

**Disability-Competent Care Webinar Roundtable Series: Training in Disability-Competent  
Care and Supports  
Building Partnerships between Health Care (Plans & Providers) and Community-based  
Organizations  
Event ID: 743222**

Operator: Ladies and gentlemen, thank you for standing by, and welcome to the Disability-Competent Care Webinar Roundtable Series.

At this time all participants are in a listen-only mode. Later we will conduct a question-and-answer session live over the phone or by the web. Instructions will be given at that time. If you should require assistance during the call, please press star then 0.

I would now like to turn the call over to your host, Chris Duff. Please go ahead.

Chris Duff: Thank you, Roseanne. On behalf of The Lewin Group I'd like to welcome everyone to this next-to-last in our 2014 Webinar Roundtable Series, this one focusing on building partnerships between health plans, providers and community-based organizations. As Roseanne stated, my name is Chris Duff, and I'm a disability policy and practice consultant. We are under contract with the Medicare and Medicaid Coordination Office at the Centers for Medicare and Medicaid Services. The Lewin Group has engaged myself and my two colleagues to provide technical assistance to providers working with adults at these facilities.

First I'd like to introduce you to our platform for this presentation. If your slides are not advancing, please push F5 on your computer keyboard. Also, please note the two icons circled at the bottom of the screen. The brown icon, fourth from the left, will open a chat window for participants to pose and discuss any topic-related question to other participants and speakers. The green icon of a file folder, third from the right, provides you access to resources for this presentation. The center icon with the CC will enable closed captioning. After a brief presentation we'll also open the phone lines for participants to ask questions directly to the presenters.

As stated earlier, this is the seventh webinar in this current series. The last one will be presented next Tuesday at the current time.

Last year we published a comprehensive disability-competent care self-assessment tool describing disability-competent care in three components: individualized care coordination provided by an interdisciplinary care team; redesigned primary care delivery; and threshold long-term services and support. We followed this up with nine webinars focusing on individual components of disability-competent care. All webinars are recorded and available along with a PDF of the slides at the link at the bottom of this slide.

Our goal in this series is to be highly practical, using experts in each topic area with organizational examples or first-person stories to demonstrate key messages. The presentations will be no more than 30 minutes, allowing the remainder of time just for questions or issues submitted by the participants.

The chat feature is available to participants throughout the webinar. Beyond this feature and the open phone lines we'll be using instant polling to ask specific questions to help guide our presentation. To demonstrate this process, here's the first polling question for today. To give us a sense of where you're operating out of, could you answer the question: At present are you working within a health plan; community-based organization -- and we look at that pretty broadly, AAA, Center for Independent Living and so on; a provider organization; government entity; or other? If you can make your choice and submit we'll review the results shortly.

Today we are exploring the issue of collaboration between health plans, healthcare providers and community-based or advocacy organizations. Historically, entities such as these have been operating in parallel for years, each with their own role and responsibility and serving a shared population. Their approaches and drivers have commonly been divergent, creating a fertile ground for conflict and misunderstanding. While everyone working with an individual participant wants the best for the person, their ways of doing so have varied greatly.

Perhaps most significantly, health plans and providers have historically viewed the individual through a medical lens or model, while community-based organizations have operated on an independent living or participant-driven model. As more and more states are looking to integrating Medicaid and Medicare, along with acute primary and long-term service and support, it is increasingly important for the payers and providers to be well aligned. Today the presenters will share what they have learned as they have built relationships between key entities and players in Northern California.

Let's go back and review the results of our first polling question. I see most of you are with a health plan now. That's actually very helpful information to give the perspective here. And it's interesting the number of people we have from government. This is very helpful, and our speakers will take that into consideration as we move forward.

Before introducing the speakers I'd like to ask one more polling question to help guide us, and that is while CBOs and health plans may both work with persons with disability, how comparable would you say they are in terms of mission, values and culture? This will give us a bit of a foundation for talking about the relationships.

So while you answer that let me introduce the speakers. Yomi Wrong presently manages disability access programs for the Palo Alto Medical Foundation, a Sutter Health affiliate. From 2009 until early 2014 she served as Executive Director of the Berkeley, California-based Center for Independent Living, where she worked closely with providers and health plans to design innovative models for delivering long-term services and supports. An experience trainer and consultant in the fields of independent living and consumer-driven community-based services, Yomi is also a leading voice for patient-centered care under California's dual demonstration pilot.

David Nolan is presently Chief Performance Officer at the Alameda Alliance for Health, responsible for assessing, monitoring and improving overall performance of the Alliance in all phases of its work. Prior to joining the Alliance, he consulted with the Alliance on the California

Medi-Cal demonstration and continues to serve as the Interim Executive Director for long-term services and supports. In this role he works with community providers and aligns internal systems to prepare the Alliance for the integration of Medicaid and Medicare, with a targeted population of roughly 24,000 new members. Additionally, he completed a strategic plan for long-term care integration for the city and county of San Francisco in preparation for their entry into the duals initiative in 2015.

