Snapshot of Medicaid Managed Care Ombudsman and Grievance Procedures

Prepared by

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Purpose

This project, funded by the David and Lucile Packard Foundation, examines how five states handle Medicaid managed care enrollee complaints specifically through grievance processes, ombudsman programs, and fair hearings. The linkages among these aspects of grievance and complaint systems are explored and different characteristics of various state programs are highlighted.

States selected for review were those that reported the existence of an ombudsman program on the National Academy for State Health Policy's (NASHP) 1994 survey of state Medicaid programs. States reporting the existence of an ombudsman program in 1994 were: Minnesota, Missouri, Oregon, and Tennessee.\(^1\) The state of Delaware was also selected for review because it developed an ombudsman program as part of its 1115 research and demonstration waiver program subsequent to the NASHP survey. A preliminary review of responses to the fall 1996 NASHP survey show that at least 10 states subsequently have established ombudsman programs for their Medicaid managed care programs, eight of which are operated by the Medicaid agency.\(^2\)

Systems of capturing and resolving Medicaid managed care enrollee complaints and problems are an important aspect of monitoring and ensuring

\(^1\) While Missouri reported having an ombudsman program on the 1994 NASHP survey, an ombudsman program was under development at the time work this work for this paper began. As a result, the Missouri system of grievance and complaint is discussed but the state is excluded from any discussion of ombudsman programs.

\(^2\) The results of the most recent survey of Medicaid managed care activities are scheduled for release by January 1997.

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quality care, and creating an overall high quality managed care system. These state
Medicaid programs are quite diverse in the operational detail of their complaint
collection and resolution systems. The diversity of these five states is indicative of
the diversity that exists among all state Medicaid managed care programs.

One specific focus of this project was to look at state ombudsman programs. It
is important to take a close look at programs reported as ombudsman programs for
several reasons. First, state Medicaid programs operate or fund a variety of different
systems, all of which are commonly referred to as ombudsman programs, and the
differences among them can be important (including scope of authority). It is also
important to understand the relationships of these programs to both the grievance
system required of Medicaid-contracting managed care organizations (MCOs) and to
the state systems of complaint resolution (a grievance or fair hearing process for
example).

Federal rules require the each Medicaid contracting MCO have an internal
grievance procedure. While not specific to managed care, federal Medicaid rules
also require each state to maintain a process of fair hearings to resolve disputes
concerning eligibility and coverage for all Medicaid beneficiaries, including those
enrolled in Medicaid managed care plans. These mechanisms, are the two basic
building blocks from which states can develop dispute resolution systems
specifically for Medicaid managed care enrollees.

Dispute Resolution Systems Overview

All of the review states had a variety of methods built into their Medicaid
managed care systems to allow enrollees to express complaints and to resolve those
complaints. In general, each state established multiple venues in which enrollees
can express dissatisfaction including those within the Medicaid contracting MCO,
within the state, and in the case of Delaware and Tennessee, within contracting
agencies apart from both Medicaid and the health plans.

For purposes of this report and for purposes of comparing relatively diverse state systems, a distinction is made between formal and informal grievance or complaint processes at both the state and health plan levels.

An informal complaint/grievance process within a health plan would generally accept complaints from Medicaid managed care enrollees and would work to resolve those complaints through dispensing information or making some phone calls on behalf of the enrollee. It typically does not involve the filing of a written complaint by the enrollee, would not characteristically involve a formal, individualized review by an official of the MCO and does not necessarily require a written response to the complainant. A formal grievance process within the health plan would be a system where a written complaint is filed by an enrollee which is formally addressed by designated MCO staff. (This staff may or may not have other responsibilities or functions in addition to a grievance function). Some MCOs also have an internal appeal process in addition to the grievance process to petition for a change in the grievance decision of the health plan.

