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Good afternoon everyone this is Adam Mosey from NASUAD. Many thanks to everyone for joining us for today's webinar . We are very excited for you to hear from our esteemed panelists today. We have Camille Dobson from NASUAD and Deanna Clingan-Fischer and Kelli Todd from Iowa's State Long-term Care Ombudsman Program office. A brief word the background, Camille Dobson is the deputy executive director for NASUAD and has significant experience working with Medicaid managed care including at the federal centers for Medicare and Medicaid services. She is also a nationally recognized expert on managed long-term services and supports. We are also very excited to have Ms. Deanna Clingan-Fischer with us today who is currently the state long-term care ombudsman for Iowa and has had a career working and elder services and elder rights for over two decades.

We also have Kelli Todd , Iowa managed care ombudsman coordinator also with us today. Please submit, and feel free to submit them throughout, comments and questions through the Q&A feature which is located at the bottom right-hand side of the webinar screen. Feel free to submit questions throughout. We do have a question-and-answer period planned for the end of the webinar.

Also there is live captioning available for the webinar. If you look to the bottom right-hand corner of your webinar screen and click on the multimedia viewer panel, you can click on that, briefly submit your information and then the live captioning should become available immediately.

And what that I will hand things off to Camille.

Great good afternoon, everyone. I am here today to follow-up on the webinar that the ombudsman resource Center put together in January that gave you the grounding around Medicaid managed care and how it is and how it operates. This 201 is really going to take us in detail about how Medicaid managed model works for long-term services and support and also talk a little bit about the special protections that are given to enrollees in an MLTSS program through the at Medicaid managed care rules engaged rules and then I will turn it over to Deanna and Kelly to talk about how that process and those requirements are really working real-time in the state of Iowa.

Without any delay we will get started. Adam, what I will do today is talk a little bit about MLTSS, the new requirement, and how the long-term ombudsman can participate.

What is MLTSS? It is actually the delivery of long-term services support either state plan services such as personal care, home health , as well as waiver services,] things like supported employment, peer support , personal assistant, chore services , assistive technology , home modifications, things that are delivered for individuals with disabilities and older adults, that's to help them live safely and independently in their home and so those benefit packages -- those benefits are delegated to a health plan to provide under arrangements but it can also include nursing facility services and in most states it

does include long term care facility services as well as community-based services .

In most states, the health plans that are contracted to deliver LTSS also provide acute medical services to the same enrollees , so they provide a comprehensive one-stop shop as it were delivery system for Medicaid consumers.

I get this question a lot when I speak around the country about MLTSS, wire states doing it, and this first bullet -- the slide tells most of the story. The reality is that the last year that federal data was available, that was two fiscal years ago, LTSS expenditures and represented about a third of the Medicaid budget across the country , and those services still remains out largest set of services that remain in the fee for services to because as you heard in January, for the acute and medical care services, the vast majority of states have put those in managed care plans across the country, and what it does essentially is have a person treated sort of completed separately.

On top of that, what we found is that of those total, those hundred \$46 billion in spending on long-term services and support , the majority of it is spent on fewer than 10%. The rule of very few number of users using up lots and lots of services really cause problems for the entire system.

States also prefer a managed-care system because they have a better opportunity to enforce some accountability, so you have got a couple things. The health plans have a focus on the consumer themselves rather than specific services, they are looking at the whole person, and the financial arrangements that the state has with the health plan gives the plan incentive to try and work to keep people healthier and keep them in the least restrictive setting that is appropriate for them as long as possible.

They also find it administratively simpler. For example, a state that has three or 4000 individual and a community-based service provider, the state has to manage it with each of those providers. In a managed-care system states have only got to contract of say four or 10 health plans who in turn are responsible for managing those relationships with providers on the ground . It does free up resources and allows the state to be very focused on accountability and oversight.

The states get budget predictability out of a managed-care system. Fee for services is widely varies depending on how many services are actually rendered to a particular Medicaid person.

However, within managed care, the state has a pretty good idea of how many people they are serving and they know exactly how much it is going to cost because they give a fixed amount to each plan every month.

