December 17, 2014

Business Opportunity for Community-based Organizations:

MLTSS Ombudsman

NASUAD
National Association of States United for Aging and Disabilities

Introduction

Over the course of the last 18 months, a significant opportunity has emerged for community-based organizations (CBOs), such as Area Agencies on Aging and Centers for Independent Living, to provide the independent ombudsman function that the Centers for Medicare & Medicaid Services (CMS) has begun requiring states to employ when they implement new managed long-term services & supports (MLTSS) programs.[1]

Although the concept of an MLTSS ombudsman is not new, it gained tremendous traction as Home and Community Based Services (HCBS) programs across the country shifted from fee-for service 1915(c) waivers to MLTSS. Half the states have transitioned their delivery of long-term services & supports, including both institutional care and home- & community-based services to capitated managed care models. These include both states operating Financial Alignment Demonstrations as well as those operating Medicaid-only MLTSS programs. The CMS Medicare-Medicaid Coordination Office has provided funding to support ombudsman programs in the states operating capitated financial alignment demonstrations.[2]

Prior to 2011, only a handful of states had transitioned their long-term care systems (HCBS services, nursing facility care, or both) from fee-for-service to managed care, and of those, only three states had explicitly incorporated an ombudsman program for MLTSS beneficiaries: Hawaii, Minnesota and Wisconsin. None of these pioneer states elected to use AAAs or CILS as their MLTSS ombudsman, but two – Hawaii and Wisconsin – contract with non-profit agencies to carry out some or all of the MLTSS function. As "early adopters", all three states have valuable lessons to teach regarding program design, including the relationship of the MLTSS ombudsman to the MCOs and the Medicaid contracting agency and advocacy approach. There are differences in how these three states set up their MLTSS ombudsman programs, but also striking similarities.

[1] "Guidance to States using 1115 Demonstrations or 1915(b) Waivers for Managed Long Term Services and Supports Programs" http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Delivery-Systems/Downloads/1115-and-1915b-MLTSS-guidance.pdf.

[2] http://www.cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination-Office/FinancialAlignmentInitiative/FundingtoSupportOmbudsmanPrograms.html

State Case Studies

Below the Hawaii, Minnesota, and Wisconsin MLTSS ombudsman programs are outlined, including their similarities and differences. As states' experience with operating an ombudsman program under the auspices of CMS' Financial Alignment Demonstrations grows, there will be additional examples to add to this body of knowledge. For now, the discussion of these three states' experiences may improve instructive to other states that have yet to establish a MLTSS ombudsman programs.

Hawaii

In 2009, Hawaii migrated 45,000 seniors and persons with disabilities into a new MLTSS program known as QExA (Quest Expanded Access for Healthy Long-Term Living). Discussions between the state, stakeholders and CMS had surfaced the concept of utilizing enrollment brokers and ombudsmen to assist beneficiaries transitioning into managed care. Initially, there was no state contract to deliver these services. Hilopa'a, Hawaii's Family-to-Family Health Information Center (F2FHIC), a non-profit foundation funded by the federal Health Resources and Services Administration (HRSA) offered to leverage its experience in advocating for children with special health needs by providing MLTSS ombudsman services at no cost when QExA went live in 2009. A year later, the state issued an RFP to formally procure MLTSS ombudsman services, ultimately selecting Hilopa'a as the "only qualified and interested entity." In 2012, Hawaii re-procured the ombudsman contract, and expanded the scope to include all 300,000 beneficiaries of Medicaid managed care. Again, the state selected Hilopa'a to operate the ombudsman program.

The decision by Hilopa'a to provide MLTSS ombudsman services at no cost during QExA's first year benefited the nonprofit in several respects. It allowed Hilopa'a to assess whether the ombudsman program would be a good fit for the organization and gave it a chance to gauge the number of staff required to handle the caseload. Moreover, Hilopa'a started building a track record and establishing relationships and experience that established its credibility with managed care plans and the state, which likely influenced the state's later decision to award the contract to Hilopa'a when it went out to bid for this service.