Similar to the MCO process, an informal state complaint/grievance process generally accepts complaints from Medicaid managed care enrollees and works to resolve those complaints through dispensing information or making phone calls on behalf of the enrollee. The informal process does not involve a formal, individualized review by a state official and does not necessarily require a written response to the complainant. In contrast, a formal state complaint process typically includes written documentation submitted by the enrollee, a formal presentation of the complaint to a state official (or officials) at some level below the fair hearing, and a written response from the state agency. The formal process is distinct and separate from the standard fair hearing process, which is federally required.
The **fair hearing** process referred to in this paper is the standard adjudication process required by federal Medicaid law that applies to all Medicaid beneficiaries and is open to issues concerning those well beyond Medicaid managed care (program eligibility, coverage, long term care, etc.). States have different names or terms for this level of adjudication (Oregon refers to it as an administrative hearing) but for purposes of clarity, it will be referred to as a fair hearing in this paper.

Two states, Minnesota and Oregon, do not have a formal state-level managed care enrollee grievance process apart from the fair hearing process, although they both have ombudsman programs. Only Missouri makes a distinction between the terms “complaint” and “grievance” and the distinction signifies the point in the system at which the issue is taken up. Only Missouri had no ombudsman program, although as will be discussed later, there was considerable diversity among the remaining four states about what is considered an ombudsman program.

All the Medicaid managed care programs reviewed have hotlines which take enrollee complaints and questions. The states either operated telephone hotlines, or required their MCOs to operate hotlines, or did both. Some of these hotlines are designed expressly to try and resolve the complaints, while others collect complaints during the course of enrollee education and outreach.

All states have fairly thorough approaches to informing enrollees about the existence of a complaint or grievance process (or multiple processes) and the sources of assistance to both lodge a complaint and to obtain resolution. In addition, all the reviewed states informed enrollees about their rights to lodge grievances/complaints.
### Overview of State Complaint/Grievance System

<table>
<thead>
<tr>
<th>State</th>
<th>Formal Grievance System (Other than HMO or fair hearing)</th>
<th>Distinction Between Terms Complaint and Grievance</th>
<th>Ombudsman Program</th>
<th>Consumer Hotlines</th>
</tr>
</thead>
<tbody>
<tr>
<td>Delaware</td>
<td>yes</td>
<td>no – interchangeable</td>
<td>yes</td>
<td>MCO</td>
</tr>
<tr>
<td>Minnesota</td>
<td>no</td>
<td>no – use only complaint</td>
<td>yes</td>
<td>MCO, state and county</td>
</tr>
<tr>
<td>Missouri</td>
<td>yes</td>
<td>yes</td>
<td>no</td>
<td>MCO, state</td>
</tr>
<tr>
<td>Oregon</td>
<td>no</td>
<td>no – use only complaint</td>
<td>yes, for disabled and elderly populations</td>
<td>state</td>
</tr>
<tr>
<td>TennCare</td>
<td>yes</td>
<td>no – interchangeable</td>
<td>yes, for mental health program and hotline contractor for special needs enrollees</td>
<td>state and non-MCO contractor</td>
</tr>
</tbody>
</table>
Grievance Systems

There are a number of interesting similarities among the five states and their grievance processes as well as some notable differences. One interesting comparison is the use of the term ‘grievance’ or ‘complaint’. Generally, the terms are interchangeable when discussing the state process and enrollee options in Delaware and Tennessee. Minnesota uses the term ‘complaint’ to describe all aspects of the process at the health plan level and ‘appeal’ to refer to the state hearing process, while Missouri has a very organized typology of complaints, grievances, and appeals where the terms are not interchangeable; use of a term implies a specific point in the process. Oregon uses only the term ‘complaint’ in rule. Because of the diversity, these systems will be referred to in this paper and the related charts as complaint/grievance systems, regardless of what each state names the process.

Regardless of the different system structures or designations, these five states generally describe a complaint and grievance system that is designed to resolve enrollee problems on an informal basis as quickly as possible without having to resort to time-consuming formal processes. State officials almost uniformly place a much greater emphasis on the role of the informal complaint resolution process, where there is no written complaint lodged. All the states required their health plan contractors to address informal, verbal complaints and most required their MCOs to record those complaints via phone logs for state monitoring.

