State Approaches to Developing and Operating Ombudsman Programs for Demonstrations under the Financial Alignment Initiative

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IN BRIEF

Ombudsman programs can offer beneficiary protections as part of Medicaid managed care programs. These programs are particularly important for beneficiaries with complex physical and behavioral health conditions, including many dually eligible individuals. For the demonstrations under the Financial Alignment Initiative, the Centers for Medicare & Medicaid (CMS) and states incorporated ombudsman programs to help to resolve enrollees' problems and alert Medicare-Medicaid Plans (MMPs), states, and CMS of emerging trends and issues. This technical assistance brief compares approaches that states took in structuring ombudsman programs and discusses the benefits and challenges of both models. It also examines the services offered by ombudsman programs and the value these programs have brought to the demonstrations. This brief is designed to help state Medicaid agencies that are developing beneficiary support systems or implementing new integrated care programs to better understand the full range of beneficiary needs within their dually eligible populations and how ombudsman programs or similar support systems could bring value to their efforts.

Introduction

People who are dually eligible for Medicare and Medicaid often have multiple chronic physical and behavioral health conditions, long-term services and supports needs, and risk factors related to social determinants of health.[1,2] Despite these challenges, the lack of coordination between Medicare and Medicaid often makes it difficult for them to access needed care and increases program costs. Under the Financial Alignment Initiative, first announced in 2011, the Centers for Medicare & Medicaid Services (CMS) and states are testing new payment and service delivery approaches that fully integrate care for dually eligible individuals.[3]

CMS and states sought to ensure that demonstrations under the Financial Alignment Initiative would include beneficiary protections – ombudsman programs in particular – that would help to resolve enrollees' problems and alert Medicare-Medicaid Plans (MMPs), states, and CMS of emerging trends and issues.[4] States took one of two approaches in developing demonstration ombudsman programs. Some states (for example, Illinois, Ohio, South Carolina, Texas, and Virginia) funded their Department of Aging to perform this function or otherwise located the ombudsman within a broader health and human services agency,[5] while other states (for example, California, Massachusetts, Michigan, New York, and Rhode Island) contracted with non-profit organizations.

This technical assistance brief compares these approaches and discusses the benefits and challenges of both models. It also examines the types of support offered to beneficiaries by ombudsman programs and describes the value these programs have brought to the demonstrations. To inform the development of this brief, ICRC interviewed state Medicaid agency staff in California, Massachusetts, Ohio, and South Carolina who oversee the demonstrations in those states; staff from each demonstration's ombudsman program; staff from the Medicare-Medicaid Coordination Office at CMS; and staff from the Administration on Community Living (ACL) (see **Appendix**). The CMS staff interviewed coordinate CMS activities in each state demonstration, and the ACL staff provide support to ombudsman programs. We also interviewed ombudsman staff in Virginia for perspective on how the ombudsman program there transitioned from serving demonstration enrollees to enrollees in a new statewide integrated care program administered through aligned Dual Eligible Special Needs Plans (D-SNPs) and managed care organizations providing Medicaid managed long-term services and supports (MLTSS).[6]

This brief is designed to help state Medicaid agencies that are developing beneficiary support systems or implementing new integrated care programs to better understand the full range of beneficiary needs within their dually eligible populations and how ombudsman programs or similar support systems could bring value to their efforts.

Ombudsman Program Structures

The four states interviewed for this brief used two different approaches to designing a demonstration ombudsman program: 1) leveraging internal state government agencies or departments; or 2) contracting with non-profit organizations (see **Table 1**). Some of the benefits and challenges of each structure are discussed below.

Table1. Ombudsman Program Structures in States Interviewed

State	Demonstration Name	Ombudsman Program Name	Ombudsman Program Structure
California	Cal MediConnect	Health Consumer Alliance	Non-Profit Organization
Massachusetts	One Care	My Ombudsman	Non-Profit Organization
Ohio	MyCare Ohio	MyCare Ohio Ombudsman	State Department of Aging
South Carolina	Healthy Connections Prime	Healthy Connections Prime Advocate	State Department on Aging

A. Leveraging Internal State Agencies or Departments

In designing demonstration ombudsman programs, states can leverage existing state government agencies. Ohio and South Carolina followed this approach by designing their demonstration ombudsman programs as an extension of their existing State Long-Term Care (LTC) Ombudsman programs, which are within, but separate and distinct from, each state's Department of Aging.[7] This arrangement offered several advantages:

- In both Ohio and South Carolina, the LTC Ombudsman had experience serving a particularly vulnerable portion of the dually eligible populations to be enrolled in the states' demonstrations – individuals residing in long-term care facilities and, in the case of Ohio, individuals receiving Medicaid home- and community-based services. Staff from Ohio's demonstration ombudsman program noted

that they were able to leverage this institutional knowledge for their work serving demonstration enrollees.

