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Testimony in Support of SB 160
Senate Public Health & Welfare Committee
February 14, 2017

Chair Schmidt and members of the Committee:

My name is Mike Burgess. I am the Director of Policy & Outreach at the Disability Rights Center of Kansas (DRC). DRC is a public interest legal advocacy organization that is part of a national network of federally mandated organizations empowered to advocate for Kansans with disabilities. DRC is the officially designated protection and advocacy system in Kansas. DRC is a private, 501(c)(3) nonprofit corporation, organizationally independent of state government and whose sole interest is the protection of the legal rights of Kansans with disabilities.

Madam Chair, thank you for the opportunity to provide testimony in support of SB 160. Over the previous two sessions, there has been a growing interest among legislators about creating an independent ombudsman program very similar to one Governor Walker's administration created in Wisconsin. I am happy to be here today to support those legislators as well as the advocacy groups who have supported this type of program for a number of years.

I just want to be clear, SB 160 has no impact on the current internal KanCare Ombudsman program. KDADS would still be able to have the positions assigned to the internal Ombudsman office and the flexibility to have those employees do whatever KDADS wanted. My concerns are not with the current ombudsman or her performance in any way. It is just to support this bill which is in line with the recognized best practices for a managed care ombudsman program.

As you know, CMS was extremely critical of KanCare in its Jan. 13, 2017, audit report. CMS's report included findings about how the current internal KanCare Ombudsman program does not comply with the Special Terms and Conditions of KanCare.

Thankfully, Wisconsin has established a truly independent Ombudsman Program for its HCBS beneficiaries. Like Kansas, Wisconsin has been a leader in Medicaid Managed Care. Wisconsin Governor Scott Walker has been a national leader in ensuring that its HCBS Ombudsman Program is both truly independent and effective. The Wisconsin model follows the best practices established by the federal government, the American Bar Association, and policy papers completed on this topic (by the AARP, etc.).

SB 160 is patterned after the Wisconsin independent Ombudsman Program, and it would satisfy the legitimate concerns raised by CMS about the current internal KanCare Ombudsman program. Perhaps most importantly, SB 160 would help your constituents who have the greatest needs, those served by Home and Community Based Services Waivers (HCBS). It would provide your constituents with access to the intensive, legally-based advocacy services in a program that is truly independent by being outside state government and free from conflicts of interest. These constituents of yours have disabilities and impairments and need intensive services to navigate the complexities of such an intricate and confusing program, such as service denials, reductions in hours, plans of care, and imposing administrative appeals.

The current KanCare Ombudsman is not independent, they are an employee of KDADS who works at the pleasure of the Secretary and Governor. SB 160 responds directly to the concerns and findings raised by the recent CMS report in regards to Ombudsman services under KanCare. Again, perhaps more importantly, it responds to the concerns raised by your constituents who receive HCBS Waiver services and by dozens of senior, disability, and health care organizations.

- **This bill will help respond to an important portion of the recent CMS audit which was highly critical of KanCare. More importantly, it will help provide much needed intensive advocacy supports to your constituents who are HCBS KanCare beneficiaries.**

- **CMS Calls Out Problems with current Internal KanCare Ombudsman Program** – The Jan. 13, 2017, CMS Audit which found Kansas substantially out of compliance with federal law and the Special Terms and Conditions (STC) vividly identifies problems with the operations and structure of the current Ombudsman program.

- **Independence is Paramount –** CMS made clear in its findings that Kansas has a duty to ensure that "independence is preserved" with its Ombudsman program (CMS KanCare Findings and Recommendations Spreadsheet, pages SB-1 and SB-2).
  - Special Term and Condition (STC) 42 refers to this an "Independent Consumer Supports (Ombudsman) program."
  - The STCs are binding on Kansas. They are an agreement between CMS, the State of Kansas and, ultimately, the people of Kansas.
- **Kansas is Not Addressing All Ombuds Services as Required by STCs –** The STCs are clear. The STCs require the "independent consumer supports (Ombudsman)" program to be "staffed sufficiently" in order **"to address <u>all</u> requests for support"** from beneficiaries.
  - The internal Ombudsman is not an attorney, and cannot do legal cases. It is a huge conflict of interest to have an attorney or Ombudsman be a state employee and represent the consumer harmed by the state's actions. The internal Ombudsman does not handle the intensive case work and legal appeals that beneficiaries with HCBS in particular need and the STCs require.
  - Wisconsin's goal is to have 1 Ombudsman staff member for every 2,500 Medicaid beneficiaries. That is also the goal in SB 160. Appropriations levels may not reach that goal, but it is a great target to have.
  - Kansas currently has 1 principle internal Ombudsman and some other state agency support staff and volunteers for nearly 25,000 HCBS members.
- **Kansas is Not Doing the Heavy Lifting of Appeals & Intensive Services –** CMS was critical that the current internal Ombudsman "did not assist participants through the appeals process as described in STC 42". (CMS KanCare Findings and Recommendations Spreadsheet, pages SB-1 and SB-2).
  - CMS went on to be critical of the level of support the internal Ombudsman offers beneficiaries noting "the extent of the Ombudsman's office's involvement with appeals was helping participants understand the appeals process and providing referrals as needed to legal resources."
  - Advocates and consumers have pointed out for years that the current internal Ombudsman program does not provide the

intensive services needed for complex grievances to the MCO or appeals to the State. CMS is also pointing out this problem.

- **"Proactive Assistance" is Needed** – CMS is also calling out the expectation is that Kansas is meant to have "proactive assistance" including the tough work and heaving lifting like intensive case advocacy and Medicaid appeals (CMS KanCare Findings and Recommendations Spreadsheet, pages SB-1 and SB-2).
- **Not Enough Support for Ombudsman services** – CMS expressed "concerns about whether access to the Ombudsman is being supported as required in the STC" (CMS KanCare Findings and Recommendations Spreadsheet, pages SB-1 and SB-2).
- **CMS has a "Required Action" on Ombudsman** – The "Required Action" in CMS's Jan. 13 report directs the State of Kansas must **"ensure that all functions ascribed to it [the Ombudsman program] are carried out effectively and that its independence is preserved."**
  - This means "all requests for support" from beneficiaries, include the complex, legal cases and intensive advocacy must be provided in a manner which ensures "independence is preserved."
- **Reporting Concerns** – CMS was also critical of the lackluster reporting of the current internal Ombudsman, stating that "They do not include compliance with the access standard, the actions taken to resolve request for assistance, or any analysis of the data provided." (CMS KanCare Findings and Recommendations Spreadsheet, pages SB-1 and SB-2).
- **"Small Size" of Ombudsman Program** – CMS also expressed concern that funding level for the current Ombudsman services was not sufficient and noted its "small size."

Attached to my testimony are a fiscal analysis based on information shared with me by the program manager of the Wisconsin Independent Ombudsman program, the CMS KanCare Findings and Recommendations, and two white papers on the best practices for a managed care ombudsman.

Thank you for the opportunity to share our support with you. I would be happy to stand for questions at the appropriate time.

Fiscal Analysis of SB 160

SB 160 is patterned directly after the Wisconsin Independent Ombudsman program. In Wisconsin, approximately 49,260 HCBS Waiver members are eligible for the independent Ombudsman program, and funding is approximately $1.2 million all funds ($600,000 state funds). In Wisconsin there are 12.5 total staff, for a total ratio of 1 ombuds office staff member for every approximately 3940 eligible HCBS members. The statutory goal in Wisconsin is 1 ombuds office staff for every 2500 members, just like in SB 160. However, Wisconsin's funding does not meet that goal.

In Kansas, there are nearly 25,000 HCBS Waiver members who would be eligible for the independent Ombudsman program, or 51% of the total number in Wisconsin. If the Kansas program was passed into law and funded at the same ratios as the Wisconsin program, the fiscal note would be approximately $612,000 all funds ($306,000 state general funds). This represents an appropriation which is 51% of the Wisconsin program, the same ratio of HCBS enrollees in Kansas versus Wisconsin. Such an appropriation would fund the Kansas independent Ombudsman program at a ratio of 1 ombuds office staff member for every 3,940 HCBS Members, like Wisconsin's current amount. If Kansas were to fund the independent Ombudsman at the goal level set out in SB 160 of 1 ombuds office staff for every 2500 HCBS members, the appropriation would be approximately $941,500 all funds ($470,750 state general fund).

According to the Wisconsin Ombudsman program, they believe an effective floor for a ratio is 1 Ombuds office staff for every 3500 HCBS Members. If Kansas were to fund the independent Ombudsman program at 1 ombuds office staff for every 3500 HCBS Members, then the amount of funding would be $659,050 all funds ($329,525 state general fund).

KanCare MLTSS Review Corrective Action Plan

January 13, 2017

In October through December 2016, CMS conducted an onsite review of the operation and administration of the Kansas Medicaid program, KanCare. This review resulted in a number of findings of noncompliance with Federal requirements, and led CMS to require Kansas to submit a Corrective Action Plan to resolve those findings. This document contains CMS' findings related to particular regulatory and guidance areas relevant to Managed Long Term Service and Support programs (MLTSS). Columns describe the laws, regulations, and sub regulatory guidance that CMS based the review on, and evidence demonstrating how KanCare was not in compliance with those rules. Additionally, there are columns that describe the actions that CMS is requiring Kansas to take to correct the identified noncompliance, including 1915(c) and 1115 waiver STC amendments, State plan amendments, and contract amendments, as well as other required actions.

States are expected to maintain the highest level of quality in all MLTSS operations and services through the development and implementation of a comprehensive quality strategy that is integrated with any existing state quality strategies. The design and implementation of a quality improvement strategy must be transparent and appropriately tailored to address the needs of the MLTSS population. The Quality Strategy must include a system for continuous quality improvement (CQI) that builds upon previous and current development efforts and resources, reduces duplication, and fosters standardization of core elements across Medicaid authorities including quality measures that are focused on outcomes and critical processes; an appropriate, representative, statistical sampling methodology where applicable; and mechanisms for the tracking and aggregation of data, remediation and systems improvement efforts. State Medicaid Agencies (SMAs) maintain ultimate responsibility and accountability for the quality and operation of MLTSS programs, and may not delegate this responsibility. States must provide adequate oversight and monitoring of MLTSS systems and Managed Care Organizations (MCOs). State contracts must clearly specify state and MCO responsibilities, and clarify that MCO subcontractors are accountable to the MCO.

While CMS did not conduct a comprehensive data review of managed care quality data through the KanCare onsite, CMS has identified multiple areas where the State is not requiring the MCOs to report in a standardized manner. In addition, CMS identified significant issues and noncompliance in 1915(c) quality reporting measures. Per a CMS letter dated December 14, 2016 to KDHE, Kansas is required to submit a corrective action plan related to CMS-372 quality data. As States must develop and implement a comprehensive quality strategy sufficient to oversee and monitor MLTSS programs, CMS is requiring Kansas to assess the existing KanCare quality strategy and implement a comprehensive strategy that aligns with other systems of care, including HCBS quality strategies. This strategy should take into account findings identified in this report and ways to measure and oversee corrective action and improvement across the KanCare program.

MLTSS Key Elements	Federal Rules and Criteria Findings/Observations		Recommended Corrective Action: Federal regulations at 42 C.F.R. § 430.35 allow CMS to withhold Federal Financial Participation payments from a State after a finding that the State's plan fails to comply, or to substantially comply, with the provisions of section 1902 of the Act. Kansas' execution of the CAP and measured performance improvement will ultimately inform the extension of Kansas' 1115 demonstration program , as well as future managed care contracts and 1915(c) waiver actions.				
			HCBS Waiver Amendment	SPA	MCO /EB Contract Amendment	1115 STC Amendment	Additional Required Action
Adequate Planning/ Administrative Authority	**42 CFR § 431.10 (b) - Designation and certification.** A State plan must— (1) Specify a single State agency established or designated to administer or supervise the administration of the plan; and (2) Include a certification by the State Attorney General, citing the legal authority for the single State agency to—(i) Administer or supervise the administration of the plan; and (ii) Make rules and regulations that it follows in administering the plan or that are binding upon local agencies that administer the plan. **HCBS Technical Guide, pgs. 54 and 55 -** When the waiver is not operated by a division/unit of the Medicaid agency, there must be a formal, written agreement between the Medicaid agency and the operating agency that explicitly spells out the waiver activities and functions that the operating agency performs on behalf of the Medicaid agency....An agreement...must be sufficiently detailed so that it clearly delineates those activities, functions and responsibilities that the Medicaid agency delegates to the operating agency and the responsibilities of the operating agency in carrying out those functions.... The agreement may not undermine the ultimate authority and responsibility of the Medicaid agency for the operation of the waiver, including meeting the waiver assurances....[W]hen a waiver is not operated by the Medicaid agency, the Medicaid agency must ensure that the operating agency performs its assigned waiver operational and administrative functions in accordance with waiver requirements.						Update the MOU, or produce another written agreement between KDADS and KDHE that indicates the roles and responsibilities of each agency in operating the waivers. The agreement should specify how often it will be reviewed and updated. Any management by KDADS (or other operating agency) must be under the direct guidance of KDHE with ongoing KDHE review and oversight. Each HCBS waiver must be amended as needed to accurately reflect KDHE/KDADS/other delegated entity roles and responsibilities once the MOU has been revised.
	Evidentiary Examples	The State has failed to ensure that KDHE retains ultimate administrative authority over the Medicaid program. KDHE, the State Medicaid agency, does not appear to have sufficient oversight over the operating agency, KDADS.					
		The Memorandum of Understanding (MOU) between KDHE and KDADS was last updated in 2010 and references State departments that no longer exist. The MOU does not specify the criteria upon which KDADS' performance will be evaluated.	X		X		
		Recent HCBS 372 data demonstrates that KDADS submitted only one of four required Quality Review reports to KDHE in 2014.					
Adequate Planning/ Administrative Authority	**42 CFR § 438.66 Monitoring procedures.** The State agency must have in effect procedures for monitoring the MCO's, PIHP's, or PAHP's operations, including, at a minimum, operations related to the following: (a) beneficiary enrollment and disenrollment. (b) Processing of grievances and appeals. (c) Violations subject to intermediate sanctions, as set forth in subpart I of this part. (d) Violations of the conditions for FFP, as set forth in subpart J of this part. (e) All other provisions of the contract, as appropriate. **May 20, 2013 Guidance to States using 1115 demonstrations or 1915(b) waivers for Managed Long Term Services and Supports Programs** ESSENTIAL ELEMENT #10: Quality. States are expected to maintain the highest level of quality in all MLTSS operations and services through the development and implementation of a comprehensive quality strategy that is integrated with any existing state quality strategies. The design and implementation of a quality improvement strategy must be transparent and appropriately tailored to address the needs of the MLTSS population. Reporting and Transparency: States must develop mandatory MCO reports related to the critical elements of MLTSS, including areas such as network adequacy; timeliness of assessments, service plans and service plan revisions; disenrollment; utilization data; call monitoring; quality of care performance measures; fraud and abuse reporting; participant health and functional status; complaint and appeal actions. These reporting requirements must be specified in the MCO contract. States must analyze MCO reports as part of its quality oversight and based on the results, take corrective action as needed.						KDHE must establish methods for analyzing overall program data, tracking and identifying trends, and remediating identified issues. MCO contracts must be amended to outline specific, consistent reporting requirements and data elements/definitions to enable tracking and identification of trends across MCOs. KDHE and KDADS should define what types of feedback can be provided verbally, and what types of feedback should be provided formally, in writing.
	Evidentiary Examples	The State has not effectively tracked MCO performance according to contract standards on a centralized and timely basis in the following areas: (1) Network adequacy for LTSS; (2) Quality of care; (3) Access to care and appointments; (4) Utilization management; (5) Prior authorization process (including consistent/statewide application of medical necessity criteria); and (6) Grievances and appeals. While the MCOs submit many reports, there is no evidence that the state engages in any significant analysis or subsequent program changes based on those reports. Each report is delegated to one person in either KDHE or KDADS for review, but there is no centralized way for the findings from each report to be shared among the agencies, communicated to leadership, and tracked for overall systemic performance.					
		The purpose and/or effectiveness of some required MCO reports is unclear. Reporting is inconsistent and definitions of data elements vary among MCOs, which hinders State oversight and ability to identify trends across the program.					
		KanCare Contract Section 2.2.11.4 States that MCOs are to submit health screenings and examination reports quarterly in a State approved format. There was no evidence that the State reviewed these reports in their totality or issued comments regarding the reports. MCO staff indicated that although they provide many required reports to KDHE and KDADS staff, they receive little feedback on them, and what feedback they do receive is typically verbal.	X		X		
		The State has not effectively monitored MCO operations in critical program areas including: care coordination and care management, development of plans of care, critical incident reporting, and grievances and appeals. Contractual requirements regarding oversight of MCO performance in these areas are also weak.					
		The State's oversight of the MCOs has diminished over the four years of KanCare operation, as evidenced by it's annual onsite reviews of the MCOs and subsequent reports. The 2013 annual report was a comprehensive document, and corrective action plans were issued to the MCOs regarding identified issues. The 2014 and 2015 annual reports were each 2 pages long, with little content of substance.					

