Colorado Ombudsman for Medicaid Managed Care

The Ombudsman for Medicaid Managed Care Annual Report is presented by MAXIMUS reviewing cases handled by the Ombudsman during FY10-11.

Annual Report
July 2011

Transmittal Letter

July 29, 2011

Dear Reader,

The purpose of this letter is to officially transmit the Ombudsman for Medicaid Managed Care FY 10-11 Annual Report. MAXIMUS, Inc. administers the Ombudsman Program under contract with the Colorado Department of Health Care Policy & Financing.

The Medicaid Managed Care landscape shifted dramatically in FY10-11. Not only has Medicaid enrollment continued to increase due in large part to the lingering economic recession, but new programs were also introduced. In April of 2011 the Accountable Care Collaborative (ACC) was introduced. The goal of this program is to provide Medicaid clients with a medical home and reduce reliance upon emergency room and urgent care providers. This is a program in which all participating medical providers are coordinated by a Regional Care Collaborative Organization (RCCO). These Medicaid clients will fall under the scope of the Ombudsman as they are considered part of Medicaid Managed Care.

Along with being a resource for managed care clients, the Ombudsman staff also gathers data about the issues and outcomes associated with each Ombudsman case. This annual report summarizes trends in complaint data from the client's perspective when dealing with either their medical or mental health plans.

The hope of the Ombudsman office is that such information can be used to help improve programs offered to Medicaid clients. The fewer obstacles a client faces when seeking care the fewer complaints they are likely to have about their care. This of course benefits not only the clients, but providers as well.

It is our hope that this report will prove useful to the State policy-makers and administrators, and to the health plans and advocates in their shared goal to make Medicaid managed care better serve its members.

Respectfully submitted,

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Health Services West, MAXIMUS

Ombudsman for Medicaid Managed Care

Annual Report FY 2010-2011

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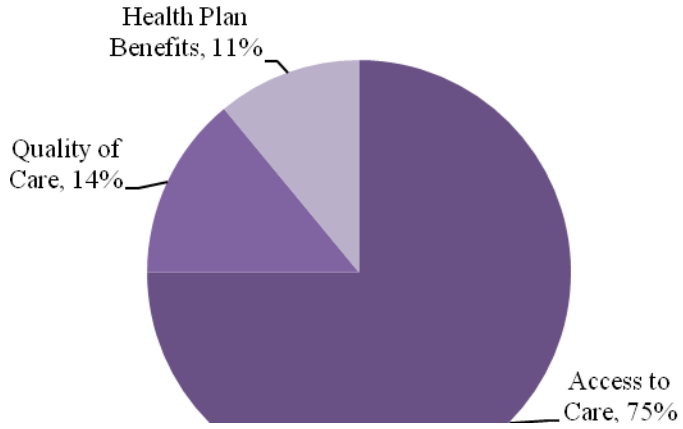
The Ombudsman for Medicaid Managed Care

The purpose of the Ombudsman for Medicaid Managed Care is quite simple: to assist clients enrolled in Medicaid Managed Care. The Ombudsman acts as an independent intercessor to assist the client who is enrolled in Medicaid Managed Care which includes Managed Care organizations (MCO), the Primary Care Physician Program (PCPP), Accountable Care Collaborative (ACC) and Behavioral Health Organizations (BHO). The Ombudsman is to, upon the client's request; act as the client's representative and or mediator in the resolution of client's complaints about quality of care issues, denial of medically necessary services and benefits, and access to services and benefits issues. Further the Ombudsman is a resource of community services and an educator of client rights and responsibilities.

While the purpose of the Ombudsman is quite simple, the role of the Ombudsman may not be so much so. Often times the role of the Ombudsman is to help the interested parties work through misunderstandings, or assisting in the coordination of care services between health plans, providers, and other agencies to resolve the client's problems. On occasion it falls upon the Ombudsman to educate members, health plans and providers about Medicaid program rules and policies.
Managed care clients contact the Ombudsman with questions regarding the complicated and sometimes confusing business of navigating Medicaid managed care. Consistent with prior years, a very large portion (75%) of contacts in Fiscal Year '10-11 were in regard to access to care complaints; approximately 14% related to issues of quality and 11% were concerning health plan benefit issues.



The Ombudsman adds value to the Colorado Medicaid system with its impartial, independent, and confidential handling of each member's concerns. It also accumulates and reports qualitative information to State policy makers, who use it to manage health plans and to improve program design and processes.

An independent Ombudsman is especially important in a public healthcare system designed to assist the underserved and disadvantaged. It is imperative to balance the business goals of service providers with the

health care needs of clients. When a health plan is unable to help clients solve their problems, it is often necessary to have an impartial body that can mediate, and advocate for their healthcare needs to be met.

An independent office such as the Ombudsman can be of vital importance in assisting clients in framing their complaint to the plan, identifying solutions, and facilitating dialogue between provider and client. As an objective and impartial third party, the Ombudsman can offer a perspective or potential solutions which may otherwise go overlooked.

The purpose and focus of this annual report is upon the managed care enrollee's problems with their health plans. While the purpose of the report could be interpreted as being quite negative, the intent is quite contrary. Information gathered regarding the breakdown of performance in health plans gives plan and program administrators vital information with which to improve Medicaid benefits and services to their members.

It is worth noting that 83% of all FY '10-11 Ombudsman cases were related to a BHO, an MCO service or benefit, or the PCPP. As was noted in the FY '09-10 annual report, the Ombudsman was also contacted by clients with concerns regarding access to health care under Medicaid fee-for-service or establishing Medicaid eligibility. The Ombudsman provides information and referral for every client but tracks these cases which fall outside of managed care less closely than those clients who raise concerns regarding managed care plans.