- The states' demonstration ombudsman could build on the relationships already created by the LTC Ombudsman with non-profit organizations and long-term care providers. For example, South Carolina's demonstration ombudsman staff described how they were able to resolve a nursing facility access issue because they knew the facility's administrators from their LTC Ombudsman work.
- LTC Ombudsman staff in both Ohio and South Carolina had prior experience working as State Health Insurance Programs (SHIP) counselors,[8] roles that helped familiarize them with Medicare policies, benefits, and appeal processes.
- Building on existing systems helped these states save money on start-up costs because the demonstration ombudsman programs were able to make use of existing staff, office space, and information systems. Ombudsman staff in Ohio highlighted this point by noting the importance of efficient knowledge transfer between state agencies, particularly related to data systems.

States that have built demonstration ombudsman programs within existing state systems have also faced some challenges. For example:

- In one state, it was difficult to obtain approval to hire the additional staff needed to implement the program due to budget constraints/hiring freezes.
- Differences in vision between state agencies or departments may be challenging to overcome or communications may be siloed.
- External stakeholders, particularly beneficiary advocates, may not view an ombudsman program housed within the state as being sufficiently neutral to protect beneficiary interests.

B. Contracting with Non-Profit Organizations

States can also operate demonstration ombudsman programs through non-profit organizations. Massachusetts elected to contract with the Disability Policy Consortium (DPC), an advocacy organization experienced in supporting individuals with disabilities, to administer its ombudsman program, now called My Ombudsman.[9] California opted to follow a similar approach, operating its demonstration ombudsman through a system of local, county-based legal aid entities coordinated through the Health Consumer Alliance.

Contracting with non-profit organizations to operate ombudsman programs offers some advantages to states:

- Ombudsman programs operated by non-profit organizations may be viewed by stakeholders as neutral and focused on the needs of dually eligible individuals, which builds trust with stakeholders. This was especially important in California, where some stakeholders (for example, beneficiary advocacy organizations, health care providers, and people with disabilities) were initially skeptical of the demonstration. Because the ombudsman program was housed outside of the state government, ombudsman staff in California believe they were better able to gain the trust of beneficiaries and other stakeholders. Similarly, staff from the My Ombudsman in Massachusetts noted that it was especially important that beneficiaries understood that the ombudsman program was not operated under the state Medicaid agency in order to build trust with the community.
- Ombudsman programs operated by non-profit organizations may be more reflective of the communities they serve and likely to possess the cultural competence, background, and skills they

need to be effective. In Massachusetts, 90 percent of My Ombudsman staff have a disability, reflective of the Massachusetts demonstration, which only enrolls beneficiaries ages 21 to 64 with a disability. My Ombudsman also currently has the only demonstration ombudsman staff person – across all of the state demonstrations – who is a member of the Deaf community and fluent in American Sign Language. This person has become a go-to resource, not just for the One Care demonstration, but also for a variety of other public programs across the state. California and Massachusetts have bilingual ombudsman staff to assist demonstration enrollees who speak many different languages.[10]

- Interviewees also noted that, in some states, it may be easier to obtain leadership approval to contract with an external organization to provide ombudsman services than it is to hire additional state staff to provide these services "in-house."

One potential challenge in this model is avoiding potential conflicts of interest between the provision of ombudsman services and other services that the ombudsman organization may provide. For example, both California and Massachusetts contract with organizations that provide beneficiary advocacy services and are sometimes involved in litigation against the state. To address this challenge, states can require ombudsman contractors to build firewalls between their ombudsman and advocacy work (see **Massachusetts Creates Firewall to Ensure Ombudsman Neutrality**).

