Ombudsman for Health First Colorado Managed Care

The Ombudsman for Health First Colorado Managed Care Annual Report is presented by MAXIMUS reviewing cases handled by the Ombudsman during FY 18

Annual Report
July 2018

Transmittal Letter

July 31, 2018

Dear Reader,

The purpose of this letter is to officially transmit the Ombudsman for Health First Colorado Managed Care FY ’17-18 Annual Report. MAXIMUS, Inc. administers the Ombudsman Program under contract with the Colorado Department of Health Care Policy & Financing.

The Medicaid Managed Care landscape continued to evolve during FY’17-18. Medicaid enrollment has continued to increase due in large part to expanded eligibility categories under the Affordable Care Act. The Ombudsman continues to assist clients who have been enrolled in the Accountable Care Collaborative (ACC) under the Medicare-Medicaid Demonstration Project. These clients fall under the scope of the Ombudsman as they are considered part of Medicaid Managed Care due to enrollment into the ACC. The Medicare-Medicaid Demonstration ended their program in January 2018

Along with being a resource for managed care clients and providers, the Ombudsman also gathers data regarding 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 physical or behavioral health plans.

The hope of the Ombudsman office is that the information contained in this report will be useful in efforts to improve programs offered to Medicaid clients. Increased ease of access to both physical and behavioral health services will mean fewer clients dissatisfied with their health plans. This of course benefits not only the clients, but providers as well.

It is our hope that this report will prove useful to State policy-makers and administrators, as well as to health plans and advocates in their shared goal to continually elevate the level of care received by Medicaid Managed Care members.

Respectfully submitted,

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OMBUDSMAN FOR HEALTH FIRST COLORADO MANAGED CARE – ANNUAL REPORT

This report summarizes FY18 of the services provided by the Ombudsman for Medicaid Managed Care (OMMC) Program. This report is specific to operational activity for July 1, 2017 through June 30, 2018.

Type of Contact	Fiscal Year 2018
Total calls (ACD report)	1470
Total calls to initiate cases (within scope)	173
Out of scope Medicaid calls	234
Non Medicaid calls	274
Total existing client calls regarding active cases or inquiries	784
Face to Face client contact	0
Complaints received via	
Mail	0
Fax	0
Email	21
Complaint types (inquiries and cases)	
BHO	57
MCO	8
Accountable Care Collaborative	92
Information only provided to fee-for-service clients	158
Req. Written Material	0
Out of Scope Client calls referred to outside agencies:	
Department Staff/Customer Service	118
Colo. SHIP, Long Term Care Ombudsman	38
CHP+, CMAP, HHS	103
Board of Medical Examiners	0
Office of Administrative Courts	3
Div. of Insurance, Legal Aid	8
Department Contacts/Health*Colorado*	23
Medicaid Managed Care Managers	7
Department Quality Improvement Section/	1
Department of Regulatory Agencies	8
Other (Providers, Community Services, etc.)	113
Number of Clients with Disabilities (cases/inquiries)	123
Number of Spanish Speaking Clients (cases/inquiries)	24
Withdrawal of Request/No Response (cases/inquiries)	0

THE OMBUDSMAN FOR HEALTH FIRST COLORADO MANAGED CARE

The purpose of the Ombudsman for Health First Colorado Managed Care is simple: to assist clients enrolled in Medicaid Managed Care health plans. The Ombudsman is available to assist those clients who experience problems when attempting to access physical or behavioral health care services.

While the purpose of the Ombudsman is simple, the role of the Ombudsman is not. Often times the role of the Ombudsman is to help the interested parties work through misunderstandings, or to assist in the coordination of multiple services between health plans, providers, and other agencies to address the client's complex needs. On occasion it falls upon the Ombudsman to educate members and providers about Medicaid rules and regulations.

Beneficiaries contact the Ombudsman with questions regarding the complicated and sometimes confusing business of navigating Medicaid Managed Care. Consistent with prior years, a large percentage (85%) of contacts in Fiscal Year '18 were in regard to access to care problems; approximately 8% were related to issues of quality of care and 7% were concerning health plan benefit denials.

