Minnesota Department of Human Services **Health Care**

Mission Statement

The Department of Human Services, in partnership with the federal government, county and other public, private, and community agencies throughout Minnesota, is a state agency directed by law to assist those citizens whose personal or family resources are not adequate to meet their basic human needs. It is committed to helping them attain the maximum degree of self-sufficiency consistent with their individual capabilities. To these ends, the Department will promote the dignity, safety, and rights of the individual, and will assure public accountability and trust through responsible use of available resources.

A Report to the 1998 Minnesota Legislature as required by Laws of Minnesota 1997, Chapter 203, article 4, section 68

Ombudsman for Minnesota Health Care Programs

Recommendations for Reorganization

February 1998

Ombudsman for Minnesota Health Care Programs
Recommendations for Reorganization

Report to the Minnesota State Legislation
as required by Laws of Minnesota 1997
Chapter 203, article 4, section 68

Minnesota Department of Human Services
February 1998

Table of Contents

Cost of completing this report:

Minnesota Statutes, section 3.197, requires the disclosure of the cost of preparing this report.

Staff time	$1600	
Administrative Costs	$300	(copying, postage etc.)
Total	$1900	

Executive Summary

Introduction

In 1997, the Minnesota Legislature requested recommendations from the Department of Human Services (DHS) on reorganizing the managed care ombudsman and county advocacy services (also known as prepayment coordinator services) to ensure they are independent of DHS, county authorities, health plans, or other health care providers (Laws of Minnesota 1997, Chapter 203, Article 4, Section 68). The Commissioner was directed to seek input from recipients, advocates, and counties in making his recommendations. This report fulfills that requirement.

Actions Taken by the Department of Human Services

Ombudsman staff conducted an informal survey of enrollees in Minnesota Health Care Programs (MHCP), surveyed current County Advocates, published a Request for Information (RFI) to solicit input from advocates and other stakeholders, and met with counties in three sessions of county-based purchasing community forum roundtables.

Recommendations

While the DHS understands the concerns of advocates on the need for independence of the Ombudsman and Advocacy offices, we believe that the necessary independence can be achieved without physically removing the Ombudsman and Advocates from the DHS or the County.

For the Office of Ombudsman for MHCP, a change in reporting relationships, so that the Ombudsmen report on an annual basis to the Commissioner of DHS, allowing the Ombudsmen direct access to the Commissioner, would provide the necessary distance and independence.

The Ombudsmen would still maintain the value of their internal connections: the ease of connection to the computer mainframe system; the extensive knowledge that comes only from close and regular connection with other staff working on the metamorphosis of managed care policy, operations, contracts and systems; and the ability, because they are part of DHS, of having the power of the enforcement of the contract with the health plan behind them. All of this allows the Ombudsmen to provide effective one-on-one assistance for enrollees of MHCP. To disturb those relationships because of fears that conflicts of interest might occur conflicts with evidence that the work the Ombudsmen do is effective and efficient because the relationships do exist.

The Department agrees with the position of the Departments of Health and Commerce that our Ombudsman's efforts should be well coordinated with the other health care ombudsmen's

efforts. However, much has already been done on an informal basis to accomplish that, and much more can be done to formalize those efforts, including the establishment of telephone linkages for easier referral.

It is also clear, from the survey of enrollees, that any change that results in the removal of the Ombudsmen from the DHS would result in the need to replace those staff. The work necessary to solve each enrollee's problem does now, and will continue, to require the involvement of DHS staff. Currently, this happens effectively because of the location of the Ombudsmen with the DHS staff who can help to resolve the managed care problem, whether it's a contract issue, a contract management issue, or a system or operational issue. In addition the continuous exchange of information and ideas between the Ombudsmen and the contract managers help to identify and resolve systemic issues and problems effectively and efficiently, which is difficult to achieve if these offices are physically separated.

Similarly, the DHS believes that county advocates should remain located in the local agency. If a county chooses to purchase health care through County-Based Purchasing, the local agency can take similar steps to ensure that the county advocates remain independent from the county's purchasing program.

Introduction

In 1997, the Minnesota Legislature requested recommendations from the Department of Human Services (DHS) as to how the managed care ombudsman and county advocacy services (also known as prepayment coordinator services) could be reorganized to ensure they are independent of DHS, county authorities, health plans, or other health care providers (Laws of Minnesota 1997, Chapter 203, Article 4, Section 68).