MCO-Level Complaint/Grievance Processes: While obvious, it is worth stating here that enrollees who utilize the MCO complaint/grievance process in all five states can raise issues of benefit/service such as amount, duration, and scope of coverage as well as issues of MCO administration.

The informal MCO complaint process is typically described as a verbal process
— no written complaint is delivered in three of the states. In Missouri, an informal complaint can be either written or verbal but is more characterized as the first step in the MCO complaint process. In Oregon, an informal complaint within the MCO process can be either written or verbal. An MCO has 10 days to respond to or resolve the complaint in three states and has 30 days in Oregon and Tennessee.

Also reflective of the emphasis on quick, informal problem solving is the focus on hotlines. All the states either had state-operated 800 numbers or required the health plans to operate them, or had both. The phone hotlines are for dispensing information and handling problems/complaints, all in a verbal manner. For those states with ombudsman programs distinct from hotlines, much of the ombudsman role in these states has to do with outreach, education, and information provision to minimize the potential for problems before they even occur.

All five states require an MCO to have an internal formal complaint process (or grievance process in Missouri). This is typically characterized as a written complaint, and does not require the complainant to have first lodged an informal complaint, although this is the expectation in most states. The exception is Missouri, where a formal grievance within the MCO system is specifically defined as the appeal of an HMO’s complaint decision. Four of the states require the MCO to respond/dispose within 30 days; Delaware requires a response within 10 days (with an expedited process for urgent cases which is similar in Minnesota).

Only Delaware and Missouri stipulate that there is an appeal process of the MCO grievance decision within the MCO itself. The remaining states do not require an internal MCO appeal process (although the MCO may have one as in Oregon). Without an internal MCO appeal procedure, an enrollee would contest the MCO decision within a state process (which is also available to an enrollee in Missouri.
and Delaware). In Missouri, an MCO is required to respond within 60 days to the appeal process request (two days in the event of an urgent case) while the response time is indefinite in Delaware.

**State-Level Processes:** All the states reviewed for this paper permit an enrollee to access the state-level grievance/complaint or fair hearing process (depending on the state) without having to first go through the grievance process of the managed care health plan. However, in Oregon, under new rules that are being promulgated, a request for a hearing will automatically trigger a request by the state to the MCO to begin an internal complaint resolution process that will run concurrent with the state hearing process.

The state grievance process is more varied among the states than is the MCO complaint/grievance process, in both scope of authority and system design. Three of the states – Delaware, Missouri, and Tennessee – have a grievance process that is separate from fair hearings. In all three of the states, enrollees can use the formal, state-level grievance process to seek resolution on issues related to MCO administration, coverage, and service decisions. In two of these states (Missouri and Tennessee) the grievance (or complaint) process will also hear issues of state managed care program administration such as contested mandatory enrollments, premium amounts (in Tennessee), and assignments to MCOs. Delaware, by contrast, uses only the fair hearing process for resolution of issues concerning state administration of the program, which includes issues of mandatory enrollment and assignment. Delaware reserves the state-level grievance process for issues concerning the operation of the contracting health plans so the scope of the grievance process is considerably more narrow.

In those states without a separate state-level grievance process, the fair hearing is the first and primary state venue for all formal managed care complaints.
In these states (as in states with a state-level managed care grievance process apart from either the MCO process or the fair hearing process) an enrollee can raise all issues taken up in the MCO process. In addition to complaints/grievances related to Medicaid managed care (MCO service/administration, required enrollment, benefits, premiums, etc.), issues taken up in fair hearings in all five of the states can concern general Medicaid eligibility (general Medicaid eligibility is not taken up the grievance process and may not be managed care program specific).

Delaware, Minnesota, and Oregon have what could be considered an informal state resolution process operated through their ombudsman programs. Issues that can be addressed through this mechanism are those related to MCO service (benefits and member services). The role of the ombudsman varies, as is discussed below; however, state officials believe that a significant role of the ombudsman in resolving complaints and minimizing dissatisfaction is to provide accurate information to enrollees. As one Minnesota official put it, "...98% of resolving complaints is getting the right information to the right people and explaining the process."