And then last, but not least, and the number of states focus on this, they are using managed-care to help rebalance their system to encourage and allow individuals who might be in an institutional setting like a nursing home who would like to move back to the community or stay in

the community and defer an admission to a nursing facility to do that in the plans have incentives to do that in the way they are paid and in the contract requirements that the states put in.

This is a graph that I show across the country which has our most recent data which shows the percent. This graph shows the percent of total long-term services support spending that is spent in the community. Those bars show the community spend and you have got basically forgot all the way to the left that spends about 80% of its total LTSS dollars and community services and Mississippi all the way on the right-hand side that is about 30%.

The medium is just over 50% which is very exciting because that happened for the first time last year, and states really many times want to move their state to the left of that bar. They want to continue to move up to the higher percentage bars for two reasons. One I talked about money and the fact that actually serving individuals in the community is less expensive and preferable and having them in a nursing facility if that is appropriate and desired, and they are also under pressures from [ Indiscernible ] to provide services in the least restrictive setting and so there is a desire both operationally and financially to drive more community-based settings.

However, I will tell you that the graph that you just saw is misleading because that shows total LTSS expenditures. What you don't see under that is the breakdown between populations. In those numbers shows a very heavy community spend for a number of those states that reflects the individuals with intellectual and developmental disabilities because 75% of those consumers with those conditions are served in community settings and that has really come about because of widespread closure of facilities across the country and a strong pattern of family caregiving, including parents, and keeping adult individuals at home.

Only 40% or thereabouts of older adults and people with physical disabilities are served in a community, which is an improvement from 22% but still provides lots of opportunity for those facilities the downside and for allowing people to move into the community if they want to.

This is -- MLTSS is a delivery system has blossomed in last five or six years. This is a map that I use quite often to show where we were seven years ago. A handful of statewide programs that are in dark blue on the map here, and a handful of regional programs that are in sort of the lighter blue, that would include big states like California and Texas and New York and Wisconsin that had specific counties that had managed long-term services and support.

Now when you see 2017, this map shows a couple of things but those regional programs that were in California and Texas and New York are now statewide and cover most populations. We have got the dual demonstration initiatives that came out of the Affordable Care Act has popped up in a number of states, including South Carolina, Ohio, Virginia, and then we have got a number of states, at least four states in purple that are actively procuring or in the process of implementing

a MLTSS program , and another five states in green that have told us verbally in our surveys and interaction with them that they are interested in moving to a MLTSS system in the next several years .

So you have got a swath of sort of the upper Northwest . There a lot of rule states that don't have any managed-care for any populations and then scattered pockets around the Great Lakes and the South, but really is becoming a growing trend across the country.

There are a lot of things I could talk about MLTSS, that's one of the things we want to focus on today, are the requirements and federal regulations for consumers that are enrolled in a MLTSS program. One of the things that's like I was at CMS and with a managed-care will was being adopted and the rapid expansion of MLTSS programs in 2011 through 2014 really cause CMS to take stock of the kinds of protection and kinds of program elements that CMS felt were for the beneficiary protection and also for the strength and effective operation of the aspect of a MLTSS program to be in place as well as key elements was the beneficiary support system . CMS started requiring it in 2013 when my team issued a key elements document that outlined the things that a state needed to be putting in place and their MLTSS programs if they were going to seek CMS approval. Those elements have now been incorporated into the Medicaid managed care regulation that were finalized last May.

There are couple principles that we drove off around this piece for beneficiary support in the first is consumers, especially those that need long-term services support need support and education throughout their enrollment and their experience in a MLTSS program, and that support is more readily accepted and people engage with it if they are - it is received from an independent trustworthy source of information. In other words, not by health plans. If you are having trouble with a health plan being directed back to the health plan without any other source of assistance is really not the best outcome for individuals whose needs are regular and ongoing and tend to be the most vulnerable of our Medicaid beneficiaries.

