

"Please stand by for real-time captions." >>

Good afternoon everyone. This is Adam Mosey. In approximately 7 minutes the Medicaid managed care webinar for state and local ombudsman will be starting. Thank you. >> Good afternoon everyone and thank you for joining today's webinar. My name is Adam Mosby I am a policy analyst. Also the lead for long-term care ombudsman program. For those joining us your attendance for the webinar on Medicare managed care for state and local ombudsman, the time now is approximately 3:00 PM. we will give participants a minute or two to continue signing on. Thank you. >>

Good afternoon everyone. This is Adam, thank you again for joining today's webinar. As I mentioned previously this is a chance to webinar as chairman to -- NASUAD webinar. All participants have been placed on mute to avoid any distractions. Also at the end of the presentation we will take questions. Please a bit questions through the Q&A feature in the webinar which should be located on the right-hand side of your screen. Finally if you are experiencing technical difficulties you can contact us to the Q&A feature as well and we will do our best to give assistance anyway we can. I am pleased to introduce our presenter for today, team director from policy and planning, Damon Terzaghi. He has been with us three years prior to joining NASUAD he has an extensive public policy background including working for the Oregon Department of human services, [indiscernible] and the Center for Medicare and Medicaid services. Without further ado, Damon takes it away.

Thank you so much Adam did thank you all for joining us this afternoon. Today's webinar is focused on the basics of Medicaid managed care policy and operational considerations. This is an introductory webinar. Not intended to be for individuals with advanced knowledge of Medicaid policy or managed care. However if you are here for a refresher we welcome your participation. Please recognize that this is intended to be a 101 level description of Medicaid managed care and how it works. And how ombudsman should be thinking about interacting with plans, particularly if the state is in a managed long-term services and support environment. Or if the state is covering seniors and people with disabilities through managed care for the primary acute, or acute services.

So with that, let's move on to today's agenda.

We're going to talk about some of the basics of managed care policy and how it differs from core Medicaid fee-for-service delivery systems. We will talk more about the types of managed care that exist. Including the types of plans, the authority's states use to implement them to the Medicaid program, and then the ways the plans look like when they are implemented throughout the state. Lastly we will close with an overview of key considerations

and managed care policy that ombudsman should be aware of and be thinking of as they are working with clients who are either in a nursing facility, or another type of long-term services and support facility such as assisted living or similar types of facilities. And receiving services through managed care plans. >> The objective today is to understand the key features of Medicaid managed care as well as

important terminology and concepts that play into this delivery system. We will discuss the differences

Between fee-for-service and managed care as I mentioned. We will talk about some of the goals that states and managed care plans have when they enter into this delivery system. Discuss the authorities and considerations that states have to use when they're implementing a managed care program. And lastly we will describe some of the requirements that are placed upon both states and the plans through legislation and regulation when they move into a managed care delivery system. With that, the slide we had some key terminology that may assist participants in the webinar. To understand some of the items we talk about moving forward. There are a lot of acronyms in the managed care world. A lot of acronyms in the public policy and government at large, but definitely Medicaid, with various terms that we throw around fairly casually. I will go through all of these in order but hopefully this will be useful to you as we speak to the following slides, as well as when you look at the slide deck in the future, this can help inform your reading. >> So the first section we will talk about Medicaid fee-for-service compared to Medicaid managed care.

So fee-for-service, really use historically the predominant way that Medicaid services has been delivered. When Medicaid was created, in 1965, there was really a sense that services would be delivered through this fee-for-service method of providing care. So in this delivery system, the state contracts directly with healthcare providers. And in Medicaid there is a core policy where the state must contract with any willing and qualified provider, who wants to provide care to beneficiaries of the program. So the state is able to set provider qualifications, standards of care, and other things that are used to determine whether or not an entity, corporation or individual is qualified to deliver the services. That as long as an individual is a willing and qualified provider, the state is expected to allow them to contract directly

And provide services in a fee-for-service system. Obviously there are notable exclusions to that. For example, if there is a provider or an individual who has a history of fraud in healthcare, they can be excluded from the program with a fee-for-service system but in general were talking about an environment where it is an open public providers who are qualified to deliver services and then the individual to the participant who is enrolled in Medicaid has freedom of choice to select a provider from that pool of individuals who are delivering services and contract with the Medicaid program.