Now I'll hand it over to Yomi to review the second polling question and for her and David's presentation.

Yomi Wrong: Thank you, Chris, and good morning or afternoon to everyone, depending on your time zone. Can we please get the results of the second polling question? Okay, so it looks like at least half of us feel that community-based organizations and health plans are pretty synergistic and comparable in terms of mission, values and culture. And I think that that's mostly true, or it's becoming more and more true as we move into this realm of more integrated healthcare.

As Chris stated, my name is Yomi Wrong, and I manage ADA compliance for the Palo Alto Medical Foundation, a multispecialty healthcare provider in the San Francisco Bay Area. I'm also a consultant and trainer in disability services and policy, work I am really passionate about as a result of my tenure running the Center for Independent Living in Berkeley, which is the nation's founding independent living center.

I left CIL during a really interesting time, when California, like the rest of the country, was starting to recalibrate the way it paid for and delivered health services to more than 1 million low-income people with disabilities and seniors. The county I live and work in, Alameda County, was selected to be among eight to launch a three-year dual-eligible coordinated care demonstration called Cal MediConnect, which aims to create a seamless service delivery system with the goal of improving care quality, health and efficiency.

So to that end many years ago CIL began exploring whether and how we could engage with our local health plans who would be driving this new process. We of course wanted to ensure strong consumer protection, but we also understood there was a real need for the type of work we'd do in the community to be part of a larger vision for integrated care. This exploration, at least for us, started long before California announced the eight counties who would demonstrate this new model. In fact, one of two health plans serving our county, Alameda Alliance for Health, approached CIL as early as 2008 because they recognized our role in the history of the disability rights independent living movement and wanted to work together to improve health services to their members. So I'm really pleased that David Nolan is joining me today, and I think he'll have a lot to contribute from the health plan's perspective.

Now I'll turn your attention to my first slide, and it just talks here about some of the strengths that I feel CIL and the Alliance and other healthcare providers bring to a partnership. Once we started meeting with the Alliance our strengths and our synergies became really evident. I believe that CIL, like other community-based organizations, inherently bring a great deal of cultural competency to the table. For CIL, everything we did and do is framed by the tenets of

the independent living philosophy of consumer control and strong advocacy for civil rights and protections for safety net services.

The Alliance, meanwhile, want to drive to achieve cost effectiveness and smart care management. They demonstrated a commitment to quality and accountability by engaging not only the CIL but other providers in the community about what is needed to improve health outcomes among consumers who have multiple chronic conditions and complex medical and social needs.

Next slide, please. So with the right approach we believed our partnership could have numerous mutual benefits in the areas of political advocacy, increased flexibility in design of long-term service and support plans, and a shift away from institutional care toward more home and community-based services. And, to be real, we in the field of independent living, the IL network in California, could see that much of what we had been doing and evangelizing for more than 40 years was suddenly being paid attention to by the medical community, and we felt we needed to be at the table to drive the conversation and to make sure we established our organization as an essential key player.

Next slide, please. But how to get there -- that was the truly interesting part. How do you truly engage in a meaningful way takes a lot of thought and strategic planning. My job was to learn all I could about the world that health plans and providers operate in, to understand their business objectives and figure out how CIL might add value there. I took time to study and learn the realities facing providers and what CIL might be able to do to help them better serve our community members. We engaged in high-level planning discussions that went far beyond the basic consumer stakeholder groups that really have no influence but so many health plans like to form so that they can tick that off their list, at least that's the way it felt from our perspective.

David, do you have anything to add there about that engagement early on?

David Nolan: Well, it's interesting because you said tick them off your list. It's interesting, when we first started engaging with Yomi and CIL we had them come in once and I would say ticked them off our list. And it wasn't till we really started to get the SPD population that we realized we needed a lot more than that. And then I think we had CIL come in probably three or four times and continually reinforce what we were trying to do and what they were trying to do with us. We also have a little bit of a unique situation in that one of our sites is co-located with CIL, as well, so there's a nice sort of symbiotic relationship there.

Yomi Wrong: Absolutely. So from CIL's perspective engagement meant really stepping up our game. We had to see ourselves as a business and demonstrate good business practices as reflected by my leadership and the accountability and transparency of my team. We also decided to approach it by developing key partnerships with other community agencies that we respected, such as our local AAA and one of our sister independent living centers in Alameda County, and that led us to form an Aging and Disability Resource Center. And one day that ADRC partnership is going to be really well positioned to deliver LTSS services to health plans.

