiscernible ] and they had some different things that lead you to be a preferred provider which would make you more apt to be recommended over somebody who wasn't. But they have had so much trouble developing the provider network in general that some of that has gone out the window. So in absence of having to have a specific license for a certain service like nursing or something like that, they have pulled back on requiring or encouraging special accreditation.

This is Lee. Again, that's probably going to be based on what the state requires them and their contract with the state.

Exactly. And a state can modify those contracts as often as they want, within ECF choices I think the contracts are being modified every six months. So it's pretty frequent.

The next question is are there any

The next question is are there any bundled payment arrangements for case management and other services being done currently with either of your organizations?

Are there any LTSS bundled payment arrangements for case management and other services being done?

This is Carrie. I know it's not happening yet. But when we were part of that that's something we want to do. That is one of our goals and we know that it is happening in others dates through those bundled payments, through some of the other CBOs that were part of the cohort within our technical assistance grants. It seems to be happening more on the aging side more so than the disability side right now and so a lot of the aging organizations that were a part of that cohort were having success with the bundled payment and getting the case management piece of it.

I would say that is true here in Wisconsin as well.

What strategies did you adopt to bring along your individual and family stakeholders and she began engaging with MCOs? The comment is that some individuals and families are distrustful of how MCOs will impact their lives.

This is Carrie. Our whole state was already managed care, so there wasn't a whole lot of choice involved there. But in terms of because of our position as an advocacy organization and the waiting list that already had existed for long-term services and supports for people with intellectual and developmental disabilities, when the concept came out for this employment and community first choices program we were active long before we ever thought about becoming a service provider in just educating our families and individuals about the fact that this is your best bet for getting services at all, because as it stood at the time the only way you got services in our state in terms of Medicaid waiver services were if it was if you are in crisis. It meant your primary caregiver passed away or was incapacitated and you were homeless or your behavior was so dangerous you are injuring yourself or others. That was the only way you got services. And with the new employment and community first choices program, things were going to be done differently. There was going to be a different way to fund it and so the idea was that the waiting list would shrink and more people would get funding. So we were we worked for a couple of years around the date trying to explain the idea of right now in Tennessee a few people did everything, and we want to move to a model where more people get

something. And so we worked on that at the front-end when the initial concept for this employment and community first choices came out and I was back in 2014. And so we had plenty of time to lay the groundwork as an advocacy organization to help families get past the fear. And many of them were already used to the managed-care side of things for their healthcare, and so it was try to get them to understand it would be a similar process and on the part of our ten care organization, they worked really hard with the managed-care organizations to Corp. rate person-centered practice, to train their support coordinators and I can say with all of the glitches that we've had in this new program, we are not getting a whole lot of complaints from family members about their support coordinator which is their primary contact. For the program. They are talking about how wonderful they are trained, how helpful they are, how much they are trying to support them. So I think in a lot of cases, taking things slowly here for this program has helped families become a little more comfortable with the idea of managed-care being over over the long-term services and support side of things.

This is Lee. I would add to that. I think there is clearly some concern by families, again again in Wisconsin we have some options that both national and regional MCOs and also the option for self-direction. They have some choice. One of the selling points for the MCO would be services that they can offer that aren't offered under traditional card services so the individual families and program participants really have the -- have to decide whether they are better off self directing, or going with an option where they can have things covered that they normally wouldn't be able to have covered. I think it's a matter of educating and really provide a good services and then it is up to the consumer to decide.

Leemac, can you quickly recap or expand on the actual types of services that you guys are providing to MCOs?

Sure within the new employment community first choices program they created a set of services that we loosely defined as advocacy. But it was designed to help empower individuals and families with information so they would be possibly less dependent on services down the road. One of the services we are contracted to provide her counseling and conservatorship. So that our TennCare organization is really trying to get families to move away from just jumping to conservatorship right when a child turns 18. And to think about different options, and then if they do move toward conservatorship that they have it as limited as possible so that it is not her -- over the person or maybe just medical or what that person would really need. We work with families to understand the different options that are out there and how you could use something like a power of attorney, a healthcare directive, supportive decision-making, and then contracting that with conservatorship and helping the family really get a good picture of what is out there for them. That is one. We have been contracted for health insurance forms counseling which we have not had any referrals for that at the idea that is to help families navigate Medicaid, the care, private insurance, if they needed to get insurance through the marketplace and to help them work through their own health care system. again, that one has not been referred to us yet so they may or

may not decide whether that is something that is really needed as a service. Under the program. We have been contracted for peer to peer support which is having -- peer to peer support around self-direction and self determination and self advocacy and employment. It is peering up a self advocate, somebody somebody with an intellectual or developmental to ability with somebody who -- with that person who wants that service and so the peer would help that other individual learn how to self direct there services, how to make choices, how to look at employment, independent living, things like that. It's a peer with experience helping a peer learn those skills to having rather than having it come through a direct support professional. The fourth one is community navigation and it's really long but it is helping families and individuals connect with services and supports and their community that may fill a need that the employment community first choices program does not. And it would be for free. For example, if somebody has an interest in participating in a basketball program, then we would help that family or that individual find a program that would be appropriate for that person or if somebody wants to get connected to a church, we would help them go through different churches, see what works best for them and help them make those connections so they can develop a better natural support network.

Interesting. As we recap again with what the MCOs said last month, in that it is really understanding the environment when you are looking at the services you bring forward and this is what is important to the managed care organization, what they are monitoring and working on and also what is happening even within the states and where those priorities lie. There are some services that are broad, where a lot of providers can provide them whether it is a home support the more personal care supportive types of services hands-on thing, but a lot of what you described as niche services are really those unique specialties and making sure that the services that you are offering are understood. And being able to share with the payers that this is where the value lies. This is what we are doing that is fitting in with your goals and we can make this easier for you. Would you say that is a fair statement when evaluating as a CBO if you are evaluating or offering and what you want to sell, is that a fair way to look at?