Massachusetts Creates Firewall to Ensure Ombudsman Neutrality

The Disability Policy Consortium (DPC), the non-profit parent organization of Massachusetts' My Ombudsman program, engages in several different avenues of advocacy work, focusing on housing, architectural access, and community health accessibility for those with physical and/or intellectual disabilities. To create a separation between the DPC's My Ombudsman activities and its beneficiary advocacy activities, MassHealth (the state Medicaid agency) included the following requirements in its 2018 contract with DPC to provide ombudsman services:

- My Ombudsman may not share client complaint or appeals data without permission from MassHealth.
- My Ombudsman staff may not legally represent One Care enrollees (for example, in appeal hearings).
- MassHealth must review any public-facing materials created by My Ombudsman in advance of publication/distribution.

As required by MassHealth, DPC's contract also includes an explicit conflict-of-interest section. To ensure privacy and confidentiality of My Ombudsman client information and sufficient firewalls between DPC's My Ombudsman work and its advocacy work, DPC staff members who are not part of the My Ombudsman program are not permitted to access My Ombudsman's database and materials. DPC's executive director is the only non-administrative staff member shared by the My Ombudsman program and the organization's advocacy efforts. The executive director cannot access the My Ombudsman member database and does not work on the cases of One Care members, to ensure that his My Ombudsman program role does not conflict with his role in overseeing DPC's advocacy work.

Further, My Ombudsman may not post or share any information on its website, Facebook page, newsletter, or other public spaces that is political in nature or reflects a particular point of a view on any advocacy issues.[11]

Supports Offered to Demonstration Enrollees

Ombudsman programs provide a variety of services to demonstration enrollees. In some cases, those services have expanded or become more refined over time. Examples of the types of supports offered include:

- **Addressing Individual Enrollee Complaints and Appeals.** Across all of the demonstrations, the ombudsman programs' primary role is to investigate and resolve complaints and assist enrollees with grievance and appeal processes. Depending on the nature of the complaint, ombudsman staff may reach out to the state (for example, in relation to an eligibility issue), the provider (for example, about an improper-billing issue), or the plan (for example, about an access to care issue). The South Carolina Healthy Connections Prime Advocate described a situation where a hospital tried to transfer an enrollee to a nursing facility, but the nursing facility staff did not know that their facility was in-network with the enrollee's MMP. The ombudsman was able to overcome the breakdown in communication and help the beneficiary obtain the nursing facility services they needed.

  Staff from the ombudsman programs all viewed themselves as being a neutral party that can build productive relationships and work toward collaborative solutions in resolving beneficiary complaints. In Massachusetts, My Ombudsman staff described trying to get One Care demonstration enrollees what they needed and avoid having to file an appeal with the MMPs.

  Ombudsman programs can play an important role in addressing beneficiary complaints around eligibility and enrollment. In California, staff from the Health Consumer Alliance saw themselves as problem-solvers who could break down barriers between silos in the system – MMPs, county mental health agencies, county Medicaid offices, the State Long-Term Care Ombudsman, and Social Security Administration offices. Without their intervention, many beneficiaries would not have been able to enroll in the Cal MediConnect demonstration or would have lost their Medicaid eligibility and been disenrolled from the demonstration. In South Carolina, Healthy Connections Prime Advocate staff also serve as problem-solvers between the Family Caregiver Program, the Social Security Administration, the Long-Term Care Ombudsman, and Adult Protective Services. The Healthy Connections Prime Advocate has helped many consumers through the Medicaid eligibility process status and has referred beneficiaries to resources that have helped them obtain recertification and maintain demonstration eligibility.

  The ombudsman programs also educate enrollees about Medicare and Medicaid appeals processes. In South Carolina, Health Connections Prime staff believed their knowledge of Medicare and Medicaid made them particularly effective in helping demonstration enrollees to navigate the Medicare appeals process.

- **Tracking and Communicating Trend Data and Participating in Demonstration Stakeholder Committees.** As described above, Ombudsman programs use their complaint data to track and communicate trends to the state Medicaid agency, MMCO, and ACL through quarterly narrative reports and monthly data metrics. The ombudsman programs described the majority of complaints as being related to:
  - Medicaid eligibility;
  - Demonstration enrollment/disenrollment (particularly confusion around passive enrollment);

- Access to care and services (for example, durable medical equipment, medical transportation, nursing facility care);
- Care coordination (for example, care manager turnover, enrollees' ability to contact care managers, right to change care managers);
- Cuts to personal care attendant hours; and
- Improper billing of demonstration enrollees by providers.

Ombudsman program staff said that, while they continue to receive complaints, the volume complaints has been trending downward over the years since the demonstrations launched.