Finally, it is very important to note that MCOs cover only 14% of all Medicaid eligible persons (compared to BHOs which cover 95%). During FY '10-11, MCOs accounted for 21% of Ombudsman cases for members enrolled in health plans. This is indicative of the fact that far fewer enrollees actually utilize a BHO over the course of a year in comparison to their MCO or PCPP. This may also be a reflection upon the difficulty that people with mental illness and other disabilities experience when attempting to meet their physical healthcare needs.

The Ombudsman in an Ever-Changing Healthcare Landscape

The Ombudsman operates within a dynamic healthcare landscape. Along with external changes, the Ombudsman program underwent several internal changes during the course of this fiscal year. Between October and March of FY'10-11 the Ombudsman experienced a complete change of staff. This has allowed the Ombudsman to reevaluate the manner in which cases are handled and recorded, as well as the vision of the Ombudsman program in light of the ACC program implementation. The new staff has a new focus on the core services of the Ombudsman, and is determined to provide quality service to clients within our scope. The implementation of the ACC was quite timely in light of the Ombudsman staff change. Not only will new staff bring valuable new insight and ideas to the program, but the enrollment of several thousand Medicaid clients into the ACC will provide the Ombudsman with an opportunity to assist a much larger portion of the Medicaid client population.

The Accountable Care Collaborative (ACC)

As previously mentioned, the State of Colorado initiated the Accountable Care Collaborative (ACC) in April 2011. The focus of this program is to assist managed care entities in adopting a client-centered approach that provides efficient and coordinated care to improve the overall health of its members. This model of care is unique to the State of Colorado and differs from capitated managed care. The ACC invests directly in regional care coordination and in community infrastructure to support physicians and care teams. The new model operates by incentivizing measurable improvements in client health and reduction in avoidable health care costs. Features of the ACC include:

- A medical home for all clients with physician-managed;
- enhanced care management, data, and other provider supports;
- provider coordination across the spectrum of a client's health needs; and
- statewide data and analysis available regionally

The definition of managed care in Colorado Medicaid will shift with the implementation of this program. Colorado Access, Kaiser, and the Colorado Alliance for Health and Independence have already started the shift from managed care towards an enhanced case management model more consistent with the ACC with their Colorado Regional Integrated Care Coordination (CRICC) programs.

The role of the Ombudsman within the ACC will be of utmost importance. It is projected that nearly all Medicaid clients may ultimately be enrolled in the ACC. This would, of course, increase the Ombudsman client base dramatically. Not only would the number of potential clients rise significantly, but the number of providers with whom the Ombudsman collaborates would increase sharply as well. It is due to these increases that the implementation of the ACC presents very unique challenges of the Ombudsman. Currently, the Ombudsman works primarily with clients experiencing difficulties with providers who are under the direction of either an MCO or BHO. In those cases, a very specific process by which grievances and appeals are lodged and addressed has been established by the BHO or MCO. This is not necessarily the case within the ACC program. The providers who take part in the ACC do not receive direction from their Regional Care Coordination Organization (RCCO) regarding whether or not a certain service or procedure will be covered, nor how client complaints are to be handled. Therefore the well established grievance and appeals processes the Ombudsman typically operates within will be replaced by the processes used by each individual provider to address client concerns and complaints. This will require the Ombudsman to develop a good working relationship with individual providers to resolve issues and do so within any grievance and appeals processes the individual provider may have in place.

Appeal & Grievance Processes

When Medicaid Managed Care members are unhappy about their care, there are two avenues through which members may seek resolution:

- They may file an appeal or submit a grievance.
- The nature of the member's complaint determines which remedy is appropriate. Both grievance and appeal processes have several levels of review and each health plan/administrative body has its own timeliness requirements.

The client may file an ***appeal*** only in response to one of the following actions by the MCO/BHO (or its providers):

- Denying or restricting authorization of a requested service, including the type or level of service;
- Reducing, suspending or terminating a previously authorized service;
- Denying all or part of a payment for a service (except payment denials issued by a mental health prepaid inpatient health plan);
- Failing to provide services in a timely manner;
- Failing to act within regulatory timeframes; or
- Denying a member's request to obtain out-of-network services in areas with only one MCO.

Regulations require BHOs and MCOs to send a written Notice of Action (NOA) to clients whenever any of the above actions or situations occurs.

Clients may make in-plan appeals with the BHO and MCO. They may also choose to file a subsequent or concurrent request for a State Fair Hearing with the Office of Administrative Courts. An external state administrative law judge (ALJ) hears these appeals. Every health plan and the ALJ appeal process has its own specific timelines within which both the health plan and the clients must act while moving through the appeal process.

A client's recourse if s/he is dissatisfied with an ALJ's decision is to seek a reversal by the Department during Final Agency Action review or to file a lawsuit in federal district court.

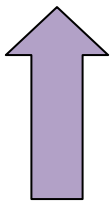
A ***grievance*** is used to express a Medicaid member's dissatisfaction about anything ***other*** than the actions previously described, including but not limited to: the quality of care or services, or interpersonal relationships such as provider rudeness or failure to respect the member's rights.

Grievances may be submitted to the BHO or MCO, either by the client in person or with the assistance of an advocate, provider, or the Ombudsman. In a grievance acknowledgement letter, the BHO or MCO notifies the client of their procedures for handling grievances, related timelines, and the client's rights.

If a client is unsatisfied with the resolution provided by the plan, the client may request the Department's review of the grievance resolution. The Department's decision on a grievance is final.

Levels of Resolution

Regardless of the issue presented to the Ombudsman, the goal is always to resolve each complaint at the lowest level possible. Ideally, an issue is addressed through member education and information, and referral to the appropriate agencies when necessary. Should it not prove possible to resolve an issue at the very lowest level of resolution, it may be achieved informally through an in-plan resolution. This may include assisting the client with service requests through care coordination with either the provider or health plan. Should these efforts not prove to be successful, the Ombudsman may assist the client in seeking a more formal in-plan resolution. If an issue is escalated to this level, the Ombudsman may assist the client with filing grievances as well as appeals to decisions made by an MCO or BHO. Finally, the client may choose to advance to the highest level of resolution; requesting a hearing before an ALJ.

