Ombudsman for Health First Colorado Managed Care

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

Annual Report
July 2023 – June 2024

Transmittal Letter

July 22, 2024

Dear Reader,

The purpose of this letter is to officially transmit the Ombudsman for Health First Colorado Managed Care FY ’23-24 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’23-24. Over the last few years Medicaid enrollment increased due to the COVID Public Health Emergency. Eligibility is now contracting as the Public Health Emergency unwinds and members go through redetermination. The Ombudsman continues to assist clients who have been enrolled in the Regional Accountable Entity (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

2023-2024 Annual Report

This report is a summary of the services provided by the Ombudsman for Health First Colorado Managed Care Program during the FY 2023-2024

Type of Contact	Jul '23	Aug '23	Sep '23	Oct '23	Nov '23	Dec '23	Jan '24	Feb '24	Mar '24	Apr '24	May '24	Jun '24
Total Inbound calls (ACD report)	**47**	**40**	**53**	**36**	**34**	**33**	**113**	**64**	**60**	**69**	**62**	**53**
Total Calls Answered	**21**	**30**	**42**	**26**	**28**	**19**	**103**	**47**	**44**	**49**	**44**	**43**
Spanish	3	1	1	3	2	6	51	11	0	1	3	1
English	19	29	41	33	32	27	52	36	44	48	41	42
Average Seconds to Answer (ASA)	7	14	6	6	9	7	7	5	8	11	8	18
Total calls to initiate cases, referrals, or inquiries (In Scope)	10	8	19	7	8	7	21	11	15	21	20	22
Call Categories												
Total client calls regarding active cases or inquiries	3	1	3	0	1	1	3	0	7	2	2	0
Out of Scope Ombudsman Calls + Emails/See Attachment	27	36	45	33	40	34	63	36	49	53	50	47
No Referral Needed	6	5	3	4	1	9	56	12	8	5	5	3
Total Outbound Calls (See Outbound Call Log)	**12**	**14**	**11**	**12**	**17**	**20**	**18**	**5**	**13**	**17**	**19**	**14**
Total calls to initiate cases, referrals, or inquiries (In Scope)	0	2	2	2	6	7	5	0	5	11	9	8
Total client calls regarding active cases or inquiries	0	1	0	0	1	0	6	1	1	2	1	3
No Referral Needed	3	0	0	1	2	9	6	1	1	1	4	3
Emails (See Email Spreadsheet)	**3**	**5**	**5**	**4**	**7**	**13**	**11**	**4**	**2**	**5**	**6**	**4**
In Scope	1	2	1	0	2	4	1	2	0	3	3	0
Out of Scope	2	3	4	4	5	9	10	2	2	2	3	4
Voicemails (See Voicemail Spreadsheet)												

Voicemails Received	10	12	8	8	13	11	13	7	12	17	19	15
Voicemails not Returned in One Day	0	0	0	0	0	1	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	0	0	0	0	0	0	0	0	0	0	0
Member Satisfaction												
Satisfaction Surveys Sent by Mail	0	2	1	0	0	0	0	0	0	0	0	0
Satisfaction Surveys Received by Mail	0	0	0	0	0	0	0	0	0	0	0	0
Completed Surveys Captured in IVR	1	2	1	0	1	2	5	0	2	0	0	4
Calls by Managed Care Entity												
MCO	4	6	5	3	5	6	6	3	6	6	6	7
Regional Accountable Entity	30	24	24	20	21	21	34	15	27	37	42	39
Other/Unknown	2	3	19	7	10	12	63	29	26	27	21	15
Categories of Referrals												