We also got really ambitious and decided to work with the health plan, with Alameda Alliance and one of our local providers in applying for a CMS Healthcare Innovations Grant. So, to our great astonishment and pride, we were awarded a grant in 2012 from CMS, and that set us on a real path to learning how to work together. Our grant is a demonstration project to test the new multidisciplinary approach to care coordination.

Next slide, please. Oh, I'm sorry. You were at the right slide. Go back one. Sorry about that. So that CMS innovations grant is a partnership between CIL, Lifelong Clinic, which is a Federally Qualified Health Center, and the Alameda Alliance for Health, our local health plan. Under the terms of that grant we have embedded professional peer counselors employed by CIL, and by peers we mean people with disabilities. Our peer counselors are embedded at Lifelong Clinic to work with Lifelong's more than 3,000 seniors and persons with disabilities who are eligible for both Medicare and Medicaid.

And those patients that we are -- they call them patients, we call them consumers, so those individuals that we are working with are what we have identified as high utilizers. So these are people who, for a variety of complex reasons, are using a lot of healthcare services. They might have revolving stays in institutions, or their care is just not well managed.

And our hope is that by working together in a multidisciplinary way as equal partners, so the peer counselor from CIL, a nurse care manager from Lifelong and with the financial support of Alameda Alliance underwriting part of the project, we might be able to offer Lifelong patients not just medical care but also independent living services and other kind of social safety net programs that might improve their outlook, and really we're trying to achieve that triple aim of quality, improved health outcomes and then also achieve some efficiency by lowering healthcare costs.

David, how would you say that's going from your perspective?

David Nolan: It's interesting to -- Lifelong is probably one of the premier Federally Qualified Health Centers. We just love working with them. Yet I think in the beginning of this process even Lifelong didn't get that it was an equal partnership. And I'm not trying to denigrate. They're really good. But it's really difficult sometimes for medical -- people who are medically oriented to understand that healthcare from a medical perspective is almost -- the quality of life for someone is almost more important than the quality of care. And so I think in the beginning the nurse, the nurse practitioner or the RN at Lifelong saw the Center for Independent Living as not quite an equal partner. And, Yomi, correct me if I'm wrong there. But I think it's much better now.

Yomi Wrong: It is much better now, but I think in the -- we're in our second year of the grant now, but in that first year there were some growing pains, because, well, for my staff, CIL peer counselors come out of this strong disability rights advocacy, consumer-controlled, consumer-driven tradition, and to be embedded within a medical model, where -- so there were some cultural shocks right there.

But then to be able to assert ourselves as authorities and experts who understand this whole realm of independent living and what that means to a senior or a person with a disability, our perspective is in many cases radically different than the approach that some of the Lifelong providers might take with a particular patient or consumer. For us the consumer is an equal member of the team and not someone to be talked about or talked around, but to be engaged as an expert on their own life.

And so I'd say that first year between finding the right fit in terms of our hiring when we were building these teams and then really learning each other's cultures and figuring out how we could work together was one of the biggest challenges of the first year of the grant. So I think you're right, David.

David Nolan: Yes, and, Yomi, I would just add that as a health plan we're still struggling, I think, to truly realize the potential of the relationship we have with you all.

Yomi Wrong: I think -- next slide, please -- this leads into the next slide -- I think, though, working together on this grant is really laying the framework for the next level of our engagement with the Alliance and also with Anthem Blue Cross, who is the -- that's the commercial plan that serves our county.

I have to say when we got down to it, when it came to that next level of engagement, and for us that meant contracting to provide services, that wasn't as quick and dirty as I thought it was going to be. For instance, I wasn't comfortable signing a boilerplate agreement, and we took months and months going back and forth with both plans to get the right scoping language and rates established.

So, for example, in terms of contract language, one of the contracts had a lot of medical jargon and a requirement that authorization for services meet a medical necessity standard. Well, CIL is not nor does it ever want to be a medical provider. We deliver independent living services. And so we pushed to have some of the medical definitions stricken from the contract and replaced with a functional necessity authorization standard which we felt more comfortable with.

So, as you are developing contracts, I think it's important to know that a lot of internal discussion has to take place. Is this right for your organization? And I'm just speaking on the perspective of the community-based organization, and I'll let David talk about some of the internal discussions that the health plans need to have. But for us it was a lot of soul searching. So is this right for us? Does it make sense? Is this in line with our mission? And do we have the capacity to deliver services?

We suddenly had to become a provider under contract with a health plan, and that meant a real shift in the way that we were delivering programs at CIL, the way that we were billing, the way we set up our back office systems. And so we had to really think about whether this was something that we wanted to move forward with.

David, anything to add there?