Problem Resolution	
Highest Level	Office of Administrative Courts fair hearing appeal
	State review of grievance
	Resolved through formal health plan grievance or appeal procedures
	Resolved through mediation with health plan or provider
	Resolved informally "in-plan" with the health plan
	Resolved informally "in-plan" with the provider
Lowest Level of Intervention	Resolved by the Ombudsman through information, research and referral

The table below illustrates the number of cases the Ombudsman handled at each level of resolution during FY'10-11.

Level of Resolution	Total Cases/Inquiries FY '10-11	Percentage
1. Education, information & referral	133	52%
2. Assistance with service request through care coordination with provider/plan	87	34%
3. Grievance or appeal filed	33	13%
4. State Fair Hearing request	3	1%

It is the best interest of all parties involved that each case or inquiry be resolved at the lowest possible level of resolution. Should a client's issue go unresolved for an extended period of time, not only is it likely that the client may be going without needed treatment, but it may damage the provider/client relationship irreparably. There may be significant ramifications for the health plan or provider as well. A client who feels as though their complaint is not being addressed adequately is more likely to require a higher level of resolution to resolve their issue. This in turn will result in increased cost to the health plan in terms of time and financial resources.

When working to resolve an issue for a client regarding their BHO or MCO, the Ombudsman often has to take on the role of investigator. It may require a significant amount of clarification to determine what the member's complaint is, and the resolution they are seeking. For example, a client who believes that a requested service is being denied may approach the Ombudsman for assistance but may not have received a formal Notice of Action from their health plan. In certain instances an NOA may not have been issued as a passing comment from a client to provider was not recognized as a formal request, therefore it is not being formally denied. Such situations often only require clarification regarding that services the client is seeking and communicating that to the provider/health plan.

While most cases are able to be resolved informally with the health plan, the Ombudsman is continuing to note a growth in cases requiring extensive case management. This can significantly complicate the conflict resolution process. This phenomenon may be rooted in several trends:

- BHOs are building toward systems that require a level of sophistication that many enrollees (already struggling with disability or mental illness) may not possess;
- Plans are less clear and careful in advising members of their rights and resources in seeking care; and The Department mandates that all complaints be handled through the grievance system, and closely monitors the grievances and appeals reported by MCOs and BHOs. This gives the State better insight into the range of complaints that clients have with the system, and more information with which to manage Medicaid policy. However, as this report was being written, many plans were in the process of reviewing and updating member handbooks so as to advise all enrollees of their rights, responsibilities, as well as the grievance and appeals process. Their goal is to provide the necessary information in a manner that is both concise and easy to understand. It should be noted, however, that while most managed care plans have very well developed processes for which to address grievances and complaints, several providers within the ACC and PCPP seemingly have no process whatsoever.
- Certain diagnoses complicate the manner in which problems are resolved as well. For the enrollees who have been diagnosed with either a traumatic brain injury or autism, the managed care landscape can be quite difficult to navigate. This is due in large part to these individuals falling into a "grey area" of sorts in which they have needs that must be addressed on both the physical and mental health sides of managed care. What makes these cases particularly difficult to resolve is reluctance on the part of plans to approve treatment services for behaviors that may be caused by a medical diagnoses (autism or a traumatic brain injury) which are then exacerbated by mental health conditions, or vice versa. These people do not fit neatly into either the medical or mental health categories and therefore experience increased difficulty accessing services.

Reasons to Contact the Ombudsman

It is clear that FY'10-11 was consistent with FY'09-10 in regard to the high percentage of clients contacting the Ombudsman with issues surrounding access to care. These issues can be as simple as a client needing to be educated on how to access care from either their BHO or MCO, to a client experiencing a high level of difficulty locating a specialist capable of managing very complex healthcare needs. There are two groups who contact the Ombudsman quite often for the reasons listed above: children in need of residential treatment and those with disabilities.

Reasons to Contact Ombudsman	Cases FY '10-11	Percentage
1. Access to Care	193	75%
2. Denial of Benefits	33	14%
3. Quality of Care	47	11%

Residential Treatment and CMHTA

The Ombudsman receives a very high number of cases from parents seeking residential treatment for their children through BHOs. This was discussed at great length in the FY'09-10 annual report. When residential treatment is denied through the BHO, the Ombudsman will assist the parent s of these children in navigating not only the BHO appeals process but the Child Mental Health Treatment Act (CMHTA) appeals process as well. CMHTA is designed to provide parents of children with mental health needs access to residential and other treatment services regardless of their Medicaid status. A CMHTA assessment for residential treatment may be used in conjunction with BHO residential treatment assessments to determine if a child meets the requisite criteria for such a high level of care. Should the two assessments differ and the parents choose to appeal the BHO decision to the ALJ seeking residential treatment, the CMHTA assessment supporting that level of care for the child may be beneficial.

The fourth most common reason members contact the Ombudsman is for help to seek remedy under the provisions of the CMHTA. Residential care is also an oft-denied benefit. Ombudsman data suggests that families have considerable difficulty accessing these essential benefits for their Medicaid eligible children.

The process may be part of the problem. Families of Medicaid-eligible children apply for residential treatment through their BHO. The BHO is financially responsible for residential care when Medicaid-eligible children are determined to require it. The exception is when an open "dependency and neglect" case is on file with the Department of Human Services (DHS); in such instances, the BHO's financial responsibility diminishes greatly.

Each community mental health center (CMHC) and BHO has designated liaisons to educate parents about the law and ensure that its timeframes, appeal rights, etc. are adhered to. The CMHC liaison is mandated to handle assessments under CMHTA for non-Medicaid children, and frequently contracts with the BHO to do them for Medicaid children, recommending to the BHO liaison whether or not to approve residential care.

A troublingly high number of parents report to the Ombudsman that CMHCs advise them to "call Social Services" in order to access residential treatment. Parents report that BHOs or CMHCs refer families to DHS even when there is no reason to suspect child abuse or neglect (the sole purview of DHS).

