Ombudsman for Health First Colorado Managed Care

The Ombudsman for Health First Colorado Managed Care Annual Report is presented by MAXIMUS

Annual Report
July 2022 – June 2023

Transmittal Letter

July 14, 2023

Dear Reader,

The purpose of this letter is to officially transmit the Ombudsman for Health First Colorado Managed Care FY ’22-23 Annual Report. MAXIMUS, Inc. Administers of the Ombudsman Program under contract with the Colorado Department of Health Care Policy & Financing.

The Medicaid Managed Care program continued to evolve during FY’22-23. Medicaid enrollment has continued to advance 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 Regional Accountable Entity (RAE).
These clients fall under the scope of the Ombudsman as they are considered part of Medicaid Managed Care due to enrollment into the RAE.

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 for both physical and behavioral health services will mean fewer clients dissatisfied with their health plan which will benefit not only the members, but providers as well.

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

Respectfully submitted,

Diana McHenry
Ombudsman Manager
Health First Colorado Managed Care Ombudsman Program
Health Services West, MAXIMUS

Ombudsman for Health First Colorado Managed Care

2022-2023 Annual Report

This report is a summary of the services provided by the Ombudsman for Health First Colorado Managed Care Program during the FY 2022-2023

Type of Contact	Jul '22	Aug '22	Sep '22	Oct '22	Nov '22	Dec '22	Jan '23	Feb '23	Mar '23	Apr '23	May '23	Jun '23
Total Inbound calls (ACD report)	**90**	**77**	**67**	**82**	**57**	**102**	**70**	**74**	**77**	**49**	**74**	**85**
Total Calls Answered	---	---	**52**	**53**	**43**	**79**	**45**	**60**	**63**	**37**	**39**	**45**
Spanish	0	8	2	3	2	44	6	2	0	2	1	1
English	90	69	65	79	55	58	64	72	77	47	73	84
Average Seconds to Answer (ASA)	---	---	1	7	5	3	6	10	51	6	21	12
Total calls to initiate cases, referrals, or inquiries (In Scope)	2	3	3	3	3	2	3	17	12	15	17	15
Call Categories												
Total client calls regarding active cases or inquiries	0	0	0	0	3	1	1	1	3	0	1	2
Out of Scope Ombudsman Calls + Emails/See Attachment	10	48	61	38	53	44	50	55	55	40	61	56
No Referral Needed	0	1	4	5	2	46	8	7	16	2	6	10
Total Outbound Calls (See Outbound Call Log)	**0**	**37**	**20**	**24**	**27**	**21**	**33**	**10**	**18**	**10**	**33**	**25**
Total calls to initiate cases, referrals, or inquiries (In Scope)	0	0	0	3	2	0	0	4	3	2	7	6
Total client calls regarding active cases or inquiries	0	6	1	3	0	0	0	2	5	0	1	1
No Referral Needed	0	13	5	9	6	3	8	3	6	3	8	3
Emails (See Email Spreadsheet)				**2**	**3**	**2**	**3**	**6**	**2**	**1**	**5**	**4**
In Scope	---	---	---	1	2	2	1	3	0	0	0	0
Out of Scope	---	---	---	1	1	1	3	3	2	1	5	4

Voicemails (See Voicemail Spreadsheet)												
Voicemails Received	15	37	11	19	19	12	24	8	18	9	28	23
Voicemails not Returned in One Day	0	0	0	0	0	0	0	0	0	0	0	0
Monitored Quality Assurance Calls Detailed on Attachment	5	5	5	5	5	5	5	5	5	5	5	5
Complaints Received Via												
Fax	0	0	0	0	0	0	0	0	0	0	0	0
Mail	0	2	0	0	0	0	0	0	0	0	0	0
Member Satisfaction												
Satisfaction Surveys Sent by Mail	0	0	2	4	4	1	3	0	0	0	0	0
Satisfaction Surveys Received by Mail	0	0	0	0	2	0	0	0	0	0	0	0
Completed Surveys Captured in IVR	0	0	5	0	9	5	7	4	7	6	5	4
Calls by Managed Care Entity												
MCO	20	20	25	24	19	10	14	10	6	10	5	5
Regional Accountable Entity	34	20	36	39	27	33	53	64	50	24	61	65
Other/Unknown	25	8	8	4	11	5	3	0	0	3	8	15