David Nolan: Yes, I would say the discussion with Yomi about functional necessity got us to go back and look at every single community-based service that we were hoping to deliver, adult day healthcare and MSSP and everything and create functional necessity requirements for each of those, and then go back and change our provider manual so that we had both a medical necessity section and a functional necessity section. So it was a good process for us. I will say that it seems a little more difficult sometimes to do the functional necessity part. I'm not quite sure why, but it seems harder to quantify that.

Yomi Wrong: Right. Well, because, just thinking from an independent living perspective, when we work with consumers, these -- it's not in 15-minute increments. It's not an appointment like a medical appointment where they're coming in to see a provider and maybe they might have one follow-up visit and that's it. We establish relationships with consumers over a long period. We're in it for the long game.

We are supporting people to develop independent living goals, define for themselves what they want their life to look like, and then work with them to achieve those goals. And that can take a couple of visits or it could take several dozen visits. It could be a relationship that lasts a few months. It could be a relationship that lasts years. And so it's been interesting to work with health plans and also when I do consulting and training with providers and having them understand how the way we work with consumers differs from the way that they work with consumers but both have value and both are important.

Next slide, please. So we're almost nearing the end of my presentation. I just wanted to point out that once we had the contracts in place we all went great, great, gave ourselves high five. We were so excited to be working together. And then came the really hard part, and that is how do you operationalize this stuff? A lot of hard work and good lessons were learned here, and I think David would agree. This is where that trust and transparency that we built on the back end is really important, because we needed to be able to talk about what was working and what wasn't working and not be afraid to flag problems early on so that we didn't go down a rabbit hole in terms of losing sight of our financial objectives and our programmatic deliverables.

For CIL it changed dramatically the way my staff works. We were delivering independent living services and we were also delivering independent living services that were now considered LTSS. We had to change the way that we were doing billing. I had to invest, or my board had to invest and agree to invest significantly in staff development. We had to become HIPAA compliant.

The way CIL decided to work with the Alliance and with Anthem, because we had spent so many years building these relationships, and we were a fairly big independent living center and we had the capacity to do the billing and the training, we brought smaller organizations, other independent living centers under our scope as subcontractors, and so we also had to learn how to manage those relationships.

We had to figure out how to measure outcomes and evaluate the program in a way that it would meet the requirements of the health plan and meet -- and then in turn meet the requirements of the states who were going to be watching this demonstration. And then we had to make some

adjustments, I think David would agree, a couple of times on reimbursement. Rates that we proposed a year and a half ago, once we got down to actually delivering services, we realized we weren't covering our costs, and we needed to be able to have that transparent upfront conversation with the Alliance about raising the flag and saying hold on here, we don't want to lose money, we can't lose money on this. And so we needed to renegotiate rates, and we had to in some cases do a little bit of scope revision. Would you agree with that, David?

David Nolan: Yes, I would, and it's interesting, because you described taking steps toward us about HIPAA, billing, outcomes and things like that, and in essence the relationship will only work if both sides are willing to take steps toward the other side. We had to make a number of changes in how we do business just because this is just something new for us. And you just can't require -- it's not just a contract, it's a partnership. So requiring Yomi's organization to come to us without taking steps toward them really wouldn't have worked well.

Yomi Wrong: Right. Next slide, please. So, in summary, I think we talked about how partnering can better meet the needs of adults with disabilities and seniors. We know that. And to start a constructive partnership the parties need to individually identify their competencies and needs for partnering.

Such a partnership requires a commitment from all levels of the organization, with executive leadership and sponsorship. It's really important that I do a lot of education with my board of directors and get their buy-in, because in order for CIL to become ready for this, to become ready to be a fee-for-service provider at this level, we had to invest some financial resources and had to make a lot of upfront investment in the organization, and my board needed to be in agreement with that, and they were, luckily.

Traditional provider contracts used by health plans lack the shared values and specificity needed to support collaborations with community-based organizations. At least that was my experience, and I know it's been the experience of some of the community-based organizations and independent living centers in California. So one size fits all is not going to cut it when it comes to contracting with community-based organizations. And I think that you would be better in the long run by really taking time to develop contracts that make sense and scopes that make sense and reimbursement rates that ensure that services can be delivered at a very high level, quality services.

And with that I will turn it back over to Chris.

Chris Duff: Yomi and David, thank you very much. That was a very meaty discussion. You really raised a lot of issues, and I'm trying to figure out where to start. But in the meantime I just wanted to remind people that you have a chance to submit questions on your platform. We also have someone who's monitoring some of the chat going on and seeing if there are some questions that are coming up there. And I'd like to ask the operator at this point to open up the phone lines, too.

Operator: Ladies and gentlemen, if you wish to ask a question over the phone, we ask that you please press star then 0, which you'll hear a tone indicating you have been placed in queue to be

answered by an operator, who will ask for your name and give you further instructions on how you can queue up so that I can open your lines so you can verbally ask your question. Once again, if you wish to ask a question star then 0.