This creates problems beyond simply wasting precious time. Parents who call DHS report being told that if DHS opens a case and becomes a funding source for treatment, the parents risk losing parental rights to all of their children and may compromise their careers and reputations as educators or helping professionals.

People throughout human services, medical services and community referral networks widely believe that the expedited appeal timelines and independent third party review provided by CMHTA reduces the incidence of DHS involvement with children with mental illness. From the Ombudsman's viewpoint, as DHS referrals continue to rise, this does not appear to be true with respect to Medicaid children.

When children do not receive an appropriate level of care, their illnesses and behaviors continue to escalate. Many eventually do meet the threshold for expensive hospitalization, but in the meantime may severely harm themselves or others or damage essential supportive community relationships.

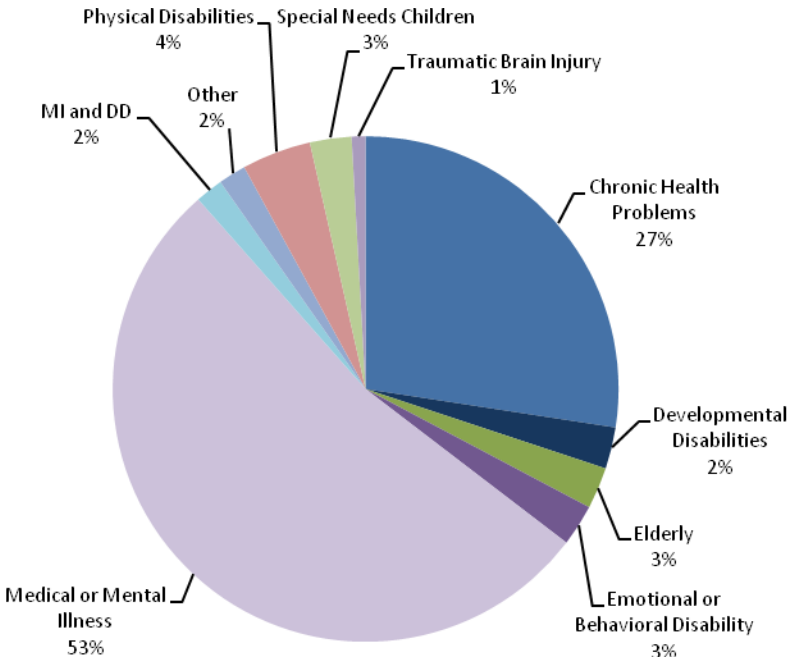
Today, 12 years after the enactment of the CMHTA law, BHOs and CMHCs still seem confused about how the Act applies to Medicaid-eligible children.

Both CMHC and BHO liaisons have told the Ombudsman of their (erroneous) belief that the CMHTA does not apply to Medicaid-eligible children. This notion persists despite the fact that the Division of Behavioral Health Services at the DHS (which is charged with oversight of CMHTA) posts a clear statement on its website that the law pertains to both Medicaid-eligible and non-Medicaid eligible children and that the CMHC and BHO are the agents designated to facilitate assessments.

The CMHTA cases tend to be more complex and to require more negotiation and escalation to resolve than the average Ombudsman case.

Disability

The Ombudsman also receives a very high number of calls from individuals with disabilities. A whopping 91% of the cases handled by the Ombudsman in FY'10-11 had a disability code associated with Medicaid eligibility or self reported a disability. The range of disabilities recorded is very broad, and includes many clients with mental illness, chronic health problems, traumatic brain injuries as well as developmental disabilities.



The high volume of contacts from individuals with disabilities speaks volumes to the ease with which they are able to navigate the Medicaid managed care system. This may be due to both the complexity of the BHO and MCO organizations as well as an already limited ability to navigate such networks on the part of the clients.

Client Satisfaction

The Ombudsman asks members at the point of case closure to rate their satisfaction with the final resolution. Member responses are summarized and compared to last year in the table below:

CLIENT SATISFACTION WITH RESOLUTION ACROSS PLANS	FY 09-10	FY 10-11
1 - Satisfied	59%	47%
2 - Somewhat satisfied	12%	24%
3 - Not satisfied	8%	13%
4 - No expression either way	20%	16%

The Ombudsman also surveyed members separately and by mail about their satisfaction with the Ombudsman services after final case closure.

The survey asked the following questions:

1. Was the Ombudsman's phone number easy to find?
2. Were you able to speak to an Ombudsman within 2 days?
3. Did the Ombudsman treat your issue professionally?
4. Was the information the Ombudsman shared easy to understand?
5. Did the Ombudsman answer your question(s)?
6. Did the Ombudsman seem knowledgeable?
7. Did the Ombudsman treat you with respect?
8. How satisfied are you with the assistance you received?

The Ombudsman's performance averages 4.6 on a 5-point scale. The lowest score regards ease of finding the Ombudsman's phone number (3.5).


Client Satisfaction
July 10 - June 11
Score (Scale 1-5)
5.50
5.00
4.50
4.00
3.50
3.00
2.50
2.00
1.50
1.00
3.50
4.28
4.92
4.76
4.76
4.48
4.96
4.64
4.60
1
2
3
4
5
6
7
8
9
Survey Question Number

The Ombudsman Helped Shape Managed Care Practice

The Ombudsman's unique perspective on individual cases allows it to spotlight areas where health plan practice conflicts with state Medicaid policy, or areas where Medicaid policy has unintended and unwanted consequences. The Ombudsman regularly communicates with the Department Contract Manager who is its liaison to State policy makers and administrators. These communications feed into State policy and practice for all Medicaid clients.