In addition to submitting regular reports, staff from the ombudsman programs in most states meet regularly with state Medicaid officials and MMPs. Some ombudsman staff also participate in the consumer advisory groups run by the MMPs.[12] In Massachusetts, the demonstration ombudsman has always been required to attend meetings of the Implementation Council, a majority-consumer body that provides input on the One Care demonstration. In 2018, the Implementation Council voted to make the My Ombudsman program's executive director a non-voting participant of the Council.

- **Conducting Beneficiary Education and Outreach.** All of the demonstration ombudsman staff interviewed for this brief conducted extensive beneficiary education and outreach during the early stages of demonstration launch, and those outreach and education efforts have continued throughout the life of the demonstrations (see **Examples of Successful Ombudsman Outreach Campaigns**). Topics covered in outreach include explanations of what the demonstrations are, the potential benefits to enrollees, and enrollee rights and protections. The ombudsman staff were careful to emphasize that they do not counsel individual beneficiaries to enroll into one MMP over another (or to enroll in or disenroll from the demonstration generally). Ombudsman agencies have conducted outreach events at a variety of locations, including senior centers, senior housing complexes, health fairs, county fairs, and homeless shelters to reach as many dually eligible individuals as possible in their respective states.

  With the onset of the COVID-19 pandemic, ombudsman programs have shifted to using online and virtual outreach campaigns, as well as creative strategies such as putting fliers describing the availability of ombudsman support in enrollees' home-delivered meals. California's ombudsman program has used virtual campaigns to target specific communities during the COVID-19 pandemic, including: using virtual webinars to continue training and outreach, hosting virtual townhall and Facebook live events to permit direct engagement with CMC beneficiaries, and posting videos for Pride Month in partnership with several non-profit organizations to promote awareness of its organization within the LGBTQ+ community.

  While neither state Medicaid agencies nor ombudsman staff considered these outreach efforts to be a major driver of demonstration enrollment, they all said that the activities have been beneficial in raising beneficiary awareness of the demonstrations and building beneficiaries' and advocates' confidence in the attention to consumer rights under the demonstrations.

Examples of Successful Ombudsman Outreach Campaigns

Demonstration ombudsman programs have conducted a variety of beneficiary outreach campaigns. A 2018 campaign conducted by MyCare Ohio's Ombudsman reached nearly 10,000 beneficiaries through more than 1,000 visits to long-term care facilities, in addition to in-service training for facility staff, attendance at resident and family council meetings, billboard advertisements, and distribution of postcards and calendars. Campaign materials in both English and Spanish explained what the ombudsman's office did, the potential benefits of demonstration enrollment, and how the ombudsman could help individuals navigate the process.

In Massachusetts, the My Ombudsman program developed a series of educational videos in English, American Sign Language, Spanish, Portuguese, Haitian-Creole, and Chinese to explain the rights of persons with disabilities under federal and state law and how to contact the ombudsman's office.[13]

- **Providing Input on Program Design or Early Implementation.** In both Ohio and South Carolina, ombudsman staff played important roles in program design or early implementation. Prior to launching its demonstration, Ohio's Department of Medicaid held a series of stakeholder meetings to inform program design. The state's LTC Ombudsman participated in those stakeholder meetings and was heavily involved in a subgroup working on communications materials to potential members (letters, flyers, presentations, etc.) to ensure they were appropriate and clear. The LTC ombudsman was also one of the advocates for changing the name of the demonstration from the "Integrated Care Delivery System" to "MyCare Ohio" to make it more consumer friendly. In South Carolina, the demonstration ombudsman participated in MMP readiness reviews, both to build its visibility with the plans and to ensure that enrollee rights were kept at the forefront of conversations. The South Carolina demonstration ombudsman believes that this type of early involvement was important to make sure that operating processes and procedures related to beneficiary rights, choice, and access to services were robust from the start. In California and Massachusetts, where the states contracted with non-profit organizations to provide demonstration ombudsman services, the organizations that would eventually hold those contracts also participated in early discussions about demonstration design. California's ombudsman provided extensive feedback to the state's Department of Health Care Services both prior to and during demonstration implementation.[14]

- **Referring Enrollees to Community Services.** Ombudsman programs view connecting beneficiaries to community services as within the scope of their mission. In South Carolina, for example, Healthy Connections Prime Advocate staff partner with the Office on Aging's Information and Referral Assistance program to locate additional resources for demonstration enrollees. If a demonstration enrollee contacts the ombudsman and presents a need that could be addressed by local community services the ombudsman staff use the Information and Referral Assistance program staff or database to refer the enrollee to other entities for assistance (for example, to housing or legal aid organizations). Ombudsman staff in South Carolina are cross-trained in several service areas to ensure that they know what services are available to dually eligible individuals in their communities. In California, the ombudsman program can internally refer issues affecting demonstration enrollees to services provided by other parts of its legal services parent organization (for example, eviction defense, housing discrimination, consumer fraud and debt collection harassment protections, government benefits assistance, or family law assistance).