Under the terms of its contract with the state, Hilopa'a provides information, referrals, advice and coaching to MLTSS plan beneficiaries, and much of this

assistance involves helping beneficiaries to navigate the system (e.g., explaining the process, interceding with care coordinators from the plan, identifying and obtaining permission to see an out-of-network provider, interpreting coverage notices and advising beneficiaries regarding grievance and appeal processes, and in some cases, representing beneficiaries in those appeals). Approximately 10 percent of the MLTSS beneficiary inquiries fielded by Hilopa'a entail issue identification. Roughly one in four involve complaints by beneficiaries regarding coverage, placement or quality of care issues.

Hilopa'a provides ombudsman services to MLTSS beneficiaries statewide, with staff in Oahu, where 66 percent of the state's QExA participants reside, and two of the neighbor islands. Beneficiaries can reach the ombudsman program by calling local phone numbers that automatically route all calls to a central call center on Kaua'i.

A key characteristic of Hawaii's MLTSS ombudsman program is the constructive relationships it has developed with the state Medicaid program that administers the managed care contracts, and with the MCOs themselves. Hilopa'a provides extensive training, not only skills training for beneficiaries learning to self-advocate and navigate the MLTSS system (central theme for Hilopa'a), but also trainings for providers and the managed care plans themselves. Hawaii's MLTSS ombudsman also convenes focus groups for the state and MCOs and acts as a sounding board for the plans with respect to customer satisfaction, plan performance, proposed coverage changes or plan design. Moreover, Hilopa'a also provides direct feedback both to the plans and to contract officers at the Medicaid agency.

Leadership at the Medicaid agency has facilitated and embedded the ombudsman's role in Hawaii's MLTSS system. Hilopa'a describes itself as an "equal partner" with the MCOs and, indeed, the ombudsman is included in the state's monthly meetings with the plans and accompanies state staff during the onsite reviews of the MCOs.

Minnesota

Minnesota has one of the oldest Medicaid managed care programs in the country, and pioneered the use of managed care in HCBS and long-term care when it implemented Minnesota Senior Health Options (MSHO) via a Medicaid waiver in 1997. Initially serving only seniors, the state amended the waiver and extended MSHO to include persons with physical disabilities in 2001.

Minnesota enacted legislation mandating an MLTSS ombudsman in 1998, providing an advocate.

. . . for recipients enrolled in prepaid health plans through complaint and appeal procedures . . . ensur[ing] that necessary medical services are provided either by the prepaid health plan directly or by referral to appropriate social services.

The structure of Minnesota's MLTSS ombudsman program differs markedly from Hawaii's approach. The ombudsman office is located in state government, within the Health Care Administration at the Minnesota Department of Human Services, and in the same state agency that houses the Medicaid program and manages the state's contracts with MCOs. Statewide administration is handled by five full-time staff at the state level, with 87 managed care advocates employed by the counties.

Significantly, Minnesota's ombudsman staff has responsibility for both the Medicaid MLTSS programs, and the state's Medicaid managed care programs for children and families. The state and county staff divide their time between these populations, triaging based on the urgency of a beneficiary's problem. Total managed care enrollment in Minnesota's Medicaid programs is roughly 615,000, with approximately 89,000 seniors and people with disabilities enrolled in MLTSS.

Minnesota's MLTSS ombudsman program has a job description quite similar to its sister program in Hawaii: information and education of enrollees regarding beneficiary rights, and coaching beneficiaries when they need to avail themselves of the MCOs internal grievance and appeal processes and the state Medicaid Fair Hearing process.

However, due to their co-location with Medicaid within the Department of Human Services, the Minnesota MLTSS ombudsman program does not represent beneficiaries at MCO grievances / appeals or state fair hearings. Instead, the ombudsman office systematically reviews denial, termination and reduction in coverage notices (DTRs), and monitors MCOs' internal appeals and grievance proceedings, watching for trends. The office may make recommendations, based on the frequency or type of such disputes, to the Medicaid agency for targeting MCO audits or enforcing/amending contracts with the MCOs.