The following are among the issues the Ombudsman raised in this manner through last year and this year as well:

- Recommended that all BHOs systematically issue *written benefit authorizations*, with clearly identified end-dates and instructions for requesting new services. This process will alleviate many current situations where members are unaware that service authorizations are time limited, and that extensions can only be negotiated through a new service authorization request;
- Affirmed the rights of Medicaid members to participate with health plans and their treatment teams in decisions about their health care;
- Identified for the Division of Behavioral Health Services at DHS the need for better training of BHO and CMHC liaisons on the provisions of CMHTA as it relates to Medicaid-eligible persons;

The Ombudsman also works directly with health plans and providers to educate them about those areas where the members' experience of their practice violates or falls short of regulatory requirements. Examples of this kind of activity undertaken:

- Inspiring one BHO to implement a corrective action plan to re-train providers about NOA requirements; and
- Communicating with another BHO about the need for its emergency room providers to inform parents of children with mental illness of their broader rights under CMHTA when its practice had been to turn them away from the hospital or refer them to social services.

Recommendations for Further Action

Analysis of Ombudsman cases for this annual report suggests further need to continue to address the following recommendations with regard to Medicaid managed care:

Customer Service Departments at health plans need to improve their capacity to serve the more disabled and vulnerable among the Medicaid population. Specifically,

- Call center 1-800-numbers should have resources to divert unusual or complex calls for expert individual handling when menu-driven response is insufficient. Particular attention should be given to comprehensive problem-solving, troubleshooting system errors, and coordinating care for persons with mental illness and other disabilities, and children.
- Customer service representatives should be specially trained and capable of handling the more complex situations that Medicaid clients face.
- BHOs and MCOs should frequently update provider network lists and information with correct information so they are useful to members.

- Personnel need to describe decision-making authority accurately in talking with members. Shorthand attribution such as "Medicaid denied" when decisions are actually made by the BHO/MCO or its administrative agent does little to help members understand or navigate the complex tangle of managed care players and processes. Members ask for clear information that cites the entity making a denial and their authority for taking an action.
- Personnel should routinely explain to clients their rights to appeal.

Notices of Action (NOAs) should be routinely issued by health plans as required by Medicaid regulations.

- All level of contact staff should be trained in this regard.
- Checklist NOAs should be changed to meet both the spirit and the letter of Medicaid noticing requirements. Members and advocates should be able to review NOAs and determine what service is being denied, what alternate services are authorized, what their appeal rights are, where they can go for further assistance, and what appeal timeframes pertain. Members also have asked that NOAs cite the statutory and regulatory authority for denials.

Network Adequacy: The clustering of concerns related to referrals, limited providers, difficulties getting assessments, and long wait times suggests problems with network adequacy that both the State and the health plans should review and address. This cluster of complaints increased markedly from prior years.

CMHTA: CMHC and BHO liaisons should be trained and held accountable for adhering to the CMHTA, particularly as it pertains to Medicaid-eligible children.

- Hospital emergency rooms should assess children who present with mental health emergencies for lower levels of care including residential treatment. As a routine part of evaluating children in mental health crises BHOs and their networks of providers (most notably CMHCs and hospital ERs) need to provide parents a summary of CMHTA appeal rights, processes, and timeframes, as well as their right to a second opinion.
- Training should be provided throughout the emergency referral network (including health providers, community mental health centers, law enforcement personnel, ERs and urgent care centers) that the social service system handles children's crises that are related to child abuse and neglect. Erroneous or circular referrals delay needed health care and degrade health outcomes.

Counseling Disenrollment: MCOs continue to offer disenrollment as a solution for members' problems rather than meeting needs appropriately within their plans. More effective follow-up and sanctions are needed to curb this behavior.

Discharge Planning: BHOs and their participating hospitals need to implement adequate hospital discharge planning, particularly with regard to child and adult members with mental illness.

Preauthorization Policies: Health plans should maintain and make generally available their preauthorization policies and guidelines, along with transparent, clearly stated processes and timelines for preauthorization requests. These steps would reduce time-wasting delays for the members who need services that require preauthorization, especially for such benefits as residential treatment, mental health services, and vision and hearing services and medical supplies.

MAXIMUS, in its role as administrator of Colorado's Ombudsman program, continues to believe that implementing these recommendations would significantly strengthen and improve how clients experience the Medicaid managed care system.

Summary

FY ’10-11 was a year filled with several changes both internal and external for the Ombudsman. Not only was there a complete Ombudsman staff change, but the implementation of the ACC program will dramatically change the landscape of managed care in Colorado. This will also directly impact the work of the Ombudsman by dramatically increasing the managed care client population the Ombudsman may assist, and allowing the Ombudsman to assist providers in developing grievance and appeals processes for their clients.

Despite the large amount of change, there was also quite a bit of consistency for the Ombudsman this fiscal year. The Ombudsman continued to see a very large number of cases regarding access to care problems as well as a significant number of clients with disabilities. Children being denied residential treatment and eligible for CMHTA continue to be a constant for the Ombudsman as well.

The Ombudsman continues to play a vital role in Medicaid managed care. It is a resource for those clients who would otherwise have very few options for assistance in navigating both the managed care system, and grievance and appeals processes. It is the hope of the Ombudsman that the information contained in this report will prove useful to State policy-makers and administrators, as well as health plans and advocates in the shared effort to make Medicaid managed care better able to serve its members.

Appendix 1 – Case Vignettes

Case examples #1, #2, #3 and #4 demonstrate the involvement of the Ombudsman to ensure that clients are afforded all levels of appeal that are available to resolve Medicaid managed care issues.

Case Example #1

Background

The client's mother contacted the Ombudsman to discuss her concerns regarding the recommendations made by a mental health institute regarding her son being transferred to a group home. The client's mother was concerned for his safety and was seeking assistance to prevent her son being sent to a group home.

Story

Client's mother was initially very concerned with the recommendation being made by the mental health institute where her son was residing that he go back into a group home. The client's mother was afraid that the client would relapse and begin using drugs again if he returned to a group home. She was also concerned because the client was stabbed while residing in a previous group home. An ROI was obtained to authorize the Ombudsman to speak with the client's mother, as well as the mental health institute where the client was residing.