For payment methodology, the state then sets a rate for each service and is a very standard way of paying for healthcare services. For example the Medicaid program will say for personal care services we have a 15 minute increment, the unit of service, and for that 15 minute increment of care we will pay say \$15. So the provider then receives a fee for each service they deliver. For each 15 minutes increment of personal care the provider delivers, they submit a bill to the Medicaid program demonstrating what was delivered, when it was delivered, and receiving the state payment for that service. >> In the type of the environment, providers do not bear any financial risk to the more services you deliver; the higher you're level of payment. So there is always concerns of the healthcare system that in a fee-for-service environment, there is an incentive to over

deliver care and not any incentives, to focus on potentially wellness initiatives or other types of intervention that would limit the delivery of care, as opposed to simply having more and more services provided to individuals. >> As I mentioned, fee-for-service has historically been the dominant delivery system in the Medicaid program. Particularly when it was created in the 1960s throughout the 70s and 80s. But we have seen a shift in that starting really with the delivery of primary and acute care services.

But more recently, we have seen that transition from fee-for-service to managed care expand into the provision of long-term services and supports as well.

That transition has been most accelerated I would say in the past five years or so. It really did start in the mid-90s with a few initial steps and earlier than that with a couple of others. >> And comparing fee-for-service to managed care. In managed care the state does not contract with each individual service provider, instead they contract with a managed care organization. An HMO. These are the companies you think of in the healthcare space your United healthcare's, Centene, Molina, Well Care, etc. In some places there are also local plans that are not the big national names I referenced. That managed care organization becomes responsible for the coordination, delivery, and payment of healthcare services. >> In this type of service delivery system it does not necessarily have to be all of their Medicaid services. States can contract with managed care plans to provide the full array of Medicaid services and supports, ranging from doctors' visits to hospitalization. All the way up to skilled nursing facility services, home health, personal-care, and other lawn care services and supports. Or they can contract with just a portion of the Medicaid program, such as primary and acute care services. And carve out as it is termed to retain parts of their Medicaid program in the fee-for-service environment. Similarly, states can include certain populations in their managed care contracts and no other populations. We will talk about this a little bit later, but in general historically, states have included parents, pregnant women, children, and those types of less "risky or high need those quote populations in their managed care programs, as opposed to the full array of Medicaid beneficiaries think then do the managed care environment. As I mentioned that is changing. But that is a policy choice states can have been

So when you go into the managed care environment, the managed care entity then becomes responsible for paying for the services the managed care plans receive a capitated payment from the state, which is essentially a global rate that is set up, that is intended to be far all of the services that are included in the managed-care contract for all of the beneficiaries that the managed-care company is expected to cover. So it really is a single monthly rate. We usually use the terminology p.m. p.m., remember permanent weight -- rate. The managed-care plan then becomes responsible for taking that payment rate and coordinating and delivering all of the necessary covered Medicaid services for that individual. When this type of an environment, you will see that the capitation rate really creates a financial risk for the managed-care entity. If the individual over utilizes services above what is provided in that capitation rate, to the managed-care entity, they

would take a loss on that individual. Similarly, if the managed-care program does a good job of managing utilization, and providing targeted coordinated benefits, they would understand that capitation rate and potentially receive a financial benefit for the provision of the services in this manner. Now some of the historic arguments about managed-care have focused on whether there is an inherent incentive to inappropriately limit the provision of care, yet in a functioning, quality-based managed-care environment, there are performance metrics, contractual requirements, and oversight of the plans to ensure that any care management processes and ultimate financial benefits the plan receives, are not due to inappropriately limiting care but instead due to better care coordination that limits the provision of expensive and unnecessary care, and instead focuses on wellness types of things. That's the core

benefit and core policy aim of a high functioning managed-care program, to shift away from that thing for volume of services and instead focus on paying for better health outcomes, prevention, and implement coordination of services while reducing unnecessary and costly types of services .