This requirement means that states have got to create an advocate or an ombudsman for consumers receiving trends report that is a requirement that they can expand it to individuals that are probably enrolled in a managed-care program but they don't have to and I'll just stop your and say we use the word ombudsman I think probably it was a poor choice of words at the time from CMS. It really should have been called the consumer advocate position or something else because the term ombudsman, as you all know is a term of art used for the state want term care ombudsman under the older Americans act and so there has been a lot of confusion about what a managed-care ombudsman does versus ace state long-term care ombudsman using the same term is not helpful .

Be that as it may, that is unfortunately the term that is being used and so it really requires some very clear to definition and guidance about who's doing what in the state program.

These are the core functions on the slide, that the ombudsman office, the managed-care, but LTSS office is supposed to provide and so we have a place for a member to call if they have got concerns or complaints about their health plan that is not the health plan, the helping of individuals to try to informally resolve the issues with the plan if at all possible, helping members understand their appeal rights to get different decisions around services within their managed-care plan, helping them file an appeal or figuring out what they need as documentation, referring them to the state fair hearing process if in fact they have a decision from the health plan that they don't agree with them in last, but not least, referring beneficiaries and consumers to legal counsel if they need to have legal counsel and representation for their state fair hearing.

CMS does not specify where this ombudsman function or advocate function needs to be housed. It can be state managed as CMS prefers it not be in the Medicaid agency if at all possible because they are doing oversight of the health plan and the intent is purposeful to be independent. In some states that function has been embedded with the state long-term care ombudsman program or can be contracted out and go out for proposal to have a nonprofit or some other entity managed that function on their behalf.

And then one of the last pieces I think is the most important and critical actually for strong MLTSS program is ombudsman has eyes and ears in to the system and they do just that they can be very, very effective in identifying trends and patterns across health plans. So rather than one health plan might know what their complaints and grievances look like and just another might know which conceals or having the most complaints, which topics are most frequently asked about? Do they find regional variations? That information can be funneled back to the Medicaid agency for engagement corrective action with a health plan for identification of policy changes that might be needed. It is a very, very good quality and movement and quality insurance -- assurance operation.

I mentioned it briefly that this is a potential opportunity for the long-term care ombudsman. The states have seen this as a natural skill set fit with the SLTCO. Because your work does make you work already with the individuals navigating nursing homes, problem-solving process, your skill at managing appeals and grievances, understanding how to be an advocate for the present of a nursing home, although skills really lend themselves to this work as a LTSS ombudsman. What I have got here on this slide is a chart that shows you of the states that actually have a LTSS ombudsman or what we call managed-care ombudsman in place who is actually providing it and if you just do a quick glance down about half of those states to actually have that function embedded in their state long-term care ombudsman office. It is a pretty nice mix of that function, a couple states actually have it in their sister state agency and then a handful have them actually contracted out, the largest of which is in Wisconsin and in New York and in California where they have actually contracted that out to nonprofits, typically legal aid or disability rights organizations who handle that work.

You'll see a couple states are highlighted with notes that they don't have a MLTSS ombudsman in your state might be among them. If you see it does matter that is primarily because those states had long-standing pre-existing LTSS programs prior to the guidance coming out in 2013 and the regulations in 2016 requiring it. The expectation I think is that as CMS reviews those programs on an ongoing basis -- I would have said typically that CMS would be asking the states to build that function into their programs. I'm not sure that is currently where the leadership at CMS is at on this issue but you could see states like Arizona and New Jersey, Tennessee and Wisconsin has one voluntarily, but those other states being asked to create a program specifically for their MLTSS program even though they don't have it today.

I will stop there, giving a very high-level high-speed overview of MLTSS. The beneficiary support system and what functions it provides and then turning over now to Deanna and Kelli from Iowa who can talk to about the real-life experience of action providing those services.

Great. Thank you so much but before we send things over to Deanna and Kelly are just want to remind everyone that if you do have questions to please submit those through the Q&A feature.. We do have time for Q&A at the end but feel free to submit them now and we can go through them once we get the second presentation.

Okay. Is what I believe I am on. This is Deanna and I and the state long-term care ombudsman for Iowa. Our role today is to really talk to you a bit about the Medicaid managed long-term services and supports program and how we interact and have interplay with the long-term care ombudsman program.