MLTSS Key Elements	Federal Rules and Criteria Findings/Observations		Recommended Corrective Action Federal regulations at 42 C.F.R. § 430.35 allow CMS to withhold Federal Financial Participation payments from a State after a finding that the State's plan fails to comply, or to substantially comply, with the provisions of section 1902 of the Act. Kansas' execution of the CAP and measured performance improvement will ultimately inform the extension of Kansas' 1115 demonstration program , as well as future managed care contracts and 1915(c) waiver actions.				
			HCBS Waiver Amendment	SPA	MCO /EB Contract Amendment	1115 STC Amendment	Additional Required Action
Adequate Planning/ Administrative Authority	**42 CFR § §438.10(b)(2)** Basic rules - The State must have in place a mechanism to help enrollees and potential enrollees understand the State's managed care program. (3) Each MCO and PIHP must have in place a mechanism to help enrollees and potential enrollees understand the requirements and benefits of the plan.						KDHE and/or KDADS must implement new or improve existing mechanisms for sharing clear and consistent information with stakeholders regarding KanCare benefits and administration, and regarding policy and guidance changes.
	Evidentiary Examples	KanCare stakeholders lack clear and consistent policy, direction, guidance, and State leadership. Policy changes are frequent and policy information can be difficult to locate and understand. This results in significant inconsistency among MCO operations as well as miscommunication, fear, and "change fatigue" among members and other stakeholders seeking to understand the program.					
Adequate Planning/ Administrative Authority	**42 CFR 430.12 (c) (1) Plan amendments** - The plan must provide that it will be amended whenever necessary to reflect (i) Changes in Federal law, regulations, policy interpretations, or court decisions; or (ii) Material changes in State law, organization, or policy, or in the State's operation of the Medicaid program. **STC # 6. Changes Subject to the Amendment Process.** Changes related to eligibility, enrollment, benefits, enrollee rights, delivery systems, cost sharing, evaluation design, sources of non-federal share of funding, budget neutrality, and other comparable program elements must be submitted to CMS as amendments to the demonstration. All amendment requests are subject to approval at the discretion of the Secretary in accordance with section 1115 of the Act. The state must not implement changes to these elements without prior approval by CMS. Amendments to the demonstration are not retroactive and FFP will not be available for changes to the demonstration that have not been approved through the amendment process set forth in STC 7 below. **HCBS Waiver Technical Guide, page 26** - Whenever there is a change that affects an element of an approved waiver, the State must submit an amendment to the waiver. The approved waiver must be kept in synchronization with State waiver polices, practices, procedure and operations.						KDHE and KDADS must identify policies and procedures implemented from 2013 to the present that would require CMS approval through an HCBS Waiver Amendment, State Plan Amendment, or 1115 STC amendment. Identified changes should be submitted to CMS within 90 days of receipt of this CAP. (The capable person policy changes that were implemented have been rescinded and do not need to be readdressed.)
	Evidentiary Examples	The state has failed to properly submit policy changes for CMS approval. Such policy changes include but are not limited to: (1) Cost Adjustment Factors for Critical Access Hospitals; (2) Inpatient Hospital Interim Billing Charges; (3) Kansas University Hospital Inpatient Reimbursement Methodology Change; (4) Budget Payment Reduction for Hospitals Subject to the HCAIP Reduction; (5) Pharmacy prior authorization requirements; and (6) Capable Person Policy.					

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	42 CFR 431.12 - (b) State plan requirement. A State plan must provide for a medical care advisory committee meeting that requirements of this section to advise the Medicaid agency director about health and medical care services. **(c) Appointment of members.** The agency director, or a higher State authority, must appoint members to the advisory committee on a rotating and continuous basis. **(d) Committee membership.** The committee must include - (1) Board-certified physicians and other representatives of the health professions who are familiar with the medical needs of low-income population groups and with the resources available and required for their care; (2) Members of consumers' groups, including Medicaid beneficiaries, and consumer organizations such as labor unions, cooperatives, consumer-sponsored prepaid group practice plans, and others; and (3) The director of the public welfare department or the public health department, whichever does not head the Medicaid agency. **(e) Committee participation.** The committee must have opportunity for participation in policy development and program administration, including furthering the participation of beneficiary members in the agency program. **42 CFR 431.408 - (a) General.** A State must provide at least a 30-day public notice and comment period regarding applications for a demonstration project, or an extension of an existing demonstration project that the State intends to submit to CMS for review and consideration. **HCBS Waiver Technical Guide, pg. 49** - The State must provide at least a 30 day public notice and comment period, and be completed at a minimum of 30 days prior to submission of the proposed change to CMS. The State...must include a summary of the public comments received during the public input process, and if any comments were not adopted, the reasons why. The State must also specify in their summary any modifications to the waiver that they made as a result of the public input process. **STC # 15** - Within six months of the demonstration's implementation, and annually thereafter, the State will afford the public with an opportunity to provide meaningful comment on the progress of the demonstration....the State must include a summary of the of the comments and issues raised by the public at the forum and include the summary in the quarterly report....{and} in its annual report. **May 20, 2013 Guidance to States using 1115 demonstrations or 1915(b) waivers for Managed Long Term Services and Supports Programs** ESSENTIAL ELEMENT #2: Stakeholder Engagement. Successful programs have developed a structure for engaging stakeholders regularly in the development and implementation of new, expanded or reconfigured MLTSS programs. This includes cross- disability representation of individual participants as well as community, provider, and advocacy groups in order to obtain meaningful input into both the planning and operation of MLTSS programs. CMS will expect states to have a formal process for the ongoing education of stakeholders prior to, during, and after implementation, and states must require their contractors to do the same. **STC #40 State Advisory Committee** - The state must maintain for the duration of the demonstration, a public managed care advisory group comprised of individuals, family members, interested parties, and stakeholders impacted by the demonstration's use of managed care, regarding the impact and effective implementation of these changes. Membership on this group should be periodically updated to ensure adequate representation of individuals receiving LTSS as well as other eligibility groups. The state shall maintain minutes from these meetings and use them in evaluating program operations and identifying necessary program changes. Copies of committee meeting minutes must be made available to CMS upon request and the outcomes of the meetings may be discussed on the bimonthly demonstration calls in STC 78. **STC #41. MCO Participant Advisory Committees.** The state shall require each MCO, through its contracts, to create and maintain participant advisory committees through which the MCO can share information and capture enrollee feedback. The MCOs will be required to support and facilitate participant involvement and submit meeting minutes to the state. Copies of meeting minutes must be made available to CMS upon request.					
Stakeholder Engagement	Providers, members, guardians, and advocates describe a lack of engagement and adversarial communication from the State and/or MCOs. Comments from KanCare stakeholders at multiple stakeholder sessions overwhelmingly reflect an inability to obtain clear and consistent information, making it difficult for KanCare enrollees to navigate their benefits.					KDHE must develop an education and outreach plan that includes provider education and support, such as collaborative efforts to work with contractors and MCOs to provide educational sessions, newsletters, and notices targeted to LTSS providers. KDHE must publicize a method for beneficiaries to obtain consumer support (e.g., hotline, ombudsman, etc.) and require contractors and MCOs to publish consistent

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			HCBS Waiver Amendment	SPA	MCO /EB Contract Amendment	1115 STC Amendment	Additional Required Action
	Evidentiary Examples	The state maintains the KanCare Advisory Committee; however, this committee does not meet key requirements for Medical Care Advisory Committees. Primarily, committee members report not having an opportunity for participation in policy development or program administration, as required by 42 CFR 431.12(e). As identified through interviews and documentation review of meeting minutes, the state and MCOs report out to the committee but provide little opportunity for feedback or input from the committee members. In addition, CMS could not determine whether the membership of the committee is updated periodically as required by both 431.12(c) and STC 40.				X	information. The state must ensure that the KanCare Advisory Committee meets all requirements as outlined in 42 CFR 431.12, including but not limited to allowing for committee participation in policy development and program administration. Recommendations for improvement include the development a charter with established goals, measurable deliverables, and a strategic plan. KDHE must amend the STCs for its 1115 waiver to include methods of ensuring: (1) that advisory board membership fairly represents KanCare stakeholders; (2) that MCOs operate the boards in ways that are reasonably convenient and transparent to the members; and (3) that board members feel free to be candid without fear of retaliation. KDHE must also develop methods of overseeing the MCO advisory boards to ensure that they fulfill their intended purpose. These methods can be included in the STCs, or outlined in the CAP. CMS recommends that these methods include having a member of State staff present at each MCO advisory board meeting. KDHE and KDADS must establish stakeholder consultation policy and practices that meet federal public comment/input requirements. Requirements for summarization of comments received and changes made must be adhered to through the execution of amendments related to this CAP and beyond, as appropriate to the type of amendment being made.
		All three MCOs did have member advisory boards. However, some stakeholders were not aware that member advisory boards existed. Stakeholders who had participated in the advisory boards reported not being invited back if they expressed dissatisfaction. Stakeholders also reported feeling that the input of the advisory boards was discounted if it contradicted what the State or MCO desired, and that advisory board meetings were constantly frequently cancelled and rescheduled, making them hard to actually attend.					
		Stakeholders noted that the State often does not respond to public comments or include changes in final policy documents to address public comments.					

MLTSS Key Elements	Federal Rules and Criteria Findings/Observations	Recommended Corrective Action				
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		HCBS Waiver Amendment	SPA	MCO /EB Contract Amendment	1115 STC Amendment	Additional Required Action
Support for Beneficiaries	**42 CFR 438.6(f)** *Compliance with contracting rules.* All contracts must meet the following provisions: (1) Comply with all applicable Federal and State laws and regulations including title VI of the Civil Rights Act of 1964; title IX of the Education Amendments of 1972 (regarding education programs and activities); the Age Discrimination Act of 1975; the Rehabilitation Act of 1973; and the Americans with Disabilities Act of 1990 as amended. **42 CFR 438.10** including requirements regarding basic rules; language; format; information for potential enrollees, including (ii) Information specific to each MCO, PIHP, PAHP, or PCCM program operating in potential enrollee's service area on: (A) Benefits covered (B) Cost sharing, if any (C) Service area (D) Names, locations, telephone numbers of, and non-English language spoken by current contracted providers, and including identification of providers that are not accepting new patients; general information for all enrollees of MCOs, PIHPs, PAHPs, and PCCMs; and specific information requirements for enrollees of MCOs and PIHPs. **Social Security Act Section 1903(b)(4)(A) and (B) and 42 CFR 438.810(a)** including requirements regarding conditions that enrollment brokers must meet, including independence, freedom from conflict of interest, and approval. "Choice counseling means activities such as answering questions and providing information (in an unbiased manner) on available MCO, PIHP, PAHP, or PCCM delivery system options, and advising on what factors to consider when choosing among them and in selecting a primary care provider;" **May 20, 2013 Guidance to States using 1115 demonstrations or 1915(b) waivers for Managed Long Term Services and Supports Programs** ESSENTIAL ELEMENT #2: Stakeholder Engagement. Successful programs have developed a structure for engaging stakeholders regularly in the development and implementation of new, expanded or reconfigured MLTSS programs. This includes cross- disability representation of individual participants as well as community, provider, and advocacy groups in order to obtain meaningful input into both the planning and operation of MLTSS programs. CMS will expect states to have a formal process for the ongoing education of stakeholders prior to, during, and after implementation, and states must require their contractors to do the same. **STC 27** b. Enrollment Process after January 1, 2013 - All individuals must have the opportunity to make an active selection of a KanCare MCO during the application process. If no MCO is selected, the state will pre-select an MCO for each KanCare member and enroll the individual in that MCO. That pre-selection shall be based on the principles set forth in 42 CFR 438.52(f), taking into account the MCO affiliation of the individual's historic providers, with a prior history with the MCO being taken into account first. c. Additional Enrollment Supports for Beneficiaries using LTSS. For individuals residing in a nursing facility or other residential facility, the nursing or residential facility will be used first to determine the selection of a KanCare MCO. For individuals using HCBS providers at the time of enrollment, the selection process must be customized to the specific waiver with specific attention paid to the types of providers critical to positive outcomes of the individuals within each of the waivers. All individuals enrolled in one of the 1915(c) waivers in STC 21 at the time of KanCare enrollment must have the opportunity to receive counseling from an independent options counselor to assist them in making an MCO selection and switching MCOs if desired.					
	Evidentiary Examples: The State's contract with their enrollment broker does not address a number of Federal regulatory requirements. Furthermore, the state provided limited evidence regarding its oversight of enrollment broker functions performed by its contractor, including choice counseling. Furthermore, the booklet provided to new enrollee and during annual open enrollment does not describe how enrollees can access choice counseling.			X	X	KDHE must amend its enrollment broker contract to address the requirements of section 1903 (b)(4)(A) and (B) of the Social Security Act, 42 CFR 438.6(f)(1), 42 CFR 438.10, and 42 CFR 438.810. KDHE must develop a plan to monitor and oversee the enrollment broker functions performed by its contractor.
	STC 42. Independent Consumer Supports (Ombudsman). To support the beneficiary's experience receiving medical assistance and long term services and supports in a managed care environment, the state shall maintain a permanent system of independent consumer supports (hereafter referred to as the Ombudsman) to assist enrollees in understanding the coverage model and in resolving problems regarding services, coverage, access and rights....The Ombudsman shall help enrollees understand the State's Medicaid fair hearing process, grievance and appeal rights, and grievance and appeal processes provided by the health plan, and shall assist enrollees in navigating those processes and/or accessing community legal resources, if needed/requested....The State shall develop an access standard to measure the availability and responsiveness of the system to beneficiaries and others seeking support from the Ombudsman, and shall report compliance with this standard to CMS...The system shall be staffed sufficiently to address all requests for support consistent with this access standard...The Ombudsman shall include a robust system of data collection and reporting (including) the following elements: ...the current status of the request for assistance, including actions taken to resolve.					
	The Ombudsman Quarterly Reports include numbers of contacts, method of contact, contacts by type (provider, consumer, etc.) and average days to resolution. They do not include compliance with the access standard, the actions taken to resolve requests for assistance, or any analysis of the data provided. The 2016 reports show a significant increase in the number of inquiries received (an increase of over 100% in the first quarter of 2016), but no corresponding increase in staffing, causing concerns about whether access to the Ombudsman is being supported as required in the STC.					