Categories of Referrals												
Client Referrals to Outside Agencies: (Requests may have more than one referral)	**12**	**50**	**55**	**36**	**55**	**46**	**48**	**79**	**61**	**43**	**74**	**63**
Billing/Collections Manager	1	11	13	4	6	2	3	7	14	7	8	11
Health First Colorado Member Contact Center	2	8	3	8	6	5	10	10	5	6	11	6
CO. SHIP, LTC Ombudsman, MMP Advocate Other Ombudsman (Medicare, PACE, etc.)	0	0	4	2	1	1	2	2	4	2	4	2
CHP+, CMAP, HHS, DHS	3	9	8	5	11	9	5	5	11	5	17	8
Behavioral Health Ombudsman	0	1	0	1	3	1	3	3	6	6	8	6
Office of Administrative	0	0	1	0	0	1	0	0	1	0	2	1
Div. of Insurance, Legal Aid	0	0	0	0	0	0	0	4	0	0	0	0
HFC Enrollments	2	0	0	0	3	2	3	2	0	1	1	2
Provider Relations	0		3	1	1	2	2	3	1	1	1	3
HCPF	0	1	0	1	1	0	3	3	4	1	4	5
Department of Regulatory Agencies	2	4	3	1	4	2	3	4	1	1	6	3
RAE/MCO	2	5	7	6	12	12	6	14	7	4	4	5
Other (Providers, Community Services, etc.)	0	8	12	5	5	9	7	7	0	5	7	11
DentaQuest	0	2	1	2	2	0	1	4	0	4	1	0

Other Reporting:												
Req. Written Material	0	0	0	0	0	0	0	0	0	0	0	1
Number of Clients on Waiver and/or with Disabilities (cases/inquiries)	0	1	8	12	5	6	11	7	9	7	9	11
Withdrawal of Request/No Response (cases/inquiries)	0	0	0	2	0	0	0	0	0	0	0	0
Behavioral Health Complaints Per RAE (See Monthly Behavioral Health Complaints Report)	---	---	---	---	---	---	---	1	6	1	1	0

OMBUDSMAN FOR HEALTH FIRST COLORADO MANAGED CARE – ANNUAL REPORT

Accumulative Numbers July 2022- June 2023

Type of Contact	Fiscal Year 2023
Total calls (ACD report)	904
Total Contacts to initiate cases (within scope)	136
Out of scope	571
No Referral Needed	174
Total existing client calls regarding active cases or inquiries	31
Face to Face client contact	0
Complaints received via	
Mail	0
Fax	0
Email (Data from Oct 2022 – June 2023)	28
Complaint types (inquiries and cases)	**764**
MCO	168
Regional Accountable Entity	506
Other/Unkown	90
Req. Written Material	1
Client calls referred to outside agencies:	**622**
Billing/Collections Manager	87
Health First Colorado Member Center	80
CO, SHIP, MMP Advocate, Other Ombudsman (PACE Medicare, LTC, etc.)	24
CHP+, CMAP, HHS, DHS	96
Behavorial Health Ombudsman	38
Office of Administrative Courts	6
Div. Of Insurance, Legal Aid	4
HFC Enrollments	16
Provider Relations	18
HCPF	23
Dept of Regulatory Agencies	34
RAE/ MCO	84
Other (Providers, Community Services, etc.)	76
DentaQuest	17
Number of Clients with Disabilities (cases/inquiries)	86
Number of Spanish Speaking Clients (cases/inquiries)	71
Withdrawal of Request/No Response (cases/inquiries)	2
Behavorial Health Complaints Per RAE (See Monthly Behavorial Health Report) - Implemented Feb 2023	9

THE OMBUDSMAN FOR HEALTH FIRST COLORADO MANAGED CARE

The purpose of the Ombudsman for Health First Colorado Managed Care Department 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 health care services.

While the purpose of the Ombudsman is simple, the role of the Ombudsman is not. Often 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 (80%) of contacts in Fiscal Year '23 was regarding access to care problems; approximately 10% were related to issues of quality of care and 10% 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 solution, 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.