Kelli and I kind of decided I would go ahead and be the one that led us through this discussion and then Kelli will be available for questions and answers after the period of time of our presentation if you are interested in hearing more about our programs is also available off of this call to talk about how I what is structured it's managed-care program.

Kelli is the program manager for the managed-care ombudsman program here in Iowa.

I think it is important to start out with just a little bit of background on how our program and how our office operates. In Iowa, the office of the long-term care ombudsman really has two distinct and parallel programs. Our first program is the long-term care ombudsman program and in the second program is the managed care ombudsman program. Within the long-term care ombudsman world where the state and local, we call them local versus regional ombudsman as well as our certified volunteers. We also have a volunteer ombudsman program coordinator and a discharge specialist. With Don that in the managed-care ombudsman program whenever program manager and we have managed-care ombudsman.

Most of you and long-term care ombudsman world are aware of this, but the basis of the long-term care ombudsman care is through federal older

Americans act. In Iowa we codified the older Americans act portion of that requirement into our state law, which is the [ Indiscernible ] and although it doesn't older Iowans, we do serve anyone that resides in a nursing facility, residential care facility, assisted living program or elder group home regardless of age.

[ Pause ]

The Iowa managed-care ombudsman program is also that authorized by CMS guidance. Escamilla alluded to, and we actually did codify that guidance into state law to give us some support and that can be found in the same ombudsman chapter for the long-term care ombudsman authority. We can be found in the older Iowans act as well.

The managed-care office program advocates for people who reside in healthcare facilities, assisted living programs, group homes as well as for those seven home and community-based waivers programs. And we have found it very beneficial to actually have both programs within the same office and we collaborate on mutual issues of concern, and it is just a great way to be able to best serve the people we are here [ Indiscernible ] perks but the master functions within Iowa are dedicated to providing education and information to those members that reach out to our office. We advocate and provide outreach perked we make people aware of our existence. We have two -- new member packets that are sent also that members can be aware that they have an advocate in the corner and available to reach out to us.

We do assist with grievances, appeals, state fair hearings, we provide information, and certainly read -- legal referrals if a member should choose to have an attorney and do so.

We collect data and we give reports to CMS to come onto a state legislator, to the governor's office, as well as our state Medicaid agency, and we develop and maintain systemic collaboration because not only is it individual advocacy that we are about but we also look at the whole system to say what are the pitfalls are downfalls of the gaps within the system that we can bring to the attention of the Medicaid agency and to bring about resolution because the impact a tremendous amount of members.

In the beginning this was a few years ago, Iowa decides transition from traditional fee-for-service Medicaid for Medicaid managed care and delivery system for long-term services and support, that is a multiple. We looked at CMS guidance and of course as Camille mentioned it requires an ombudsman function to exist. Are Medicaid agency put out a request for proposal, RFP, which stated within their that it would take one of -- the role would be fulfilled by a current state ombudsman program. That left it to basically two programs, the state ombudsman, which is the ombudsman entity in our state and a match most of you have this that takes on complaints regarding state and local government. They are complaint based. They are not advocacy based. The other type of ombudsman program in our state is long-term care which of course is very advocacy based.

Early on our two offices met to determine which one of us would throw in our hat to become the managed-care office program and it was decided that the state office program did not feel it was in the wheelhouse because they were complaint based and not really advocacy based, but I will tell you now that we have been in this for about a year we have developed a great relationship with our state ombudsman program and we have parsed out how each of our programs help don't members and the providers who have issues.

That is how we get started and pulled into this managed-care world. The Medicare it agency then submitted their waiver to CMS that happened to mention our office says that managed-care ombudsman. We worked with them. We tried to get ourselves up to speed very quickly. CMS came into our stay, do the readiness review and an on-site visit.

At that point when it looks like reality was going to destroy our office was going that was going to our program, we start having discussions with legislators and the governor's office because we wanted more than just a CMS guidance. We needed legal authority under the code to be able to take on this task and funding, quite honestly, and staff. We did not have enough long-term care ombudsman staff to meet the need of the managed-care ombudsman program so we were successful in that pursuit. Iowa code and 30 began in July 2015 and he gave us funding for two positions which may not sound like enough, and some days we say it was not, but it actually was not and I'll get to the last bullet in the second.