Oversight and monitoring has become a model for newer ombudsman programs, such as the programs funded by MMCO to advocate for beneficiaries in the duals demonstrations. In this sense, the MLTSS ombudsman program may serve as the

state's "eyes and ears on the ground", detecting systemic weaknesses and trends that should be remedied either in the course of the state's contract enforcement activities, application of sanctions, or contract revisions.

As with Hawaii, the Minnesota MLTSS ombudsman accompanies the state during its onsite review of the managed care plans. But the Minnesota program also has two other very influential responsibilities: the ombudsman program convenes the MCO appeals and grievance committee, and defines the reason and service codes used to explain coverage decisions and denials. The Minnesota program is also consulted, by both MCOs and the state, regarding MCO policies and procedures, beneficiary notices, member rights and evidence of coverage.

Proponents of the Minnesota approach – operating the ombudsman program out of the Medicaid agency which oversees MCOs, - assert that such an arrangement afford the ombudsman ready access to state managed care databases and collegial relationships with the state's enrollment representatives and MCO contract managers. The Minnesota ombudsman office believes that its organizational relationship to Medicaid permits input into the content of MCO contracts and puts ombudsman staff at the table with the state's managed care policy experts. It should be noted, however, that many of the "advantages" of co-location can be replicated with clear operating procedures designed to assure that the MLTSS ombudsman program has unfettered access to state personnel and data (e.g., MCO and provider records, grievance and appeal records, etc.)

Wisconsin

Wisconsin's approach to the MLTSS ombudsman function differs from the other two states discussed here and, in fact, it has two markedly different models – one serving seniors and the other advocating for people with disabilities.

Wisconsin's move into managed long-term care started in 1998 with approval of the Family Care waiver, serving frail elders, people with physical disabilities and people with intellectual/developmental disabilities. When Wisconsin decided to build an ombudsman function into its Family Care Medicaid managed long-term care system, the state decided to leverage its existing long-term care ombudsman (LTCO) program which had traditionally advocated for residents of nursing and residential care facilities. In 2008, the state added one additional full-time staff person to the

existing LTC ombudsman complement employed by the Board of Aging and Long Term Care (BOALTC), an independent state agency that sits outside of the Department of Health Services and the Medicaid program. The LTC ombudsman program then cross-trained all the regional ombudsmen whose job responsibilities now included advocacy for residents of long-term care facilities, as well as seniors enrolled in Family Care.

For individuals with disabilities, the state pursued a competitive procurement process, which resulted in a contract award to a nonprofit entity, Disability Rights Wisconsin (DRW), which also serves as the designated Protection and Advocacy agency. With a staff of eight MLTSS ombudsman located in three offices across the state, supported by a program manager, intake specialist and program attorney, DRW's ombudsman program, the Family Care and IRIS Ombudsman Program (FCIOP), works with Family Care enrollees age 18-59 with physical or developmental disabilities.

By design, the original long-term care ombudsman program was housed at the autonomous BOALTC where it would not encounter conflicts-of-interest with the Department of Health Services agencies responsible for funding and regulating nursing facilities. This strategy also informed the state's decision to add MLTSS to the ombudsman program's portfolio in 2008.

The structure in Wisconsin also illustrates the appeal of leveraging existing infrastructure (the LTC ombudsman staff and administrative structure) when a state builds ombudsman services into its MLTSS program. With an existing staff, already experienced in advocating for seniors, and located in offices across the state, the BOALTC was in a position to rapidly integrate the MLTSS ombudsman responsibilities into its scope of work.

Addition of the MLTSS population to its caseload – with most seniors receiving services in HCBS settings – could also be seen as a recognition by the Wisconsin Board of Aging and Long Term Care that nursing facilities are no longer the dominant means of providing long-term care to seniors, as rebalancing has steadily shifted the locus of care to home and community-based alternatives.