MCO or RAE?

Medicaid Managed Care Health Plan	Total Cases FY '23	Percentage
MCO	168	21.98%
RAE	506	66.23%
OTHER	90	11.78%

The data above illustrates the contacts received by the Ombudsman for each type of health plan during FY'23. The number of contacts the Ombudsman received for MCO's decreased as did contacts regarding other needs not connected to a members health plan. The contacts regarding the RAE increased; 506 such contacts were recorded in FY'23 while 217 were recorded in FY'22. This is notable as the bulk of the Medicaid population has or will be enrolled with the RAE and those cases have been increasingly complex and requiring more collaboration between the RAE plans and BHOs. Between July 1, 2022, and June 30, 2023, the Ombudsman handled a total of 571 cases. This is a slight decrease from the 580 cases addressed in FY'22.

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 FY'23 as calls from fee-for-service plan enrollees and those seeking information regarding Medicaid eligibility dropped notably.

The increasing number of beneficiaries with RAE 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 RAE plans during FY'23 which is consistent with FY'22.

The Regional Accountable Entity (RAE)

The State of Colorado initiated the Regional Accountable Entity (RAE) 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 RAE 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 RAE include:

- A medical home for all clients.
- enhanced care management, data, and another 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 a RAE plan increased 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, RAE 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 FY'23. These beneficiaries have been enrolled in the RAE 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 RAE for those clients who are both Medicare and Medicaid eligible is of utmost importance. The enrollment of these clients into the RAE 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.

Denial, 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 a denial of service, 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 a RAE, 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 they are 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 RAE 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 needs 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 RAE. Finally, the client may choose to advance to the highest level of resolution, requesting a hearing before an Administrative Law Judge.

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, 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 RAE 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 an NOA. Such situations often only require clarification regarding those services the client is seeking and communicating that to the provider/health plan.

REASONS TO CONTACT THE OMBUDSMAN

Reasons to Contact Ombudsman	Cases FY '23	Percentage
1. Access to Care	50	34%
2. Denial of Benefits	34	23%
3. Quality of Care	62	42%

Fiscal year '23 was not consistent with previous years regarding the high percentage of clients who contacted the Ombudsman reporting problems accessing care. Quality of care issues are slightly higher this year than access to care concerns. Resolving the complaints can be quite simple, such as a client needing to be educated on how to access support from their BHO, MCO or RAE plan. These issues can also be complex, such as a client experiencing a high level of frustration not seeing their current provider as 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 with quality of care or due to a denial of a requested service: children in need of residential or day treatment and those members with disabilities.

Residential Treatment, CYMHTA and Creative Solutions

Residential treatment and CYMHTA have been discussed in 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 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 and Youth Mental Health Treatment Act (CYMHTA) process as well and Creative Solutions can play a key role in establishing services, to render an appeal unnecessary. CYMHTA 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 to preserve and/or reunify the family. And, to avoid parents having to go through the dependency and neglect process when there is no abuse or neglect of the child. A CYMHTA 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 CYMHTA 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 calls from individuals with disabilities, as has been the case in previous fiscal years. A total of 86 of the cases addressed by the Ombudsman in FY23 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, RAE 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.

Member Satisfaction

Member Satisfaction Surveys were implemented for the Ombudsman Program at the end of August 2023. Member Satisfaction Surveys are captured in the IVR as well as mailed out to members where a case is opened. Callers completed the survey for a total average score of 100%. The Ombudsman received the highest possible score on all calls for FY '23.

Members also have the opportunity to leave Survey Feedback and the following messages were left regarding the members experiences for the FY '23:

8/18/2022:

I spoke with Valerie today from Colorado Medicaid Ombudsman and I just wanted to send her tons of praises. We came to her feeling frustrated and not knowing what our next steps were and she provided some options and numbers we could call. This helped us to continue pushing forward to get my dad adequate care. So huge kudos to Valerie.

9/27/2022:

Thank you very much, your customer service is very awesome. I appreciate you. You gave me good courtesy and customer service. You gave me all the answers that I needed delivered. You were very pleasant and you gave me the answers that I needed. I wanted to tell you that I appreciate you.