We did start with two positions and we were thrilled to get those positions, but since this became a new program for us, we had to develop job description so we could hire people to fulfill those positions and to fulfill the mandate. We hired staff in the fall of 2015 and in Iowa we decided to hire a program manager and then to have one managed-care ombudsman. That program manager it really does the day to day program activities and then managed-care ombudsman is one it takes to complaints and does the individual case advocacy.

In Iowa we went live April one of 2016 so we did -- had been at this about a year. Last legislative session in 2016 we did seek additional legal authority, kind of like the long-term care ombudsman, we thought to be an entity that providers and NCOs could share information with without worrying about violating Phipps and we did get additional funding for one bondsman. Now we have three.

When we got the word that we were going to be the managed-care ombudsman we tried to model all program after best practices from both the long-term care ombudsman program as well as what other states were doing related to managed-care. We quickly discarded and discovered that Iowa was unique and how they were approaching it in many states may think that as well but one would reach out to the other states no one really could fit the mold that Iowa was going down the path for, so we developed our own program based upon best practices from the programs of other states as well as internal from the long-term care side of things.



We decided to develop a parallel program to the long-term care ombudsman program.

We drafted policies and procedure manuals. We directed administrative rules which we have now filed a because we are trying to get our code section cleanup before we file the rules, but an independent program, not subject to undue influence.

The managed-care ombudsman program and long-term care ombudsman interact . The interactions are such that all the work for the program is conducted with state funds. Older American's Act dollars are intended only for the long-term care ombudsman program. They are not used for the managed-care program, but the state long-term ombudsman does see over that oversee All state activity. Our office, also has a Medicaid assistance advisory council and I have appointed Kelli Todd to serve as our representative.

Just some general reflections, what needs to be done to implement managed-care ombudsman program within a long-term program, you really have to start and sit down and learn, learn about what is the managed-care ombudsman role, what how does it differ from long-term care ombudsman role, and does it differ? Have to learn a lot about Medicaid. We had a brief knowledge base, a very cursory knowledge base about Medicaid and eligibility and waivers but to be as effective advocate we needed to learn a lot more, and we did that to individual meetings with the Medicaid agency in different MCOs and providers.

And reading. Reading a lot. We reached out to other states to learn other programs operated. It is imperative that you read each of the contracts between the state Medicaid agencies and the MCO to see what they are agreeing to, what are the rights of the members, to read the member handbooks, to build the referral network for members. We knew the long-term care world from the perspective of a nursing facility and assisted living and aging network but we really did not have the same network for persons with disabilities or persons under waivers for the piece of it works but we met a lot of people so that we could determine what was an appropriate referral to the members we were serving.

We also provided network. We had initial meetings and we had must continue does my continued a monthly meetings with her Medicaid state agency, each MCO, providers and our protection and advocacy and the state ombudsman program.

To start the ombudsman program you need to determine what type of structure do you want . In Iowa we start with program manager and a management care ombudsman. A program manager looks at systemic issues and really the face of the program. Are managed-care ombudsman receives a complaint and investigate any work to resolve those concerns with the and Medicaid agency.

In order to get started you need to really consider what software system so we use, what case management system do we need to collect this data to effectively meet the new members needs and how do we collect data? And we need to determine what data needs are so that we

can report that to the Medicaid agency and CMS and we do report that information monthly to our Medicaid agency as well as CMS. That information is on our website which is Iowa aging.gov if you are interested. We have a monthly report that is to and as a program stands we decided there a lot of systemic issues that we were not necessarily addressing within our quarterly reports or pointing out, so we decided to do it up quarterly report which really sums up to three months with the data and then also highlights what are the systemic issues that are program has been addressing during that timeframe. For the monthly report there is this contact for any other issues, what types of calls and the quarterly report which was using to develop an annual report looks more high level at what are the numbers per quarter as well as what are some of the systemic issues that we were involved in and seeing.