Value of Demonstration Ombudsman Programs

The ombudsman programs in the demonstrations examined in this brief all made significant contributions to enrollees, states, CMS, MMPs, and other stakeholder groups. Interviewees described the value of the demonstration ombudsman as being:

- **A Neutral Third Party.** The ombudsman programs are viewed by beneficiaries and other stakeholders as neutral third parties. This was true both in states where the ombudsman was in a state department, agency, or office, as well as when the ombudsman was housed in a non-profit organization, but perhaps more so in the latter approach. This neutrality allows the ombudsman to create bridges between the various stakeholders involved in the demonstrations and foster communication among them.

> *"[The ombudsman is] out there firsthand, meeting with individuals face-to-face to provide them all the necessary resources and to help them with their enrollment. [This] has great value, not only to the demonstration but also to consumers. They are the first stop to assist the individual, and by the time it comes to [the state], we're able to move things along more quickly. The ombudsman is able to work with the members more intimately than we are able to."*
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> — State Medicaid Official

- **Boots on the Ground.** Direct contact with beneficiaries, often in local or regional offices throughout a state, allows the ombudsman to serve demonstration enrollees effectively by creating an opportunity to resolve an individual's concerns at that level rather than elevating issues up to the state. This frees up state resources for other operational and oversight activities. The ombudsman's direct contact with consumers also allows them to assist with beneficiary outreach and education and with locating beneficiaries who are hard to reach.
- **The Beneficiary's Voice.** Ombudsman programs were consistently described as the "beneficiary's voice." They are often the only group at the administrative 'table' solely dedicated to representing consumer interests. In meetings with state Medicaid agencies, MMPs, or other stakeholders, the ombudsman keeps conversations focused on how policies or operational decisions will affect beneficiaries.
- **An Early Warning System for Potential Problems.** The ombudsman's direct work with beneficiaries and its ability to track and trend data allows it to alert the state and MMPs of potential problems with a demonstration's operations. State officials cited several examples of where they were able to make changes to aspects of their demonstrations based on information provided by the ombudsman, such as tightening up vague contract language around whether members could request a new care coordinator or requiring revisions to beneficiary notices with incorrect information. These changes may have resulted in increased enrollee satisfaction, enrollment retention, and provider buy-in.

> *"It's incredibly valuable to have a window into how your program or policy functions at the ground level. Some of the things that we've been able to understand about how our MMPs operate in actuality, as opposed to what we would have expected based on our guidance documents or our contracts, are really important."*
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> — State Medicaid Official

Virginia saw similar value in the ombudsman program developed for its demonstration, Commonwealth Coordinated Care. When that demonstration concluded at the end of 2017 and the state launched a new integrated care program for dually eligible individuals called Commonwealth Coordinated Care Plus, the state retained and expanded its demonstration ombudsman to serve enrollees in the new program (see **Spotlight on Virginia: Expanding the Demonstration Ombudsman Program**).

Spotlight on Virginia: Expanding the Demonstration Ombudsman Program

Commonwealth Coordinated Care (CCC), Virginia's capitated model Financial Alignment Initiative demonstration, began in June 2014 and ended in December 2017. CCC served five demonstration areas – Central Virginia, Tidewater, Northern Virginia, Roanoke and Western/ Charlottesville, and had enrollment of 22,991 at its close.[15] To provide ombudsman services for demonstration enrollees, CCC utilized Virginia's existing Long-Term Care (LTC) Ombudsman, housed within the Department for Aging and Rehabilitative Services.