Client Referrals to Outside Agencies: (Requests may have more than one referral)	**35**	**41**	**60**	**39**	**43**	**36**	**71**	**45**	**54**	**64**	**64**	**56**
Billing/Collections Manager	5	8	6	4	4	5	9	8	3	2	5	1
Health First Colorado Member Contact Center	1	2	4	6	1	1	4	2	3	1	4	2
CO. SHIP, LTC Ombudsman, MMP Advocate Other Ombudsman (Medicare, PACE, etc.)	1	0	3	1	4	0	2	1	1	2	1	5
CHP+, CMAP, HHS, DHS	1	5	14	7	2	5	4	4	8	14	13	1
Behavioral Health Ombudsman	5	5	4	1	3	1	2	1	5	2	1	1
Office of Administrative Courts	2	2	2	2	3	3	2	1	1	3	7	6
Div. of Insurance, Legal Aid	0	0	0	0	0	0	0	0	0	0	0	0
HFC Enrollments	1	1	1	0	3	2	0	1	3	3	0	5
Provider Relations	3	0	2	0	2	0	4	2	1	2	0	0
HCPF	2	2	7	4	10	8	24	13	19	14	18	12
Department of Regulatory Agencies	1	0	2	3	1	1	7	2	1	3	3	4
RAE/MCO	7	7	5	6	1	2	3	3	2	5	3	8
Other (Providers, Community Services, etc.)	5	7	9	4	7	8	8	6	7	12	8	9
DentaQuest	1	2	1	1	2	0	2	1	0	1	0	2
Other Reporting:												

Req. Written Material	0	0	0	0	0	0	0	0	0	0	0	0
Number of Clients on Waiver and/or with Disabilities (cases/inquiries)	5	6	11	8	11	12	22	13	16	17	14	24
Withdrawal of Request/No Response (cases/inquiries)	0	0	0	0	1	0	0	0	0	0	0	0
County Complaints (see County Reported Issues Report)	---	---	---	---	---	---	---	7	8	4	6	3
Behavioral Health Complaints Per RAE (See Monthly Behavioral Health Complaints Report)	2	5	6	3	3	1	1	1	0	0	1	0

OMBUDSMAN FOR HEALTH FIRST COLORADO MANAGED CARE – ANNUAL REPORT

Accumulative Numbers July 2023- June 2024

Type of Contact	Fiscal Year 2023
Total calls (ACD report)	664

Total Contacts to initiate cases (within scope)	245
Out of scope	445
No Referral Needed	148
Total existing client calls regarding active cases or inquiries	54
Face to Face client contact	0
Complaints received via	
Mail	0
Fax	0
Email	69
Complaint types (inquiries and cases)	**631**
MCO	63
Regional Accountable Entity	334
Other/Unkown	234
Req. Written Material	0
Client calls referred to outside agencies:	**611**
Billing/Collections Manager	60
Health First Colorado Member Center	31
CO, SHIP, MMP Advocate, Other Ombudsman (PACE Medicare, LTC, etc.)	21
CHP+, CMAP, HHS, DHS	78
Behavorial Health Ombudsman	34
Office of Administrative Courts	34
Div. Of Insurance, Legal Aid	0
HFC Enrollments	20
Provider Relations	16
HCPF	133
Dept of Regulatory Agencies	32
RAE/ MCO	52
Other (Providers, Community Services, etc.)	90
DentaQuest	13
Number of Clients with Disabilities (cases/inquiries)	159
Number of Spanish Speaking Clients (cases/inquiries)	83
Withdrawal of Request/No Response (cases/inquiries)	1
County Complaints (see monthly County Complaints Report) - Implemented Feb 2024	28
Behavorial Health Complaints Per RAE (See Monthly Behavorial Health Report)	23

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. Sometimes, the Ombudsman must 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. Unlike with prior years, a large percentage of contacts in Fiscal Year '24 was regarding the denial of Medicaid benefit issues related to the PHE Unwind. 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	63	10.02%

RAE	334	52.93%
OTHER	234	37.08%

The data above illustrates the contacts received by the Ombudsman for each type of health plan during FY'24. The number of contacts the Ombudsman received for MCO's decreased drastically; however, contacts regarding other needs not connected to a member's health plan increased due to issues with Medicaid benefit eligibility approvals. The contacts regarding the RAE decreased around 13%; 506 (66.23%) such contacts were recorded in FY'23. 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, 2023, and June 30, 2024, the Ombudsman handled 445 cases. This is a decrease from the 571 cases addressed in FY'23.