However, dividing the time and attention of the ombudsman staff between institutional settings and managed care may create new challenges. As the director of the program has acknowledged, Wisconsin initially encountered "cultural misalignment" when BOALTC added MLTSS ombudsman services to its LTC

ombudsman program, partly because the culture, processes and organizational imperatives of a skilled care facility differ significantly from that of an insurance company. Moreover, ombudsmen began working in long-term care facilities four decades ago and their advocacy role in those clinical care settings is well-established and accepted by the industry. In contrast, the use of ombudsmen / patient advocates in MLTSS is a relatively recent phenomenon, and many of the managed care organizations now providing MLTSS are unfamiliar with the concept.

Finally, it will be important for states and CBOs to ensure that, in leveraging an existing program, such as the long-term care ombudsman, resources are not diverted that could compromise the effectiveness of the original program. In funding the ombudsman demonstration for duals financial alignment states, MMCO explicitly required that states "not divert resources from or diminish the capacity of existing consumer protection services . . . [and] avoid compromising the capacity of the State or designated entity to provide current services to its existing service populations."

As noted earlier, Wisconsin took a different approach when implementing MLTSS ombudsman services for people with physical and developmental disabilities enrolled in Family Care. DRW's mission and history of advocating for persons with disabilities proved an advantage when it took on the MLTSS ombudsman program. As Wisconsin's most prominent advocacy organization dedicated to serving adults with disabilities, DRW had extensive experience with the long-term care delivery system serving disabled adults, including consumer-directed models, as well as Medicaid and Medicare law.

DRW added new staff to carry out the MLTSS ombudsman function and introduced a "firewall" between its existing programs and the new ombudsman program. DRW's hiring criteria emphasizes familiarity with the HCBS system for adults, and previous experience interfacing with the Medicaid program and managed care organizations.

The types of advocacy that the MLTSS ombudsmen at the Bureau of Aging and DRW engage in on behalf of Family Care enrollees closely resemble the MLTSS ombudsman programs in Hawaii and Minnesota. Significantly, both the BOALTC and DRW have in-house legal counsel and routinely represent beneficiaries at grievance hearings and fair hearings. Both agencies' organizational status (the BOALTC as an independent state agency, and DRW as a nonprofit), mission (advocacy), and separation from the State's MLTSS financing and contracting

apparatus afford them the license to represent beneficiaries directly in these proceedings without raising questions of intragovernmental conflict. As with the Hawaii and Minnesota programs, both the Bureau of Aging and DRW endeavor to maintain positive, constructive relationships with all the key players in the Wisconsin MLTSS system, including the MCOs, the state Medicaid agency, contractors / providers, and agencies such as the ADRCs (where financial eligibility determinations and options counseling occur).

Their ombudsman work also brings them into contact with contractors (network providers, such as nursing or assisted living facilities, homecare agencies, transportation or meal providers, etc.). Some of these interactions – involving reimbursement disputes or care plan changes with the Family Care beneficiary often caught in the middle -- require intervention and mediation by the MLTSS ombudsman between the provider and the MCO. This further illustrates the implications of conflict-of-interest on the part of the CBO: AAAs or CILs cannot act as MLTSS ombudsmen – a role that could bring them into conflict with providers – if they contract with or conduct oversight of those providers . . . or are themselves service providers in the MLTSS system.

Acknowledgements

The information in this paper was collected during a pre-conference intensive held at NASUAD's 2013 Home and Community Based Services Conference. That intensive was supported in part by a grant from The SCAN Foundation—advancing a coordinated and easily navigated system of high-quality services for older adults that preserve dignity and independence. For more information, visit www.TheSCANFoundation.org.

To request technical assistance or to learn more about our work in MLTSS, please contact Camille Dobson, Deputy Executive Director, at cdobson@nasuad.org.

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