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, some clients may need additional help from an entity outside the framework of the health plan. An independent office such as the Ombudsman can be of vital importance in assisting clients in framing their complaint or request to the health plan. In addition, the Ombudsman can assist the client in 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 to effectively communicate managed care enrollees' problems and/or complaints with their health plans. While the report could be interpreted as negative, the intent behind it is not. Information gathered regarding the performance in health plans gives plans and program administrators vital information which may be utilized to improve Medicaid benefits and services for members.

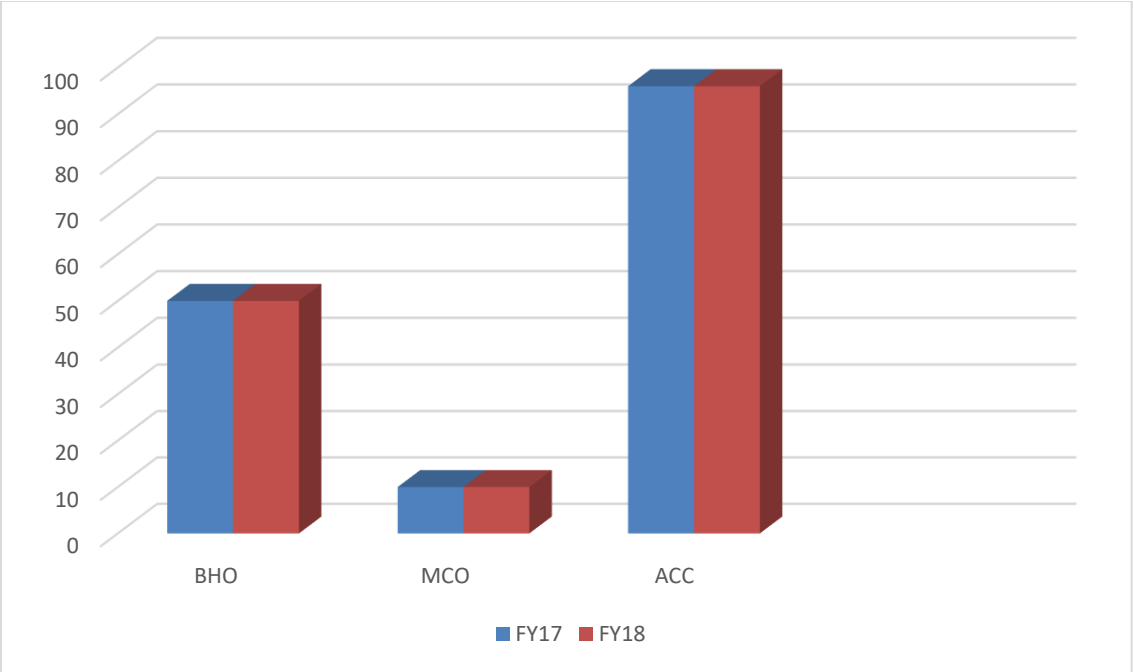
BHO, MCO or ACC?

Medicaid Managed Care Health Plan	Total Cases FY '18	Percentage
BHO	57	43%
MCO	4	4%
ACC	78	22%

The data above illustrates the contacts received by the Ombudsman for each type of health plan during FY18. The number of contacts the Ombudsman received for MCOs increased as did contacts regarding BHOs. The contacts regarding the ACC decreased; 78 such contacts were recorded in FY'18 while 94 were recorded in FY'17. This is notable as the bulk of the Medicaid population has or will be enrolled with the ACC and those cases have been increasingly complex and requiring more collaboration between the ACC plans and BHOs. Between July 1, 2017 and June 30, 2018 the Ombudsman handled a total of 173 cases. This is an ever so slight increase from the 147 cases addressed in FY17.