MLTSS Key Elements	Federal Rules and Criteria Findings/Observations	Recommended Corrective Action				
		Federal regulations at 42 C.F.R. § 430.35 allow CMS to withhold Federal Financial Participation payments from a State after a finding that the State's plan fails to comply, or to substantially comply, with the provisions of section 1902 of the Act. Kansas' execution of the CAP and measured performance improvement will ultimately inform the extension of Kansas' 1115 demonstration program , as well as future managed care contracts and 1915(c) waiver actions.				
		HCBS Waiver Amendment	SPA	MCO /EB Contract Amendment	1115 STC Amendment	Additional Required Action
Support for Beneficiaries	The Ombudsman's office provides information and referrals to KanCare members, helping them to understand who to call or how to resolve their concerns. However, the Ombudsman's office did not assist participants through the appeals process as described in STC 42; the extent of the Ombudsman's office's involvement with appeals was helping participants understand the appeals process and providing referrals as needed to legal resources. Stakeholder reports reflected the lack of active assistance through the appeals process as well. Two advocates reported being told that the Ombudsman was not allowed to assist with filing appeals. The lack of proactive assistance with appeals may be due to the Ombudsman program's small size. The Iowa and Kansas Medicaid programs have comparable HCBS waivers and similarly sized managed care populations. In September 2016, the KanCare Ombudsman's office included 3 State staff positions (one of which was vacant) and 10 volunteers. In contrast, in 2015 Iowa's Long-Term Care Ombudsman Office employed 9 state staff, 8 local ombudsmen, and 131 volunteers. (Kansas does also have a Long-Term Care Ombudsman office separate from the KanCare Ombudsman, which includes 2 state staff and 7 local ombudsmen, but it only serves residents of LTC facilities.)					KDADS must develop methods of overseeing the KanCare Ombudsman Program, to ensure that all functions ascribed to it in the STCs are carried out effectively and that its independence is preserved. The quarterly and annual reports must be updated to include all elements of reporting required by the STCs. KDHE and KDADS should review the resources dedicated to the Ombudsman's office, to ensure that they are adequate to execute the Ombudsman's role as described in the STCs.
	42 CFR 438.208(b) - Care and coordination of services for all MCO...enrollees. Each MCO...must implement procedures to deliver care to and coordinate services for all MCO...enrollees. These procedures must meet State requirements and must do the following:...(2) Coordinate the services the MCO...furnishes to the enrollee: (i) Between settings of care, including appropriate discharge planning for short term and long-term hospital and institutional stays; (ii) With the services the enrollee receives from any other MCO, PIHP, or PAHP; (iii) With the services the enrollee receives in FFS Medicaid; and (iv) With the services the enrollee receives from community and social support providers. **KanCare Program Description and Objectives:** The KanCare demonstration will assist the state in its goals to provide integration and coordination of care across the whole spectrum of health to include physical health, behavioral health, mental health, substance use disorders and LTSS.					
Support for Beneficiaries	Stakeholders reported frequent turnover among the care coordinators assigned by the MCOs, and that some care coordinators are unprepared, asking questions of members and providers about their duties and basic knowledge needed about waiver programs. Stakeholders also reported that care coordinators often do not return phone calls or emails. Stakeholders also reported that one MCO assigns and changes care coordinators seemingly arbitrarily, and that members and their guardians aren't notified that the member's care coordinator has changed.					KDHE must amend the MCO contracts to specify requirements for dedicated customer service access point for LTSS members. KDHE must design and track performance metrics related to MCO provision of care coordination and member satisfaction with care coordination. KDHE and KDADS must clearly document the roles and responsibilities of each agency for oversight of MCO performance with regard to care coordination.
	The care management model used by the three MCOs is divided based on the following service types: (1) non-LTSS medical; (2) LTSS; (3) behavioral health; and (4) pharmacy. CMS found limited support for this specialized care management model resulting in effective care coordination. Additionally, two of the MCOs reported having separate care management systems depending on the service being accessed by the enrollee.					
	42 CFR 440.169(b) - Targeted case management services means case management services furnished without regard to the requirements of §431.50(b) of this chapter (related to statewide provision of services) and §440.240 (related to comparability). Targeted case management services may be offered to individuals in any defined location of the State or to individuals within targeted groups specified in the State plan.					
Support for Beneficiaries	MCOs, consumers, advocates, and providers all expressed a lack of clarity around the roles of the Targeted Case Manager in the I/DD waiver system and the MCO care coordinator. One stakeholder reported that a member's care coordinator introduced herself as the member's Targeted Case Manager, causing the member a great deal of anxiety regarding whether she had lost her Targeted Case Manager.					KDHE and KDADS should review existing documents describing the roles and responsibilities of the TCM and the MCO care coordinators to ensure they are clear, accurate, and complete. Once any needed revisions to these documents are complete, KDHE and KDADS must ensure that they are easily available to MCOs and stakeholders. KDHE and KDADS must implement oversight of the MCOs to ensure that: both TCMs and care coordinators execute their roles as defined; and that TCMs and care coordinators work together to meet beneficiaries' needs.

MLTSS Key Elements	Federal Rules and Criteria Findings/Observations	Recommended Corrective Action				
		Federal regulations at 42 C.F.R. § 430.35 allow CMS to withhold Federal Financial Participation payments from a State after a finding that the State's plan fails to comply, or to substantially comply, with the provisions of section 1902 of the Act. Kansas' execution of the CAP and measured performance improvement will ultimately inform the extension of Kansas' 1115 demonstration program , as well as future managed care contracts and 1915(c) waiver actions.				
		HCBS Waiver Amendment	SPA	MCO /EB Contract Amendment	1115 STC Amendment	Additional Required Action
Person Centered Processes	**42 CFR 441.301(c)(1)** ...the person-centered planning process:...(iii) Is timely and occurs at times and locations of convenience to the individual. (2) The Person-Centered Service Plan. ...the written plan must:...(ix) Be finalized and agreed to, with the informed consent of the individual in writing, and signed by all individuals and providers responsible for its implementation. **42 CFR 441.301 (c)(2) -** The person-centered service plan must reflect the services and supports that are important for the individual to meet the needs identified through an assessment of functional need, as well as what is important to the individual with regard to preferences for the delivery of such services and supports. ...the written plan must:... (xiii) Document that any modification of the additional conditions, under paragraph (c)(4)(vi)(A) through (D) of this section, must be supported by a specific assessed need and justified in the person-centered service plan. The following requirements must be documented in the person-centered service plan: (A) Identify a specific and individualized assessed need. (B) Document the positive interventions and supports used prior to any modifications to the person-centered service plan. (C) Document less intrusive methods of meeting the need that have been tried but did not work. (D) Include a clear description of the condition that is directly proportionate to the specific assessed need. (E) Include a regular collection and review of data to measure the ongoing effectiveness of the modification. (F) Include established time limits for periodic reviews to determine if the modification is still necessary or can be terminated. (G) Include informed consent of the individual. (H) Include an assurance that interventions and supports will cause no harm to the individual. **42 CFR § 441.302** State assurances. Unless the Medicaid agency provides the following satisfactory assurances to CMS, CMS will not grant a waiver under this subpart and may terminate a waiver already granted: (d) Alternatives—Assurance that when a beneficiary is determined to be likely to require the level of care provided in a hospital, NF, or ICF/IID, the beneficiary or his or her legal representative will be—(1) Informed of any feasible alternatives available under the waiver; and (2) Given the choice of either institutional or home and community-based services. **42 CFR § 438.208(c)(3) -** Treatment/service plans. MCOs, PIHPs, or PAHPs must produce a treatment or service plan meeting the criteria in paragraphs (c)(3)(i) through (v) of this section for enrollees who require LTSS .... The treatment or service plan must be: (i) Developed by an individual meeting LTSS service coordination requirements with enrollee participation, and in consultation with any providers caring for the enrollee; (ii) Developed by a person trained in person-centered planning using a person-centered process and plan as defined in §441.301(c)(1) and (2) of this chapter for LTSS treatment or service plans. **42 CFR § 438.210 (b) -** Authorization of services. For the processing of requests for initial and continuing authorizations of services, each contract must require...(2) That the MCO, PIHP, or PAHP—...(iii) Authorize LTSS based on an enrollee's current needs assessment and consistent with the person-centered service plan.					
	Staff of one MCO indicated that while a service plan is developed for each waiver participant within 14 days of entering the waiver, the Person Centered Support Plan is not discussed or developed until 3-6 months after services are authorized.					
	None of the MCOs have processes in place that ensure all final Plans of Care are signed and agreed to by the member. All three MCOs described processes that required members to sign "interim" or "proposed" plans of care that were then reviewed and possibly revised by a utilization review committee within the MCO. If changes were made, MCOs attempted to obtain member signatures on the final plans, but stated they not always successful in obtaining those signatures.					
	The comments of members/guardians, advocates, and providers reflect the MCOs' processes. At a listening session for members and guardians hosted by CMS, approximately half the attendees reported being asked or required to sign incomplete plans of care that did not indicate the types of services or numbers of hours they would receive. Some of these stakeholders also reported experiencing long delays in receiving a copy of final plans of care, or never receiving a final plan of care.					KDHE and KDADS must work with the MCOs to require implementation of a person-centered planning process that follows all the regulations at 42 CFR 441.301. The

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			Federal regulations at 42 C.F.R. § 430.35 allow CMS to withhold Federal Financial Participation payments from a State after a finding that the State's plan fails to comply, or to substantially comply, with the provisions of section 1902 of the Act. Kansas' execution of the CAP and measured performance improvement will ultimately inform the extension of Kansas' 1115 demonstration program , as well as future managed care contracts and 1915(c) waiver actions.				
			HCBS Waiver Amendment	SPA	MCO /EB Contract Amendment	1115 STC Amendment	Additional Required Action
Person Centered Processes	Evidentiary Examples	None of the three MCOs currently require the signature of providers responsible for plan implementation.		x		x	process should be consistent across all MCOs. KDHE must amend MCO contracts to require implementation of and compliance with the person-centered planning process KDHE and KDADS design. KDHE and KDADS must also amend the 1915(c) waivers to reflect the required person-centered planning processes.
		One MCO did not document rights restrictions, such as limiting access to food for members with conditions affected by their nutrition, in the person-centered plans.					
		Recent HCBS 372 data demonstrates that: -service plans address goals of participants less than 61% of the time in 5 out of 7 waivers; -an average of only 21% of participants with documented changes in needs had their service plan modified to address the change; -service plans address goals of participants less than 61% of the time in 5 out of 7 waivers -documentation of being offered a choice of community-based or institutional services; a choice of self-directed or agency-directed care; or a choice among waiver services was not available for many waiver participants.					
		None of the MCOs indicated that copies of the person-centered service plan are provided to the individual and those involved in its development.					
		CMS requested a sample of service plans from each of the three MCOs. CMS is currently conducting a record review of those service plans. Upon completion, CMS will provide further direction regarding any additional findings or required corrective action.					

MLTSS Key Elements	Federal Rules and Criteria Findings/Observations		Recommended Corrective Action				
			Federal regulations at 42 C.F.R. § 430.35 allow CMS to withhold Federal Financial Participation payments from a State after a finding that the State's plan fails to comply, or to substantially comply, with the provisions of section 1902 of the Act. Kansas' execution of the CAP and measured performance improvement will ultimately inform the extension of Kansas' 1115 demonstration program , as well as future managed care contracts and 1915(c) waiver actions.				
			HCBS Waiver Amendment	SPA	MCO /EB Contract Amendment	1115 STC Amendment	Additional Required Action
	42 CFR 438.206(b) Delivery network. The State must ensure, through its contracts, that each MCO...meets the following requirements: (1) Maintains and monitors a network of appropriate providers that is supported by written agreements and is sufficient to provide adequate access to all services covered under the contract. In establishing and maintaining the network, each MCO...must consider the following: (i) The anticipated Medicaid enrollment. (ii) The expected utilization of services, taking into consideration the characteristics and health care needs of specific Medicaid populations represented in the particular MCO.... (iii) The numbers and types (in terms of training, experience, and specialization) of providers required to furnish the contracted Medicaid services. (iv) The numbers of network providers who are not accepting new Medicaid patients. (v) The geographic location of providers and Medicaid enrollees, considering distance, travel time, the means of transportation ordinarily used by Medicaid enrollees, and whether the location provides physical access for Medicaid. **42 CFR 438.207 Assurance of adequate capacity and services.** (a) *Basic rule.* The State must ensure, through it's contracts, that each MCO... gives assurances to the State and provides supporting documentation that demonstrates that it has the capacity to serve the expected enrollment in its service area in accordance with the State's standards for access to care under this subpart. (b)*Nature of supporting documentation.* Each MCO...must submit documentation to the State, in a format specified by the State to demonstrate that it complies with the following requirements: (1) offers an appropriate range of preventive, primary care, and specialty services that is adequate for the anticipated number of enrollees for the service area. (2) Maintains a network of providers that is sufficient in number, mix, and geographic distribution to meet the needs of the anticipated number of enrollees for the service area. (d)*State review and certification to CMS.* After the State reviews the documentation submitted by the MCO..., the State must certify to CMS that the MCO... has complied with the State's requirements for availability of services.						
Provider Network Adequacy	Evidentiary Examples	The State's approach to tracking, monitoring, and overseeing provider network adequacy and access to care for KanCare consumers is limited given the comprehensive nature of the program and the inclusion of most Medicaid consumers. MCOs must submit the following reports to the State: -an access to care report (based on time and distance standards) -annual provider network report including information on all providers of health services -a monthly provider network report on net additions and subtractions in specific categories of providers -a quarterly network adequacy assurance reflecting members by geographic designation -an annual report on net percentage change in licensed mental health providers. However, there seemed to be little analysis of or trending based on these reports at the State level. CMS staff have asked KDHE staff multiple times in late 2016 for the State's analysis of network adequacy. Although KDHE provided MCO provider network reports in response to these requests, CMS has never received any evidence of the State's own analysis of network adequacy.					KDHE and KDADS must develop methods to analyze data from the MCOs that supports the assurance of the adequacy of the network. KDHE should prescribe the data format and definitions of data elements and codes MCOs use to produce provider network reports, to ensure the validity of the data reported. The State should consider requirements for the MCOs around provider network reporting, and how effective those reports are in assessing the adequacy of the networks. The state should begin work to comply with managed care final regulations for the network adequacy standards found at 42 CFR 438.68. While these standards are not required until 2018, CMS encourages the State to consider developing additional network adequacy standards to monitor provider network enrollment and capacity.
		The provider network data produced by the MCOs for much of 2015 contained incorrect and inconsistent information on provider specialties related to HCBS, making the data less useful for analyzing HCBS provider network adequacy. The MCOs report that the data now being reported is correct, after a data clean up effort in 2015.					