Along with the initial concerns voiced by the client's mother, she also became very concerned that her son's medications were being changed and that her concerns were not being heard by the mental health institute. In light of these concerns, the Ombudsman assisted the client's mother with a conference call to the mental health institution to address these concerns with the client's case manager and social worker as well.

The Ombudsman was contacted by the client's social worker who clarified the situation with the client's medication. It was explained that the client's medications were reviewed daily by a doctor and that the situation at the prior group home would be taken into consideration at discharge planning. The social worker also noted that the client was stable prior to leaving for a weekend pass and upon return to the institution was quite unstable. It was noted that the mother's living situation may be a factor in the client's deterioration while on a weekend pass. The social worker also stated that the institution was unable to share information with the client's mother as they did not have a current ROI to speak with her.

In order to facilitate a care plan for the client between his mother, the institution, and the Ombudsman, a DCR was obtained. Despite all of this, the client's mother was still concerned that the institution had not yet released him. The Ombudsman spoke with the social worker at the institution who clarified the reasoning for the client having not been released. The social worker clarified that the care team was trying to determine what sort of facility would be best for the client based upon his fragile mental state and drug seeking behaviors. The social worker also noted that the client's behavior deteriorated any time the client went home on a weekend pass and it was clear the client needed a much more structured environment. This concern on the part of the social worker was validated when the client's mother indicated that her home life

and personal relationships were not stable and in a state of upheaval. The situation with the client's mother began to deteriorate soon thereafter and she was denied assistance in attempting to obtain guardianship. After multiple declines to attend meetings and failure to abide by visitation policies it was determined by the mental health institution that very firm boundaries would be set for the client's mother by the mental health institution. This was done in an effort to prevent further destabilization of the client.

Outcome:

In light of the circumstances with the client's mother, it was determined by the Ombudsman that no further assistance was needed on the part of the client. As the client was receiving appropriate care and his mother had been denied guardianship, it would be inappropriate to move forward. The Ombudsman determined that moving forward would not be in the best interest of the client.

Conclusion:

This case illustrates the importance of the OMMC acting to assist the client. At times what may be in the best interest of the client may not be in line with what family members would like to see as an outcome. The goal of the OMMC is to assist the client by being a neutral and objective party who is able to assist that person in navigating the often confusing Medicaid Managed Care landscape.

Case Example #2

Background:

Client contacted the Ombudsman for assistance filing a grievance regarding a denial for inpatient care for an eating disorder. The client felt that the treatment services being offered were not appropriate for the level of care needed to address her eating disorder.

Story

Client initially contacted the Ombudsman for assistance with the internal grievance process and potentially filing a fair hearing appeal. The client was seeking a higher level of treatment than that which was approved by her Behavioral Health Organization (BHO). The client was hospitalized for a short period of time for her eating disorder and was informed that she would be able to receive inpatient treatment for behavioral health issues, but not her eating disorder. The client had refused the inpatient treatment for behavioral health, and was seeking more information from her primary care physician to support her need for inpatient treatment for her eating disorder. A conference call was placed to the primary care doctor's office in an effort to follow up on the status of the request the client had placed for such information. The doctor's nurse verified that the request had been received and a letter supporting her need for inpatient treatment would be provided. The nurse also informed both the client and the Ombudsman that a letter supporting her needs for inpatient care had already been sent to the appropriate parties within the client's Medicaid managed care organization. The nurse agreed to send a copy of that letter to the client. Along with the supporting

information the client was seeking from her primary care, the client's psychologist had also provided information supporting the client's need for inpatient treatment. The client agreed to send a copy of her hospital records and the doctor's letter of support to her BHO.

Along with this information that was provided by the client's primary care physician, the client was informed that the physician that denied her inpatient treatment was a specialist in children's psychiatry. The client was approached by the administrative organization for her BHO to do an intake for a treatment center out of state. The client did not particularly want to seek treatment out of state; the client also stated that she felt as though part of her failure to recover was due in part to being denied coverage for inpatient treatment for her eating disorder six months prior. The client asked the Ombudsman for assistance completing her appeal letter to her BHO.

The biggest hurdle for the client was accessing inpatient treatment for longer than 2 weeks. This continued to be a problem while the Ombudsman was assisting the client. The client was informed that the longest stay available to her even out of state would be two weeks. The client delivered her supporting documentation and appeal as promised, all of which were reviewed by her BHO. In this case, the client was approved for extended inpatient treatment at an out of state facility.

Outcome:

The client was able to access the treatment that she felt was necessary for her recovery with the assistance of the Ombudsman. The client was very pleased with the outcome of her case.

Conclusion:

This case illustrates how the OMMC may be of assistance to clients who are struggling to access certain types of benefits under Medicaid Managed Care. The OMMC was able to facilitate conversations between the client and her primary care physician, as well as her BHO. This helped the client to access the care that she needed in a timelier manner. It is also important to note that this case also illustrates the lack of knowledge on the part of many providers regarding the services provided by the OMMC. This is based on the fact that at least one provider for this patient was totally unaware of the OMMC, or the services provided by this program.

Case Example #3

Background:

The client's legal guardian contacted the Ombudsman seeking assistance locating a specialist to treat the client's brain injury as well as mental health issues. The legal guardian was experiencing difficulty being able to obtain assistance from the BHO.

Story:

The client's legal guardian contacted the Ombudsman after experiencing several problems trying to locate a neuropsychologist to treat the client. The client had suffered a traumatic brain injury several years before

and both the client and legal guardian had been covered by private insurance until just a few months prior to contacting the Ombudsman. The legal guardian was very frustrated due to not being able to locate a provider that was accepting new Medicaid patients. After several attempts were made by both the Ombudsman and legal guardian to locate a provider, the Ombudsman and legal guardian contacted the BHO for assistance. Due to the complex nature of the client's brain injury, the BHO did not have a provider immediately available for the client. Staff at the BHO went to work trying to locate a provider that would be appropriate to treat the client.