Chris Duff: Thank you, Roseanne, I appreciate it.

What we've really laid out here is a partnership that's really almost a three-legged stool. There's the health plan. There's the community-based organization, in this case the Center for Independent Living at Berkeley. And then thirdly is the FQHC, or the primary care component. Each of them have a world that they're used to operating in that needs to change really very dramatically, and that's challenging. That's challenging for every one of them.

I'd like to point out here I was surprised, David, you had mentioned that you started this discussion with the CIL back in '08, so you've been at this for six years. And everything you talked about is very comparable to what I hear from other organizations across the country who are trying to build these kinds of relationships.

So really what we're talking about is what are the key components in collaboration and alignment? How can we make sure that the different organizations start looking at the services they provide in a way that's more focused on the triple aim versus their own kind of realm that they're used to operating in?

So, with that as a lead-in, I'd like to go to the third polling question here, and just to give both David and Yomi a heads up, I'm going to ask you to give your responses, your ideas on that polling question, and then we'll look at and see what the audience says. And that's about the financial relationships between the partners.

The polling question specifically states, and it'll be up in just a minute, how important is it for the health plan and the community-based organization and/or provider to share financial risk? Highly important, direct collaboration; moderately important, risk-sharing or payment for services can be effective; or it's best not to share risk at all.

David, why don't you take a start at this first and kind of give your thoughts about how do you build -- how do you make sure that the relationship, the collaborative relationship is supported by the financial relationship you have with both the provider side as well as the CBO side?

David Nolan: Yes, it's interesting. If you asked me this question three or four months ago I would've suggested that there shouldn't be a risk level on the CBO side, but as we get further and further into this and we become -- when we move from a relationship where the CIL is a contractor and they're a partner, then some level of financial risk is probably appropriate.

We do have to be a little careful. Most health plans are fairly -- they have a lot of money. And those of you who are in health plans are probably rolling your eyes right now saying, "We don't have that much." But these are small organizations we're dealing with with small budgets, so when you ask about financial risk you have to be a little careful about the level of financial risk that you're going to push out to them.

Chris Duff: Yomi, how would you respond?

Yomi Wrong: I think that -- well, I'll start by saying we never viewed -- yes, health plans have more money than independent living centers, but I never viewed the health plans that we worked with as cash cows. I understood that these were businesses that had goals and objectives that they had to meet and that in order for this to be a true collaboration and one that would last over time we had to bring value, and we had to help them achieve their objectives just as we wanted them to help us achieve ours.

And so I've always taken the perspective that risk should be shared, and so should the incentives. I think that CIL took on a tremendous risk early on in deciding that we were going to go down this path. We saw the landscape changing. We saw not just the healthcare landscape changing but the landscape of funding for independent living centers. And things were looking a little bleak, and we understood that we needed to evolve or become irrelevant. We needed to become part of the process and manage the process rather than be managed.

And so we -- I made a strategic decision as Executive Director to take our organization in a certain direction, and we took a huge, huge risk in doing that, not just a financial risk, but we had to explain to our constituents, to our community, to our partners in advocacy around California and throughout the nation why we were doing this, why we felt that it was important, and how this was not going to erode the independent living network or erode disability rights but actually strengthen them.

Chris Duff: I'm now going to turn to some of the questions. There's actually a lot of questions that have been submitted online. And I'm going to start with kind of more of a broader question, and that is that you spoke eloquently about the challenges of building your partnership. What would you say have been the biggest surprises for you in building that relationship?

David Nolan: Let me just take a shot at it. Yomi, you can -- I was going to say you can correct me if I'm wrong. I've been in home and community-based services for 25 years, so I thought I really -- I thought I got it. But until we really started working, Yomi and I started working together on this, I didn't realize how stuck I still was in sort of a medical model. And Yomi's push that people make their own decisions, whether we like those decisions or not, and that those are their quality-of-life decisions really -- it took a while for that to kind of stick with me.

Chris Duff: Yomi, your thoughts?

Yomi Wrong: I think one of the surprises for me was really understanding some of the everyday realities of providers working with the good folks at Lifelong. I'd always felt good about them in our community, because I knew that they served a low-income population. I knew that they served many of the people that we also were serving and working with in the community. And I thought that it would be kind of naturally synergistic relationship.

And I was a little surprised by how entrenched Lifelong and, I would say, my own employees, and CIL was in just sort of our way -- our world view. We weren't as evolved as we had hoped

we would be going into that grant, that innovations grant project. And so it was really eye opening for me to understand what some of their challenges and realities were and having to take a step back and rethink our approach. Because you can't just go into a relationship like this constantly at odds and saying we are advocates and it's going to be this way or no way. It really is about compromise and figuring out the best path forward.