You can also see in the Medicaid program non-risk contracts, you have managed-care entities not actually a financial risk, more of an intermediary and incurred cost reimbursed to the managed-care plan as opposed to having the capitation rate that I just described. I would say the move in Medicaid managed care is towards capitated payments are not risk contracts are not as common you can see on the slide, over a third of all Medicaid expenditures are capitated as of 2014. That is a number that we expect to continually increase over the next several years. Particularly because we have seen more populations included in Medicaid managed care, and importantly more services including long care services and supports included in Medicaid managed care across the country.

So moving to an overview of the environment, and the way Medicaid managed care exist right now, as I mentioned earlier historically managed-care was largely limited to some of those low income populations such as children, parent template that women. That comprised the Medicaid eligible population, whereas individuals with disabilities and older adults historically were not included in managed-care programs. We then saw some states transition by offering and including primary and acute care services for older adults and individuals with disabilities in their managed-care contracts. So that would be doctor visits, hospitalization, pharmaceuticals, and other types of benefits in that manner, included. Whereas some of the more complex services such as rehabilitative services, personal-care, habilitation, long-term services and supports more broadly, were not included.

And then after that kind of evolution in the managed-care policy, we saw more states expanding programs to include additional populations and additional services, whether individuals with intellectual and developmental disabilities have often been excluded, historically. Or the array of long-term services and supports that I know we are all concerned about an interested in on today's call.

So overtime managed-care really has become the predominant Medicaid delivery system. We have 39 states now delivering at least some Medicaid benefits through managed-care. And fully two thirds of enrolled Medicaid beneficiaries are enrolled in some form of managed-care, whether it is a comprehensive plan that covers all of their services, or a plan that has some limited benefits included in it. >> So the goal of going to the managed-care plan as I mentioned earlier, is really focusing on improved care coordination, improved health and quality of life, and having those outcomes drive the lower overall costs of delivering services and supports. So in a fee-for-service system, you have a single Medicaid entity that is responsible for contracting with many different providers for many different individuals for many different services. There is not a single point of accountability

For the outcomes and the care coordination in many cases. Many people have a tongue-in-cheek interpretation of fee-for-service. The HCBS -- FFS acronym is sometimes termed send for self as opposed to fee-for-service because of the view that in a fee-for-service system, the individual really has to be the person that is accessing their healthcare providers and securing sources of services, as opposed to having an entity such as a managed-care plan responsible for ensuring that

The individual receives the services and supports they require.

Another benefit is there is more budget predictability in a managed-care environment. Every month you have a per member, month payment. So when you have outlier cost, the state does not get caught unaware or surprised by that budget item increase. In many cases, when states are doing their annual budget, having this level of predictability is incredibly valuable when you are working through your Office of Management and Budget, the state budget office, your legislature and in order to get the appropriate level of authorized funds to provide services for your Medicaid program.

The other thing that managed-care can provide in a Medicaid program is a little bit more flexibility that many -- managed-care plans can be more nimble in the delivery of services, and the coordination of care. They do have some flexibility in the services provided that we will talk about in a second. They have some opportunities to look at providing care coordination and services in a slightly different way than some of the historic Medicaid statutory and regulatory requirements for states and a fee-for-service environment to provide for them. One great example of this flexibility is what we call in lieu of services that