Another key piece of this is how is managed-care program going to interact with long-term care ombudsman program and as I said earlier we saw very beneficial. We were able to make referrals between each other, to and from things like closures, on issues like provision or lack of services to residents and members, M.D. SQ, and transition to the community, discharges on involuntary discharges as well as with the assigned case managers.

We reviewed the long-term care ombudsman program and modeled them for the managed-care program. You have to have some discussion about disclosure of records and confidentiality standards between the programs. We modeled our ship of privacy rule for for a long-term and that was given from and we had joint meetings for consultations and we provide educational sessions for each other.

Some of the challenges, and I think this is my last slide, but I'll does make some of our challenges have really been creating a program that just as general guidance and some guidelines to establish but there were no real regulations when we started out, not like the Older American's Act which says this is what a program will look like, and so we really hoped that our program could become a model for the nation so that desperate because we really did put a lot of time and energy and thought into how this program should look and act and best meet the needs of the members that we serve. That had not previously existed in our state so we really started from scratch trying to figure out what this is going to look like. Access to CMS is a little bit different than from the long-term care perspective because in managed-care most of our communications flow from the Medicaid agency and they are not directly with CMS themselves. And then our authority. Certainly we need to ensure that all parties understand the managed-care Ombudsman role and authority to receive confidential information, to access medical and administrative records and Medicaid client eligibility data, and at times I will be honest. We still do find that to be a challenge.

And with that I will leave you with our information. If you have any questions or you would like to reach out to us or visit our website, there is a lot of great information on our website about managed-care Ombudsman program. We have a lot of fact sheet publications and a monthly reports as well that you might find interesting to look at.

Great. Thank you so much. We have plenty of time for questions. We have had a number of questions come in through the Q&A. I think along to your presentation you may have answered some of them, but there are still some, and what I will do is read the question out loud so that everyone can hear it and either Iowa folks or Camille or myself can try and get all the different questions answered.

Our first question is how will managed-care be impacted by the new AHCA a American healthcare act and changes that are planned to Medicaid.

I will take this one.

Thank you but I think it is too early to say. The new Sec. of HHS, Dr. Price and the new CMF administrator sent out a letter to the governor's last week signaling new flexibilities for states as they operate their Medicaid programs. They did say they were taking a look at the Medicaid managed care rule but no indications about what parts of the rule might be changed where there may be additional flexibility so I think it is too early to tell. We just don't know. I think these requirements for beneficiary protection have been pretty widely treated with a lot of six sort of joy and praise, so hopefully there are other areas of the regulation that would be first for some additional flexibility. I think the states have really against so I'm not sure I can say too much more than that. It is a little too early to say.

My second question is are the Iowa volunteer Ombudsman for both programs the same?

This is Kelli. At this time our volunteer Ombudsman program currently supports the long-term care Ombudsman program at this time we don't have a volunteer Ombudsman program specific for the managed-care program, but we are certainly open and keep the conversation on the table as we discussed and evolve the program over the course of time perspective is interaction with the in terms of the training that we do just make sure that we feel comfortable to stay in a absurd questions high-level about the managed-care Ombudsman program and they are always welcome to refer any questions that are specific to managed-care to our program, but generally the interactions are primarily referrals and then just educating them on when best to contact us and giving us high-level education about the program.

And I will add that the managed-care Ombudsman program works differently than the long-term care Ombudsman program in the sense that the managed-care program works primarily from the office, and they were to resolve issues over the phone. Does not currently do home visit, and while we educate members on how to file appeals and grievances and fair hearings we don't necessarily go to them to help fill out the paperwork. We involve the legal services providers to help with that, so there is currently less need to have volunteers since we are not going into each of the facilities.

Thank you for that response. The next question one of the attendees notes that Pennsylvania starting managed-care long-term services in

2018 has been advocating for an MLTSS Ombudsman but said told know because of the cost and the status saying that it is not a requirement for the beneficiary support system. The plans use legal services, but not for typical Ombudsman services and they are asking for advice.