As mentioned earlier, Delaware, Missouri, and Tennessee have formal, state-level, grievance/complaint systems for managed care enrollees that are other than a fair hearing system. In general, these systems are designed to bring complaints about the MCO or the state managed care program into a formal process that is outside the fair hearing process. No state has a process by which an enrollee can appeal a state grievance system other than directly through a fair hearing.

In Delaware, the arbiter in the state grievance system is the Chief of Medicaid Managed Care Administration, who works in conjunction with the Medicaid medical director. An MCO is not permitted to appeal the decision of the Chief but an enrollee may take the complaint to a fair hearing process. In Missouri, the state
reviewer hears the grievance after which the issue could go to fair hearing. The situation is similar in Tennessee where grievances are heard by state TennCare Bureau staff and the next level of complaint resolution is a fair hearing.

Ombudsman Programs

All the states but Missouri actually operate, or contract for operation of, some type of ombudsman program. As mentioned earlier, all but one state reviewed for this project reported the existence of an ombudsman program on a 1994 NASHP survey of state Medicaid managed care programs. Because the reported Missouri program is under development, Delaware was added to the review mix because it has a statewide ombudsman program which became operational after the NASHP survey was conducted.

There is great variety in the types of programs that are considered to be ombudsman programs. That variety concerns the authority of the ombudsman, its role in grievance proceedings and hearings, its role in beneficiary education and enrollment in health plans, its location and connection to Medicaid, and the population it serves.

One characteristic of all the ombudsman programs is that they are all Medicaid funded operations. Two of the programs (Minnesota and Oregon) are part of the Medicaid agency, housed within the Medicaid central office. The direct connection of the ombudsman programs in these two states to the respective Medicaid agencies has implications for the authority of the ombudsman in these states relative to the other programs: in Minnesota and Oregon the ombudsmen operate with the full weight and authority of the Medicaid agency, even while the ombudsman is not imbued with a sanction authority separate and distinct from the authority of the Medicaid agency. This is quite different than in Delaware or Tennessee where the ombudsman is not a component of state government and may
have more independence (discussed in detail below).

All reviewed states indicated that their ombudsman programs were initiated proactively – before the start up or significant expansion of risk-based managed care was operational. Interestingly, among states with 1115 waiver programs, the ombudsman or advocacy program was not a condition of receiving waiver approval from HCFA which indicates that the programs were state-initiated and not resultant of federal requirements. In some cases, the ombudsman or advocacy program was initiated by the Medicaid agency, while in others, the program came about as a result of the state legislative process. Another commonality among these states is that individuals are not required to use the services of the ombudsman.

Delaware

In Delaware, the ombudsman is the enrollment broker and its authority is no greater than that of an enrollment broker even though it has taken on the added responsibility of an ombudsman. The broker has the authority to change the enrollment status of a beneficiary, consistent with program rules. Further, the broker is expected to forward complaints and grievances to the state or health plan (see the previous detailed discussion of the grievance system). However, the broker is expected to remain in contact with the beneficiary and assist the beneficiary throughout the grievance process. The expected role of the ombudsman in Delaware is that of an advocate without any specific authority to resolve complaints other than the broker authority to enroll and disenroll.

Tennessee

In Tennessee, the ombudsman role for TennCare is a hotline, the TennCare Advocacy Project, operated by the Crisis Intervention Center and funded by Tennessee Medicaid. While characterized as an ombudsman program by state officials on the 1994 NASHP survey, state officials interviewed for this project were...
reluctant to describe the hotline as an ombudsman program. State officials view the hotline as a problem solving resource for enrollees and potential enrollees that lacks any specific authority to take action to resolve problems for enrollees or potential enrollees.