So in lieu of services, are what essentially, they are, they have to be medically appropriate. They are cost effective attorney tends to a service that is included in the state Medicaid plan. So the Medicaid statute has a list of mandatory services a state must provide, optional services that a state can provide, and sometimes very challenging to get approval to provide any service outside of that. You have to go through a Medicaid waiver in many cases. In other cases you cannot do anything. So when a managed-care environment, states can authorize plans to have cost-effective alternatives to a Medicaid covered service? Those individuals can voluntarily receive, in lieu of the covered Medicaid benefit. So you see the example up on the screen it talks about a home modification being a potential in lieu of service that can allow an individual to return

home more quickly than they would be able to without such service. So in lieu of home modification, would be paid for because it is more cost-effective than continuing to pay for a daily rate in a rehab facility or skilled nursing facility or hospital. And in many cases copy individuals is better off because they can go home faster. There able to do their rehabilitation in the place they live as opposed to in a facility-based setting. And the plan is better off because you have a flexible service that ultimately is a cost-effective alternative to what otherwise has to be provided.

Some other great examples we have heard, states talk about using air-conditioners or air purifiers in the event of an individual with asthma or something like that but you can provide that as an in lieu of service to offset the cost of an emergency room visit, or other sorts of care that would be required in the event of an asthmatic episode.

The former director from Tennessee always used to love telling the story about a managed-care plan being able to provide an individual with a companion dog that was able to deal with anxiety and loneliness issues, and ultimately drastically reduce the level of hospital utilization, emergency room utilization for that member. Those are some of the things we are talking about in terms of in lieu of services.

And contrast there is a similar but slightly different policy and a Medicaid managed care called value added services. One of the main differences between value-added service and then and Lou of service, is in lieu of services are included in the contract as a cost-effective alternative , where a value added service is not included in the contract, not included in the capitation rate, but plans are able to provide them at their own discretion, in order to potentially offset additional cost and/or improve the quality of care for beneficiaries that one of our favorite examples of value-added services are adult dental benefits, as many of you probably know, adult dental is an optional service in the Medicaid program, that is quite often not covered by the states for adults. And the lack of oral health services is a significant problem for many older Americans,

Individuals with physical and developmental disabilities do have high levels of need when it comes to dental caries, infections and other sorts of things. So we have seen several states , Tennessee and Texas are two great examples of states, that include , the plans include dental benefits to enrolled individuals can't even though the state itself does not have a Medicaid adult dental benefit. You can see some potential flexibilities and value from having these types of services provided through the managed-care plan. >> Now one of the other things to keep in mind is that managed-care and Medicaid is actually right now, at a significant moment in its history. Because for the first time in over a decade, CMS issued regulations less than a year ago that are really focused on strengthening and modernizing managed-care in the Medicaid program. CMS, the federal agency that administers Medicaid, stated some are goals that they had. In implementing this final rule. Focusing on delivery system reforms, trying to align managed-care with other health coverage programs so when we pay other health coverage programs we are large in a slightly talking about Medicare and the insurance provided through the affordable care act exchanges. Looking at

beneficiary protections, to both of their experience and that there are opportunities for them to have appeal rights and ways to challenge decisions that the plan makes that they might feel are adverse. Focusing on accountability, transparency and quality of care. Those are some of the core measure core outcomes at CMS, they wanted to achieve through the issuance of this final rule. As I mentioned it's the first time in over a decade that CMS updated the regulations around managed-care. So a lot to update particularly gave the large changes in the evolution in managed-care that has happened over the intern. .

One of the big

Changes that have happened since the last time the will was issued was as I mentioned, this increasing push towards manage long-term services and supports. So CMS actually codified some provisions around MLTSS. It's the first time there's been a regulatory framework for these types of services, and deliveries >> so within those, CMS has some provisions that they expect states to adhere to. Particularly around compliance with the eight CBS savings will come with Medicaid policy those might be familiar, I will published in 2014 that creates new requirements around what is an allowable setting for individuals in the community based services. HCBS. Person centered planning requirements is a big push federally. Ensuring that individuals are able to have a person centered plan, and that it's really a consumer centric, consumer driven , long-term services and supports program. There is a stakeholder advisory group to oversee that individuals who receive long-term services and support have a role in oversight and a voice and the way the plans are delivering the long-term services and supports. And probably most important for this group is the creation of this individual support system. I will mention there are some provisions that place requirements on states and plans to have grievance and appeals systems as well as to have an outside entity that helps the individual understand the plan requirements and