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. In FY'24 calls from fee-for-service plan enrollees and those seeking information regarding Medicaid eligibility increased 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 more contacts regarding RAE plans during FY'24, consistent with FY'23.

The Regional Accountable Entity (RAE)

The State of Colorado initiated the Regional Accountable Entity (RAE) in April 2011 and it continues to evolve. This program's continued focus is to help managed care entities adopt a client-centered approach that provides efficient and coordinated care to improve its members' overall health. 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 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 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, 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. During the last fiscal year Maximus entered into a data sharing agreement with the Behavioral Health Agency (BHA).

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'24. These beneficiaries have been enrolled in the RAE and can access assistance from the Ombudsman and 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 too. 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 escalate to this level, the Ombudsman may assist the client with filing grievances and 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, so it is not 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	63	25%
2. Denial of Benefits/Benefit Termination	129	50%
3. Quality of Care	63	25%

Fiscal year '24 was not consistent with previous years regarding the high percentage of clients who contacted the Ombudsman reporting problems accessing care. Instead benefit termination or the denial of Medicaid benefit eligibility were the primary concern of contacts/cases. This is likely related to the PHE Unwind. Quality of care issues are equal this year to the 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.

Disability

The Ombudsman received calls from individuals with disabilities, as has been the case in previous fiscal years. 159 of the cases addressed by the Ombudsman in FY24 had a disability code associated with their Medicaid

eligibility or were self-reported which has increased from previous years. 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. Note that the collaboration between BHOs, RAE plans and community resources has been 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 2022. Member Satisfaction Surveys are captured in the IVR and mailed to members where a case is resolved when the member cannot use the IVR system. Callers completed the survey for a total average score of 100%. The Ombudsman received the highest possible score on all calls for FY '24. Participation in the survey is low, as is often the case with satisfaction surveys. There are several months where we had zero participation in the survey which resulted in zero percent satisfaction for those months. We are trying to mention the satisfaction survey early in the call and late in the call to improve participation.

Members also have the opportunity to leave Survey Feedback and the following message was left regarding the members experiences for the FY '24:

01/31/2024

This is Brenda Mueller and this is about Miss Valerie. She is awesome! If I could give her a raise I would. Give her kudos, do something for her on my behalf. She is awesome, thank you so much.

*Voicemail recording can be sent upon your request.

We also received the following member email responses:

1. I appreciate you so much!! I spoke to my local DHS. They escalated my case and I'm waiting for a return call. The person I spoke with said "Something is off, and I can't figure out why you're over income". I also filled out the initial paperwork for Legal Services. Valerie, you took time with me and showed me avenues I never knew were there. I am so grateful.

2. Again, thank you so much. I got a call from my Developmental Pathways case manager today. I know that was you & God working on my behalf. This is such a big burden released. Now I can focus on preparing for the surgeries as far as other things go.