As Virginia transitioned to Commonwealth Coordinated Care Plus (CCC+), its statewide integrated care program built on D-SNPs aligned with Medicaid MLTSS plans, the Department of Medical Assistance Services (DMAS), which operates Virginia's Medicaid program, decided to retain its agreement with the Department for Aging and Rehabilitative Services' Office of the State LTC Ombudsman, which would expand its services to provide beneficiary supports for Medicaid managed care enrollees statewide. State LTC Ombudsman staff cited several reasons for this decision. First, DMAS understood the role of the ombudsman and saw the value it provided to demonstration enrollees. The LTC Ombudsman brought extensive experience working with individuals receiving long-term care as well as demonstration enrollees. In addition, the LTC Ombudsman had expertise in person-centered advocacy, problem solving, and the social determinants of health that affect CCC+ enrollees. The LTC Ombudsman's office also has a shared vision with DMAS to strengthen beneficiary protections/rights and ensure the beneficiary experience informs ongoing quality improvement - while still retaining its separate and independent voice. Finally, the LTC Ombudsman has built strong relationships with non-profit organizations, including Area Agencies on Aging that house LTC Ombudsman staff as well as the state's long-term care facilities, which was important because, as a part of a large state agency with expansive administrative/funding responsibilities, DMAS staff do not tend to have the same level of close interpersonal connections with or understanding of community-based service providers.

The basic structure and roles of Virginia's Ombudsman Program remained the same during the transition to CCC+. It continued to investigate complaints and assist enrollees in accessing and navigating Medicare and Medicaid appeals processes, and it also continued to help individuals navigate the managed care system and access the services they need. It also kept its organizational structure, with both ombudsman and managed care advocate staff housed in regional offices around the state and a core team located in the capital.

The transition to CCC+ also provided opportunities for program change, especially with regard to data collection. Another major change has been in program funding. Under the demonstration, the ombudsman program received grants in the amount of $924,237 over four years.[16] Now, state General Funds of approximately $400,000 are the primary source of funding for ombudsman services. Virginia also obtains federal match payments for qualifying activities that serve Medicaid beneficiaries (for example, helping beneficiaries access their benefits, assisting individuals with understanding appeal rights, and providing information and outreach to targeted communities).

Virginia's LTC Ombudsman staff offered several key takeaways for states interested in developing new demonstrations or integrated care programs for dually eligible individuals:

- States should consider involving ombudsman staff in program development, especially with regard to beneficiary education and outreach.
- Stakeholder education about the role of the ombudsman is also key.
- A regional approach (to placement of ombudsman staff/offices) ensures that ombudsman staff understand the communities where enrollees live and helps to foster connections with local non-profit organizations. These strategies help establish strong communication and trust between the ombudsman and key stakeholders from the beginning.

Key Lessons

Interviews with state Medicaid and ombudsman program staff highlighted several lessons from the development and operation of the ombudsman programs serving dually eligible individuals enrolled in demonstration programs.

- **Ombudsman entities should have experience serving the target population and staff should reflect the diversity of the enrollee populations served.** States found it very beneficial for their demonstration ombudsman programs to have experience serving the enrolled populations. In South Carolina, the Department on Aging specializes in elder care and elder needs. When the state chose to focus its demonstration on dually eligible individuals age 65 and over, it was a natural fit to build the demonstration ombudsman program within the Department on Aging. Similarly, the One Care demonstration in Massachusetts enrolls dually eligible individuals ages 21-64, all of whom have a disability. In choosing the DPC to operate its demonstration ombudsman program, Massachusetts followed that same approach of matching experience to the needs of the enrolled population.

  Beyond having experience serving the broad population groups to be enrolled in the integrated care program, when ombudsman staff reflect the diversity of demonstration enrollees, the ombudsman program may be better able to develop trust with enrollee populations, as sharing lived experience helps to build trust and communication.

  As noted by the Administration for Community Living, there does not appear to be a clear advantage of basing an ombudsman program within an existing state agency/department over contracting with a non-profit organization. Rather, it seems important to allow states the flexibility to choose the structure that works best for them.

- **Ombudsman staff should have deep Medicare *and* Medicaid program knowledge.** To effectively serve dually eligible individuals, ombudsman staff need deep knowledge of both Medicare and Medicaid program policies, benefits, and appeals processes. Demonstration ombudsman staff in both Ohio and South Carolina had prior experience working in the organizations that operate the states' SHIP programs. Having extensive knowledge of Medicare was cited as being very helpful for ombudsman staff in both states and providing value to demonstration enrollees.