As originally envisioned, the staff of the Tennessee Crisis Intervention Center were to be dedicated to addressing the concerns, problems, and needs of people with very special health care needs who are required to enroll in the TennCare managed care program. However, the contractors were directed toward more general aid — offering assistance and problem solving for all TennCare enrollees and potential enrollees because the state hotline (intended to answer enrollment questions) was overburdened for the first two years of operation. As a result, the Intervention Center took on a broader assistance role in order to address the actual need. Now, however, the state hotline is adequately staffed to handle existing volume for the general TennCare population so the Crisis Intervention Center hotline will return to its original mission of assisting a subset of the enrolling population.

Tennessee also recently commenced a risk-based, carve out program for behavioral health services. (Prior to July 1996, behavioral health services were included in the general managed health care contracts, and services were the responsibility of TennCare contractors.) This new program will have its own ombudsman program, which is structurally different from the hotline of the general TennCare program. The behavioral health ombudsman program will be Medicaid funded although it will report to the Department of Mental Health. There will be three ombudsman offices throughout the state with three staff. Similar to the hotline for the general program, these ombudsman will provide assistance to behavioral health enrollees and will operate in a reactive manner to problems or potential problems in the field by either providing information/assistance to
enrollees or referring problems to the Department of Mental Health or Medicaid.

**Oregon**

The Oregon ombudsman program is similar to the operation in TennCare in that it is designed to serve the needs of the disabled/SSI Medicaid population which is required to enroll in the Oregon Health Plan. The ombudsman serves potential enrollees as well as those already enrolled in a risk-based managed care organization or those who have selected a Primary Care Case Manager. Like the Tennessee behavioral health ombudsman program, there are three staff for the caseload.

Unlike the Tennessee program, the Oregon ombudsman program operates directly from the Medicaid agency. Ombudsman staff are state employees and represent the full authority of the Medicaid agency. While the ombudsman do not have direct authority to impose sanctions, the Medicaid agency generally has authority to enforce contract provisions.

**Minnesota**

Like Oregon, the Minnesota ombudsman office operates within the Medicaid agency and therefore has the authority of the Medicaid agency in mediating disputes and obtaining resolution from MCOs. Unlike other programs, Minnesota has made a direct linkage between the work of the ombudsmen and MCO quality assurance contract oversight. While there is communication between Medicaid ombudsmen and Medicaid contract oversight personnel, the linkage and relationship is now becoming formalized so that information obtained through the ombudsman function can be fed directly into contract management and oversight, which is information in addition to that obtained by monitoring formal hearings or the MCO complaint process.

Unlike other states in this review, Minnesota has an advocacy and education
program at the county level, called County Advocates. The purpose of these advocates is to educate people about the Medicaid managed care program, thereby circumventing problems, and to assist an enrollee through an MCO complaint process, or state appeals process if necessary.

**Quality Assurance/Quality Improvement**

The respective grievance/complaint and/or ombudsman programs of Minnesota, Missouri, and Oregon all support state monitoring of health plans. In Minnesota, the relationship is direct in that the state ombudsman is directly linked organizationally to the Medicaid managed care Quality Improvement (QI) office while in Missouri, the state grievance system is linked to QI operations.

Grievances and complaints, whether lodged formally or informally, can serve as an early warning system that all is not well within a particular health plan or can highlight flaws in the design of the overall administrative system. An example of a health plan problem may be complaints about the availability of providers or coverage decisions. The complaint system could demonstrate that the state (or its contractor) has done a poor job in educating beneficiaries about selecting a health plan and navigating the system.

**Conclusions**

Clearly there is considerable diversity in state systems of receiving complaints from Medicaid managed care enrollees, which is wholly consistent with the nature of the Medicaid program. The only consistent characteristic across these states (and likely across other Medicaid managed care programs) is the requirement that health plan contractors have an internal enrollee complaint or grievance system.