10/18/2022:

I just want to appreciate – whoever is listening to this message – Miss Valerie. She was more than courteous to me after letting her know I am illiterate in writing and my spelling and my computer – all this stuff. She was more than considerate with me and understood me perfectly and treated me with respect. So, I do appreciate you very much to have people like her providing services you provide. Thank you very much.

11/15/2022:

Valerie gave me a lot of information that I needed and will help me take care of a complaint that I need to do with her. I appreciate all of her help. She was really, really, knowledgeable in the things that I needed help with.

11/16/2022:

Hi this is Megan Ruel and I am taking a moment to share some of my personal thoughts regarding my experience with Valerie the Ombudsman. I really appreciate her. She really truly listened to me. She truly seems like she really cares about people and their situation and that is everything. Especially in a time that is very difficult for me as I try to navigate through a health care system that many times doesn't feel like it is very personal at all. I just want to say that she is an incredible listener, very patient, and super sweet. Some of the things I feel like have been very wrong that's happened to me so it just feels so good to know that somebody listens.

11/29/2022:

Hello, I wanted to say that I just talked to Valerie and she helped me immensely and I am truly blessed to have reached her at this point in my life. I appreciate all you do for low-income families. Please take care and don't forget – Valerie is "the rock".

01/11/2023:

I just wanted to say that after a week of being on the phone with Medicaid for hours and getting the run around, being in tears and frustrated; the woman who helped me today got on the phone and heard what I had to say. She let me speak, heard what I had to say and then did everything in her power to help me. I finally made some headway for what I needed and it's like a weight is being lifted off my chest. I just can't thank her enough for actually taking the time to help me.

2/7/2023

The lady who helped me name was Valerie and she was very nice, very courteous, and very helpful. I would like to commend her. Thank you.

2/14/2023

I just wanted to compliment Valerie. She was very helpful, very kind, and very pleasant to talk to. She is definitely a credit to the organization she works for and the people she works for.

4/19/2023

The person I talked to seems to be the first person I've talked to that actually listened and cared. I believe she gave me the right information and gave me some numbers to call. They were great. You know, I just have gotten some nasty feedback from all the places I called. I needed to file a complaint against National Jewish Hospital. Everyone I have talked to has just thrown me off but your person that I talk to actually cared and listened and realized my situation and gave me the information. She was great and helped calm me down. Thank you

4/20/2023

Hi, my name is Gage Lemers and I just called in and spoke with a Miss Valerie. She was not only helpful but very informational. She gave me more than I knew I needed and every step that I needed to do to go forward with the issue that I am having and I am just extremely pleased with her customer service, it was top notch. She even deserves a raise because there is some stuff I have going on that I didn't realize I did. So, I just want to appreciate her for her time and bringing things to my attention. That's all I have to say so thank you.