The Ombudsman was also contacted by clients with concerns or questions regarding health care benefits under the Medicaid fee-for-service program or seeking information regarding Medicaid eligibility. Due to the expansion of Medicaid programs in Colorado under the Affordable Care Act, the Ombudsman had experienced an increase in such calls. That was not the case in FY17 as calls from fee-for-service plan enrollees and those seeking information regarding Medicaid eligibility dropped notably. In FY17, the Ombudsman was contacted by 243 fee-for-service clients and only 158 such calls were received in FY18. Due to the high volume of calls received from individuals who are not yet enrolled with Medicaid, the Ombudsman has been separately tracking calls that do not have a Medicaid identification number for the past four fiscal years. A total of 242 such out of scope calls were received during FY17, and 422 were recorded during FY18. The Ombudsman provides information and referrals to every client but tracks these cases which fall outside of managed care less formally than those clients who raise concerns regarding managed care plans.

The increasing number of beneficiaries being with ACC health plans has meant that the contacts received by the Ombudsman have steadily increased as well. The Ombudsman also sees a significant number of calls from clients regarding their BHO due to both the number of beneficiaries enrolled with those plans and the complex nature of the services provided. However, the Ombudsman again recorded a higher number of contacts regarding ACC plans during FY18 which is consistent with FY17.



The Ombudsman in an ever changing healthcare landscape

The Ombudsman operates within a dynamic healthcare landscape, and FY18 was no exception. The transition by the Department to a new system to manage Medicaid beneficiary eligibility and enrollment information directly impacted the Ombudsman. During the transition period the Ombudsman did receive calls from beneficiaries and providers alike in the event they were not able to obtain the information needed from this new system.

The Accountable Care Collaborative (ACC)

The State of Colorado initiated the Accountable Care Collaborative (ACC) in April 2011 and it continues to evolve. The continued 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;
- 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 total number of cases handled by the Ombudsman regarding an ACC plan decreased during the fiscal year though the complexity of the issues presented did not. The Ombudsman has experienced an increased need for greater collaboration being required between clients' BHOs, ACC plans, community based services and other State agencies. This has gone well and this coordination of care and other services has been very helpful for beneficiaries.

As healthcare in Colorado continues to evolve, methods to best serve beneficiaries continue to evolve as well. The State of Colorado continued to take part in a Demonstration serving both Medicare and Medicaid eligible beneficiaries during FY18. These beneficiaries have been enrolled in the ACC and have access to assistance from the Ombudsman as well as the Medicare/Medicaid Advocate for the Demonstration. Along with the Advocate and the Beneficiaries Rights and Protections Alliance, the Ombudsman has continued working to establish and implement procedures to best serve and refer beneficiaries who are a part of the Demonstration. The more streamlined the process of addressing grievances and appeals under the Demonstration, the more expeditiously clients may have their problems resolved.

The role of the Ombudsman within the ACC for those clients who are both Medicare and Medicaid eligible is of utmost importance. The enrollment of these clients into the ACC has increased the contacts received by the Ombudsman. The number of beneficiaries has risen and the number of providers with whom the Ombudsman collaborates has increased as well. A significant amount of client and provider information/education has been provided by the Ombudsman. Providing the appropriate information, education and referrals will continue to be addressed through collaboration with other advocacy groups, the Medicare/Medicaid Advocate and HCPF for the duration of the Demonstration.

Appeal & Grievance Processes

The Ombudsman handles both grievances and appeals for Health First Colorado Managed Care members. When members are unhappy about their care, there are two avenues through which they may seek resolution:

- 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) after receiving a Notice of Action from the health plan:

- 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;
- 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 file 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. If a service is denied by HCPF while a client is enrolled with an ACC, the client may request a hearing before an Administrative Law Judge (ALJ). An external ALJ hears these appeals. Health plans have very specific timelines for their appeals processes. The ALJ appeal process has its own specific timelines as well. It is important for a client to be aware of this, especially when filing with the health plan and ALJ concurrently.

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. The bullet points included below are examples of when a client may seek out the assistance of the Ombudsman with filing a grievance.

Grievances may be submitted to the BHO, MCO or ACC 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.