MLTSS Key Elements	Federal Rules and Criteria Findings/Observations	Recommended Corrective Action				
		Federal regulations at 42 C.F.R. § 430.35 allow CMS to withhold Federal Financial Participation payments from a State after a finding that the State's plan fails to comply, or to substantially comply, with the provisions of section 1902 of the Act. Kansas' execution of the CAP and measured performance improvement will ultimately inform the extension of Kansas' 1115 demonstration program , as well as future managed care contracts and 1915(c) waiver actions.				
		HCBS Waiver Amendment	SPA	MCO /EB Contract Amendment	1115 STC Amendment	Additional Required Action
Participant Protections	**42 CFR § 441.302 State assurances**. Unless the Medicaid agency provides the following satisfactory assurances to CMS, CMS will not grant a waiver under this subpart and may terminate a waiver already granted: (a) Health and Welfare—Assurance that necessary safeguards have been taken to protect the health and welfare of the beneficiaries of the services. **STC 37. Comprehensive State Quality Strategy.** The state shall adopt and implement a comprehensive and holistic, continuous Quality Improvement Strategy that focuses on all aspects of quality improvement in KanCare including acute, primary, behavioral and long term services and supports. The Quality Strategy shall meet all the requirements of 42 CFR 438 Subpart D and must include components relating to HCBS that address the following: administrative authority, level of care determinations, person-centered service planning process and outcome of person-centered goals, health and welfare, and qualified providers. The Quality Strategy must include State Medicaid Agency and MCO responsibilities, with the State Medicaid Agency retaining ultimate authority and accountability for ensuring the quality of and overseeing the operations of the program. The Quality strategy must include distinctive components for discovery, remediation, and improvement.... **STC 49. Critical Incident Management System.** The state Medicaid agency or the MCO operates a critical incident management system according to the State Medicaid agency's established policies, procedures and regulations. On an ongoing basis the State Medicaid agency ensures that all entities, including the MCOs, prevent, detect, report, investigate, and remediate instances of abuse, neglect and exploitation, and ensures participant rights are maintained through policies concerning seclusion, restraint and medication management....MCO and provider obligations include specific action steps that MCOs and providers must take in the event of suspected or substantiated abuse, neglect, or exploitation, including risk mitigation. If the State Medicaid agency delegates the responsibility for the critical incident management systems to the participating MCOs, the State Medicaid agency must collect and analyze the data collected by the MCOs on a regular, periodic basis, and ensure that the individual situations are remediated in a timely manner and that system-wide issues are identified and addressed. **HCBS Waiver Technical Guide, pg. 228** - An effective incident management system entails conducting oversight to make sure that applicable policies and procedures are being followed for the reporting of critical incidents or events and that necessary follow-up is being conducted on a timely basis. A critical element of effective oversight is the operation of data systems that support the identification of trends and patterns in the occurrence of critical incidents or events in order to identify opportunities for improvement and thus support the development of strategies to reduce the occurrence of incidents in the future.					
	Evidentiary Examples: Currently, providers report incidents to the Adverse Event Reporting System (AIRS); AIRS generates email notifications to both KDADS and staff of the appropriate MCO. MCO staff transfer AIRS reports to their own internal systems for follow-up. MCO staff cannot enter new records in AIRS, or update existing records, and reported that they are not required to report resolution of incidents to KDADS. When MCOs do report resolutions to KDADS, they do so by phone or email. KDADS staff indicated that they are working on improvements to the Adverse Incident Reporting System (AIRS) to allow MCOs to enter and/or update records. There is currently no centralized system for the state to receive information regarding reported and/or investigated incidents. The lack of a centralized system prevents the State from doing anything but the most basic tracking and trending of incidents. MCOs report a lack of clarity for providers around the definitions of various types of incidents and where and how to report.		x		x	KDHE and KDADS must develop methods to ensure effective oversight of adverse incidents. The state must develop a centralized system for capturing critical incidents that allows for consistent methods of tracking and trending critical incidents across all MCOs and providers. KDHE and KDADS must also identify specific staff responsible for tracking and trending critical incidents across the program. KDHE and KDADS must ensure that follow-up on critical incidents takes place as required and that resolutions are communicated to involved parties as required. KDHE and KDADS must develop clearly written policies and procedures describing the types of incidents to report, where to report incidents, the role of the member, provider, KDHE, KDADS, and the MCO in investigation, follow up, and trending of incidents. Finally, KDHE and KDADS must provide training on critical incident reporting, resolution, and tracking requirements to MCOs, providers, and other stakeholders as necessary to ensure correct implementation of requirements and procedures. KDHE must amend MCO contracts and the 1915(c) waivers to reflect the procedures, requirements, and oversight methods described above. KDHE may also need to amend the STCs if the changes made affect the
	Providers, advocates, and members indicated that they report incidents and often do not receive resolution. These stakeholders also reported feeling that there is little follow up done on reported incidents, by MCOs or the State. Attendees at a provider listening session held in late October 2016 reported that there had been one training hosted by the State on reporting abuse and neglect that year, and the previous training on this subject was held in 2013.					
	Recent HCBS 372 submissions provided no data to demonstrate that: -unexpected deaths were investigated within required timeframes; -reviews of critical incidents were initiated and reviewed within required timeframes; -the use of restraints, seclusion or other restrictive interventions followed procedures as specified in the approved waiver; or -the unauthorized use of restrictive interventions was detected.					

MLTSS Key Elements	Federal Rules and Criteria Findings/Observations		Recommended Corrective Action				
			Federal regulations at 42 C.F.R. § 430.35 allow CMS to withhold Federal Financial Participation payments from a State after a finding that the State's plan fails to comply, or to substantially comply, with the provisions of section 1902 of the Act. Kansas' execution of the CAP and measured performance improvement will ultimately inform the extension of Kansas' 1115 demonstration program , as well as future managed care contracts and 1915(c) waiver actions.				
			HCBS Waiver Amendment	SPA	MCO /EB Contract Amendment	1115 STC Amendment	Additional Required Action
		All three MCOs described sending a monthly report to the State on critical incidents. However, one MCO ranked incidents from 0 to 5, while the other two ranked incidents 0-4. Each MCO described a different minimum level when defining the incidents included in the monthly reports. Further, MCOs' methods of tracking and trending the incidents to identify patterns varied. MCOs also reported highly varying numbers of critical incidents reports to the State - ranging from 2 to 30 since late 2014.					requirements of the STCs.
Participant Protections	**42 CFR § 441.302** Unless the Medicaid agency provides the following satisfactory assurances to CMS, CMS will not grant a waiver under this subpart and may terminate a waiver already granted: (a) Health and Welfare—Assurance that necessary safeguards have been taken to protect the health and welfare of the beneficiaries of the services. **HCBS Technical Guide, pg. 186-189:** Quality Improvement, Service Plan - Services are delivered in accordance with the services plan, including in the type, scope, amount, duration, and frequency specified in the service plan.						
	Evidentiary Examples	The state does not employ effective methods to ensure that participants receive services and supports in the amount, duration, and scope identified through the person-centered assessment and service planning process. While it was clear that the MCOs monitor whether services are delivered to each waiver participant as documented in the PCSP, the MCOs only report aggregate data on service increases and decreases in each waiver to the State.		x		x	KDHE and KDADS must implement effective oversight to ensure that waiver participants receive services and supports as specified in their person-centered service plan. The methods of oversight developed must be consistent among all MCOs. KDHE must amend the MCO contracts to reflect the duties of the MCOs in providing information to carry out the oversight methods. KDHE must also amend Section D-2-a of the 1915(c) waivers to reflect changes in the procedures and oversight described above.

MLTSS Key Elements	Federal Rules and Criteria Findings/Observations	Recommended Corrective Action				
		Federal regulations at 42 C.F.R. § 430.35 allow CMS to withhold Federal Financial Participation payments from a State after a finding that the State's plan fails to comply, or to substantially comply, with the provisions of section 1902 of the Act. Kansas' execution of the CAP and measured performance improvement will ultimately inform the extension of Kansas' 1115 demonstration program , as well as future managed care contracts and 1915(c) waiver actions.				
		HCBS Waiver Amendment	SPA	MCO /EB Contract Amendment	1115 STC Amendment	Additional Required Action
Participant Protections	**42 CFR § 438.100** Enrollee rights. (a) General rule. The State must ensure that: ...(2) An enrollee of an MCO... has the following rights: The right to...(v) Be free from any form of restraint or seclusion used as a means of coercion, discipline, convenience or retaliation, as specified in other Federal regulations on the use of restraints and seclusion. **42 CFR § 441.302** State Assurances. Unless the State Medicaid agency provides the following satisfactory assurances to CMS, CMS will not grant a waiver under this subpart and may terminate a waiver already granted: (a) *Health and Welfare* --Assurance that necessary safeguards have been taken to protect the health and welfare of the beneficiaries of the services. **STC 49. Critical Incident Management System**. ...On an ongoing basis the State Medicaid agency ensures that all entities, including the MCOs, prevent, detect, report, investigate, and remediate instances of abuse, neglect and exploitation, and ensures participant rights are maintained through policies concerning seclusion, restraint and medication management....MCO and provider obligations include specific action steps that MCOS and providers must take in the event of suspected or substantiated abuse, neglect, or exploitation, including risk mitigation. If the State Medicaid agency delegates that responsibility for the critical incident management systems to the participating MCOs, the State Medicaid agency must collect and analyze the data collected by the MCOs on a regular, periodic basis, and ensure that the individual situations are remediated in a timely manner and that system-wide issues are identified and addressed. **HCBS waivers, items G-2-a, G-2-b, and G-2-c:** The IDD waiver allows the use of restraints, restrictive interventions and seclusion; the SED waiver allows the use of restraints. Kansas' other HCBS waivers do not permit the use of restraints, restrictive interventions, or seclusion. All of the waivers specify methods for detecting the unauthorized use of such interventions and methods for oversight to remediate instances of unauthorized use and detect patterns of incidents relating to unauthorized use. KDADS field staff have primary oversight responsibility to detect unauthorized use of interventions through in-person reviews with waiver participants.					
	Evidentiary Examples None of the MCOs had methods in place to track and/or report unauthorized use of restrictive interventions to the state. Two MCOs reported monitoring the use of restrictive interventions through the service plan development process. They described identifying any restrictions that are currently being used with members, and documenting whether regulatory requirements have been met, such as whether less intrusive methods have been tried, and monitoring the effectiveness of the intervention. Staff of one MCO mistakenly believed that none of Kansas' HCBS waivers authorize the use of restraints, restrictive interventions, or seclusion. Therefore, this MCO had no formal monitoring efforts in place regarding the use of such interventions. This MCO did report informal monitoring during contacts with members, such as being aware of whether the member seems afraid or whether the member's guardian or service provider is speaking for him/her.		x		x	KDHE and KDADS must implement effective oversight to ensure consistent methods to monitor the use of restraints, seclusion, and restrictive interventions among all MCOs. These methods must ensure that any use of restraints, seclusion, or restrictive interventions is documented in waiver participants' person-centered service plans. KDHE must amend the MCO contracts to require the MCOs to monitor and report unauthorized use of restrictive interventions to the state. KDHE and KDADS must evaluate the 1915(c) waiver language in Appendix G of each waiver to identify any outdated practices and/or procedures and to clarify roles and responsibilities pertaining to monitoring and reporting use of restraints, seclusion, and restrictive interventions, and amend the waivers as needed. KDHE may also need to amend the STCs if the changes made affect the requirements of the STCs

MLTSS Key Elements	Federal Rules and Criteria Findings/Observations		Recommended Corrective Action				
			Federal regulations at 42 C.F.R. § 430.35 allow CMS to withhold Federal Financial Participation payments from a State after a finding that the State's plan fails to comply, or to substantially comply, with the provisions of section 1902 of the Act. Kansas' execution of the CAP and measured performance improvement will ultimately inform the extension of Kansas' 1115 demonstration program , as well as future managed care contracts and 1915(c) waiver actions.				
			HCBS Waiver Amendment	SPA	MCO /EB Contract Amendment	1115 STC Amendment	Additional Required Action
Participant Protections	**42 CFR § 438.400 Statutory basis, definitions, and applicability.** (b) Definitions. As used in this subpart, the following terms have the indicated meanings: *Action* means— In the case of an MCO or PIHP— (1) The denial or limited authorization of a requested service, including the type or level of service; (2) The reduction, suspension, or termination of a previously authorized service; (3) The denial, in whole or in part, of payment for a service; (4) The failure to provide services in a timely manner, as defined by the State; (5) The failure of an MCO or PIHP to act within the timeframes provided in §438.408(b); or 6) For a resident of a rural area with only one MCO, the denial of a Medicaid enrollee's request to exercise his or her right, under §438.52(b)(2)(ii), to obtain services outside the network. *Appeal* means a request for review of an action, as "action" is defined in this section. *Grievance* means an expression of dissatisfaction about any matter other than an adverse benefit determination. Grievances may include, but are not limited to, the quality of care or services provided, and aspects of interpersonal relationships such as rudeness of a provider or employee, or failure to respect the enrollee's rights regardless of whether remedial action is requested. Grievance includes an enrollee's right to dispute an extension of time proposed by the MCO, PIHP or PAHP to make an authorization decision. **42 CFR § 438.414 Information about the grievance system to providers and subcontractors.** The MCO or PIHP must provide the information specified at §438.10(g)(1) about the grievance system to all providers and subcontractors at the time they enter into a contract. **42 CFR §438.10** Information requirements. (g) Specific information requirements for enrollees of MCOs and PIHPs. In addition to the requirements in §438.10(f), the State, its contracted representative, or the MCO and PIHP must provide the following information to their enrollees: (1) Grievance, appeal, and fair hearing procedures and timeframes, as provided in §§438.400 through 438.424, in a State-developed or State-approved description, that must include the following: (i) For State fair hearing— (A) The right to hearing; (B) The method for obtaining a hearing; and (C) The rules that govern representation at the hearing. (ii) The right to file grievances and appeals. (iii) The requirements and timeframes for filing a grievance or appeal. (iv) The availability of assistance in the filing process. (v) The toll-free numbers that the enrollee can use to file a grievance or an appeal by phone. (vi) The fact that, when requested by the enrollee— (A) Benefits will continue if the enrollee files an appeal or a request for State fair hearing within the timeframes specified for filing; and (B) The enrollee may be required to pay the cost of services furnished while the appeal is pending, if the final decision is adverse to the enrollee. (vii) Any appeal rights that the State chooses to make available to providers to challenge the failure of the organization to cover a service.						
	Evidentiary Examples	According to Federal definitions, a grievance is any expression of dissatisfaction about any matter other than an adverse benefit determination. An appeal means a request for a review of an action; one type of action is the failure to provide services in a timely manner. In response to a question posed by CMS, the State said that the MCOs report NEMT issues as grievances. These NEMT issues were mostly related to NEMT providers showing up late or not showing up at all, which constitutes failure to provide services in a timely manner. By allowing the MCOs to report these issues as grievances, rather than as actions, members may have been inadvertently denied their right to appeal the lack of service provision.			x		KDHE must amend its contracts with the MCOs to ensure correct definitions and use of grievances and appeals, and to ensure that members are allowed appeal rights as required by Federal rules. Once CMS approves the revised contract reflecting the standardized provider appeals process, KDHE must also amend the MCO contracts to reflect the standard process for Provider Appeals.
		Section 2.2.23 of the contract between the State and the MCOs defines a grievance incorrectly, stating "Grievances may include: denial of service, partial denial of service, not given clear or accurate information..." According to Federal definitions, a grievance is any expression of dissatisfaction about any matter other than an adverse benefit determination.					
		Since the implementation of KanCare, the MCOs have been allowed to design their own provider appeal processes. This has lead to varying processes and methods of counting and reporting provider appeals. These processes should have been developed or approved by the State, rather than by the MCOs. In late 2015, the State asked the MCOs to develop on standard approach to provider appeals. That standard approach was submitted to CMS for approval, but has not yet been approved. Until the revised approach is approved, MCOs continue to use varying processes for provider appeals.					

AMERICAN BAR ASSOCIATION

ADOPTED BY THE HOUSE OF DELEGATES
February 9, 2004

RESOLVED, That the American Bar Association endorses the revised Standards for the Establishment and Operation of Ombuds Offices dated February, 2004.

STANDARDS[1] FOR THE ESTABLISHMENT AND OPERATION OF OMBUDS OFFICES

REVISED FEBRUARY, 2004

PREAMBLE

Ombuds[2] receive complaints and questions from individuals concerning people within an entity or the functioning of an entity. They work for the resolution of particular issues and, where appropriate, make recommendations for the improvement of the general administration of the entities they serve. Ombuds protect: the legitimate interests and rights of individuals with respect to each other; individual rights against the excesses of public and private bureaucracies; and those who are affected by and those who work within these organizations.

Federal, state and local governments, academic institutions, for profit businesses, non-profit organizations, and sub-units of these entities have established ombuds offices, but with enormous variation in their duties and structures. Ombuds offices so established may be placed in several categories: A Legislative Ombuds is a part of the legislative branch of government and addresses issues raised by the general public or internally, usually concerning the actions or policies of government entities, individuals or contractors with respect to holding agencies accountable to the public. An Executive Ombuds may be located in either the public or private sector and receives complaints concerning actions and failures to act of the entity, its officials, employees and contractors; an Executive Ombuds may either work to hold the entity or one of its programs accountable or work with entity officials to improve the performance of a program. An Organizational Ombuds may be located in either the public or private sector and ordinarily addresses problems presented by members, employees, or contractors of an entity concerning its actions or policies. An Advocate Ombuds may be located in either the public or private sector and like the others evaluates claims objectively but is authorized or required to advocate on behalf of individuals or groups found to be aggrieved.

As a result of the various types of offices and the proliferation of different processes by which the offices operate, individuals who come to the ombuds office for assistance may not know what to expect, and the offices may be established in ways that compromise their effectiveness. These

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1. The ABA adopted a resolution in August, 2001, that supported "the greater use of 'ombuds' to receive, review, and resolve complaints involving public and private entities" and endorsed Standards for the Establishment and Operation of Ombuds Offices. These standards modify those Standards in four regards. First, they clarify the issue of notice in Paragraph F; secondly, they modify the limitations on the ombud's authority; third, they provide for a new category of executive ombuds that is described in Paragraph H; and, fourth, they modify the definition of legislative ombuds and the standards applicable to them to make them conform to the new category of executive ombuds. The 2001 Standards, in turn, expanded on a 1969 ABA resolution to address independence, impartiality, and confidentiality as essential characteristics of ombuds who serve internal constituents, ombuds in the private sector, and ombuds who also serve as advocates for designated populations.