It is interesting that two of the five states (Minnesota and Oregon) have no
formal state-level managed care grievance system apart from the traditional fair hearing process. However, both these states’ ombudsman programs have somewhat more authority than those of the other states which, by contrast, have a distinct and formal grievance system that is separate from a fair hearing. A point of further investigation could be to see if more states fall into one of the two models that seem to exist among these five states: strong ombudsman with no state-level grievance other than fair hearing, or weak (or no) ombudsman but a formal state-level grievance process below the level of fair hearing.

It also appears that, in states where the ombudsman program is part of the Medicaid agency, the ombudsman can act with more authority – the authority of the state. This is not the case in states where the ombudsmen are contractors and, as a result, have much less authority to bring to bear on a problem situation. However, in states such as Delaware and Tennessee where the ombudsman are not state employees, there can be a greater degree of independence among the resource people from whom enrollees seek assistance and advice. In at least one of the states with a strong in-house ombudsman program, state officials indicated that advocates would prefer a more independent ombudsman’s office. However, among the states examined here, independence also equates with less authority to resolve problems. Of the two models of ombudsman program actually in use by the states, it is not clear which model is best for beneficiaries because of the trade-offs of authority and independence and the answer may be state specific.

There is a model not used by any of these states, which is an independent ombudsman that has authority to take action. The limitations of existing models concerning independence v. authority would be resolved to the benefit of the enrollee. While the lack of independence did not seem to pose an actual problem among states using a model where the ombudsman is part of the Medicaid agency, the potential for problems exist within the model. However, the model implies a
level of cooperation between the ombudsman and the Medicaid agency to resolve problems that may not exist between independent agencies with separate authority, the potential result being slower resolution of enrollee problems.
Appendix A:
State Grievance Systems Detail Chart
<table>
<thead>
<tr>
<th>Step</th>
<th>Delaware</th>
<th>Minnesota</th>
<th>Missouri</th>
<th>Oregon</th>
<th>TennCare</th>
</tr>
</thead>
<tbody>
<tr>
<td>Enrollee can proceed directly to state grievance/complaint process</td>
<td>yes.</td>
<td>yes. (directly to fair hearing)</td>
<td>yes.</td>
<td>yes. (directly to fair hearing, which in future will trigger the state to initiate a MCO complaint process to run concurrently)</td>
<td>yes.</td>
</tr>
<tr>
<td>Informal MCO grievance/complaint process</td>
<td>yes. Verbal complaints to health benefit manager Issues for MCO process: member services/MCO admin., medical benefits. MCO Response Time: 10-30 days</td>
<td>yes. Verbal complaints Issues for MCO process: member services/MCO admin., medical benefits. MCO Response Time: 10 days</td>
<td>yes. Verbal or written. Informal = &quot;complaint&quot; = first time issue is raised by enrollee Issues for MCO process: member services/MCO admin., medical benefits. MCO response time: 10 days</td>
<td>yes. verbal and written complaints Issues for MCO process: member services/MCO admin., medical benefits, care coordination for special needs populations. MCO Response time: 5 days to acknowledge, 30 days to dispose</td>
<td>yes. Verbal complaints Issues for MCO process: member services/MCO admin., medical benefits MCO Response time: 30 days</td>
</tr>
<tr>
<td>Formal MCO grievance/complaint process</td>
<td>yes. Written complaint. MCO Response Time: 10 days or 24-48 hrs for jeopardy cases</td>
<td>yes. Written complaint. MCO Response Time: 30 days</td>
<td>yes. Written = appeal of complaint decision. MCO Response Time: 30 days</td>
<td>yes. written and verbal New Admin. Rules require that any expression of dissatisfaction be handled as a formal complaint if enrollee desires. MCO Response Time: 5 days to acknowledge, 30 days to dispose</td>