select an appropriate managed-care plan, kind of an option of counseling function that those types of programs we believe will be the important for ombudsman to be aware of and potentially coordinate and collaborate with, if they do operate in a state that has a manage long-term services and supports program. LTSS. I would note that the ombudsman resource Center tends to have a follow-up webinar focusing a little bit more on this type of a role support system and the functions of an ombudsman

And potential overlap in the areas of collaboration moving forward. >> So with that background let's move on to the different types of managed-care that can exist in Medicaid.

These are three of the most common. A comprehensive managed-care organization. Up-to-date ambulatory health plan. And a prepaid inpatient health plan. Comprehensive managed-care organization , that is largely what I think people think of when they think of a Medicaid managed care plan that the health plan that has inpatient hospital services, as well as at least three Medicaid mandatory benefits. Kind of a regulatory distinction. Essentially if you have a managed-care entity that is providing comprehensive services and supports to individuals enrolled in the program, it is most likely a MCO. All MCO must use a capitated method. We talked about capitated versus non-risk payments. So

comprehensive MCO must have to have a capitated payment methodology. And in general, you are likely to come across these types of models when you're looking at Medicaid managed care.

Prepaid ambulatory health care program, PAHP

But generally outpatient types of supports. Talking about a less comprehensive way of delivering care. Not including inpatient services. And it has less than three of the mandatory benefits and Medicaid optional benefits. You sometimes see stuff like a dental care plan in Medicaid services and supports. That would likely be a prepaid ambulatory health plan, if you have a state that is contracting with a standalone dental care organization. That is one example.

Now in this environment, you either have a risk-based capitation payments or non-risk-based payments. Similarly a prepaid inpatient health plan, PIHP, does have inpatient services that are less comprehensive. You might see for example states contracting with the behavioral health plan for these types of models. Like up-to-date inpatient health plan might have inpatient care for behavioral health needs, as well as outpatient rehabilitation supports or those suits are things that sorts of things possible. That is the and 12 model of delivering care

The last type we commonly see referred to in Medicaid is primary care case management. PCCM. When you look at this from a federal level CMS calls this a type of managed-care because you do have an entity, most likely a primary care provider that is responsible for providing that type of case management care coordination facilitating access to services type of function, within the state Medicaid system. Primary care case management models have historically been very popular in certain parts of the country. North Carolina, for many years has used a robust primary care case management model for delivering their services and supports put that is something that might be changing presently. If you are thinking about what a primary care case management care looks like looking at the historic North Carolina model, a great place to look at. We are also seeing through Medicaid health, similar care coordination, and team-based model it is kind of a similar focus of looking at coordination, facilitating access to care, monitoring services

For certain individuals. When you look at CMS data federally, the federal Medicaid administration, they tend to count the CCM -- PCCM as a form of managed-care. When they talk about Medicaid managed care, there talking much more like contracts of health plans as previously discussed as opposed to a PCCM. In PCCM you are not at risk, there's no Titian-based payment it's a single monthly payment that pays for all of the coordination and the underlying services are fee-for-service. >> So here is some example. I went through this before but if you are coming back and reviewing the slides at a later date, these are good to help kind of think through

What the different types of delivery services might entail. What might be included in those types of contracts so as we stand today

Here are the different models of delivering services and support across the country. You can see there is a wide range delivery systems used for providing managed-care in Medicaid and a lot of states use managed-care and many states use multiple models of managed-care. >> Living on to the different authorities, this is how the states are able

to structure their managed-care plans. There are various authorities that are used

To authorize managed-care in the Medicaid statutes. Some of them are what we call state plans authorities, essentially embedding the managed-care as the core component of the Medicaid program at large. Others are waivers, which waves are part of Medicaid policy, requiring approval from the federal CMS entity, and in most cases require ongoing renewal because waivers are on a time-limited basis. Each of these provisions have different requirements about the can be required to be enrolled, where it can happen and those sorts of things. >> There are four core way states deliver them you can see these are all references to sections of the Social Security act that if you are curious about reading the statutory language, you can go to these sections of the Social Security act and figure out and read through the statutory authorization of these programs.