2. The term ombuds in this report is intended to encompass all other forms of the word, such as ombudsperson, ombuds officer, and ombudsman, a Swedish word meaning agent or representative. The use of ombuds here is not intended to discourage others from using other terms.

standards were developed to provide advice and guidance on the structure and operation of ombuds offices so that ombuds may better fulfill their functions and so that individuals who avail themselves of their aid may do so with greater confidence in the integrity of the process. Practical and political considerations may require variations from these Standards, but it is urged that such variations be eliminated over time.

The essential characteristics of an ombuds are:

- independence
- impartiality in conducting inquiries and investigations, and
- confidentiality.

ESTABLISHMENT AND OPERATIONS

A. An entity undertaking to establish an ombuds should do so pursuant to a legislative enactment or a publicly available written policy (the "charter") which clearly sets forth the role and jurisdiction of the ombuds and which authorizes the ombuds to:

(1) receive complaints and questions about alleged acts, omissions, improprieties, and systemic problems within the ombuds's jurisdiction as defined in the charter establishing the office

(2) exercise discretion to accept or decline to act on a complaint or question

(3) act on the ombuds's own initiative to address issues within the ombuds's prescribed jurisdiction

(4) operate by fair and timely procedures to aid in the just resolution of a complaint or problem

(5) gather relevant information and require the full cooperation of the program over which the ombuds has jurisdiction

(6) resolve issues at the most appropriate level of the entity

(7) function by such means as:

(a) conducting an inquiry

(b) investigating and reporting findings

(c) developing, evaluating, and discussing options available to affected individuals

(d) facilitating, negotiating, and mediating

(e) making recommendations for the resolution of an individual complaint or a systemic problem to those persons who have the authority to act upon them

(f) identifying complaint patterns and trends

(g) educating

(h) issuing periodic reports, and

(i) advocating on behalf of affected individuals or groups when specifically authorized by the charter

(8) initiate litigation to enforce or protect the authority of the office as defined by the charter, as otherwise provided by these standards, or as required by law.

QUALIFICATIONS

B. An ombuds should be a person of recognized knowledge, judgment, objectivity, and integrity. The establishing entity should provide the ombuds with relevant education and the periodic updating of the ombuds's qualifications.

INDEPENDENCE, IMPARTIALITY, AND CONFIDENTIALITY

C. To ensure the effective operation of an ombuds, an entity should authorize the ombuds to operate consistently with the following essential characteristics. Entities that have established ombuds offices that lack appropriate safeguards to maintain these characteristics should take prompt steps to remedy any such deficiency.

(1) Independence. The ombuds is and appears to be free from interference in the legitimate performance of duties and independent from control, limitation, or a penalty imposed for retaliatory purposes by an official of the appointing entity or by a person who may be the subject of a complaint or inquiry.

In assessing whether an ombuds is independent in structure, function, and appearance, the following factors are important: whether anyone subject to the ombuds's jurisdiction or anyone directly responsible for a person under the ombuds's jurisdiction (a) can control or limit the ombuds's performance of assigned duties or (b) can, for retaliatory purposes, (1) eliminate the office, (2) remove the ombuds, or (3) reduce the budget or resources of the office.

(2) Impartiality in Conducting Inquiries and Investigations. The ombuds conducts inquiries and investigations in an impartial manner, free from initial bias and conflicts of interest. Impartiality does not preclude the ombuds from developing an interest in securing changes that are deemed necessary as a result of the process, nor from otherwise being an advocate on behalf of a designated constituency. The ombuds may

become an advocate within the entity for change where the process demonstrates a need for it.

(3) Confidentiality. An ombuds does not disclose and is not required to disclose any information provided in confidence, except to address an imminent risk of serious harm. Records pertaining to a complaint, inquiry, or investigation are confidential and not subject to disclosure outside the ombuds's office. An ombuds does not reveal the identity of a complainant without that person's express consent. An ombuds may, however, at the ombuds's discretion disclose non-confidential information and may disclose confidential information so long as doing so does not reveal its source. An ombuds should discuss any exceptions to the ombuds's maintaining confidentiality with the source of the information.[3]

LIMITATIONS ON THE OMBUDS'S AUTHORITY

D. An ombuds should not, nor should an entity expect or authorize an ombuds to:

(1) make, change or set aside a law, policy, or administrative decision

(2) make binding decisions or determine rights

(3) directly compel an entity or any person to implement the ombuds's recommendations

(4) conduct an investigation that substitutes for administrative or judicial proceedings

(5) accept jurisdiction over an issue that is currently pending in a legal forum unless all parties and the presiding officer in that action explicitly consent

(6) address any issue arising under a collective bargaining agreement or which falls within the purview of any federal, state, or local labor or employment law, rule, or regulation, unless there is no collective bargaining representative and the employer specifically authorizes the ombuds to do so,[4] or

(7) act in a manner inconsistent with the grant of and limitations on the jurisdiction of the office when discharging the duties of the office of ombuds.

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3. A legislative ombuds should not be required to discuss confidentiality with government officials and employees when applying this paragraph to the extent that an applicable statute makes clear that such an individual may not withhold information from the ombuds and that such a person has no reasonable expectation of confidentiality with respect to anything that person provides to the ombuds.

4. Under these Standards, the employer may authorize an ombuds to address issues of labor or employment law only if the entity has expressly provided the ombuds with the confidentiality specified in Paragraph C(3). An ombuds program as envisioned by these Standards supplements and does not substitute for other procedures and remedies necessary to meet the duty of employers to protect the legal rights of both employers and employees.

REMOVAL FROM OFFICE

E. The charter that establishes the office of the ombuds should also provide for the discipline or removal of the ombuds from office for good cause by means of a fair procedure.

NOTICE

F. An ombuds is intended to supplement, not replace, formal procedures.[5] Therefore:

(1) An ombuds should provide the following information in a general and publicly available manner and inform people who contact the ombuds for help or advice that –

(a) the ombuds will not voluntarily disclose to anyone outside the ombuds office, including the entity in which the ombuds acts, any information the person provides in confidence or the person's identity unless necessary to address an imminent risk of serious harm or with the person's express consent

(b) important rights may be affected by when formal action is initiated and by and when the entity is informed of the allegedly inappropriate or wrongful behavior or conduct

(c) communications to the ombuds may not constitute notice to the entity unless the ombuds communicates with representatives of the entity as described in Paragraph 2

(d) working with the ombuds may address the problem or concern effectively, but may not protect the rights of either the person contacting the office or the entity in which the ombuds operates[6]

(e) the ombuds is not, and is not a substitute for, anyone's lawyer, representative or counselor, and

(f) the person may wish to consult a lawyer or other appropriate resource with respect to those rights.

(2) If the ombuds communicates[7] with representatives of the entity concerning an allegation of a violation, then —

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5. An ombuds program as envisioned by these Standards supplements and does not substitute for the need of an entity to establish formal procedures that may be necessary to *protect legal rights and to* address allegedly inappropriate or wrongful behavior or conduct.

6. The notice requirements of Paragraph F do not supercede or change the advocacy responsibilities of an Advocate Ombuds.

7. Under these standards, any such communication is subject to Paragraph C(3).

(a) a communication that reveals the facts of

(i) a specific allegation and the identity of the complainant or

(ii) allegations by multiple complainants that may reflect related behavior or conduct that is either inappropriate or wrongful

should be regarded as providing notice to the entity of the alleged violation and the complainants should be advised that the ombuds communicated their allegations to the entity; but otherwise,

(b) whether or not the communication constitutes notice to the entity is a question that should be determined by the facts of the communication.

(3) If an ombuds functions in accordance with Paragraph C, "Independence, Impartiality, and Confidentiality," of these standards, then —

(a) no one, including the entity in which the ombuds operates, should deem the ombuds to be an agent of any person or entity, other than the office of the ombuds, for purposes of receiving notice of alleged violations, and

(b) communications made to the ombuds should not be imputed to anyone else, including the entity in which the ombuds acts unless the ombuds communicates with representatives of the entity in which case Paragraph 2 applies.

LEGISLATIVE OMBUDS

G. A legislative ombuds is established by the legislature as part of the legislative branch who receives complaints from the general public or internally and addresses actions and failures to act of a government agency, official, public employee, or contractor. In addition to and in clarification of the standards contained in Paragraphs A-F, a legislative ombuds should:

(1) be appointed by the legislative body or by the executive with confirmation by the legislative body[8]

(2) be authorized to work to hold agencies within the jurisdiction of the office accountable to the public and to assist in legislative oversight of those agencies

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8. This restates the 1969 ABA Resolution, which remains ABA policy, that a legislative ombuds should be "appoint[ed] by the legislative body or . . . by the executive with confirmation by the designated proportion of the legislative body, preferably more than a majority, such as two thirds."

(3) be authorized to conduct independent and impartial investigations into matters within the prescribed jurisdiction of the office

(4) have the power to issue subpoenas for testimony and evidence with respect to investigating allegations within the jurisdiction of the office

(5) be authorized to issue public reports, and

(6) be authorized to advocate for change both within the entity and publicly.

EXECUTIVE OMBUDS

H. An executive ombuds may be located in either the public or private sector and receives complaints from the general public or internally and addresses actions and failures to act of the entity, its officials, employees, and contractors. An executive ombuds may either work to hold the entity or specific programs accountable or work with officials to improve the performance of a program. In addition to and in clarification of the standards contained in Paragraphs A-F, an executive ombuds:

(1) should be authorized to conduct investigations and inquiries

(2) should be authorized to issue reports on the results of the investigations and inquires, and

(3) if located in government, should not have general jurisdiction over more than one agency, but may have jurisdiction over a subject matter that involves multiple agencies.

ORGANIZATIONAL OMBUDS

I. An organizational ombuds facilitates fair and equitable resolutions of concerns that arise within the entity. In addition to and in clarification of the standards contained in Paragraphs A-F, an organizational ombuds should:

(1) be authorized to undertake inquiries and function by informal processes as specified by the charter

(2) be authorized to conduct independent and impartial inquiries into matters within the prescribed jurisdiction of the office

(3) be authorized to issue reports, and

(4) be authorized to advocate for change within the entity.

ADVOCATE OMBUDS

J. An advocate ombuds serves as an advocate on behalf of a population that is designated in the charter. In addition to and in clarification of the standards described in Paragraphs A-F, an advocate ombuds should:

(1) have a basic understanding of the nature and role of advocacy

(2) provide information, advice, and assistance to members of the constituency

(3) evaluate the complainant's claim objectively and advocate for change or relief when the facts support the claim

(4) be authorized to represent the interests of the designated population with respect to policies implemented or adopted by the establishing entity, government agencies, or other organizations as defined by the charter

(5) be authorized to initiate action in an administrative, judicial, or legislative forum when the facts warrant, and

(6) the notice requirements of Paragraph F do not supersede or change the advocacy responsibilities of an Advocate Ombuds.

REPORT

The American Bar Association (ABA) adopted a resolution in 1969 recommending that state and local governments consider establishing ombudsmen who would be authorized to inquire into administrative action and to make public criticism. That policy also recommended that the statute or ordinance creating the ombudsmen contain twelve essential points. The ABA then adopted a resolution in 1971 recommending that the Federal government experiment with the establishment of ombudsmen for certain geographical areas, specific agencies, or for limited phases of Federal activities. In 2001, ABA the adopted a resolution supporting the greater use of "ombuds9" to receive, review, and resolve complaints involving public and private entities. That policy also endorsed Standards for the Establishment and Operations of Ombuds Offices (Standards). The 2001 Resolution and Standards broadened the ABA's existing policy to address ombuds who are appointed within government, academia, and the private sector, and who respond to complaints from individuals from within and outside the entity. The 2001 Resolution and the Standards also clarified that independence, impartiality in conducting inquiries and investigations, and confidentiality are essential characteristics of all ombuds. Ombuds must operate consistently with these essential characteristics to discharge the duties of the office effectively.

This Resolution recognizes that entities that create ombuds offices should adhere to the Standards for the Establishment and Operations of Ombuds Offices, dated February, 2004. The fundamental underlying premise of this resolution is that all ombuds must operate with certain basic authorities and essential characteristics. The effort here is to provide practical advice and guidance on the structure and operation of ombuds offices so that ombuds may better fulfill their functions and so that individuals who avail themselves of their aid may do so with greater confidence in the integrity of the process. These Standards modify the Standards for the Establishment and Operation of Ombuds Offices that were adopted by the ABA in August, 2001, in four regards. First, they clarify the issue of notice in Paragraph F; secondly, they modify the limitations on the ombud's authority in Paragraph D; third, they provide for a new category of executive ombuds that is described in Paragraph H; and, fourth, they modify the definition of legislative ombuds and the standards applicable to them to make them conform to the new category of executive ombuds.

INTRODUCTION

Over the past three decades, and particularly recently, an extraordinary growth in the number and type of ombuds has taken place. Congress has established several ombuds in various programs. In addition to specific legislation concerning ombuds, the Administrative Dispute Resolution Act authorizes Federal agencies to use "ombuds." As a protector of individual rights against the excesses of public and private bureaucracies, an ombuds receives complaints and questions from individuals concerning the functioning of an entity, works for the resolution of particular issues, and where necessary, makes recommendations for the improvement of the general administration of the entity. As an independent, impartial, and confidential complaint handler, an ombuds serves as an alternative means of dispute resolution – a means by which issues may be raised, considered, and resolved.

Federal, state and local governments, academic institutions, for profit businesses, non-profit organizations, and sub-units of these entities have established ombuds offices, but with enormous

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9. The term ombuds in this report is intended to encompass all other forms of the word such as ombudsperson, ombuds officers, and ombudsman, a Swedish word meaning agent or representative. The use of ombuds here is not intended to discourage others from using other terms.

variation in their duties and structures. Ombuds offices so established may be placed in several categories. A Legislative Ombuds is established by the legislature as part of the legislative branch and addresses issues raised by the general public or internally, usually concerning the actions or policies of a government agency, official, public employee, or contractor. An Executive Ombuds may be located in either the public or private sector and receives complaints from the general public or internally and addresses actions or failures to act of the entity, its officials, employees, or contractors; an Executive Ombuds may either work to hold the entity or specific programs accountable or work with officials to improve the performance of a program. An Organizational Ombuds may be located in either the public or private sector and ordinarily addresses problems presented by members, employees, or contractors of an entity concerning its actions or policies. An Advocate Ombuds may be located in either the public or private sector, and like the others evaluates claims objectively but is authorized or required to advocate on behalf of individuals or groups found to be aggrieved.

As a result of the various types of offices and the proliferation of different processes by which the offices operate, individuals who come to the ombuds' office for assistance may not know what to expect, and the offices may be established in ways that compromise their effectiveness. The ABA endorsed Standards that were developed to provide advice and guidance on the structure and operation of ombuds offices to the end that ombuds may better fulfill their functions and so that individuals who avail themselves of their aid may do so with greater confidence in the integrity of the process. The ABA action was based on the collaborative efforts of the Sections of Administrative Law and Regulatory Practice and of Dispute Resolution who worked together and appointed a steering committee consisting of representatives from the Coalition of Federal Ombudsmen, the National Association of State Ombudsman Programs, the International Ombudsman Institute (IOI subsequently withdrew), The Ombudsman Association, the United States Ombudsman Association,10 and the University and College Ombuds Association, as well as other experts in the field. The committee consulted with numerous ombuds from Federal, state, and local agencies, academic institutions, companies, and non-profit organizations. Further, it solicited, received, and considered comments from the international community of ombuds. Within the ABA, the Commission on Law and Aging, based on its experience with advocate ombuds, was instrumental in distinguishing among the types of ombuds. The Section of Business Law collaborated extensively with the committee to further the understanding and appreciation of the role of the ombuds in the business environment. Consultations with the Section of Labor and Employment Law resulted in refining the limitations on the ombuds' jurisdiction.

The Standards for the Establishment and Operation of Ombuds Offices dated August 2001 have been widely distributed and utilized by Federal, state and local governments, academic institutions, for profit businesses, non-profit organizations, and sub-units of these entities. For example, Congress is currently considering legislation to reauthorize an ombuds at the U.S. Environmental Protection Agency and has relied upon the ABA's Standards in defining the position.