- **Ombudsman should build strong relationships with demonstration stakeholders.** In order to effectively handle the broad range of concerns brought to the demonstration ombudsman, interviewees placed strong emphasis on the importance of building relationships with a variety of stakeholders. This included relationships with state Medicaid agencies, MMPs, long-term care providers, non-profit organizations, and consumer advocates. Ombudsman programs repeatedly credited positive relationships with stakeholders as the key to breaking down silos, solving problems, and getting demonstration enrollees the care and services they needed. In particular, ombudsman programs found that building trust and lines of communication with MMPs allowed them to better respond to consumer complaints (see **Spotlight on South Carolina: Building Plan Partnerships**).

- **States and Ombudsman should clearly communicate the ombudsman's role(s).** Clearly communicating the ombudsman's role(s) helped beneficiaries understand what these programs do and better utilize them. The role of the ombudsman should also be clearly defined and communicated to health plans – the MMPs, in the case of the demonstrations – so that they understand the value these programs can provide.

- **Ombudsman should be proactive in engaging with beneficiaries and resolving problems.** Ombudsman programs in the demonstrations are more effective when they are proactive. The MyCare Ohio Ombudsman conducted an extensive outreach campaign to educate demonstration

enrollees about its program and how it could help them. In California, the Health Consumer Alliance recognized early on that dually eligible individuals were having problems with eligibility and enrollment in Cal MediConnect, and it quickly expanded its range of activities beyond just assisting with complaints and appeals to address these issues.

- **Ombudsman should maintain appropriate firewalls between ombudsman and advocacy functions.** A final lesson is the need to balance the advocacy and ombudsman functions of the entity administering the program. A firewall built into ombudsman organization contracts can help to ensure that these roles, while both important, stay distinctly separate. Without this distinction, state, health plan, and ombudsman communication may become more difficult, and relationships may become strained, which makes the ombudsman less effective.

Spotlight on South Carolina: Building Plan Partnerships

During the initial rollout of the Health Connections Prime demonstration in South Carolina, MMPs were hesitant to involve ombudsman staff in resolving enrollee complaints. This apprehension stemmed from the plans' perception that referrals to ombudsman staff would reflect poorly on them. However, over time, as plans observed how the ombudsman program assisted enrollees, the plan-ombudsman dynamic shifted. Now, plans and ombudsman staff work collectively and collaboratively as partners.

Conclusion

As more states look to develop integrated care programs to serve their dually eligible populations, they should consider the value that ombudsman programs could bring to these efforts. The ombudsman's support in addressing an individual's complaint or appeal is key to providing beneficiary protections, but ombudsman programs can also take on other activities, including: tracking and communicating data trends; conducting beneficiary outreach and education; and providing input on program design. Taken together, these activities provide value to both beneficiaries and state Medicaid agencies by building stakeholder trust, improving enrollee and provider satisfaction, and providing an early warning when problems arise.

The decision to house an ombudsman program within an existing department or agency or to contract with a non-profit organization will likely depend on specific state circumstances, such as experience implementing managed care programs, the involvement of beneficiary advocates, budgetary considerations, and existing knowledge and resources. Regardless of the way an ombudsman program is structured, states have the ability to shape contracts, reporting requirements, and communications to ensure that their ombudsman programs function in ways that maximize their value.

Appendix

Interviewee Name	Organization/Agency
Michele Vasquez	California Department of Health Care Services
Jennifer Scott	California Department of Health Care Services
Jack Dailey	California Ombudsman Services Program, Legal Aid Society of San Diego/Health Consumer Alliance
Malinda Ellwood	MassHealth
Daniel Cohen	MassHealth
Colin Killick	Disability Policy Consortium
Leslie Diaz	Disability Policy Consortium
Karla Warren	Ohio Department of Medicaid
Teresa Teeple	Ohio Department of Aging
Dustin Welch	South Carolina Department of Health and Human Services
Dale Watson	South Carolina Department on Aging
Sherhonda Jones	South Carolina Department on Aging
Gloria McDonald	South Carolina Department on Aging
LaQuasha Dixon	South Carolina Department on Aging
Joani Latimer	Virginia Department for Aging & Rehabilitative Services
Linda Hamrick	Virginia Department for Aging & Rehabilitative Services
Kerry Branick	CMS Medicare-Medicaid Coordination Office
Marc Steinberg	CMS Medicare-Medicaid Coordination Office
Jennifer Baron	CMS Medicare-Medicaid Coordination Office
Lauren Gavin	CMS Medicare-Medicaid Coordination Office
Latonya Phipps	CMS Medicare-Medicaid Coordination Office
Melissa Seeley	CMS Medicare-Medicaid Coordination Office
Gretchen Nye	CMS Medicare-Medicaid Coordination Office
Melissa Simpson	Administration on Community Living