<td>yes. Written grievances MCO Response time: 30 days</td>
</tr>
<tr>
<td>Step</td>
<td>Delaware</td>
<td>Minnesota</td>
<td>Missouri</td>
<td>Oregon</td>
<td>TennCare</td>
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<tr>
<td>------------------------------</td>
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<td>-------------------------------------------------</td>
<td>----------</td>
</tr>
<tr>
<td>MCO appeal process</td>
<td>yes. Appeal of MCO grievance decision</td>
<td>no.</td>
<td>yes. Appeal of MCO grievance decision</td>
<td>MCO may elect to have internal appeal process.</td>
<td>no.</td>
</tr>
<tr>
<td>MCO Response Time:</td>
<td>indefinite</td>
<td></td>
<td>MCO Response Time:</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>60 days, 2 days for urgent cases</td>
<td></td>
<td></td>
</tr>
<tr>
<td>State informal complaint</td>
<td>yes, through ombudsman (see other chart)</td>
<td>yes,</td>
<td>yes, through ombudsman or advocate programs</td>
<td>yes, through ombudsman (see other chart)</td>
<td>no.</td>
</tr>
<tr>
<td>(managed care program specific)</td>
<td>Issues: MCO service/benefit</td>
<td>through</td>
<td>(see other chart)</td>
<td>Issues: MCO service/benefit</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>ombudsman</td>
<td></td>
<td>Issues: MCO service/benefit</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>or advocate programs (see other chart)</td>
<td></td>
<td>Issues: MCO service/benefit</td>
<td></td>
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<tr>
<td></td>
<td></td>
<td>Issues: MCO service/benefit, managed care</td>
<td></td>
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<tr>
<td></td>
<td></td>
<td>enrollment</td>
<td></td>
<td></td>
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</tr>
<tr>
<td>State formal grievance/complaint</td>
<td>yes.</td>
<td>no.</td>
<td>yes.</td>
<td>MCO may elect to have internal appeal process.</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Issues: Either 1) appeal of MCO decision or 2)</td>
<td></td>
<td>Issues: Initiate MCO service complaint, appeal</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>original grievance against MCO</td>
<td></td>
<td>of MCO appeal decision, or contest state managed</td>
<td></td>
<td></td>
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<tr>
<td></td>
<td></td>
<td></td>
<td>care administration issues (e.g. mand.</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>enroll., assignment ).</td>
<td></td>
<td></td>
</tr>
<tr>
<td>State grievance appeals</td>
<td>no.</td>
<td>no.</td>
<td>no.</td>
<td>no.</td>
<td>no.</td>
</tr>
<tr>
<td>(not fair hearing)</td>
<td></td>
<td></td>
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<tr>
<td>Fair hearing</td>
<td>yes.</td>
<td>yes.</td>
<td>yes.</td>
<td>yes.</td>
<td>yes.</td>
</tr>
<tr>
<td></td>
<td>Issues: independent of grievance process. Admin. Issues: adverse actions, elig. term., reduction in benefit, mand. enroll.</td>
<td>Issues: contest MCO service decisions, and state adverse actions.</td>
<td>Issues: contest MCO appeal decision or state formal grievance decision</td>
<td>Issues: contest MCO service decision or state adverse action or enrollment. In the future, an appeal of MCO service decision that has not run through the MCO process will automatically trigger a MCO grievance process to run concurrent with fair hearing.</td>
<td>Issues: contest MCO appeal decision or state formal grievance decision</td>
</tr>
<tr>
<td></td>
<td>Response Time: 90 days from date filed</td>
<td>Response Time: 30-90 days</td>
<td>Response Time: indefinite</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Court</td>
<td>option after state grievance or fair hearing for enrollee only</td>
<td>option for enrollee after fair hearing decision</td>
<td>option after fair hearing for enrollee only</td>
<td>option after fair hearing</td>
<td>fair hearings decisions cannot be contested in court.</td>
</tr>
</tbody>
</table>
Appendix B:
State Ombudsman Programs Detail Chart
<table>
<thead>
<tr>
<th>State</th>
<th>Funding</th>
<th>Staffing/Creation</th>
<th>Authority</th>
<th>Location</th>