To ensure that ombuds can protect individual rights against the excesses of public and private bureaucracies, now, again, the Sections of Administrative Law and Regulatory Practice, Business Law, Dispute Resolution, and Individual Rights and Responsibilities have worked together and with

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10. The United States Ombudsman Association did not endorse the Standards that were adopted in 2001 and was not involved in the subsequent revisions to the Standards.

the ombuds community and other ABA entities to develop a resolution to support amendments to the Standards for the Establishment and Operations of Ombuds Offices.

STANDARDS

Section A. Establishment and Operations

An ombuds is a person who is authorized to receive complaints or questions confidentially about alleged acts, omissions, improprieties, and broader, systemic problems within the ombuds's defined jurisdiction and to address, investigate, or otherwise examine these issues independently and impartially.

Importantly, the ombuds' jurisdiction – who complains and who or what are complained about – needs to be defined in advance, setting out the scope of the duties and authority. The ombuds's jurisdiction must be defined in an official act that establishes the office, which is appropriately called the "charter" in the Standards. The charter may be a legislative enactment or a publicly available written policy. The jurisdiction may be limited to a defined constituency or population. For example, a state ombuds may receive complaints or questions from any person, while a university student ombuds may receive complaints or questions only from students at that university, and a long-term care ombuds has jurisdiction only to resolve complaints initiated by or on behalf of residents receiving long-term care.

The ombuds determines whether to accept or to act on a particular complaint or question. The ombuds also has the discretion to initiate action without receiving a complaint or question. An ombuds may determine that the complaint is without merit. Or, an ombuds may receive a complaint or question on a specific topic and conduct an inquiry on a broader or different scope.

Appropriate subjects for an ombuds to review include allegations of unfairness, maladministration, abuse of power, abuse of discretion, discourteous behavior or incivility, inappropriate application of law or policy, inefficiency, decision unsupported by fact, and illegal or inappropriate behavior. It is essential that the ombuds operate by fair procedures to aid in the just resolution of the matter. Ombuds need access to all information relevant to a complaint or a question so that the review is fair and credible, and the charter should authorize access to all relevant information and require the full cooperation of the program over which the ombuds has jurisdiction. The entity must be responsible for protecting those seeking assistance from or providing information to the ombuds from personal, professional, or economic retaliation, loss of privacy, or loss of relationships.

An ombuds may make a formal or informal report of results and recommendations stemming from a review or investigation. If such a report is issued, the ombuds should generally consult with an individual or group prior to issuing a report critical of that individual or group, and include their comments with the report. Moreover, the ombuds should communicate the outcome, conclusion or resolution of a complaint or an inquiry to the complainant and may also communicate with other concerned entities or individuals.

In addition, to ensure the office's accountability, an ombuds should issue and publish periodic reports summarizing the ombuds's findings and activities. This may include statistical information about the number of contacts with the ombuds, subjects that the ombuds addressed evaluation by complainants, etc. These reports may be done annually, biannually, or more frequently.

In receiving complaints or questions and examining problems, the ombuds may use a variety of dispute resolution and other techniques. These processes include: conducting an inquiry; investigating and reporting findings; developing, evaluating, and discussing the options which may be available for remedies or redress; facilitating, negotiating, and mediating; making recommendations for the resolution of an individual complaint or a systemic problem to those persons who have authority to act on them; identifying complaint patterns and trends; and educating.

As necessary, the ombuds may advocate on behalf of affected individuals or groups when authorized by the charter and the situation warrants that action. An ombuds may initiate litigation to enforce or protect the authority of the office. For example, if an ombuds issues a subpoena and the subpoena is ignored, the ombuds should be able to initiate litigation to compel a response. In addition, an ombuds may initiate litigation as otherwise provided by these standards or as required by law. For example, an advocate ombuds should be authorized to initiate action in an administrative, judicial, or legislative forum when the facts warrant.

An ombuds uses the powers of reason and persuasion to help resolve matters. The goal of the ombuds's efforts is to provide a path to fairness and justice. Therefore, the ombuds' quest is to seek the fair and just resolution of the matter.

Section B. Qualifications

An ombuds should be a person of recognized knowledge, judgment, objectivity, and integrity. The establishing entity should provide the ombuds with relevant education and the periodic updating of the ombuds's qualifications.

Section C. The Essential Characteristics

The original 1969 resolution contained twelve essentials for the ombuds described in it. These have been distilled and expanded in the Standards. The core qualities are independence, impartiality in conducting inquiries and investigations, and confidentiality. Without them, an ombuds cannot discharge the duties of the office effectively. The Standards therefore provide that an entity should authorize an ombuds it establishes to operate consistently with these essential characteristics to ensure the effective operation of the duties of the office. The Standards also recognize, however, that some entities may have already established offices that lack appropriate safeguards to comply fully with the characteristics. The Standards then provide that such entities should take prompt steps to remedy any such deficiency.

1. Independence in structure, function, and appearance

To be credible and effective, the office of the ombuds is independent in its structure, function, and appearance. Independence means that the ombuds is free from interference in the legitimate performance of duties and independent from control, limitation, or a penalty imposed for retaliatory purposes by an official of the appointing entity or by a person who may be the subject of a complaint or inquiry. In assessing whether an ombuds is independent, the following factors are important: whether anyone subject to the ombuds's jurisdiction or anyone directly responsible for a person under the ombuds's jurisdiction (a) can control or limit the ombuds's performance of duties, or (b)

can, for retaliatory purposes, (1) eliminate the office, (2) remove the ombuds, or (3) reduce the office's budget or resources.

Historically, ombuds were created in parliamentary systems and were established in the constitution or by statute, appointed by the legislative body, and had a guarantee of independence from the control of any other officer, except for responsibility to the legislative body. This structure remains a model for ensuring independence for Legislative Ombuds, and a number of states have followed it. In more recent times, however, Executive Ombuds have been created by public officials without legislation, by regulation or decree, and by private entities. Ensuring the independence of the ombuds is equally important in these instances, but will require other measures.11

Great care has to be exercised in establishing the ombuds structure to ensure that the independence described in the resolution is, in fact, achieved. Choosing which of these approaches are appropriate will depend on the environment. The instrument used to establish independence should be the strongest available and should guarantee the independence of the ombuds from control by any other person.

The twelve essential characteristics of the 1969 ABA Resolution continue to serve as the model for an ombuds reporting to the legislative branch of government who is authorized to investigate administrative action, help provide legislative oversight, and offer criticism of agencies from an external perspective. While there are a number of potential avenues of achieving independence, experience on the state and local level has demonstrated rather consistently that unless there is a structural independence for these ombuds akin to the 1969 ABA Resolution that independence will not be accomplished and the office will not be able to function as envisioned in this resolution and the accompanying standards.

Structuring independence for ombuds who serve inside organizations require similar care. These elements should be in the charter. The ombuds position should be explicitly defined and established as a matter of organizational policy, authorized at the highest levels of the organization; the ombuds should have access to the chief executive officer, senior officers and the oversight body or board of directors of the organization; the ombuds should also have access to all information

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11. In the United States since the late 1960s, a number of other ways have been developed to ensure independence. Examples of approaches that contribute to an ombuds's independence include: establishment of the office through a formal act of a legislature or official governing body of an organization; establishment outside the entity over which the ombuds has jurisdiction; a direct reporting relationship to a legislative body, the official governing body of an organization or the chief executive; designation as a neutral who is unaligned and objective; a broadly defined jurisdiction not limited to one part of the entity or one subject matter; appointment or removal of the ombuds free of influence from potential subjects of a complaint or inquiry; a set term of office; no reporting relationship to someone with assigned duties that conflict with the ombuds's role; no assignment of duties other than that of the ombuds function; specifically allocated budget and sufficient resources to perform the function; freedom to appoint, direct, and remove staff; sufficient stature in the organization to be taken seriously by senior officials; placement in an organization at the highest possible level and at least above the heads of units likely to generate the most complaints; discretion to initiate and pursue complaints and inquiries; access to and resources for independent legal advice and counsel; prohibition of disciplinary actions against the ombuds for performing the duties of the office; removal only for cause; provision of an employment contract that the ombuds will receive a significant severance provision if terminated without good cause.

within the organization, except as restricted by law; and the ombuds should have access to resources for independent legal advice and counsel.

The Standards recognize that at this time there are ombuds who have not achieved this goal. The Standards urge and anticipate that these variations will be eliminated over time.

2. Impartiality in conducting inquiries and investigations

The ombuds' structural independence is the foundation upon which the ombuds' impartiality is built. If the ombuds is independent from line management and does not have administrative or other obligations or functions, the ombuds can act in an impartial manner.

Acting in an impartial manner, as a threshold matter, means that the ombuds is free from initial bias and conflicts of interest in conducting inquiries and investigations. Acting in an impartial manner also requires that the ombuds be authorized to gather facts from relevant sources and apply relevant policies, guidelines, and laws, considering the rights and interests of all affected parties within the jurisdiction, to identify appropriate actions to address or resolve the issue.

The ombuds conducts inquiries and investigations in an impartial manner. An ombuds may determine that a complaint is without merit and close the inquiry or investigation without further action. If the ombuds finds that the complaint has merit, the ombuds makes recommendations to the entity and/or seeks resolution for a fair outcome. Impartiality does not, however, preclude the ombuds from developing an interest in securing the changes that are deemed necessary where the process demonstrates a need for change nor from otherwise being an advocate on behalf of a designated constituency. The ombuds therefore has the authority to become an advocate for change where the results of the inquiry or investigation demonstrate the need for such change. For example, when an ombuds identifies a systemic problem, it would be appropriate for the ombuds to advocate for changes to correct the problem. An advocate ombuds may initiate action and therefore serve as an advocate on behalf of a designated population with respect to a broad range of issues and on specific matters when the individual or group is found to be aggrieved. But, when determining the facts, the ombuds must act impartially.

3. Confidentiality

Confidentiality is an essential characteristic of ombuds that permits the process to work effectively. Confidentiality promotes disclosure from reluctant complainants, elicits candid discussions by all parties, and provides an increased level of protection against retaliation to or by any party. Confidentiality is a further factor that distinguishes ombuds from others who receive and consider complaints such as elected officials, human resource personnel, government officials, and ethics officers.

Confidentiality extends to all communications with the ombuds and to all notes and records maintained by the ombuds in the performance of assigned duties. It begins when a communication is initiated with the ombuds to schedule an appointment or make a complaint or inquiry. Confidentiality may apply to the source of the communications and to the content of the communications. Individuals may not want the ombuds to disclose their identity but may want the ombuds to act on the information presented. Therefore, an ombuds does not reveal the identity of a complainant without that person's consent. The ombuds may, however, disclose confidential

information so long as doing so does not compromise the identity of the person who supplied it. It should be emphasized that the decision whether or not to disclose this information belongs to the ombuds, and it would not be appropriate for anyone to demand that the ombuds disclose such information, except as required by statute. To the extent that an ombuds may not maintain confidentiality, the ombuds should discuss those exceptions with individuals who communicate with the office.

The authorizing entity should allow the ombuds to provide confidentiality of the identity of persons who communicate with the ombuds and of information provided in confidence. The authorizing entity should not seek information relating to the identity of complainants nor seek access to the ombuds's notes and records.

Providing for confidentiality and protection from subpoena in a statute is particularly important because, where statutes have not provided confidentiality, state courts have not consistently recognized an ombuds privilege nor granted protective orders to preserve the confidentiality of communication made to ombuds. One Federal district court, *Shabazz v. Scurr*, 662 F. Supp. 90 (S.D. Iowa 1987), recognized a limited privilege under Federal law for an ombuds with a state statutory privilege. The only Federal circuit court to have addressed the issue, *Carman v. McDonnell Douglas Corp.*, 114 F. 3d 790 (8th Cir. 1997), failed to recognize an ombuds privilege.

Short of explicit statutory authority, ombuds offices should adopt written policies that provide the fullest confidentiality within the law, and the entities that establish ombuds offices should expressly provide the ombuds with fullest confidentiality specified in the standards. These policies should be publicly available, broadly disseminated, and widely publicized. Several existing model ombuds acts and policies of ombuds organizations address confidentiality.

An ombuds will rarely, if ever, be privy to something that no one else knows. Therefore, providing confidentiality protection to the ombuds allows the ombuds to perform assigned duties while at the same time, society continues to have access to the underlying facts. As evidenced by the statutes and policies that have been developed, there may be instances in which other, competing societal interests dictate that the ombuds must disclose some information. If an individual speaks about intending harm to himself or herself or others, an entity may require an ombuds to disclose this information. Moreover, an ombuds may be compelled by protective service laws or professional reporting requirements to report suspected abuse.

Section D. Limitations on the ombuds' authority

An ombuds works outside of line management structures and has no direct power to compel any decision. The office is established by the charter with the stature to engender trust and to help resolve complaints at the most appropriate level of the entity. To ensure the ombuds's independence, impartiality, and confidentiality, it is necessary to establish certain limitations on the ombuds's authority.

An ombuds should not, nor should an entity expect or authorize an ombuds to make, change, or set aside a law, policy or administrative/managerial decision, nor to directly compel an entity or any person to make those changes. While an ombuds may expedite and facilitate the resolution of a complaint and recommend individual and systemic changes, an ombuds cannot compel an entity to implement the recommendations.

It is essential that an ombuds operate by fair procedures which means that the actions taken will likely vary with the nature of the concern, and that care must be taken to protect the rights of those who may be affected by the actions of an ombuds. Furthermore, since due process rights could well be implicated, it would not be appropriate for the ombuds's review to serve as the final determination for any disciplinary activity or civil action, nor as a determination of a violation of law or policy. An ombuds's inquiry or investigation does not substitute for an administrative or judicial proceeding. In an administrative or judicial proceeding, the deciding official should not consider the ombuds's review or recommendations to be controlling. Rather, the deciding official must conduct a de novo examination of the matter.

Moreover, it would not be appropriate for the ombuds to act as an appellate forum when a complainant is dissatisfied with the results in a formal adjudicatory or administrative proceeding. Thus, an ombuds should not take up a specific issue that is pending in a legal forum without the concurrence of the parties and the presiding officer. It may, however, be fully appropriate for an ombuds to inquire into matters that are related to a controversy that is in litigation so long as they are not the subject of the suit.

Further, an ombuds should not address, nor should an entity expect or authorize an ombuds to address, any issue that is the subject of a collective bargaining agreement or that arises under labor or employment law. Even where an employee is not covered by a collective bargaining agreement, the involvement of an ombuds in matters that fall within the purview of labor or employment laws raises sensitive issues that may implicate the rights and liabilities of the parties under those laws, such as the issue of notice mentioned in Section F of the Standards. Accordingly, the Standards contemplate that an employer, in establishing an ombuds office, should consider its overall policies for maintaining compliance with those laws, and determine in that light whether to authorize the ombuds to address those matters. The entity should do so only if the ombuds office meets the three essential characteristics of Independence, Impartiality, and Confidentiality. This recommendation is in no way intended to suggest, however, that a policy of authorizing an ombuds to address labor or employment-related matters should be a suspect or disfavored practice. Involvement in such matters is a role typically performed by Organizational Ombuds, and the growing reliance on ombuds at institutions across the country is largely attributable to the broad satisfaction with ombuds' fulfillment of that role on the part of both management and the affected employees. Thus, the language in the Standards indicating that an employer should specifically authorize an ombuds to address labor or employment related matters does not require any detailed or ponderous recitals. Rather, it should be read as simply a particularized application of the generalized expectation in Section A of the Standards that the jurisdiction of an ombuds office should be identified in its charter.

Finally, an ombuds should not act in a manner inconsistent with the grant and limitations on the jurisdiction of the office when discharging the duties of the office of ombuds.

Section E. Removal from office

Entities which establish ombuds offices need to ensure their accountability. Therefore, the charter that establishes the office of ombuds should also provide for the discipline or removal of the ombuds for good cause by means of a fair procedure.