ABOUT THE INTEGRATED CARE RESOURCE CENTER

The ***Integrated Care Resource Center*** is a national initiative of the Centers for Medicare & Medicaid Services Medicare-Medicaid Coordination Office to help states improve the quality and cost-effectiveness of care for Medicare-Medicaid enrollees. The state technical assistance activities provided by the *Integrated Care Resource Center* are coordinated by Mathematica and the Center for Health Care Strategies. For more information, visit www.integratedcareresourcecenter.com.

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[1] Centers for Medicare & Medicaid Services (CMS). Medicare-Medicaid Coordination Office. "Medicare-Medicaid Coordination Office Fiscal Year 2019 Report to the Congress." 2020. Available at: https://www.cms.gov/files/document/mmco-report-congress.pdf

[2] Assistant Secretary for Planning and Evaluation. "Report to Congress: Social Risk Factors and Performance under Medicare's Value-Based Purchasing Programs." December 2016. Available at: https://aspe.hhs.gov/pdf-report/report-congress-social-risk-factors-and-performance-under-medicares-value-based-purchasing-programs

[3] For more information on the demonstrations, see: Centers for Medicare & Medicaid Services. "Financial Models to Support State Efforts to Integrate Care for Medicare-Medicaid Enrollees." SMDL 11-008. July 2011. Available at: https://downloads.cms.gov/cmsgov/archived-downloads/SMDL/downloads/Financial_Models_Supporting_Integrated_Care_SMD.pdf

[4] This brief focuses on the experiences in states operating capitated model demonstrations that deliver care through MMPs.

[5] State Departments on Aging are responsible for administering the Older Americans Act's Long-Term Care Ombudsman program, which started in 1972. Some states leveraged the structure and/or staff resources from the agencies involved in Long-Term Care Ombudsman programs in developing their demonstration ombudsman programs. For more information on Long-Term Care Ombudsman programs, see: https://acl.gov/programs/Protecting-Rights-and-Preventing-Abuse/Long-term-Care-Ombudsman-Program

[6] Virginia's demonstration ended on December 31, 2017, and its new integrated care program launched January 1, 2018.

[7] ACL requires that the Office of the State Long-Term Care Ombudsman be a "distinct entity, separately identifiable" in order to provide ease of access for residents and complainants and to effectively meet other statutory requirements of the Office. For more information on State Long-Term Care Ombudsman programs, see: https://acl.gov/programs/Protecting-Rights-and-Preventing-Abuse/Long-term-Care-Ombudsman-Program

[8] State Health Insurance Programs (SHIPs) provide free, unbiased, one-on-one health insurance counseling and assistance to Medicare beneficiaries, their families, and caregivers. For more information, see: https://acl.gov/programs/connecting-people-services/state-health-insurance-assistance-program-ship

[9] The One Care demonstration in Massachusetts is designed for dually eligible individuals who are under the age of 65 and have qualified for Medicare due to a disability.

[10] Ohio's ombudsman program also has bilingual staff. In South Carolina, the ombudsman program does not have a bi-lingual staff member, but the state's bilingual language line and the South Carolina Department of Minority/Hispanic Services are available to help with translation and communications.

[11] DPC maintains a separate website that describes its advocacy activities. See: https://www.dpcma.org/

[12] As part of their contracts with states and CMS, all MMPs are required to operate consumer advisory groups.

[13] My Ombudsman's educational videos are available at: https://myombudsman.org/one-care-ombudsman-healthcare-access-videos

[14] For more information see: Justice in Aging. "CCI Fix List." Available at: http://www.dualsdemoadvocacy.org/california/cci-fix-list/

[15] Medicaid and CHIP Payment and Access Commission. "State Profile for the Capitated Financial Alignment Demonstration." September 2015. Available at: https://www.macpac.gov/wp-content/uploads/2015/09/Virginia-Capitated-Financial-Alignment-Demonstration.pdf

[16] CMS. Medicare-Medicaid Coordination Office. "Beneficiary Counseling and Ombudsman Programs." Available at: https://www.cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination-Office/FinancialAlignmentInitiative/BeneficiaryCounselingandOmbudsmanPrograms