Chris Duff: For Yomi, maybe, similar kind of follow-up on this, and this is from Marissa at ACL, how did you build trust between the organizations as you were like starting off? We all come from our own perspective -- health plans, they have all the money, and their answer or goal is to get to no, and community-based, health plans view them as they just want to give things away to everyone. And how do you kind of get people out of those, and providers are seen similarly, so how did you get your respective staffs into a place where you could start closing those perceptions down and building new perceptions?

Yomi Wrong: We did a lot of work at CIL with our staff on educating our staff on the political landscape, what was happening and changing in California, some of the opportunities that we saw on the horizon as a result of the Affordable Care Act, what some of those opportunities might be and also what some of those challenges might be if we weren't in the game. So we did a lot of internal discussion, a lot of understanding where we might fit in all of this.

And with the health plans, particularly working with the Alliance, before I would even entertain a discussion of contracting or working together I started doing training with their staff, and I provided a whole lot of in-service at all levels of their organization so that they really, really understood the independent living philosophy, what our history was, and then I showed them the 504 video. And every single person at the Alliance has seen the 504 video. Every single person at the Alliance -- and they continue to do these in-service trainings as they add staff, understands the world that CIL grew up in and understands from our consumers' perspective and from an advocacy perspective why healthcare is still essential to our community, why access to quality healthcare is essential.

One of the points that I always drive home when I'm doing in-service and training and consultation with plans and providers is that disability itself is a health disparity, and understanding what that disparity is and where they exist and how we can mitigate those disparities and what their role is in reducing disparities and what our role could be in reducing disparities.

And I think that when we talk about it not just from you have to do this because it's the law, not just from perspective of compliance, but also for achieving greater health outcomes so that people can just live better and live healthier lives, and that healthcare needs extend beyond the medical. It's really about the whole person. And so for us it was a lot of two-way education.

Chris Duff: David, do you want to add to that at all?

David Nolan: I keep thinking of the same thing, and that is that when you -- I'll take myself, for an example, when you do not have a disability, this becomes -- it can be anecdotal for you. In other words, you can go in and out of this -- thinking about this.

And so I just want to reiterate what Yomi said. Yomi came in here time after time. It wasn't a one-time thing. You just can't come in one time and think people are going to get it, because they go back to a different reality. So her coming back consistently, us being engaged consistently, helps the new people, helps the people that forget from day to day that there are significant challenges to this.

Chris Duff: I would like to just absolutely enforce what you're saying. I built a similar relationship in Minnesota, 15 years started that, and the best opportunity I had was to get people with disabilities in front of both the leaders as well as the line staff within the health plan. If I could just get out of the way and have them engage with each other, have them just kind of see each other, and look at them as people and together problem solve. First-person stories are very helpful in explaining the perspective. And so the more we worked to get the -- to build the relationship on human beings, so it's not a diagnosis, it's Sally or Beth, that was what pulled down the barriers across the board, both at the plan, both at the CBO as well as at the state, even, in getting the policy people to really get engaged to a different level.

Move on to another question that's actually somewhat close, and it's come from both the ACL, again, as well as someone else. Yomi, you spoke of -- and as you thought before you did this how to price your services, you realized that some of the prices you came up with, it was a good educated guess, but it didn't work. So the question is then how did you approach the health plan or other partners to discuss that? And how did you -- I guess that's ultimately the question, is how did you bring that forward in a way that wasn't just going to be heard as you're just trying to milk more money?

Yomi Wrong: Well, at CIL that usually started with some kind of panic (inaudible) from my finance manager going, "We haven't been reimbursed," or something, right? So it's usually the folks in the accounting office that will flag something. And we would spend some time just trying to solve it internally and figure out, well, is this our issue, is it that we aren't submitting for reimbursement in a timely fashion? Are we not being reimbursed? Did we not get prior authorization? Do we not have our documentation in place? We tried to figure out what the problem was, if it was originating from our end, was it originating from the Alliance's end? Were they just not paying us on time? Or what was the issue? Because sometimes it was like little technical things.

But, for instance, what the Alliance decided to do was sort of -- I created a menu of all of our IL services, and Ingrid Lamirault, who's the CEO of the Alliance, she basically looked at it kind of like a cafeteria plan, and she checked off the things that she wanted to purchase from CIL. And some of those things we established an hourly rate and some things we established like a flat rate. So, for instance, for our Living Well with a Disability Wellness classes we established a flat rate, and as long as we had at least I think it was six Alliance members in the class, then we could meet our costs and then we could open it up to other people.