Section F. Notice

When meeting with an ombuds, people discuss allegations of unfairness, maladministration, abuse of power, and other sensitive subjects. They may fear personal, professional, or economic retaliation, loss of privacy, and loss of relationships. Faced with sexual or racial harassment, for example, many will quit, get sick, or suffer in silence. People often need help in developing ways to report or act so that these matters will be considered and resolved. Because an ombuds is intended to supplement, not replace, formal procedures, the Standards recognize that the person contacting the ombuds for assistance needs to understand the difference between working with an ombuds and seeking formal redress. It may be that the ombuds informs people coming to the ombuds office of the issues identified in the Standards; it may be that the ombuds office has a brochure or web page that explains the functioning of the office, working with the ombuds office, and the items listed in Section F(1); or, it may be that the entity itself includes similar information in a manual, other information provided to affected people, or as part of the charter for the ombuds office. But the standards recognize that responsibility needs to be allocated in a way that ensures the communication will actually be made in the relevant circumstances, so it places it at the point of contact with the individual: the ombuds office.

Communications must be protected if people are to be willing to visit and speak candidly with the ombuds. As noted above, some ombuds have confidentiality protected by law. Under these Standards, entities that establish an ombuds should authorize the ombuds to operate with confidentiality and independence, and an ombuds should inform anyone who contacts the ombuds offices, that the ombuds will not voluntarily disclose to anyone outside the ombuds office, including the entity in which the ombuds operates, any information the person provides in confidence or the person's identity, unless necessary to address the imminent risk of serious harm or with the person's express consent. The standards recognize, however, that in some limited circumstances an ombuds may be compelled by a court to divulge confidential information.

The standards are designed to make sure that a person coming to the ombuds will be aware that legal rights might well be at stake and that the person may have to take action beyond working with the ombuds to protect those rights. This is to ensure that the person approaching the ombuds office to redress some particular problem understands that protecting rights may depend on just when formal action is initiated and whether notice is given to the entity. Working with the ombuds does not change that requirement or the specific time when the action must be started. In addition, the ombuds should advise persons that communications to the ombuds may not constitute notice to the entity unless the ombuds contacts the entity.

Further, the ombuds should describe to visitors that working with the ombuds is an informal process that may well address the person's concern effectively, but doing so may not protect that person's legal right or indeed, those of the entity for whom the ombuds functions. Moreover, the ombuds needs to make clear that the ombuds is not serving as anyone's lawyer, representative or counselor — not for the complainant nor for the entity. Thus, the ombuds is not the person's lawyer or labor representative nor a human resources or social work counselor. So that the person is not lulled into putting off checking what legal rights may be affected, the Standards provide that the ombuds should inform the person that he or she may wish to consult a lawyer or other appropriate resource with respect to preserving and protecting those rights. The standards do not contemplate the ombuds providing any sort of legal advice as to what the legal rights and procedures are, only that they may exist and that the person coming to the office may wish to consult with a lawyer or other resource to determine them.

If an ombuds functions in accordance with these Standards by operating with confidentiality and independence, the details of what is told to the ombuds will not be told to anyone in the entity itself, and hence it would not be appropriate or accurate to impute it to the entity — that is, holding the entity responsible for knowing something it cannot know. Further, the Standards provide that the ombuds should not be deemed an agent of any person or entity, other than the Office of the Ombuds, for purposes of receiving notice of alleged violations. Rather, the ombuds would be deemed independent of the entity itself for these purposes. Thus, it would not be appropriate for the ombuds to accept notice on the entity's behalf with respect to any alleged grievance.

When an ombuds works to address an issue, he or she may need to work with those in the entity. An ombuds may therefore communicate with representatives of an entity which, under the standards, the ombuds has the discretion but not the requirement to do. Any such communication would be subject to the confidentiality provisions of Paragraph C(3). If the communication reveals the facts of a specific allegation and the identity of the complainant, then the entity should be regarded as having notice of the alleged violation. Similarly, if the ombuds communicates allegations of multiple complainants that may reflect related behavior or conduct that is either inappropriate or wrongful then here too the entity should be regarded as having notice of the alleged violation since the multiple complainants makes up for the lack of specific identity. In these cases, the complainants should be informed that the ombuds has communicated their allegations to the entity so they may decide whether or not to take formal action. In both instances, the information provided would need to be sufficiently detailed that the entity could conduct its own investigation with respect to the allegations. Furthermore, the ombuds may provide enough information — even though confidentiality is maintained — that the entity in fact is on notice that a potential offense has occurred. The Standards provide, therefore, that when an ombuds communicates with representatives of the entity concerning an allegation by an individual, whether or not that communication constitutes "notice" to the entity is a question that should be determined by the facts of the communication.

Thus, the Standards draw a clear distinction between communications to an ombuds when the ombuds makes no further communication to the entity and those situations where the ombuds communicates with agents of the entity. In the former case, the Standards would provide that it is not appropriate to impute the communication to the entity in the form of notice since it has no way of learning what was communicated. But in the second instance, whether or not the entity has notice depends on the facts relayed and the applicable law.

Section G. Legislative Ombuds

A Legislative Ombuds is established by the legislature as part of the legislative branch and receives complaints from the general public or internally and addresses actions and failures to act of a government agency, official, public employee, or contractor. For Federal, state, and local governments that want to create a Legislative ombuds who would be authorized to address, investigate or inquire into administrative action and to criticize agencies, officials, and public

employees, the ABA's 1969 policy continue to serve as a model.12 A Legislative Ombuds should be appointed by the legislative body or by the executive with confirmation by the legislative body.13 A Legislative Ombuds should be authorized to work to hold agencies within the jurisdiction of the office accountable to the public and to assist in legislative oversight of those agencies. A Legislative Ombuds may conduct inquiries or investigations and suggest modifications in policies or procedures. To ensure access to all pertinent facts, a Legislative Ombuds should be granted subpoena power for testimony and evidence relevant to an investigation. In addition, a Legislative Ombuds should be authorized to issues public reports and to advocate for change both within the entity and publicly.

Section H. Executive Ombuds

An Executive Ombuds may be located in either the public or private sector and receives complaints from the general public or internally and addresses actions and failures to act of the entity, its officials, employees, and contractors. An Executive Ombuds may either work to hold the entity or specific programs accountable or work with officials to improve the performance of a program. In addition, an Executive Ombuds should be authorized to conduct investigations and inquiries. An Executive Ombuds should also be authorized to require the full cooperation of the program over which the ombuds has jurisdiction, including, where appropriate, subpoena power. It may not be appropriate, however, to authorize subpoena power where an Executive Ombuds has been established to receive complaints from regulated entities with regard to an agency's regulatory or enforcement activities. An Executive Ombuds should be authorized to issue reports on the results of the investigations and inquiries. Finally, if located in government, an Executive Ombuds should not have general jurisdiction over more than one agency, but may have jurisdiction over a subject matter that involves multiple agencies. For example, an Executive Ombuds may oversee a variety of governmental agencies having jurisdiction over child welfare, crime victims, or mental health issues.

Section I. Organizational Ombuds

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12. The twelve essential characteristics that were identified in the original ABA resolution continue to have vitality and remain ABA policy. They are: (1) authority of the ombudsman to criticize all agencies, officials, and public employees except courts and their personnel, legislative bodies and their personnel, and the chief executive and his personal staff; (2) independence of the ombudsman from control by any other officer, except for his responsibility to the legislative body; (3) appointment by the legislative body or appointment by the executive with confirmation by the designated proportion of the legislative body, preferably more than a majority of the legislative body, such as two thirds; (4) independence of the ombudsman through a long term, not less than five years, with freedom from removal except for cause, determined by more than a majority of the legislative body; (5) a high salary equivalent to that of a designated top officer; (6) freedom of the ombudsman to employ his own assistants and to delegate to them, without restrictions of civil service and classifications acts; (7) freedom of the ombudsman to investigate any act or failure to act by any agency, official, or public employee; (8) access of the ombudsman to all public records he finds relevant to an investigation; (9) authority to inquire into fairness, correctness of findings, motivation, adequacy of reasons, efficiency, and procedural propriety of any action or inaction by any agency, official, or public employee; (10) discretionary power to determine what complaints to investigate and to determine what criticisms to make or to publicize; (11) opportunity for any agency, official, or public employee criticized by the ombudsman to have advance notice of the criticism and to publish with the criticism an answering statement; and, (12) immunity of the ombudsman and his staff from civil liability on account of official action.

13 This restates the 1969 ABA Resolution, which remains ABA policy, that a legislative ombuds should be "appoint[ed] by the legislative body or . . . by the executive with confirmation by the designated proportion of the legislative body, preferably more than a majority, such as two thirds."

An Organizational Ombuds ordinarily addresses problems presented by members, employees or contractors of an entity concerning its actions or policies. An Organizational Ombuds may undertake inquiries and advocate for modifications in policies or procedures.

Section J. Advocate Ombuds

The Advocate Ombuds may be located in either the public or private sectors, and like the Legislative and Organizational Ombuds, also evaluates claims objectively. However, unlike other ombuds, the Advocate Ombuds is authorized or required to advocate on behalf of individuals or groups found to be aggrieved. Because of the unique role, the Advocate Ombuds must have a basic understanding of the nature and role of advocacy. In addition, the Advocate Ombuds should provide information, advice, and assistance to members of the population identified in the law or publicly available written policy. Further, the Advocate Ombuds represents the interests of a designated population with respect to policies implemented or adopted by the establishing entity and government agencies. The notice requirements of Paragraph F do not supersede or change the advocacy responsibilities of an Advocate Ombuds.

CONCLUSION

Government, academia, and the private sector are answering demands for fairness and responsiveness by establishing ombuds. Ombuds receive complaints and questions concerning the administration of the establishing entity. However, the basic authorities of these persons called ombuds and the independence, impartiality, and confidentiality with which they operate vary markedly. An ombuds works for the resolution of a particular issue, and where necessary, makes recommendations for the improvement of the general administration of the entity. To be credible and effective, the office of the ombuds must be independent in structure, form, and appearance. The ombuds's structural independence is the foundation upon which the ombuds's impartiality is built. The ombuds must conduct investigations and inquiries in an impartial manner, free from initial bias and conflicts of interest. Confidentiality is a widely accepted characteristic of ombuds, which helps ombuds perform the functions of the office. Without these Standards, individuals may be reluctant to seek the ombuds's assistance because of fear of personal, professional, or economic retaliation, loss of privacy, and loss of relationships. This Resolution and the Standards for the Establishment and Operation of Ombuds Offices are appropriate now to ensure that ombuds can protect individual rights against the excesses of public and private bureaucracies. Practical and political considerations may require variations from these Standards, but it is urged that such variations be eliminated over time.

Respectfully submitted,

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Designing State-Based Ombuds Programs in MLTSS and the Dual Eligible Demonstrations

A beneficiary perspective from AARP, The Arc, the Center for Medicare Advocacy, Inc., Community Catalyst, the Disability Rights Education and Defense Fund, Families USA, the Medicare Rights Center, the National Committee to Preserve Social Security and Medicare, the National Consumer Voice for Quality Long-Term Care, the National Council on Aging, the National Health Law Program, and the National Senior Citizens Law Center

Managed care is increasingly becoming the vehicle for delivering health and long-term services and supports (LTSS) to seniors and persons with disabilities, including dual eligibles (individuals who qualify for both Medicare and Medicaid). To help this very vulnerable group of consumers navigate the complexities of managed care, beneficiary advocates have consistently urged the inclusion of an independent ombuds[1] as an essential beneficiary protection.

In some states the transition to utilizing managed care to serve this population and provide LTSS is being implemented through a Medicaid waiver. In other states it is being done under the dual eligible financial alignment demonstration. Under either approach, managed care introduces significant and complex changes to the way seniors and persons with disabilities receive care. Including an effective ombuds in Medicaid Managed Long Term Services and Supports (MLTSS) waivers and dual eligible demonstrations will help ensure that these changes improve rather than impede access to care by assisting individual beneficiaries, spotting systemic problems early and giving voice to beneficiary concerns as program modifications are considered.

This paper outlines a beneficiary advocate perspective on the functions an ombuds office in a MLTSS waiver program or a dual eligible demonstration should perform, the elements necessary to make an ombuds work effectively, and options for funding.

The paper also discusses factors to consider when deciding which organization or entity is best suited to perform the ombuds role in any particular state. Finally, the paper highlights a few models for providing effective ombuds services to beneficiaries in managed care.

Why do states need an ombuds program?

Within the next two years, up to two million dual eligibles in as many as 25 states are expected to be enrolled in new demonstration projects that will significantly change the

[1] In this paper we use the term "ombuds," though "ombudsman" is also widely used. We note however that, though these terms are meaningful to advocates and policy makers, neither is very consumer-friendly. States should consider using more accessible terminology when implementing an ombuds program.

way that they receive health and long-term care services. Hundreds of thousands more will be required, via state Medicaid waivers, to enroll in managed care plans to receive most or all of their long-term services and supports (LTSS).

As responsibility for deciding what care will be provided in which setting shifts from state agencies to managed care plans, consumers will need assistance navigating plan procedures and advocates to work on their behalf if errors or mistakes are made. Since managed care plans have limited experience serving this population and, in particular, providing behavioral health and LTSS, there will be systemic challenges to confront and address as new systems mature.

To help meet these challenges, beneficiary advocates have urged the establishment of an independent, conflict-free ombuds for each demonstration. States with established managed care systems have found ombuds programs to be an effective and essential tool in protecting plan enrollees and in helping to better understand and monitor plan performance.[2] An ombuds is even more essential for the plans in waiver and demonstration states that will take on the new responsibility of providing care to extremely vulnerable beneficiaries, many of whom require long-term services and supports.

The term "ombuds" can mean many different things. In this paper, the term refers to an independent, external entity that represents the needs and perspectives of beneficiaries enrolled in demonstrations and MLTSS; a role that is similar to what the American Bar Association refers to as an "advocate ombuds."[3] Housed in an organization outside of the Medicaid agency, the ombuds would provide individuals with free assistance in accessing their care and appropriate services, addressing issues of care quality, and understanding and exercising their rights and responsibilities, and would assist with appeals of adverse decisions made by a plan. Informed by the experience of assisting individuals, the ombuds would identify systemic problems and work with state and plan officials to raise and resolve issues related to state or plan action. The ombuds would collect data about problems and report regularly to state and federal policymakers, creating a valuable complement to oversight and monitoring provided by the authorizing state and federal agencies.

The activities and focus advocates envision for the demonstration and MLTSS ombuds differ from those currently provided by most long-term care ombudsmen, who generally focus their advocacy on care within nursing facilities, assisted living and board and care homes, rather than on ensuring that managed care plans provide access to the wide array of providers and services, especially home and community-based services (HCBS), covered

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[2] Existing ombuds programs in Wisconsin and Vermont are among those most directly relevant to the dual eligible demonstrations because they serve similar populations and address MLTSS issues. Contractual and statutory provisions around those two state programs will be noted throughout this paper.

[3] American Bar Association, Standards for the Establishment and Operation of Ombuds Offices (Feb, 2004) at 8, available at www.americanbar.org/content/dam/aba/migrated/child/PublicDocuments/ombudsmen_1.authcheckdam.pdf.

by Medicare and Medicaid. It also is broader in scope compared to Aging and Disability Resource Centers (ADRCs) which offer assistance and navigation but, in most cases, do not include representation in formal appeals, resolution of and tracking of complaints against plans or reporting on problems among their services.

Further, the focus of the ombuds role is different from the current role of most State Health Insurance Programs (SHIPs), which primarily centers on enrollment counseling regarding Medicare, but not Medicaid options, and does not usually include direct representation or reporting on systemic problems. Local legal services programs have experience providing individual representation and recommendations for systems improvements, but many currently lack Medicare expertise.

Distinguishing the role of the demonstration and MLTSS ombuds from existing programs that serve this population is not meant to discourage states and CMS from thinking about how to utilize and expand these organizations when developing an ombuds program. Rather, it is meant to clarify that the ombuds need is not one that is being met by any one organization now. The demonstration and MLTSS ombuds will require a new and separate contract, training, and funding.

What are the core functions for an ombuds?

The three core functions of the ombuds are:

Individual assistance: The primary role of the ombuds should be to give individual members assistance in navigating the complexities of managed care. This role includes assistance in:

- Understanding and exercising rights and responsibilities under the demonstration or waiver and existing civil rights laws, including ensuring physical and programmatic access for beneficiaries with functional impairments and the individual's right to remain in/return to one's community.
- Accessing covered benefits, including troubleshooting for individuals with urgent needs for services.
- Problem-solving for consumers confidentially.
- Resolving billing problems.
- Making enrollment and disenrollment decisions.[4]
- Assisting consumers with appeals at all levels of plan denial, reduction or termination of service decisions.[5]

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[4] Pre-enrollment choice counselling is not necessarily part of the ombuds role. These functions could be conducted by the same entity or different entities.