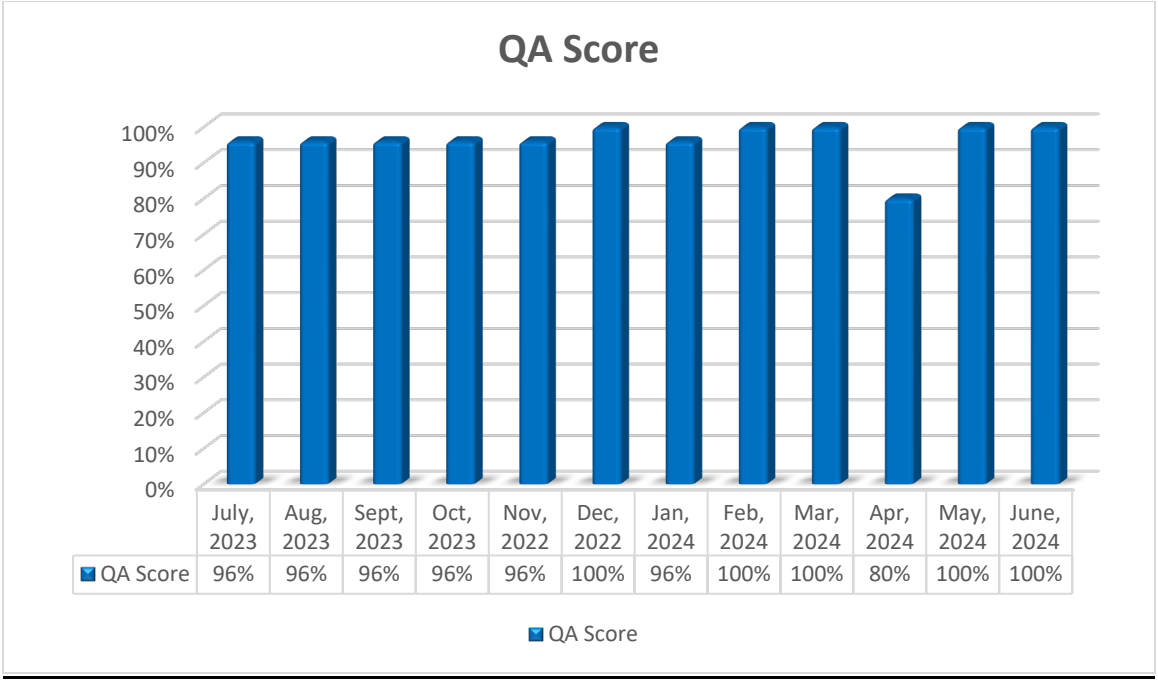
Below is a graph illustrating the Member Satisfaction scores collected in the IVR over time.

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. This year the Ombudsman also experienced a larger number of eligibility issues. 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 supported in resolving Health First Colorado Managed Care problems.

Case Example #1

Background:

A client utilized assistance from the Ombudsman regarding continued disregard of a DME provider who he had utilized to get a motorized wheelchair and a unmotorized wheelchair that Health First Colorado approved for purchase. The client had been fitted for the wheelchairs and given a rental wheelchair until his new equipment was produced.

Narrative:

The client called the Ombudsman requesting assistance due to the DME provider not returning phone calls or assisting the member with their error of delivering the wheelchairs and realizing they were measured incorrectly and were too small for the member to use. It became clear very quickly that the client's quality of life was being impacted. As an amputee, the member was falling out of the chairs, so he was unbale to leave his house in fear of injury.

The Ombudsman assisted the client with filing a complaint against the DME with the state regarding the situation and contacted both the DME and the Department of Health Care Policy and Financing about a resolution to the issue.

Outcome:

An appointment was set at the client's home with the DME provider and with a Department of Health Care Policy and Financing's Waiver Program agent to support the member's issue. It was determined that the wheelchairs were made a size too small and that the DME would need to correct their mistake. The DME took the wheelchairs back for service and a rental wheelchair was delivered to the client while corrections were being made.

Conclusion:

This case illustrates the importance of coordination between providers and health plans to provide the care needed for complex clients. This is particularly true when the client is an adult with disabilities or situations where they cannot leave the house for support of an issue they may be experiencing and their unique needs. 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. 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 the appeal process due to Rocky Moutain Health Plans Prime denying coverage of several medical services the member received while in the hospital.

Narrative:

The client was calling overwhelmed at the number of denials she had received from RMHPP when she had been approved for Medicaid and thought they were in the time frame she would have had coverage.

Narrative:

The Ombudsman began the process of assisting the client by reaching out to the client's MCO plan and it became clear that the client had not been enrolled in a Health First Colorado MCO at the time of her hospital stay. It was

learned that services had been denied because she had not been assigned to RMHPP correctly. The Ombudsman worked with Health First Colorado Enrollment to get the members missing spans corrected and with the client to get the claims resubmitted for payment.

Outcome:

The MCO plan was not able to locate a client due to the missing spans, so they denied the claims. Member was not in a position where there were true denials that would require the member to move forward with a lengthy appeal process.

Conclusion:

This case illustrates how vital communication is between eligibility and a member's assigned health plan to ensure the member has appropriate coverage. Without such, it is very difficult for the Ombudsman, health plans and the Office of Administrative Courts to provide effective and appropriate assistance to relieve a member of a lengthy appeals process that isn't even necessary.