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Minnesota Department of
Human Services

09 - 0442

Health Care

Our Mission

The Minnesota Department of Human Services, working with many others, helps people meet their basic needs so they can live in dignity and achieve their highest potential.

Our Values

- We focus on people, not programs.
- We provide ladders up and safety nets for the people we serve.
- We work in partnership with others; we cannot do it alone.
- We are accountable for results, first to the people we serve, and ultimately to all Minnesotans.

We practice these shared values in an ethical environment where integrity, trustworthiness, responsibility, respect, justice, fairness and caring are of paramount importance.

Report to the Legislature

Ombudsman for Managed Care Study

Laws of Minnesota 2008,
Chapter 364, section 13

March 2009

Legislative Report in fulfillment of MN Laws 2008, Chapter 364, Section 13,

The legislation reads:

"Within the limits of available appropriations, DHS shall study and report with recommendations on whether the duties of the ombudsman should be expanded to include advocating on behalf of public health care program fee-for-service enrollees. The report must include:

1. *a comparison of the recourse available to managed care clients versus FFS clients when service problems occur; and*
2. *An estimate of any net cost increase from this change in the ombudsman's duties, taking into account any reduction in the commissioner's duties."*

Background – The 2007 OLA audit of State Health Care Programs identified a disparity in the assistance available to Minnesota Health Care Program (MHCP) clients, depending on whether they are fee-for-service or managed care enrollees. When faced with access, service or billing issues, managed care enrollees may call the Ombudsman for Managed Care for assistance in resolving issues, go through a health plan appeal, or a State Fair Hearing. Fee-for-service (FFS) enrollees, who are disabled and may have more chronic and complex medical issues, do not have comparable resources when confronted with access, service and billing problems, as DHS does not currently have ombudsman who assist the FFS population.

Comparison of FFS and Managed Care Requirements Regarding the Grievance System and Consumer Information, Education and Assistance

Managed Care	Fee For Service
A. Notice of Action (DTR) regarding Denials, Terminations and Reduction of services or payment. (sent to enrollee at time of MCO action) • Some Managed Care Organizations (MCOs) provide an Explanation of Medical Benefits (EOMBs) in addition to the Notice of Action (DTR).	A. Explanation of Medical Benefits (EOMBs) – monthly notice, shows paid services. Clients may call SIRS Hotline if they suspect billing errors. Notice regarding service authorizations. No notice for denial of claims.
B. MCO Grievance and Appeal Process • Ombudsman assists Enrollee with the G&A process and attempts to resolve issue between the MCO and member. • Policy and procedure review by External Quality Review Organization (EQRO). • Grievance & Appeal file review by the MN Department of Health. • MCO sends detailed quarterly report to DHS on the number and types of	B. NONE

Grievances and Appeals filed with the MCO. • Ombudsman tracks and monitors all MCO Grievances & Appeals.	
C. • State Fair Hearing • Ombudsman assists Enrollee with the State Fair Hearing process and attempts to resolve issue between MCO and member before the hearing • Ombudsman's Office monitors all managed care State Fair Hearings • DHS reports quarterly to CMS on type and outcome of hearings	C. Clients can appeal denials of service or payment (from DHS) through the State Fair Hearing process.
D (1). Consumer protection through: • MHCP Member Helpdesk • Ombudsman interventions through informal dispute resolution. • Education and assistance with the MCO grievance and appeal process and State Fair Hearing process. D (2) Available points of contact for complaints, grievances and appeals: ** • Health plan member services • Appeals Offices (health plan and DHS) • County managed care advocates • Ombudsman for Managed Health Care Programs (DHS) (Ombudsman # on MCO cards, Member Rights, COCs) • Minnesota Department of Health	D. Limited consumer protection through: • MHCP Member Helpdesk (info & referral only). Helpdesk telephone # is on all MHCP cards. • SIRS Hotline
E. Local/County managed care coordinator. Enrollment staff and advocates who assist managed care enrollees with access, service and billing issues.	E. NONE
F. MCO Certificate of Coverage – 30-40 pages detailing benefits which includes the Enrollee Bill of Rights and Member Rights Notice	F. One-page description of benefits at initial eligibility.
G. List of providers – MCO Provider Directory (print) or MCO websites.	G. List of providers - on DHS website.
H. Integrated Medicaid/Medicare products (Minnesota Senior Health Options (MSHO) & Minnesota Disability Health Options (MDHO).	NONE
I. Care Coordination – MSHO & MDHO – for waiver and non-waiver services.	I. Case Management – County case managers for waiver services only.
J. Assure access to covered services. • Expand access as needed, where possible.	J. No comparable assurance of access to services.

***Note: Enrollees may contact all resources at the same time – they are not required to exhaust one level of recourse before going to the next.*

Discussion

In July, 2008, there were 463,015 people enrolled in managed health care programs and 227,485 people on FFS health care programs.

Like the Managed Care Ombudsman, the primary FFS Ombudsman function would be to investigate complaints received from clients on FFS Medical Assistance (MA) and General Assistance Medical Care (GAMC). The FFS Ombudsman would educate clients about their options for dispute resolution and intervene when possible to resolve issues. They would provide assistance with the State Fair Hearing process and attempt to resolve issues between DHS' prior authorization, claims payment and/or benefit policy units and the client before a hearing. They would inform DHS Health Care Policy, Billing, Surveillance, and Provider Enrollment as appropriate for health care access, service and billing issues for this population.

Unlike the Managed Care Ombudsman, the FFS Ombudsman would not be involved in the following managed care responsibilities because there is no comparable requirement under FFS: Monitoring denial, termination, and reduction (DTR) notices; assisting with the MCO Grievance and Appeal Process and County managed care enrollment and advocacy activities (as listed in A, B, D (2), and E under the Managed Care column in the table above).

Recommendation

DHS recognizes the value and importance of this resource for FFS enrollees. Due to the budgets constraints, we cannot recommend the addition of a FFS Ombudsman function to the DHS Managed Care Ombudsman Office.

The Staffing requirements for adding three full-time equivalents was estimated at: $292,140/first year and $262,440/annually thereafter.