5/10/2023

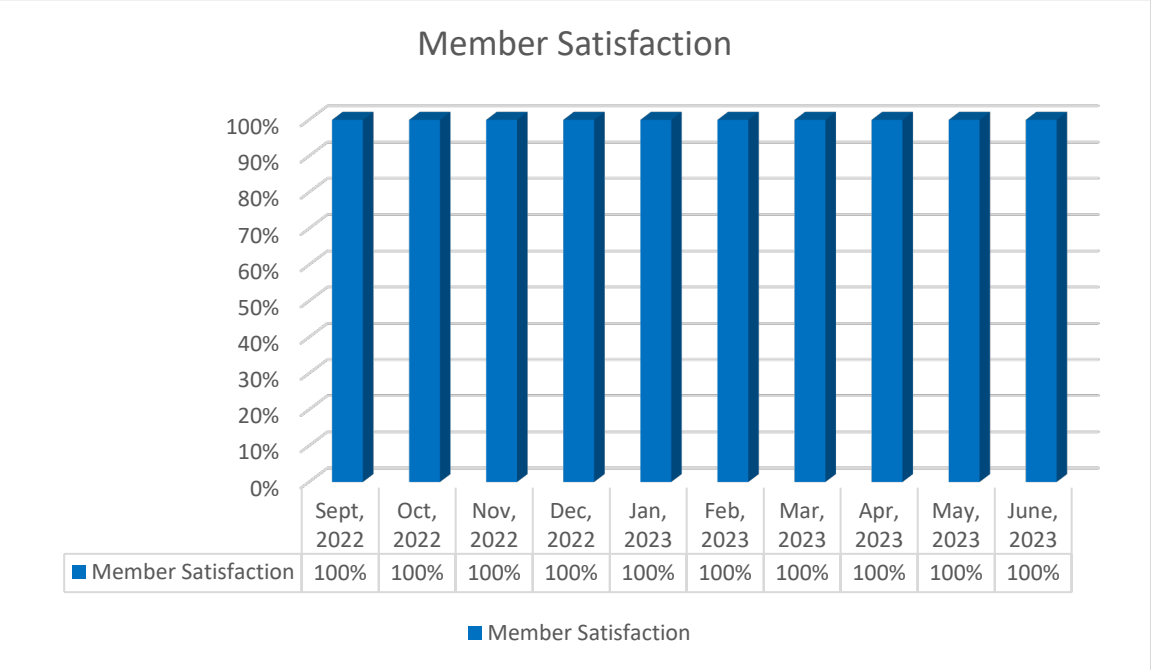
I would just l like to say thank you so much for being so kind and taking the time to help me even though the help that I was needing was outside of your area. I appreciate you still taking time to try and help me. I hope you have a wonderful day and I hope that this message will get to the right person to make sure that they are aware that you were respectful and did your best to try and get me to the right place. Thank you so much.

5/12/2023

I talked with Valerie earlier today and I want to make sure she gets a raise for her compassion, professionalism and knowledge. She was just awesome. Thank you very much.

*Voicemail recordings can be sent upon your request.

Below is a graph illustrating the Member Satisfaction scores collected in the IVR over time.



Level of Resolution

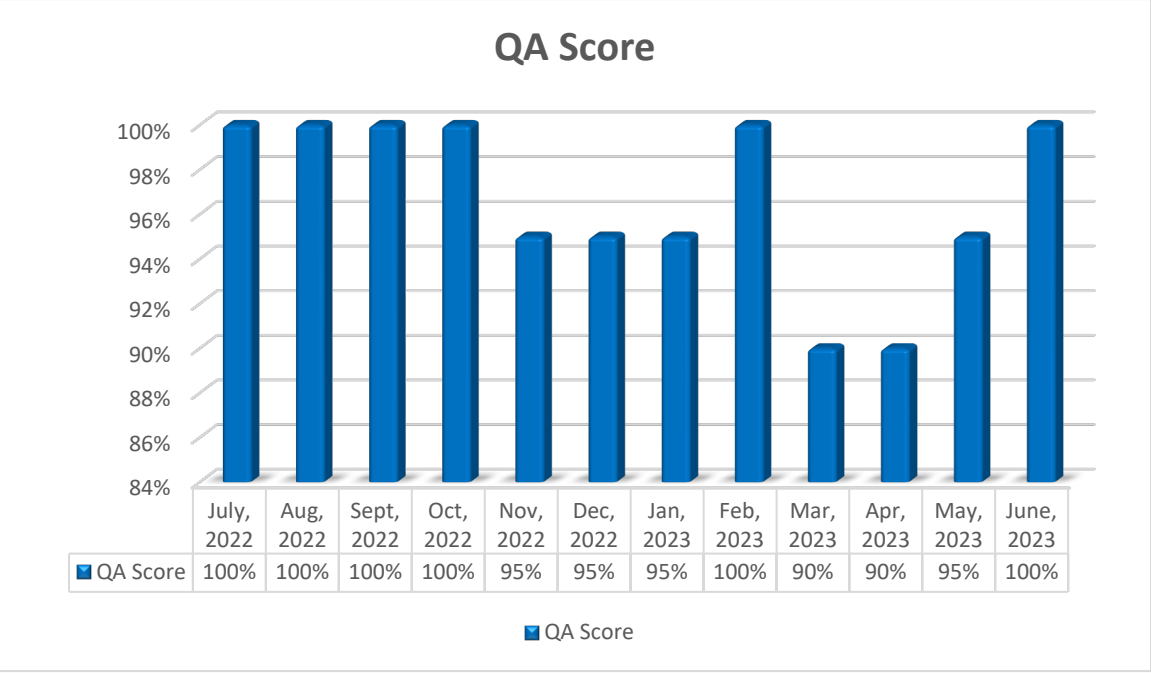
The goal of the Ombudsman is to resolve all cases and inquiries at the lowest level possible to ensure timely resolution for both the client and health plan or provider. In June all cases/inquiries handled by the Ombudsman were addressed through member education and information, and referral to other agencies when appropriate.