This report reviews the perspectives of three other groups which have been dealing with similar or related issues this past year: the Departments of Health and Commerce Report on Consolidation and Coordination of Health Care Consumer Assistance and Advocacy Offices; the Departments of Health and Department of Commerce Complaint Process Study; and the Health Care Consumer Advisory Board Recommendations for a Complaint Resolution Process. It then describes the DHS perspective on these issues and makes recommendations on reorganization.

The Current System

This section of the report describes the current ombudsman system for Minnesota's health care programs..

The DHS Ombudsman for Minnesota Health Care Programs (MHCP)

The DHS Ombudsman for State Health Care Programs is established by Minnesota Statutes, 256B.69, Subdivision 20. The duties delegated by statute are to: advocate for persons required to enroll in prepaid health plans for Medical Assistance (MA), General Assistance Medical Care (GAMC) and MinnesotaCare (hereafter in this report, these programs will be collectively called the Minnesota Health Care Programs, or MHCP); advocate for enrollees in MHCP prepaid health plans through complaint and appeal procedures; ensure that necessary medical services are provided either by the MHCP prepaid health plan directly or by referral to appropriate social services. Local agencies are required to inform enrollees and potential enrollees about the Ombudsman program, and their rights to resolution of problems by the prepaid health plan. MinnesotaCare program staff has similar duties in respect to their enrollees and potential enrollees.

Currently the Ombudsman is a function of the Purchasing and Service Delivery Division of the Health Care Administration of the Department of Human Services. It is located with the staff who negotiates and writes the contracts for managed care, the staff who monitors and manages the contracts with health plans, the staff who works on the development of new counties for PMAP Plus or County-Based Purchasing, and the Managed Care Operations staff who work on

the computer system and work with county managed care enrollment staff. The Ombudsman staff reports to the Deputy Director for Health Care Purchasing.

The Office of Ombudsman for MHCP has a staff of three persons, two of whom are funded through the general fund, and one through the Health Care Access Fund. Their activities include:

- Receiving, investigating and resolving complaints from enrollees in MA, GAMC and Minnesota Care, by acting as an intermediary between the enrollee and the health plan.
- Assisting MHCP enrollees in resolving service-related problems with the Health Plan to ensure that medically necessary services are provided.
- Educating MHCP enrollees of their rights and responsibilities, including internal health plan appeal and administrative appeal rights.
- Advocating for the MHCP enrollee throughout the problem-resolution and appeal processes.
- Referral of non-MHCP enrollees to other agencies or services.
- Training and working with County Advocates.
- Pursuant to M.S. 265.045, Subd. 3(a), ensuring that health plans properly notify enrollees of appeal rights when a service or claim is denied, terminated, or reduced.
- Coordinating activities with other state ombudsmen through the Ombudsman Roundtable, which meets to facilitate effective and efficient ombudsman services to citizens.
- Coordinating activities with the two other state ombudsmen for health care programs, a subcommittee of the Roundtable.

The Ombudsman for MHCP coordinates its activities with the complaint process which is part of the regulatory function at the Minnesota Department of Health (MDH). Calls from MHCP Enrollees which come into MDH and which are complaints about the quality of care are investigated and handled by MDH. All other complaints are referred to the Ombudsman for MHCP for handling. In 1997 MDH referred approximately 40 complaints to DHS.

In calendar year 1997 the Ombudsman for MHCP:

- Received approximately 4,760 Phone Calls, most of which required investigation.
- Assisted 201 Enrollees through the state's Administrative Appeals Process.
- Reviewed and analyzed the data from 43,400 copies of Notices health plans sent to enrollees regarding denial, termination or reduction of services or claims.

It is currently considered to be an extremely effective office. Of the 201 Appeals that were filed in calendar year 1997, 92 of them were resolved prior to the appeal hearing. Of those that went

to appeal, 29 appeals were found in favor of the health plan, and five found in favor of the enrollee. (The other appeals were dismissed, withdrawn, or are pending.)

The County Advocate Program

The County Advocate Program is established in Minnesota Statutes, Section 256B.69, Subdivison 21. Although the citation in the mandate for this report is to a "Prepayment Coordinator," the position is called a "County Advocate" in practice. The statutory duty delegated to these advocates is to assist the state agency in implementing prepaid health care programs for Medical Assistance and General Assistance Medical Care, including educating enrollees and potential enrollees about available health care options, enrolling eligible recipients, providing necessary eligibility and enrollment information to health plans and the state agency, and coordinating complaints and appeals with the Ombudsman for MHCP. Note that while MinnesotaCare is a state-administered health care program, County Advocates sometimes end up involved in resolving problems for MinnesotaCare enrollees. Often this is because other family members are on PMAP/PGAMC, or because the enrollee is familiar with and comfortable with working with the local agency to resolve problems.