But when it came to just your -- some of the other peer counseling services, I can't even remember, I'll just use for an example, maybe we said we would do this, we'd do something for \$45 an hour, and then when it came down to it we weren't meeting the cost, or maybe we hadn't

factored in salary, fringes, overhead costs, indirect costs, (inaudible), all of that. And because we have such a good relationship with David and the folks at the Alliance, I would just pick up the phone or shoot an email and say, "We need to discuss this."

And we would continue to deliver services. We wouldn't say, "Okay, everything stops until we get the rate adjustment." But the expectation was that they would take this up really quickly and take a hard look at it and work with us immediately to correct it and we would just negotiate something that we thought was more equitable, and we didn't have any problem. I think they understood what was fair and that they were still getting a pretty good deal, and so they didn't have any qualms about adjusting rates.

Chris Duff: David, your perspective?

David Nolan: Well, you've never negotiated until you've negotiated with Yomi. She's tough. Here's -- I'll give you a good example. In asking Yomi's group to do health risk assessments, for example, perhaps a health risk assessment takes an hour for a person who does not have a disability, can speak without aids and things like that, so we would put a price on that, and say, listen, an HRA costs \$60. We'll pay \$60.

Well, then, Yomi would come back and say, "Listen, it's taking us an hour and a half or sometimes taking us two hours." So that was just a learning curve for us. And, to be honest with you, it really wasn't -- I don't think we had any issues. We were willing to change and try to see how we could make it work. So it really wasn't a struggle for us.

Chris Duff: So, in summary, and, Yomi, you're saying you're not throwing a gauntlet down, you're saying do this or we're walking, and, David, you're saying help me understand what's not working here, and through that discussion you were able to get to something that worked for both of you.

David Nolan: Basically, yes.

Yomi Wrong: Absolutely. And I would say that being able to go through that with the Alliance actually helped us set more appropriate rates with the commercial plan, which in our area is Anthem Blue Cross. So that's a much larger system. That's a much larger enterprise. And it isn't going to be as easy or seamless for us to just pick up the phone and reach somebody at Anthem and say, "Oh, we've got to adjust this," because it's a bigger company. They're national, they're not local. And so because we had this trial period with the Alliance where we were delivering services under the CMS grant, we were able to know more going into our contract negotiations with Anthem.

Chris Duff: That's a really great perspective that I hadn't thought about is that you could learn -- you can both learn together and bring that to your other relationships that you may have. That made total sense.

At this point I'd like to go back to on the third polling question, and then I have a comment I'd like to read from Cheryl, who is with [Molina] now. And so it's interesting that equal numbers of

you are saying it's important to share financial risk and then some say moderate, and then equal numbers say yes, really pretty limited. And only one person says no risk at all.

The comment from Cheryl, I think, is really well stated and talks about her experience having been on both sides of the coin. "I'm currently working at a health plan, but I've been in the AAA community. My observation is that AAAs need to build experience to understand their cost structure before they go at risk. They're learning pricing structures that need to be phased in towards risk pursuit." And I think that's totally consistent with what both David and Yomi mentioned.

David, in our conversation before this call you had mentioned that you're beginning to have some ideas about the future of the financial relationship between you and some CBOs. Can you just give me a sense of where do you see this going, or do you want it to be the same platform you're using now, which is basically paying for services?

David Nolan: You know, I really would like to get more and more into sort of a risk relationship. And I actually -- we're looking more and more at pay for performance. The difficulty is trying to define exactly what performance is. In a medical setting you have HEDIS and things like that you can use, but in a community-based setting you're trying to create a better quality of life. But I do think that if we do well, our members do well, that our community-based partner should do well, as well. Now, how we put that into practice is probably something we're going to have to learn over time. And I actually also very much agree with what Cheryl said, too. I think it's a process that takes a little time.

Chris Duff: Yomi, do you want to answer that at all?

Yomi Wrong: I would agree with that. I think that sometimes -- I'll just speak from an independent living perspective -- we would see opportunities out there, for instance, in California, becoming an organization contracted with the state to transition individuals out of nursing homes. And some independent living centers jumped at that and became providers and became contractors and hired a bunch of staff, and it was going to be this new program that was going to become a revenue stream for the independent living center.

And then some independent living centers actually lost money and really suffered because the reimbursement didn't happen the way they had envisioned or the way they had planned, or they hadn't really quite planned for it. They really weren't set up to manage the risk involved with a new -- with approaching or launching a new revenue stream.

And so I would say to proceed cautiously and wisely and strategically, and contracting in this world is not for every organization. And I think that you have to get there. You need to build capacity and expertise and business acumen in order to do it successfully.

Chris Duff: Well, at this time I'm actually going to switch to a different topic. Several people have caught a little conversation we had in your presentation around functional necessity versus medical necessity. And I think, David, you brought that up, saying that one thing that you had done, which I hadn't thought about it and it's very creative, is you've tried to go side by side and

say, okay, what would be the medical necessity in this service or benefit and what would be the functional necessity for that?