Quality Assurance

Each month management listens to five calls and the counselor is evaluated on the elements below. The graph below represents QA scores month over month for the reporting year. Valerie continues to work to incorporate asking if there is anything else needed at the end of her calls. This will continue to be an area that we target for improvement.

QA Elements:

1. Was the agent professional and courteous?
2. Did the agent educate the caller?
3. Did the agent answer the caller's question?
4. Did the agent ask if there was anything else the caller needed?



SUMMARY

This fiscal year presented the Ombudsman's office with continuing change in the Medicaid Managed Care healthcare delivery system. The RAE program continues to change the landscape of managed care in

Colorado, and the Ombudsman continues to have positive and ever-increasing interactions with RAE health plans.

While the healthcare landscape is ever evolving, there is consistency in the issues presented to the Ombudsman. The bulk of the cases addressed are regarding 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 most 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 policymakers. and administrators, as well as health plans and advocates, in the shared effort to continually improve Health First Colorado Managed Care 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 client utilized assistance from the Ombudsman regarding continued disregard to the behavioral health organization. The client has been seeking living resources as the client is homeless. The client has no living arrangements and had been displaced not having suitable living arrangements for an extremely long period of time.

Narrative:

The client 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 client with the current living situation was going to complicate matters.

The Ombudsman assisted the client with filing an expedited request for a hearing before an Administrative Law Judge and participated in many meetings to obtain the requested living arrangements for the client. There can sometimes include a lot of variables regarding the safety of other adult members in the community determining services that may be appropriate in the temporary home for the adult client which can be very difficult due to the client who is involved as a court appointed spokesman or guardian. Additional 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 concerns and therefore Human Services would then have been responsible.

Outcome:

A hearing was held before an Administrative Law Judge and the decision was approved for the client to be assisted in finding housing through The Colorado Coalition of the homeless. The client was to receive housing services for

one year until the client can find reasonable housing by working with entities for subsidized housing to become available.

Conclusion:

This case illustrates the importance of coordination between agencies and health plans to provide the care needed for complex clients. This is particularly true when the client is an adult. and many parties are involved including the guardian for the adult client attempting to assist the client with their unique needs. This process can become much more complicated when there are concerns for other adults in the temporary home with other clients. It also illustrates the important role the Ombudsman can play when assisting clients by facilitating the communication between guardians/, advocates, health plans and other agencies. Sorry to say, it also highlights the gaps in services for such clients despite several entities attempting to assist the client. This case makes it clear that open and clear communication between all is imperative, and to coordinate efforts to best serve the client.

Case Example #2

Background:

The Ombudsman was contacted by a client seeking assistance with filing a grievance against a provider for denial of service.

Narrative:

The client felt discriminated against because of her gender status, as well as needing assistance with finding a provider who would agree to provide services for the client despite of the client's gender status. 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 client by reaching out to the client's RAE plan and it became clear that the client had not been totally truthful 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 provider located near the client though the client had been informed that no inappropriate behavior actions would be tolerated. The RAE plan began reaching out to other providers in the hopes of finding a new provider that the client would feel comfortable with.

Outcome:

The RAE's plan was able to locate a provider that would accept the client and be able to monitor her therapies to ensure the client would not be abusive or display inappropriate behavior.

Conclusion:

This case illustrates how vital communication is between all parties, 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 these difficult clients. Once you can gain trust from the client to truly believe that you are there for their best interest, it not only allows the client to have an ease when communicating difficult situations as well as educating the Ombudsman or any other facility that though the problem may seem small, it could easily be spiraled out of control if you cannot gain trust between the client and other agencies. A calm rapport is vital when dealing with clients, staff, and outside agencies.