So states can use one or potentially more of these authorities, to implement a managed-care program. They have to ultimately receive CMS approval, regardless of the authority they use the they still have to amend their state and receive CMS approval or get approval for a waiver of managed-care is very prominent in Medicaid, CMS has some experience with it. CMS provides technical assistance to help states work through their policy goals, their options, and the most appropriate way of delivering the services and supports and which option they can use to do so.

So here are the comparisons of these for types the four types of delivering care. For section 1915 letter a period you cannot mandate enrollment that is option for all participants.

It can be either statewide or geographically limited. Pretty much all managed-care has the option to be limited geographically, which makes sense because in many cases managed-care is able to operate more effectively and efficiently and areas with higher population can't 10 -- content that you can spread the risk around a little bit. Obviously there's financial risk involved so a larger risk pool bodes better for the delivery of Medicaid managed care.

You talk about selective contracting, that means is the status allowed to use the German process -- government assistance solicit managed-care plans and select the one that gives them the best quality outcomes, cost, other sorts of items like that. To a selective contracting. We're talking about cost test that is really the cost neutrality steps CMS requires, that is by granting this managed-care program, it has to be less expensive than the program would be without a managed-care in place. And the Medicaid fee-for-service program would essentially be. You can see the two on the right-hand side have that cost test. 1915 B and 1115 letter a period those in the have cost neutrality test were state plans don't.

There is an approval timeframe that can be put in place at CMS, when you get a proposal from a state in certain circumstances there is a clock that starts coming down. For those of us that a bit inside CMS, we always think about the clock did when you come in to work in the morning there's a thing that pops up on the computer to remind you how many

days are left on the clock for each of these particular state proposals you are working on. The clock is a very real thing. The 1932, 1915 have the clock did the other ones don't. As I mentioned for some of these proposals, there is renewal process that has to happen. The approval. For 1915 B is 1115, after that. Expires, or before the period expires of the state has to apply for a renewal of the waiver in order to continue operating the program under that authority. >> So what we have here at the like sometimes it is better to have actual real-world understanding of what the different ones look like.

So here are some examples of states that are operating under the different authorities that we just did a quick rundown of that you stay here the states that are operating under section 1915 A cost examples, California, DE Colorado, Wisconsin, Minnesota and Massachusetts the 1915 A is a voluntary program, states cannot mandate participation in the HCBS environment .

1932 it's one of the most common ways of delivering managed-care. Again you can mandate certain populations but not all populations. To participate

In a 1932 a program. You cannot mandate American Indian or Alaska native appellations. You cannot mandate individuals were duly eligible for Medicaid and Medicare participating. Those other individuals can be mandated.

And 20 states operate one or more of the programs in this manner. You can see some of the examples of the states that have this below.

1915 B is one of the waivers as I mentioned that these are the ones that can expire in have to be renewed. You do have a number of states that use this authority. This authority does allow you to mandate individuals to participate in the managed-care program. So again you can see different examples of states that use this particular authority.