And that's interesting, because there's a lot of science behind the medical necessity. There's been a lot of research done. On the functional necessity side, it's a lot softer. And so can you just spend a little time, maybe give us an example or two? And how do you go -- how did you go from the conceptual to actually being able to prepare your staff and your contractors to think of them both as they proceed in their work with your individual members?

David Nolan: Yes, and I'll just preface this by saying we're flying by the seat of our pants on functional necessity. What we're -- I think that Delta Healthcare is probably a good example of it. There's a real healthcare component to that and determining the number of days, for example, that a person needs to go to a Delta Healthcare can be very much medically focused. But the functional part of it is equally as important. There are no supports at home. The person has some level of dementia. They need socialization. They benefit from the socialization. So a lot of those things aren't necessarily medically oriented, but when you look at sort of functional necessity around that you may take someone from three days to five days just because of their life situation.

So we took all of the different elements of home-delivered meals and personal care workers and respite and things like that and we tried to not look at them from a medical perspective. We tried to look at them from how a person functions and what they need. And we kept going back to the same thing, and that was quality of life. Does this improve the quality of life? In essence, if it improves the quality of life in the end it'll probably improve the quality of care and the healthcare of the person.

So if anybody has an interest in seeing what we did around functional necessity I would be more than happy to share. We have probably a 25-page document that goes through each of our elements and describes the functional necessity we've come up with. I'm happy to send that out to people afterwards. I would also love to hear back from people telling us whether you think it makes sense or not.

Yomi Wrong: If I could add -- David, that's great -- I just wanted to give -- so in terms of the definition that we had put into the contract, I can just read what that definition was. So for authorization for services we agreed to meet a functionally necessary or functional necessity standard, which means reasonable and necessary services to enable independent living, such as assistance with activities of daily living and instrumental activities of daily living. And from our perspective, to my mind, almost everything that an independent living center does meets that -- could meet that standard.

Chris Duff: That's great. And we'll also put that in -- David, we will take you up on that, and we'd like to attach to this presentation, so when people get the link hopefully we can have that here. But, David, that's exactly what we want out of this webinar series is we want people to start talking to each other. We want people to start sharing resources, because I think that's -- when you get into this world of functional necessity, there is no science yet, and we're all flying by the seat of our pants.

I remember we had a three-step question back when I was doing this. The first step is what does the member want? Second step was what is -- what do we think -- is kind of the definition that Yomi came up with. And the third was a financial. And as we just basically had the staff take through, go through those questions, we pretty much came up with the answer. But, again, that was a fair amount of work to get there.

So I would love to see some of the language you came up with, and I'll see I can find the policy that we had developed around the thought process that we wanted staff to go through in the process. And if any of you listeners have anything you wish to or can share with us, we would love to also include that, because this is an area that everyone needs to get into, and you can't go to the medical journals and get your answers on this one.

Yomi Wrong: Chris, if I could just add, so from the independent living perspective, in terms of the services that we provide and that we can provide to Alliance members or any member of a health plan, any service or relationship that's going to allow an individual to remain living independently in community as opposed to an institution, any service or advocacy or program that's going to allow a person to achieve their goals and their dreams, to achieve economic justice, economic independence, that's going to help that person become more self-directed and more self-actualized and be able to realize their own agency and to use that agency, I will go to the mat for. And I will argue that our health plans should be supporting that and should be paying for that.

Chris Duff: Yes, and I think the other place where we just -- the field just isn't mature enough yet is how do we look back and say have we done that beyond Sally and Beth, beyond individuals? And, again, I think we're still trying to bring that forward.

Well, with that, our time is up here, and I really want to thank Yomi and David. It was extremely rich content. I think the fact that I'm leaving this conversation with more questions than I came into it with I think is really what's important here. And we would love to continue this discussion some way, and we'll look at figuring out how we can do that in the future here, and you all will be hearing from us, all of those who signed up for any of these webinars. We'll be sending out some questionnaires to ask people what would be helpful for them.

So with that I need to wrap this up. We will continue next week with our last Roundtable Series at this time. The topic next week will be in some ways similar to this, is "Integrating Behavior Health Competency within Disability-Competent Teams." In other words, how do you bring the physical and the behavioral together? And we'll be looking at it from one [person's] experience in doing so, like we have through Yomi and David in Northern California.

I would like again to thank Yomi and David for the presentation. I look forward to continuing our work this year in supporting plans and providers in meeting the needs of people with disabilities in the future.

Thank you all very much, and this concludes it.

Operator: Ladies and gentlemen, that does conclude your conference for today. Thank you for your participation and for using AT&T Executive Teleconference. You may now disconnect.