<th>Enrollee Informing</th>
<th>Work Volume</th>
</tr>
</thead>
<tbody>
<tr>
<td>Delaware</td>
<td>Medicaid</td>
<td>Medicaid initiated and funded. Not a condition of 1115 waiver approval. Created prior to program start up. 18 staff: 56000 eligibles (1:3100). Serves MCO enrollees only. Created along with managed care program.</td>
<td>Ombudsman is Health Benefits Manager (HBM) therefore, can change enrollment. No other complaint resolution authority. Required to pass along complaints to MCO or state. Works w/ member during grievance process.</td>
<td>HBM has 1 physical office. Works primarily through on-site visits to Medicaid service centers 2-3 days/week.</td>
<td>Member handbook and through enrollment process with HBM.</td>
<td>4 complaints (1 referred to state, 3 referred to MCOs) in 6 months of operation since 1/96. None has gone to formal grievance.</td>
</tr>
<tr>
<td>Minnesota</td>
<td>State Ombudsman Medicaid XIX funded. Initiated through legislation simultaneous w/ managed care program expansion. 3 staff: 168,000 eligibles (1:56,000). Serves MCO enrollees. County advocates are Medicaid funded.</td>
<td>State Ombudsman has authority of XIX agency to resolve service related enrollee problems. Linked to state quality improvement operations. County advocates have no specific authority but offer general information and assist enrollee through an MCO complaint or state appeal process. Work closely w/ state ombudsman. Either agency may (or may not) be involved in a hearing with the enrollee.</td>
<td>State Ombudsman located in central XIX office. County advocates located in each county.</td>
<td>State Ombudsman and County advocates: enrollee rights notice sent 2 times/year, information w/ denial notices, MCO member handbooks, provider meetings, and county advocates inform about ombudsman.</td>
<td>'95: 1928 calls to the Ombudsman Office related to managed care. 77 appeals filed and 26 went to hearing.</td>
<td></td>
</tr>
<tr>
<td>Missouri*</td>
<td>n/a</td>
<td>n/a</td>
<td>n/a</td>
<td>n/a</td>
<td>n/a</td>
<td>n/a</td>
</tr>
<tr>
<td>State</td>
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<tr>
<td>Oregon**</td>
<td>Medicaid funded. Created legislatively when approved SSI enrollment. Initiated by Medicaid and advocates. 3 staff for approx. 69,000 enrollees (1:23,000). Serves MCO, PCCM, and FFS Oregon Health Plan enrollees who are disabled and/or aged.</td>
<td>Operates with authority of Oregon Medicaid to enforce contract provisions. Problem solving resource for persons with disabilities and the elderly.</td>
<td>Central XIX office. Operates by phone</td>
<td>Enrollment. Ombudsman phone # on Medicaid card. Information in member handbook. Field workers inform.</td>
<td>1st qtr 96: 2,045 calls, of which 269 were cases requiring intervention.</td>
<td></td>
</tr>
<tr>
<td>TennCare Health***</td>
<td>XIX funded contractor: Crisis Intervention Ctr. Initiated by Medicaid agency. Not a condition of 1115 waiver. Approximately 17 staff. Serve MCO enrollees and potential enrollees</td>
<td>No authority to require action of MCOs. A problem solving resource and managed care educational service for persons with very special health care needs.</td>
<td>Located outside state government. Operates by phone</td>
<td>Information on service is selectively distributed to reach target population, i.e. through case workers.</td>
<td>1995: 42,000 info &amp; referral calls of which 3,060 cases opened.</td>
<td></td>
</tr>
<tr>
<td>TennCare MH</td>
<td>XIX funded. Initiated by Medicaid agency. Not a condition of 1115 waiver. 3 staff will report to Dept of Mental Health. Serve behavioral health enrollees.</td>
<td>No authority to require action of MCOs. Problem solving resource for enrollees.</td>
<td>3 offices in state</td>
<td>not available</td>
<td>not available</td>
<td></td>
</tr>
</tbody>
</table>

* Missouri is developing an ombudsman program
** Oregon has a state operated hotline for general Oregon Health Plan enrollees who are not served by the ombudsman program.
*** Tennessee has a state operated hotline for general TennCare enrollees which addresses administrative issues such as incorrect premiums.
1996

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