The BHO was only able to locate one provider that may have been able to treat the client. Unfortunately, when the legal guardian contacted the provider, it was learned the provider was no longer practicing. To compound the legal guardian's frustration, it had taken a significant amount of time for the information to be provided to the legal guardian. It was at this point that a formal grievance was filed with the BHO.

While the grievance was being addressed by the BHO, it was advised that the client not only be given a list of appropriate providers but also reevaluated and a treatment plan developed. Staff at the BHO began trying to not only locate, but also schedule an appointment for the client with an available provider. Unfortunately the one provider that the BHO was able to locate was not comfortable treating a very complex traumatic brain injury case. It was at this point that the option of a mental health center performing assessments and then referring the client to a specialist was explored. The BHO sent the client's information to a nearby mental health center in order for the mental health center to contact the legal guardian to schedule an appointment. Unfortunately this option would fail to provide any resolution to the situation either.

Upon receiving the records, the mental health center did not immediately contact the legal guardian to schedule an appointment for the client. The medical director at the mental health center had requested clarification regarding the services that were needed for the client. The mental health center was at that point trying to determine if the client's diagnosis was included under services provided by mental health centers. The legal guardian was becoming more and more frustrated with the delay. He agreed to continue taking the client to a primary care physician to prescribe her medication.

Ultimately it was decided by the BHO that the client's behaviors were due to a traumatic brain injury, which is not a diagnosis included under those treated by mental health centers. The BHO had therefore decided to limit services. The legal guardian was advised that he could continue to attempt to find a provider for the client under fee-for-service Medicaid as the client was not enrolled with an MCO and a traumatic brain injury is considered a medical diagnosis. The legal guardian elected to do that as well as request a hearing with an Administrative Law Judge. The legal guardian chose to request a hearing with an ALJ as he maintained that the client did have mental health diagnoses that also contributed to her behavior which would be covered by the BHO. It was also in an effort to avoid any question at all that the BHO was not responsible for treating traumatic brain injuries the client had suffered should Medicaid medical providers say otherwise.

<u>Outcome:</u>

A decision had yet to be issued by the ALJ at the time of this annual report. The legal guardian was not able to obtain any documentation stating the client did in fact have mental health diagnoses which would necessitate treatment by a BHO. This was due to the fact that statutory time period for which providers must keep client records had expired and all records had been destroyed. The legal guardian is continuing to locate a specialist capable of treating this very complex traumatic brain injury case.

Conclusion:

This case illustrates not only the lengthy amount of time it may take to resolve an issue a client may bring to the Ombudsman, but also the difficulty many clients have locating fee-for-service Medicaid providers. It is also very important to note that this case illustrates how difficult it can be for clients with certain diagnoses, such as a traumatic brain injury or autism, to access services from either BHOs or MCOs. This is due in large part to those clients falling into a "gray area" in which their behaviors require treatment from both mental health and medical providers. In light of that, there is also disagreement as to which provider is responsible for providing those services.

Case Example #4

Background:

The client's mother contacted the Ombudsman for assistance obtaining residential treatment for the client. The client's parents felt that the lower level of care being offered was inappropriate based upon the fact that the client's behaviors and recommendations made by other providers.

Story:

The client's mother contacted the Ombudsman after being encouraged to do so by the client's probation officer. The client's parents had been seeking residential treatment for a number of years, which had again been denied and initially were wondering if it would be beneficial for the client to remain on probation during the appeals process with the BHO. The client had failed in residential treatment several times prior, but despite this was considered a very good candidate for a specific residential treatment center. Despite multiple recommendations the client attend this particular residential treatment center made by the probation officer, the mental health center would not approve the treatment.

When the Ombudsman and the client's mother contacted the mental health center for an official letter for denial for the requested services, the mental health center did not have any records of the client, nor did the mother know any of the providers at the mental health center. It was learned that the client's treatment was being managed by an associate group of the mental health center. The Ombudsman was advised by a representative at the BHO that in order for an assessment for residential treatment to be performed as expeditiously as possible, a request would need to be made to the mental health center. To complicate matters, during the between which the residential treatment assessment was requested and scheduled the

client had been arrested. The situation was such that should residential treatment for the client not be approved his probation officer would consider taking him into custody.

In conjunction with requesting a residential treatment assessment, the client's mother also requested an assessment of the client be done under the Child Mental Health Act (CMHTA). Should that assessment show that the client was appropriate for residential treatment, this would provide the client's parents with support in requesting that service. The client was taken into police custody just prior to a denial for a request for residential treatment by the BHO was issued. The assessment of the client under CMHTA also did not find that the client was appropriate for residential treatment. The client's parents chose to appeal both decisions. The BHO decision was appealed to the BHO and a request for a hearing in front of an Administrative Law Judge was also filed by the parents. Upon appeal of the CMHTA assessment, the reviewing doctor found that the client was in need of residential treatment but the BHO would not be responsible due to the client's diagnoses not being covered for treatment by the BHO. A second appeal to the BHO also denied the request for residential treatment. The client's parents are awaiting a decision from the associate group which has been managing the client's treatment determining if residential treatment is appropriate or placement within the Department of Youth Corrections is appropriate.

Outcome:

A decision from the Administrative Law Judge regarding a request for residential treatment had yet to be issued at the time of this report.