And lastly I have the 1115 program. The 1115 has become one way, one common way that states include community-based, Long-term service transports to within their managed-care programs. 1115 are very broad and potentially flexible waivers. You can see a lot of different ways that states roll out these types of programs. 1115 can also actually be used for other type's changes beyond Medicaid managed care they receive a lot of different flexible changes implemented through 1115. These are the states, an example of some of the states that use section 1115 waiver to implement their Medicaid managed care program. Now each of these provisions as I mentioned have different requirements. And limitations associated. If you have questions or interest in what your particular state is doing, if you saw them on this list and want to know more definitely I encourage you to look at the documentation around these waivers that are approved for the state plans that are approved that if you have any questions feel free to contact us at NASUAD that we would be happy to help you secure some additional information on what's happening in your state did

Moving on after that overview of the different way states get services approved, we will talk about once a program is approved how they have a limitation happen.

So we talked about the procurements the competitive procurements allowed to three of those authorities. Section 1915 a is a noncompetitive procurement. The states that use that process to contract and select the managed-care programs that receive the contract, the states then actually write the managed-care contract the states have to comply to

extensive requirements for managed-care contracts, there is a checklist that CMS analyst have to use when they are reviewing and approving the contract and states, once they write the contract, concurrently with writing a contract they are developing the payment rates. There are very stringent rules around setting payment rates for a plan, the standard actuarial soundness. The states do have that the rates certified by an actuary and approved by CMS prior to implementing the program. So in order for a state to receive federal funding for their Medicaid managed care program they do have to have both the contract and the rate approved. >> States before they were a lot of program or changes to the program, they submit a form to consumers about changes that will occur that CMS has simply stringent requirements around public input and public notice. They pretty much always should be public forums, meetings, websites come evening -- mailings. Other ways of ensuring that no advocates, beneficiaries and providers or where of what's happening and what the implications maybe. And then you have a readiness review. Which is kind of a comprehensive look to ensure that all of the systems, processes, everything else is set up and able to actually serve the Medicaid consumer so they don't have issues with payments not being made, with authorizations following through to people not getting the services they require. And other sorts of things like that happening. That's what the readiness review is supposed to ensure. That all this happens put

One of the big changes as states had moved into this environment, had move away from claims processing and using contract management, managed oversight, so the staff really have to ensure they have the skills necessary to provide the oversight. It is different than the historic Medicaid staff responsibilities. >> Card requirements that should always be remembered when you're thinking about operating in a managed-care environment, this is what CMS holds the states to and the states hold the plans to. The network adequacy. Making sure there are enough providers that individuals are able to access services. There needs to be proper care coordination for individuals who have special needs, and/or require long-term services and supports. A strong quality reporting requirement called the external quality review organization. [Indiscernible] as well as some of the other provisions that occur around states, quality measurements and contractual requirements. Excuse me. The plans have to ensure there is sufficient access to enable individuals to really understand what they are entitled to, as well as a pill any adverse decisions that are made that they disagree with. As well as implement abuse minimization activity, that is a core part of the Medicaid program more broadly. Especially in managed-care. >> So with all of that overview of what managed-care looks like, we come to the complex which is what does this mean for me as an ombudsman. So the first thing we really want to highlight is that we are seeing a drastic expansion of managed-care, particularly more states being in managed-care services and supports that we do anticipate the along care ombudsman will be

interfacing with plans. If not you will likely be in the future. I talked about the beneficiary support system earlier. We really do think that's a core component of the managed-care system; particularly manage long care services and supports. LTSS. The beneficiary support system includes a choice counseling provided to individuals. With additional assistance to people with requirement for LTSS from a non-conflict entity. You have a local area a function in focus as an ombudsman. There are some strong opportunities for collaboration and coordination between those entities.

Plans have appeal processes and grievances but when you're talking about individuals in either along care facility or potentially

A HCBS setting such as assisted living or memory care facility, other entities like that an ombudsman might be serving that individual. There evaluable to know and understand how to help an individual walk-through that appeals and grievance process. Language interpretation supports. Knowing the plans are supposed to have that, helping a beneficiary access those can be very valuable. And also some rights of individuals to do several in plans if they don't like the plan is meeting their needs or there have been disruptions due to changes in the network, stuff like that. Those are core functions again, that if there's been a change in the residential status of a residential provider contracted with that plan. To prevail some rights on the individual to potentially switch to a new plan. A trusted source of support and guidance. They may look to you for assistance with that. It's probably valuable to know and understand those processes that your state level as well.