This is Camille. I am concerned about that statement because I have not tested I'm not quite sure exactly , I was Pennsylvania has gotten specific approval from CMS to not follow that part of the regulation, the beneficiary support system is a core part of the managed-care effective next July. I don't want to comment any further because I am not privy to the conversations and what is going on with the state , so I am wondering if perhaps the state is just because put together desperate they don't have to hire a Ombudsman per se. I wanted to stress the fact that there are functions that the encompass a beneficiary support system and there are a couple states out there that did not hire a formal Ombudsman, but pieced together from their existing systems and additional capacity building the functions that provide, and that may in fact be the approach Pennsylvania staking. I don't honestly know and so I'm reluctant to speak anymore about it, but I will query our state contacts after the call to see if I can get some additional information on that.

Okay. The next question that's a critical different questions related to funding, and one of them was where does operational funding come from the managed-care Ombudsman program.

Deanna spoke to the way it's being funded in Iowa. I think like Medicaid, the joy of Medicaid is that there is no one single approach to funding across the country. The states that are running dual eligible demonstrations, so there are nine states that have dual eligible demonstrations, CMS actually provided grants to those nine states for them to build a Ombudsman function and so that money, listlessly for the first three year period is coming from the federal government completely , and the states are asked to figure out a state ability strategy after that funding ends. At least a handful of states are accessing Medicaid administrative funds for the program where the federal government matches those expenditures 50%, and then I think as Deanna said, there are a couple states that are actually provided state funds to build that function.

And I will add in Iowa we are in the process and have been in the process for a few years to work with their Medicaid agency at CMS to bring Medicaid claiming into the state to help offset the expense of the Ombudsman program.

It is not an easy task.

It is not. That is what I will say.

[ Laughter ]

Very challenging.

Yes.

Our next question is Iowa that fact does I will keep track of the Ombudsman activities in the same system as a long-term care as -- Ombudsman activity.

This is Kelli. We are using two different systems for each program. Currently the local long-term care Ombudsman program uses manager and has been doing so for several years and in assessing what kind of system the managed-care Ombudsman program would use, we looked at a variety of different options and had determined that that point that we would just build something in-house so that we could collect all the data that was specific to our needs. Some of the variables and Ombudsman manager was not necessarily conducive to some of the data collection elements that we were deciding to collect. I am a researcher by trade, so there were a lot of questions that I had, and therefore various data elements needed to be collected to be able to answer some of those questions, so they are separate.

Thank you, Kelli. Our next question is how our MLTSS Ombudsman programs funded in states using 1915 waiver struggle much does it cost to operate the Ombudsman program.

Good questions, but unknown, as typically for Medicaid, there is not a lot of good data around costs and expenditures. For states that are using Medicaid money, so example, Deanna because in Iowa they are using state funding, she is a good idea of what her budget is and how much money it is costing. In states that are using were Medicaid money, matching money is paying for the managed-care Ombudsman piece, probably not so obvious and there is not any information research that I've seen out there that keeps track of it. It can run from a handful of people, for example in some states, a couple states only have one person trying to manage all of it. A state like Wisconsin has got a very broad and deep program that is well-funded and long-standing, so I think it sort of runs the gamut and it really depends on the staffing that you have got and desperate in a particular state is the primary driver for the expense and the cost of a Ombudsman program that I don't know if you want to add anything there, Deanna?

I think you handled it very well.

Okay.

Our next question

-- I think, Deanna, you may have partially answer, but I will say it anyways did the question is how do you handle the entire MLTSS population with one Ombudsman? Is most of the contact of individuals done by phone?

Yes. All work is done over the phone, and we have two ombudsmen now. We have one asserted in August, 2016, so now we have two managed-care ombudsmen. Still that is not a lot to handle about 39,000, 37,000 MLTSS members. We would certainly like more.

Great. Thank you for reciting that statistic because it just answered the next question.

[ Laughter ]

We do have a couple more. Are the top complaints received by the Iowa State long-term care ombudsman program much different since the inception of managed care.

No. The complaints that come into the long-term care ombudsman program have been consistent throughout the past several years. I have been the state ombudsman for and I would say that desperate they might change position once in a while but they are consistently the same complaints that we receive. The managed care ombudsman program I believe the number one complaint is access to services.

That is an interesting question. Had not thought about it. The types of complaints that we receive long-term care program have not changed since managed-care.