I think it is a fair way to look at it, and we can we have had some ongoing conversations with the MCOs. Specifically around the community navigation service. We have not had any referrals for that service yet and I think part of it is where there are different benefits packages and we think TennCare put it in the wrong benefits package, that it needs to be on the adult side, not the children's side so we have talked to them about that. If that service was provided for adults, most children are still in school and their social life revolves around school. So they don't really need community support navigation but once they fall off the cliff when they turn 22 that is usually when they need connections to community. Right now the MCOs are scrambling because they're trying to get providers to do that through personal assistance or community integration, which is is a much more expensive service that they actually don't have people available to provide, but we could help them connect with the community and do it in a way -- we have people all over the state that could do that. Could help them make

those natural support connections and they wouldn't necessarily need the ongoing community integration or personal us distance side of things. We have been working with them to see the value in doing things a different way. But again, this is the growing pains for all of us and that's what has made it so interesting to be a part of.

The next question to both of you. What you wish you had asked for or from the MCO or the state prior to signing the contract? Contingency plans, regular chickens to help flip the relationship, what you know now, what would you have asked them?

This is Lee. I have two things I would look at. One would be some kind of timeline on reimbursements for billing. And maybe a way to resolve disagreements on billing. That would be one. I just forgot the other one. Maybe I will remember after Carrie.

For us, because of our involvement with ECF choices, everything has been pretty standardized. We haven't really had traditional contract negotiations because the rates are all set. There is no negotiating around rate which is not always typical. The MCOs work together because TennCare is making them work together. That is a not situation we have three MCOs sitting in the same room talking to each other, talking to stakeholders, trying to figure out how to make this process better. Most of the things have been streamlined, so there is not a lot of difference between what one MCO is requiring over the other which again is not common. Right now for us, there is really nothing that I could say I wish I would have asked for on the front-end. Because we've got pretty good communication. We've got all those dings and TennCare has all but written into the contract with the MCOs and it has trickled down to us.

I remembered my other thought. That is to be really careful about timelines for getting out of the contract. I was not that careful initially, and we wanted to get out of one contract and we really had a six-month timeline, and that was more than that was very uncomfortable. Once you've decided decided you want to discontinue a contract. That would be the second thing I would look at carefully.

What actions do you think works the best for your organization in preparing for the first meeting with the MCO.

This is Carrie, I will start. I think for us starting with TennCare in our particular situation was the best ring that prepared us because we knew what they were after with the MCOs, and so we were able to go into those meetings knowing what TennCare is and their bottom line. What they were expecting. We were able to reference back to that when we had that meeting. We can help you with this and we know TennCare is expecting XYZ and we can help you do XYZ. For us starting with the oversight of those organizations is what made it work for us.

For me, going into an initial meeting it is really to find out what they want and give them some idea of what we can offer, and set up a time to reconnect. I don't want anybody to expect a commitment on your first meeting.

A follow-up to that question and I'm not sure which perspective this is from but the question is how did you figure out who you needed to have around the table with the MCO? I think you both have basically shared that is first trying to find out who to meet with at the MCO. And trying to get to the right person who has the right level of decision-making authority and so forth. I feel like you answered it on that side. Unless you have anything to add. But looking at it from the other side, who from your organization or what kinds of roles or functions would you bring to that meeting in order to be able to demonstrate and describe what you do and what you want to do for them.

That's an easy one. I bring my most educated program person who knows what we do best. My lead finance person, and lead HR person. And at some point you want to bring in probably your ATP person if you're dealing with electronic billing and such.

This is Carrie. We are a much smaller organization so I don't necessarily have all those people or the people that I have are not at that level where they would go to those types of meetings and so for us, it was myself and it was our development director. Ed Sheehan I worked with together because I am -- I don't always read people very well. I go in with my this is where you want to talk about and this is where I met and I'm good at delivering information but I'm not always good at sensing the mood in the room and hauling knowing how to shift gears and so that was her X or T's. So she could do this we talked piece and also kick me under the table if I was going to harden one direction. So that was how we tag teamed. She has more of a business sense and they definitely have the program side of things and the knowledge of the system. And so for us, that is what works when we have tried to do this. She was the best person with the business had and I was the best person with the program had. That was how we made it work.

When I listen to both of your responses to think about the message it is you want to convey and make sure that you have the right people with the right content knowledge to be able to present that information regardless of the size of the organization, how many you have. Not specifically Tyler volume but making sure you have the right communication and making sure that the team that you have come up that you will be able to walk away from that meeting feeling fully informed and that you walked away with everything from the meeting that you want as well with the dynamics that you just spoke about so well, Carrie. There is some benefit to evaluating the structure of that group that you bring to the table. In advance, and really really think about each person's role in that meeting. In order to make sure you make the most of it. Is that a fair summary?

Yes.

Very good. With that, we are at the end of the webinar period. 13:01 year. I apologize if there were questions we were unable to answer. We will review those and they help to inform our future webinars even if we are not able to directly respond to them here. Thank you everyone,

for participating today. As a reminder the webinar recording, the slides, slides, and the transcript will all be available on the NASUAD website where you registered for the webinar. Within a day or two of this presentation. Thank you to the administration to the Administration on Community Living for supporting our efforts in bringing this webinar series to light. With that, thank thank you everyone, have a wonderful afternoon.

Thank you. [ Event Concluded ]