A grievance may be filed when:

- A client is unsatisfied with the services that they are receiving;
- A client is in need of assistance in correcting a medical record error;
- A client is requesting a new provider due to their dissatisfaction with their current provider;
- A client is not receiving services in a timely manner

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 as expeditiously as possible. Ideally, an issue is addressed through member education and information, and referral to the appropriate agencies when necessary which is the lowest level of resolution. If it is not possible to resolve an issue at the very lowest level of resolution, it may be achieved via an informal in-plan resolution. This may include assisting the client with service requests through care coordination with either the provider or health plan. If those efforts are not successful, the Ombudsman may assist the client in seeking a formal in-plan resolution. Should an issue be escalated to this level, the Ombudsman may assist the client with filing grievances as well as appeals to decisions made by an MCO, BHO or RCCO. Finally, the client may choose to advance to the highest level of resolution; requesting a hearing before an Administrative Law Judge. The table below illustrates the number of cases the Ombudsman handled at each level of resolution during FY18.

Level of Resolution	Total Cases FY '18	Percentage
1. Education, information & referral	173	98%
2. Informal in-plan resolution	1	.06%
3. Formal in-plan resolution	0	0%
4. State Fair Hearing request	3	1.4%

It is the best interest of all parties involved that each case or inquiry be resolved as efficiently as possible. 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. 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 problem. This in turn will result in increased cost to the health plan in terms of time and financial resources to address the problem.

When working to resolve an issue for a client regarding their BHO, MCO, or ACC plan 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. For example, a comment from a client to provider may not be recognized as a formal request for services, therefore it is not being formally denied and the client will not receive a NOA. Such situations often only require clarification regarding that services the client is seeking and communicating that to the provider/health plan.

REASONS TO CONTACT THE OMBUDSMAN

Reasons to Contact Ombudsman	Cases FY '18	Percentage
1. Access to Care	123	85%
2. Denial of Benefits	8	7%
3. Quality of Care	14	8%

Fiscal year '18 was consistent with previous in regard to the high percentage of clients who contacted the Ombudsman reporting problems accessing care. These issues can be quite simple, such as a client needing to be educated on how to access care from their BHO, MCO or ACC plan. These issues can also be complex, such as a client experiencing a high level of difficulty locating specialist capable of managing very complex healthcare needs and/or coordinating care with a behavioral healthcare provider. There are two groups who contact the Ombudsman often based upon problems accessing care or due to a denial of a requested service: children in need of residential or day treatment and those with disabilities.

Residential Treatment, CMHTA and Creative Solutions

Residential treatment and CMHTA have been discussed in very great detail in past annual reports. The Ombudsman continues to see these cases, though they are often also facilitated by Creative Solutions. Creative Solutions is a service offered through the Department that brings together all parties serving children in an effort to coordinate and/or identify services that may be beneficial to the child and their family. When residential treatment is denied through a BHO, the Ombudsman will assist the parents or guardians of these children in navigating not only the BHO appeals process but the Child Mental Health Treatment Act (CMHTA) process as well and Creative Solutions can play a key role in establishing services so as to render an appeal unnecessary. CMHTA is designed to provide parents of children with mental health needs access to residential and community services regardless of their Medicaid status. This is done in an effort to preserve and/or reunify the family. And also to avoid parents having to go through the dependency and neglect process when there is no abuse or neglect of the child. 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, the CMHTA assessment supporting that level of care for the child may be beneficial. Through the help of Creative Solutions, it may be possible to avoid the appeals process all together and provide the child and family with the services needed in a much timelier manner.

Disability

The Ombudsman received a very high number of calls from individuals with disabilities, as has been the case in previous fiscal years. Approximately 99% or a total of 123 of the cases addressed by the Ombudsman in FY18 had a disability code associated with their Medicaid eligibility or were self-reported. The range of disabilities recorded is very broad, and includes: mental illness, chronic health problems, traumatic brain injuries as well as developmental disabilities and substance abuse. The high number of contacts from individuals with disabilities speaks volumes to the difficulty this population experiences when attempting to navigate the Medicaid Managed Care system. It should be noted that the collaboration between BHOs, ACC plans and community resources has been very beneficial for such clients and their guardians. It provides the coordination of care that they need to effectively manage their healthcare needs.