Okay. Our next question is do managed-care organizations tell IDD HCBS participants to go to the Department of aging for ombudsman services? ID folks never think to look at the state agency apartment for help.

That is a very good point.

This is Kelli. The MCOs are required to share information about our office, so if they call their managed-care organization and are seeking assistance through an objective or independent advocate, the MCOs are required to tell them who we are and how to contact them. Our information is also included with their right in appealing a decision made by the managed-care organization or filing a grievance if they are unhappy with -- for whatever reason that might be.

And you are correct. The person would not necessarily think about the Department of aging as the entity to contact for personal disability, but we really worked hard to try to network with those associations and the networks that serve those folks so that they are aware that we are housed in the Department of aging but we serve all people under Medicare managed-care long-term services.

And I will add that we track also which program individuals are enrolled in who are contacting our office and individuals enrolled on the ID waiver caring I was consistently one of the top three programs at contact our office I feel like that is indicative of people knowing who we are and making sure they know how to contact us.

I was going to say there are a couple states that actually because of that issue have tried to sort of brand and give their ombudsman's function a name to separate it instead it apart work that is easier said than done in those are larger states are typically have a larger budget to be able to do the marketing and branding, but I agree with you. It is not just for people with intellectual development but also individuals with disabilities that don't typically turn to a Department

of aging, and so I think Kelli is right to advertise it as -- while it might be housed in the Department of aging, it is sort of unique function.

Okay. Our next question is the managed-care ombudsman a licensed nurse?

No. Neither one of them have a nursing background.

Okay.

Our next question is I assume this pertains specifically to Iowa, are all nursing home residents covered by managed-care?

No. Only those -- certainly private pay individuals that are paying a different format are not covered by managed-care, but if they reside in a long-term care facility and someone else's not paying the bill, whether it is Medicare or themselves or a long-term care insurance policy and they are on Medicaid, then yes. They are on Medicaid and them in a long-term care facility they are part of the managed-care program, but if they are private pay for other mechanism of payment, they are not under the managed-care program.

Are there reports produced for stakeholders about the managed-care ombudsman function in Iowa that might be shared? In reference couple different things available on your website.

Yes. On a website with a variety of different reports, tools and resources. And you go to our website you will see that there is a link for members and there is a link for providers. Under those links you will find a brochure and overview about who we are, what we do when we serve, what kind of facilities to recover, and then some of the services that we provide, those are just high-level examples to give readers an example of what we do, essentially.

We also have a bookmark on members rights. We have another brochure high-level again covering grievances appeals and figure it does make area recently wrote specifically for the process. We also -- we are kind of a catchall and we are okay with people calling us when they don't know where to go, but we don't provide all the services that individual may need, for example, as Deanna had mentioned, legal services are legal representation, so there's also a document that you can find that provides additional resources for people who have a specific need that fall beyond our ability to meet, which they can contact those organizations to get the services.

The reason why bring up the provider stuff is to know that oftentimes we work closely with providers, caregivers, case managers, often times they call us to troubleshoot on issues that they might have in working with the members, so as we were building the program all, we wanted to make sure the people understood that we are not advocates for providers but we do provide doesn't understand the interaction with providers and impact they have and the members that we serve, so we tried to create material specific for them to help them work with their members and navigating the managed-care system. We also as Deanna had mentioned,

you'll see a tap on our website that is specific to reports, will promote the report, quarterly and then on our website, not in that same location, but nearby is our annual report for the office. And are website is Iowa aging.gov and when you get on it click on this office of long-term care ombudsman.

Excellent. We are just at 4:00 Eastern time, so I think we should wrap things up. If folks still have additional questions, feel free to email me. My email is amosey@nasuad.org. Feel free to reach out and I can forward your question or answer myself. A copy of the slides, recording and a copy of the live caption transcript will be available on the NASUAD page under long-term care ombudsman section of our website and will be available in approximately three or four days to go get all the information up, including the slide decks.

Thanks again to Deanna, Kelly, and Camille for their excellent presentations, and question and answer session and I hope everyone has a fantastic day. Thank you.

[ Event Concluded ]