[5] There is evidence that having an ombuds reduces the need for formal appeals. The Wisconsin ombuds reports only 2.6% of its cases were taken to an administrative hearing in its second year and only 1.9% in its third year. Disability Rights Wisconsin, Family Care and IRIS Ombudsman. Program, Year 3 Annual Report, at 1 (Oct. 1, 2011) available at http://dualsdemoadvocacy.org/wp-content/uploads/2012/03/FCIOP-Annual-Report-100111.pdf.

- Raising and resolving quality of care and quality of life issues.
- Ensuring the right to privacy, consumer direction, and consumer driven decision-making.

System monitoring and reporting: The ombuds should provide policymakers and stakeholders an 'on the ground,' beneficiary perspective on how the demonstration or waiver is performing. The program can identify areas where individual problems demonstrate broader issues with system design or implementation. This role includes:

- Tracking of problems reported and assistance provided.
- Rapid identification of urgent systemic problems based on individual requests for assistance.
- Broader identification of system elements in need of reform and unmet consumer care and service needs. Provision of recommendations for improvement.
- Representation of beneficiary perspective and interests in discussion of system modifications.
- Data collection, and analysis.
- Periodic formal reporting to state agencies, state legislatures and the public to inform monitoring and evaluation and systems improvements.[6]
- Providing a public voice for beneficiaries generally.
- In all reporting and tracking functions, protecting confidential consumer information.

Consumer education and empowerment: The ombuds must reach out to, and be a resource for beneficiaries, family caregivers and advocates. It is particularly important that the ombuds establish connections with hard to reach beneficiaries including, but not limited to, those who are limited English proficient, are homeless, are homebound, lack literacy skills, have communication impairments, or are living in institutions.

- Providing outreach to consumers and family caregivers about the availability of ombuds services and education on beneficiary rights in managed care and under Medicare and Medicaid law.[7]
- Building and maintaining relationships with senior, disability, and dual eligible communities and organizations that provide social and other services to dual eligibles and their families.
- Providing information at appropriate literacy levels, in enrollees' languages and in a culturally competent manner.

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[6] Vermont requires both quarterly statistical reporting of cases and quarterly recommendations "for changes to the program or policies and procedures that will benefit consumers." VT Health Care Ombudsman Grant Agreement (hereinafter "VT Contract"). at 4, available at http://dvha.vermont.gov/administration/03410-218-10-final-web.pdf A copy of the most recent annual report of Vermont's health care ombuds is available at www.vtlegalaid.org/assets/Uploads/2012-HCO-Annual-Report-Final.pdf

[7] Exhibit 1 to WI Ombudsman Contract (hereinafter "WI Contract") at 7 and 12, available at www.dhs.wisconsin.gov/LTCare/pdf/ombudsExhibit1.pdf (requiring that ombudsman develop an outreach plan); VT Contract at 6-7.

What qualities are needed in an ombuds office?

- Independence. An ombuds should be located outside the state agency overseeing managed care and not be affiliated with managed care plans.[8] The ombuds should be conflict-free.[9]
- Deep knowledge of Medicare and Medicaid rights, knowledge of the demonstration or waiver structure and requirements, knowledge of appeals systems and rights.
- Legal capability, either through on-staff attorneys or access to attorney resources.[10]
- Systems change focus. Capacity to identify systemic barriers within the health care system and devise solutions to those barriers.
- Trust by the community, extensive ties to consumer and community organizations.
- Aging and disability competences; language and cultural competence.[11]
- Familiarity with disability rights laws and Olmstead community integration and independent living principles.
- Ability to provide telephone, internet and in-person assistance, as appropriate.

What does an ombuds need from the state?

- Funding that permits adequate staffing relative to the population being served. [12] . (See funding discussion below.)
- The freedom to raise individual and systemic issues in any appropriate forum.[13]
- State requirements that both plans and state agencies establish specific pathways for ombuds access and provide timely responses to ombuds complaints and information requests.[14]

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[8] See VT Contract at 5.

[9] Vermont also requires that the ombuds be a non-profit organization. 8 V.S.A. § 4089d.

[10] A requirement that legal services are available to the ombuds office is found in the WI Contract at 11 and the VT Contract at 3.

[11] See WI Contract at 3 and 5 (specific requirements re interpreters, disability competencies and cultural competency training). Hawaii specifically requires that the ombuds phone line greeting offers callers the options of Tagalog, Korean, Ilocano and Mandarin Chinese. Hawaii Ombudsman Services Request for Proposals (May 6, 2010) at 32 (hereinafter Hawaii RFP), available at http://hawaii.gov/spo2/health/rfp103f/attachments/rfp7741273710524.PDF.

[12] Wisconsin uses a ratio of 1 staff member to 2500 enrollees. Wis. Stat. § 46.281(1n)(e); WI Contract at 8-9. The ratios among LTC ombudsmen with oversight over facilities vary greatly, with highly ranked ombudsman programs ranging from 1:1,342 to 1:9,248. See Institute of Medicine, Real People Real Problems: An Evaluation of the Long-Term Care Ombudsman Programs of the Older Americans Act (1995), p. 188, Table 6.1, available at www.nap.edu/openbook.php?record_id=9059.

[13] Wisconsin requires that the ombuds begin with informal advocacy but can go directly to a formal appeal upon the request of the beneficiary. WI Contract at 1. Vermont, by statute provides that "The state ombudsman shall be able to speak on behalf of the interests of health care and health insurance consumers and to carry out all duties prescribed in this subchapter without being subject to any disciplinary or retaliatory action." 8 V.S.A. § 4089f(g)

[14] The Wisconsin Department of Health Services must respond timely to requests by the ombuds program for assistance, consultation or collaboration on individual cases, and must meet regularly with ombuds program staff "to share information about identified or potential patterns of non-compliance issues either with individual MCOs" or with systems. Also, the Department must intervene when an MCO, financial service

- A requirement that state and plan officials participate in regular meetings with ombuds staff.
- Guaranteed access to real time data and records from the state and health plans, including appropriate privacy protections.

Paying for an Ombuds. What are the options?

Potential sources of funding that could be explored include:

- Medicaid. Some states are using Medicaid funding, including federal administrative claiming match, for their long-term care ombuds. This approach would be appropriate for ombuds in states with MLTSS waivers. Medicaid funds part of Vermont's Health Care Ombudsman.
- The Center for Medicare and Medicaid Innovation. CMMI recently announced a funding opportunity for follow-on implementation for the 15 states that received innovation grants and included ombuds programs as one potential element for which CMMI support be sought. Funding for an ombuds should routinely be part of those follow-on grants. More generally, CMMI has a broad mandate and significant resources to fund improvements in care delivery and access and should fund this aspect of the dual eligible demonstrations beyond the 15 states that received design contracts.
- Community Assistance Program (CAP). Although much CAP funding is going to ombuds programs for work on the Medicaid expansion and new Exchanges, CAP funds may be used to provide assistance to individuals on Medicare and Medicaid as well. Several states are using CAP funding to provide support to these populations. Of course, additional CAP funding would need to be provided to ensure that funding is not diluted from current programs, and adequate funding is provided to the programs taking on the additional responsibilities outlined in this document.[15]

Designing an ombuds program: Who is best equipped to perform the core functions?

The decision of what type of organization or organizations would be most appropriate for a demonstration or MLTSS waiver program in a particular state should take into consideration many factors:

- Focus and expertise: The demonstrations and MLTSS waivers are complex involving new rules and procedures as well as continuing rights under two complex programs, Medicare and Medicaid. Issues related to the provision of LTSS, including many specialized disability and behavioral health services, through managed care

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agency, or Aging and Disability Resource Center has refused to timely release information, despite release having been authorized by the enrollee. WI Contract at 15. See also VT Contract at 7 (requiring the state to takes necessary steps "to ensure the cooperation of state agencies" with the ombuds) and 8 V.S.A. § 4089f(d).

[15] See www.healthcare.gov/news/factsheets/2010/10/capgrants-states.html

are likely to be particularly challenging.[16] It is essential that there be a core of dedicated staff immersed in the programs.

- Nature of the demonstration or MLTSS waiver program: The most effective ombuds will have ties and trust in the communities covered by the demonstration or waiver program. Which organization or organizations would be most appropriate could depend on where the program will operate, for example, whether it is concentrated in a few urban counties or is statewide; whom it serves, for example, whether it covers all duals or particular subpopulations and similar factors. An organization serving as ombuds should be a good match with the needs of those being served.
- Size and diversity of the state and the MLTSS waiver or demonstration population: In some states, having a group of organizations working together to provide ombuds functions could be an effective option provided there is close coordination among the cooperating organizations. Although help lines can play a central role in an ombuds program, it is important that there also be some capacity for in-person assistance.
- Leveraging existing resources: Are there already organizations effectively providing navigator and advocacy functions for other programs or populations? How are they organized? Could those resources be leveraged? Could partnerships be formed to perform the functions described above?

There are many examples of programs that provide ombuds or ombuds-like services similar to those discussed in this paper. A few that are illustrative of different types of organizations that have performed similar functions include:

Wisconsin. The protection and advocacy program in Wisconsin, Disability Rights Wisconsin (DRW), operates the ombuds program for individuals under 60 who participate in Wisconsin Family Care and IRIS programs, both of which provide MLTSS. The ombuds operates as a unit in DRW with dedicated staff but can draw on the resources of DRW and the skills of other DRW personnel. DRW receives funding from the state under a contract that is renewed annually. Individuals who are 60 and older are referred to the state's long-term care ombudsman.

Vermont. Vermont Legal Aid has had a renewable grant from the state to act as the Health Care Ombudsman since 1999. After the state established its HCBS waiver program, called Choices for Care, Vermont Legal Aid took on ombuds responsibility for that program as well. Grant funds come from the Department of Financial Regulation, using ACA CAP grant funds and the state's Global Commitment to Health Waiver, which is funded under its Medical Assistance Program Grants. The state recently entered into an additional contract with Vermont Legal Aid to assess operational needs so that the ombuds program can effectively be expanded to address the needs of Exchange consumers.[17]

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[16] Wisconsin advocates in the state's ombuds program have reported informally that, although they handle all access to care issues, the vast majority involve LTSS.

[17] See http://dvha.vermont.gov/administration/vt-legal-aid-contract-21803-signed.pdf

Hawaii. The Hawaii Medicaid ombuds is housed in a non-profit, the Hilopa'a Family to Family Health Information Center. Although Hilopa'a was started to serve the needs of families of children with special health care needs, it offers ombuds services to all Medicaid recipients, including enrollees in QUEST Expanded Access, the state's mandatory managed care program for older adults and persons with disabilities. Hilopa'a is one of 51 Family to Family centers nationally that received grant funding from the Health Resources and Services Administration (HRSA).[18] The role of the Hawaii ombuds is more limited than others in that the ombuds may only assist plan members through internal reviews within the plan. The ombuds is specifically prohibited from providing direct assistance with further appeals, although it may refer the member to a legal services provider.[19]

California. California's Health Consumer Alliance (HCA) provides navigation services and advocacy assistance to all Californians, regardless of income or coverage type or lack of coverage. HCA, originally funded with foundation grants, has received funding from the state's Department of Managed Health Care using federal CAP funding. HCA consists of nine consumer centers, each sponsored by a local legal services organization, with leadership by the National Health Law Program (NHeLP) and state support from the Western Center on Law and Poverty. Although HCA is a group of many organizations, it uses a common database to report to the Department of Managed Health Care as well as to identify and address systemic problems.[20]

New York. As in California, New York's CAP grant supports a "hub and spokes" system managed by the Community Service Society and comprised of three specialist agencies and 26 community-based organizations that assist individuals throughout the state to get, keep, and use health insurance.[21] The Medicare Rights Center provides Medicare-specific training and support, and Empire Justice Center and the Legal Aid Society of New York provide additional technical support to all CAP members. Through separate funding from the New York State Office for the Aging, the Medicare Rights Center and six other organizations, including Selfhelp and StateWide Senior Action Council, provide additional support to people with Medicare and others who currently require insurance assistance and will continue to require assistance transitioning from the state's health insurance Exchange to Medicare and Medicaid.

Conclusion

Dual eligible demonstration projects and MLTSS waiver programs are new and complex. Navigating them will be a challenge for beneficiaries. An independent ombuds is an essential consumer protection for seniors, people with disabilities and dual eligibles. Certain common elements are necessary for a successful ombuds, including independence, in-depth program knowledge and strong community links. Other details will vary from state to state. Local stakeholder input and a careful assessment of how to best leverage

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[18] See www.hrsa.gov/about/news/2012tables/120523familyvoices.html

[19] Hawaii RFP at 30.

[20] For a description of HCA, go to www.healthexchange.ca.gov/BoardMeetings/Documents/September%2018,%202012/Health%20Consumer%20Alliance%20-%20Comments%20on%20Consumer%20Assistance.pdf

[21] www.communityhealthadvocates.org/about/how-we-can-help.

strengths in the state system will improve program design. In all cases, funding to support adequate staffing and operation is essential.

Three Coalitions have made KanCare Reform, including this Independent Ombudsman Bill, a Top Priority

Big Tent Coalition (Statewide) – its members:

- *Topeka Independent Living Resources Center (Shawnee County)*
- *Self-Advocates Coalition of Kansas (Statewide)*
- *Arc of Douglas County (Douglas & Jefferson Counties)*
- *Kansas Council on Developmental Disabilities (Statewide)*
- *Kansas ADAPT (Statewide)*
- *National MS Society (Statewide)*
- *Keys for Networking (Shawnee County)*
- *End the Wait Kansas (Statewide)*
- *Brain Injury Association of Kansas and Greater Kansas City (Statewide)*
- *Cerebral Palsy Research Foundation (Sedgwick County)*
- *Minds Matter (Johnson County)*
- *KAAAA (Statewide)*
- *Disability Rights Center of Kansas (Statewide)*
- *Community Works, Inc. (Johnson County)*
- *CLASS LTD (Crawford County)*
- *Community Choice, Inc. (Johnson County)*

Kansas Developmental Disabilities Coalition (Statewide) – its members:

- *Families Together (Statewide)*
- *The Alliance for Kansans with Developmental Disabilities (Statewide)– its members:*
    - *Disability Supports of the Great Plains (McPherson & Reno counties)*
    - *Easter Seals Capper Foundation (Shawnee & Cowley counties)*
    - *Quest Services (Brown, Jackson, Osage, Coffee & Lyon counties)*
    - *Rosewood Services (Barton, Pawnee, Stafford, Rice & Rush counties)*

KanCare Advocates Network (Statewide) – its members:

- *Keys for Networking*
- *Children's Alliance*
- *Disability Rights Center of KS*
- *NAMI-KS*
- *Mother & Child Health Coalition*
- *KS Advocates for Better Care*
- *Alzheimer's Association*
- *Kansas Association for the Medically Underserved*
- *KS Association of Area Agencies on Aging*
- *Oral Health KS*

- *Kansas Hospital Association*
- *Kansas Pharmacists Association*
- *CMS, Inc.*
- *Medicaid Access Coalition*
- *American Cancer Society*
- *Life Pattersn of Kansas*
- *DD Council*
- *Ks Acton for Children*
- *Institute for Health & Disability Policy Studies*
- *KU RTCIL*
- *Wichita Medical Services Bureau*
- *KS Home Care*
- *Association of Community Mental Health Centers of Kansas*
- *Jenian, Inc.*
- *AARP-KS*
- *KS Advocates for Better Care*
- *Topeka Independent Living and Resource Center*
- *Kansas Association of Local Health Departments*
- *Community Living Opportunities*
- *American Cancer Society*
- *MS Society*
- *Self Advocates Coalition of Kansas*
- *KACIL*
- *Easter Seals Capper Foundation*
- *American Heart Association KS Chapt*
- *Health Reform Resource Project*
- *National Association of Social Workers -- Kansas*
- *Minds Matter, Inc*
- *OCCK*
- *InterHab*