SUMMARY

This fiscal year presented the Ombudsman's office with continuing change in the Medicaid Managed Care healthcare delivery system. The ACC program continues to change the landscape of managed care in Colorado, and the Ombudsman continues to have positive and ever increasing interactions with ACC health plans. The role of the Ombudsman during the Medicare – Medicaid Demonstration Project when established, and the Demonstration continued to provide the Ombudsman with opportunities to assist a diverse group of beneficiaries until the program ended in January 2018.

While the healthcare landscape is ever evolving, there is consistency in the issues presented to the Ombudsman. The bulk of the cases addressed are in regard to problems experienced by clients when accessing care, as well as a significant number of clients with disabilities. The Ombudsman continues to be successful in achieving the program goal of finding resolution at the lowest level possible in the majority of cases.

The Ombudsman continues to play a vital role within Health First Colorado 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 continually improve Health First Colorado Managed Care in order to provide clients with the best care possible.

Appendix 1 – Case Vignettes

The following case examples demonstrate the involvement of the Ombudsman to ensure that clients are afforded all options available to resolve Health First Colorado Managed Care problems.

Case Example #1

Background

A collaborative group utilized by the parent of a minor client called seeking assistance from the Ombudsman regarding continued behavioral health services for the minor. Complicating matters was the number of parties involved given the needs of the client which were not limited to behavioral healthcare but included involvement from other State agencies as well. The child had been out of the home for quite some time and there was still some question as to the ability for the minor to return to the home. The child was abusive to the single mother and physically abusive with other siblings. The abuse was so bad that the other siblings had to relocate to a different state to live with other family members.

Narrative:

The collaborative group initially called the Ombudsman requesting assistance appealing a denial for specific behavioral health services for the client. It became clear very quickly that the involvement of more than one agency and the disagreement regarding how to best serve the minor was going to complicate matters.

The Ombudsman assisted the parent with filing an expedited request for a hearing before an Administrative Law Judge and also participated in many meetings in an effort to obtain the requested services for the minor. Concerns regarding the safety of other minor children in the home made determining services that may be appropriate in the home for the minor client very difficult. Further complicating matters were the number of entities involved. At times recommended services would fall under the BHO umbrella, and at other times they would be based upon safety and custodial concerns and therefore Human Services would then have been responsible. A hearing was held and the denial of services by the BHO was upheld.

Outcome:

A hearing was held before an Administrative Law Judge and the decision was in favor of the BHO.

Conclusion:

This case illustrates the importance of coordination between agencies and health plans to provide the care needed for complex clients. This is especially true when the client is a minor and many parties are involved attempting to assist the client with their unique needs. This process can become much more complicated when there are concerns for other children in the home with the client. It also illustrates the important role the Ombudsman can play when assisting clients by facilitating the communication between guardians/parents, advocates, health plans and other agencies. Unfortunately, it also highlights the gaps in services for such children despite several entities attempting

to assist the client. This case makes it clear that open and clear communication between all is imperative in order to coordinate efforts to best serve the client. The mother of child is currently trying to seek legal action.

Case Example #2

Background:

The Ombudsman was contacted by the guardian of an adult client seeking assistance finding a pain management provider.

Narrative:

The client's guardian initially contacted the Ombudsman seeking assistance finding a pain management physician who would agree to provide services for the client despite the client's difficult history with physicians. The frequent negative interactions between the client and clinic staff (which had led to the client being terminated by multiple clinics) had created a very difficult situation.

The Ombudsman began the process of assisting the guardian by reaching out to the client's ACC plan and it became clear that the guardian had not been totally forthcoming about the services that had been offered by local physicians and why the client had been terminated. It was learned that services had been offered by a pain management provider located near the client though the client had been informed that no inappropriate behavior would be tolerated. The ACC plan began reaching out to other providers in the hopes of finding a new provider that the client and guardian would both feel comfortable with.

Outcome:

The ACC plan was able to locate a provider that would accept the client.

Conclusion:

This case illustrates how vital communication is between all parties in order to provide the most appropriate services to clients in as timely a manner as possible. Without such, it is very difficult for the Ombudsman, health plans and other advocacy groups to provide effective and appropriate assistance to clients.