Conclusion:

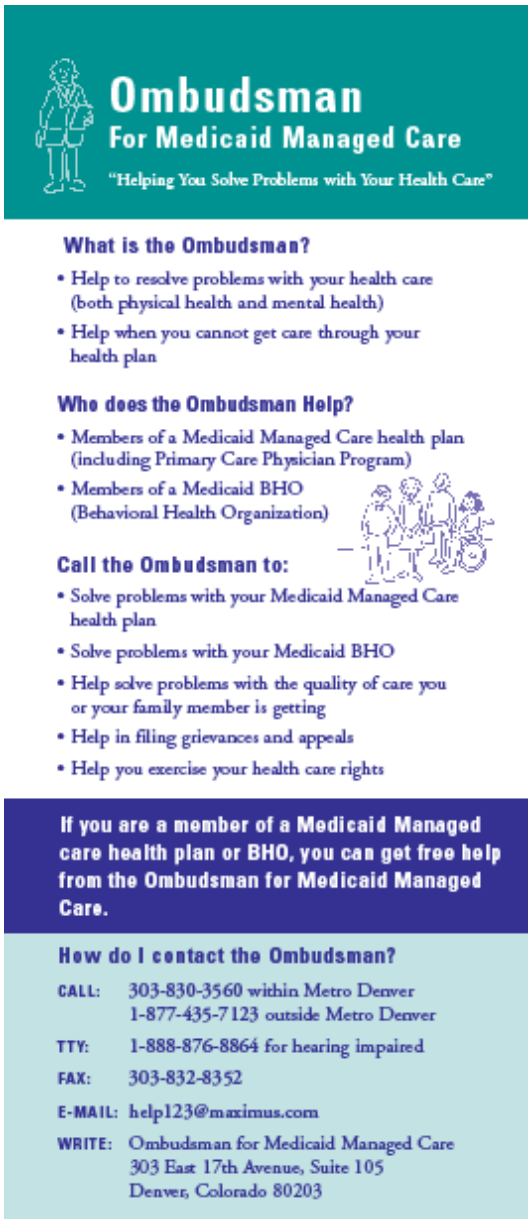
This case illustrates very well how difficult the managed care health care system can be. Not only may there be multiple parties and/or agencies involved in the treatment of a client, but their role and responsibility for the client's treatment may not always be clear. This can leave clients in a very unfortunate position of not being able to access the services they are requesting and need. This also illustrates the fact that many clients are not well informed about other services that may be available to them, such as treatment under CMHTA.

Appendix 2 – Ombudsman Advisory Board Members

Ombudsman for Medicaid Managed Care Advisory Committee

FY 10-11	
Name	Business
Adela Flores-Brennan	Colorado Center on Law and Policy Health Care /Attorney
Mary Catherine Rabbit	The Legal Center for People with Disabilities and Older People Colorado Legal Assistance Developer/Attorney
Kim Nishell	Empower Colorado
Christy Blakely	Family Voices of Colorado Executive Director
David Klemm	Rocky Mountain Health Plan Director of Medicaid Program
Mark White	Axis Health System Director of Quality
Hazel Bond	Foothills Behavioral Health Partners Director Office of Consumer and Family Affairs
Scott Utash	Behavioral Healthcare Inc. Director of Member and Family Affairs
Joe Beaver	Colorado Cross Disability Coalition , Board President
Jim Dean	Colorado Legal Services /Attorney
TBD	Colorado Access
Craig Gurule	Denver Health Medicaid Choice Program Manager
Larry Alflen	Colorado Alliance for Health and Independence Executive Director
Sarah Lang	Value Options CO - Grievance and Appeals Coordinator

Appendix 3 – Ombudsman Flyer (English)



Ombudsman
For Medicaid Managed Care

"Helping You Solve Problems with Your Health Care"

What is the Ombudsman?

- Help to resolve problems with your health care (both physical health and mental health)
- Help when you cannot get care through your health plan

Who does the Ombudsman Help?

- Members of a Medicaid Managed Care health plan (including Primary Care Physician Program)
- Members of a Medicaid BHO (Behavioral Health Organization)

Call the Ombudsman to:

- Solve problems with your Medicaid Managed Care health plan
- Solve problems with your Medicaid BHO
- Help solve problems with the quality of care you or your family member is getting
- Help in filing grievances and appeals
- Help you exercise your health care rights

If you are a member of a Medicaid Managed care health plan or BHO, you can get free help from the Ombudsman for Medicaid Managed Care.

How do I contact the Ombudsman?

CALL: 303-830-3560 within Metro Denver
1-877-435-7123 outside Metro Denver

TTY: 1-888-876-8864 for hearing impaired

FAX: 303-832-8352

E-MAIL: help123@maximus.com

WRITE: Ombudsman for Medicaid Managed Care
303 East 17th Avenue, Suite 105
Denver, Colorado 80203

Appendix 4 – Ombudsman Flyer (Spanish)

Ombudsman

Para el Cuidado Manejado de Medicaid

"Ayudandole a Resolver Problemas Con Su Cuidado de Salud"

Que es un Ombudsman?

- Ayuda a resolver problemas con su cuidado de salud (fisico o mental).
- Ayuda cuando no pueda obtener cuidado de salud dentro de su plan.

A quien ayuda un Ombudsman?

- A miembros de Medicaid que esten en un plan de manejo de salud (incluyendo Primary Care Physician Program).
- A miembros de Medicaid BHO (agencia de salud mental y aseso y servicios).

Llame al Ombudsman para:

- Resolver problemas con su Medicaid plan de manejo de salud.
- Ayudar resolver problemas con Medicaid BHO
- Ayudar a resolver problemas con la calidad de cuidado de salud que usted y miembros de su familia estan recibiendo.
- Ayuda para archivar penas y apelaciones.
- Ayuda para ejercitar sus derechos de cuidado de salud.

Si usted es un miembro de un plan de manejo de salud de Medicaid o BHO , usted puede obtener ayuda gratis del Ombudsman de los planes de manejo de salud.

Como puedo contactar al Ombudsman?

LLAMAR: 303-830-3560 dentro del area metropolitana de Denver
1-877-435-7123 fuera del area metropolitana de Denver

TTY: 1-888-876-8864 para personas con problemas auditivos

FAX: 303-832-8352

E-MAIL: help123@maximus.com

ESCRIBANOS: Ombudsman para Cuidado de Manejo de Salud de Medicaid
303 East 17th Avenue, Suite 105
Denver, Colorado 80203