The other thing we would notice this is not required that many states do have a managed-care ombudsman that is an independent entity to help individuals with the challenges, that they may encounter in a managed-care environment. There shouldn't be the same as the long-term care office obviously. However this is another area for opportunity of collaboration as I mentioned earlier we do intend to have a second webinar that provides a lot more detail around the different beneficiary supports ombudsman functions that the appeals and grievance processes, that are afforded to individuals in a managed-care environment. And after participating in this webinar, we hope it gives you the foundation where you can really participate in the follow-up webinar and take those lessons to heart and have them be actionable, and helpful information for you, as you go about your day-to-day work supporting individuals who receive services in long-term care facilities and potentially in home community-based settings as well. With that let's move on to additional resources we included in the slides, for your edification. We will take a couple of questions.

Thank you so much Damon

For that fantastic overview of Medicaid managed care. We are up near, running into the end of the webinar. We will get to a couple of quick questions. What we don't get to feel free to email either of us, anytime following the webinar.

The first question is how we know if our resident is enrolled in many -- Medicaid managed care.

That's a great question. Generally there are a couple of ways of figuring that out. They might receive enrollment material. They should receive enrollment material from their managed-care plan. They should receive communications from the state. The other thing is you might see on their Medicaid card that there is a health plan card and not necessarily a Medicaid plan card that there's a number of ways to go about that. The other thing I would strongly recommend is as an entity with some rights afforded to you through federal law to advocate for the need to beneficiaries, develop relationships with your Medicaid program. So you can speak with individuals in the Medicaid eligibility enrollment policy shop, to check in and get more information about clients you might be working with. Where they have specific Medicaid oriented questions. In addition to just being able to look through the policy documents, or documentation an individual receives, having that relationship with the Medicaid program would be very valuable for figuring out exactly what's happened with the managed care environment. But also program issues, questions, concerns that arise over the course of the work that you are doing on a daily basis.

I think we have time for one more question did --. How can ombudsman find out what the in lieu services are is there a list?

As I mentioned in lieu of services should be included in the managed-care contract. That is something that again you can look through the policy documents. Either through, states are supposed to post a model managed-care contract online somewhere. In lieu of services are potentially listed in that managed-care contract. It might be in the plan handbook or documentation. Things like that. As well as a mentioned having those relationships with the Medicaid program where you can talk with people inside the state to better understand exactly what is covered on a contractual basis for what is required from the plans to what is optional. Always a valuable way of figuring out exactly what is going on in the Medicaid program. As I mentioned you do have, services are supposed to be authorized in the state contract of the managed-care plan so that is a generally good place to look. Some are redacted for trade secrets.

You might have a model contract and you might have a redacted version that could potentially be available to individuals.

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The last question, can you explain why the managed-care ombudsman should not be the same as the long-term care ombudsman. That is part of the ombudsman roles. I can talk about that more.

We had a couple of questions coming in related to this. I think we certainly just wanted to the conflict the nature of the two. There are states that do operate them simultaneously. So there are examples of this, however, I think what Damon meant was clearly the state long-term care ombudsman program funded through BOA is specific to the parameters set by the oh a fund whereas states offering

LTSS may not operate under the same parameters. A lot of examples of coordination or combination within the actual offices, but there are a clear delineation, is the best way to put it.

Clear delineation and when you look at the ACL ombudsman final rule there is a state long-term care ombudsman funded by ACL, focused on that function.

I think that's all the time we have. We had additional questions coming in. Feel free to forward those along to me that you can always contact and reach out. [amosey@nasuad.org](mailto:amosey@nasuad.org).

Damon thanks you so much to give us this excellent overview. I look forward to speaking with you all, thank you for attending.