Activities of the County Advocates include:

- Helping enrollees understand options available to resolve complaints.
- Explaining the health plan complaint and appeal process and the state administrative appeal process.
- Advocating for enrollees through the Complaint and Appeal Processes.
- Helping enrollees prepare for the appeal, and, if requested, assisting or representing enrollees at the hearing.
- Educating other county staff.
- Coordinating with the DHS Ombudsman for MHCP, through monthly meetings and sharing of information.

County advocates are funded through an allocation from the DHS, as well as additional funding from the local agency. Currently there are 35 advocates in the 28 counties where PMAP has been implemented. Some of the advocates in counties with smaller PMAP/PGAMC enrollments work part-time as an advocate and part time on other county functions. There are multiple advocates in the metro area where the enrollment levels are higher. In total there is approximately one advocate for every 12,000 Enrollees in PMAP/PGAMC. However that figure is skewed by Ramsey and Hennepin Counties, where the ratio is closer to one advocate for every 25,000 Enrollees in PMAP/PGAMC.

DHS Actions

DHS sought input from recipients, advocates, counties, and other stakeholders.

Recipients

Enrollees of MHCP health plans were contacted through an informal telephone survey in December 1997. One of the survey questions asked was whether the enrollee would be more likely to call and/or trust an independent Ombudsman office or one located at a state or county office. Survey results indicated that recipients don't make a distinction between an independent office and a state/county office. Over half of the enrollees said they "like the current system the way it is." Several enrollees said they felt an independent Ombudsman would be more impartial, but then added, "if they didn't get help from the independent office, they would still call the state."

PMAP County Advocates

The current PMAP County Advocates were surveyed in October and December 1997. Survey results indicate that many County Advocates prefer to be located in a county office. The reasons given included:

- As county employees they have access to county and state information systems which help them resolve client complaints quickly.
- They are familiar with the county organization and are familiar with providers in their county.
- They have a good working relationship with other county staff and departments, making their job of facilitating communication between social services and health plan staff easier.
- They believe that the county advocates' timely access to program, policy, and contract information, particularly changes to those items, maximizes their effectiveness.

In spite of the advantages to being located in the county office, several advocates expressed a need for advocates to be certified or have oversight to guarantee credibility and accountability. They also expressed a desire for easy access to a good resource person for support and assistance. They feel that both of those functions are filled now by the Ombudsman for MHCP.

Several advocates find the most difficult part of their job is maintaining some independence from the county, especially when they report to a person who does not understand the scope of their responsibilities. In some cases they do not receive program information and changes on a timely basis.

In situations where the County Advocate is located with the county-based health plan staff, advocates feel there is an inherent conflict of interest, and find it difficult to represent enrollees who disagree with a health plan decision.

Counties

During three sessions with counties at county based purchasing forums, the counties present were informally surveyed for their input. Participants included county administrators, county social service workers, county public health department, other county staff, health associations, health plan representatives, and community organizations.

As far as separating advocacy from the purchasing of health care by the county, the most favorable response and support was for advocacy functions by an outside agency under contract to the county, funding for which would be through a percentage of the capitation payment or a grant from the state. They suggested a central advocacy resource with multiple access points. They believe the county still would have a role in ensuring that enrollees know where to go for advocacy. They also believe that an advocacy accountability mechanism needs to be established. Even so, most counties still feel that the county advocacy function still remains viable.

Counties believe that leaving advocacy as a function within the county, but relocating and/or restructuring the reporting relationships can serve to keep County Advocates independent. Currently the County Advocates have a lot of insider information, and they know the county system, services and resources. This knowledge serves to resolve many problems so they do not need to go through an appeal process.

They can see there are times when enrollees do not see the county worker as an advocate because of conflicts of interest. Enrollees may be hesitant to complain. There is potential in this model for political or financial influence on advocacy work. Often there are not sufficient resources to fund a staff person solely as an advocate, and the advocate will have other job duties as well. There is concern that these problems may increase if the county purchases health care through county-based purchasing.

The counties believe that MHCP enrollees need an advocacy function. There are several ways to make this function independent. There could be a centrally located advocacy office across multiple counties with multiple access points; it could be done within the county office, by establishing an appeal process, an advisory body of community representatives, and different reporting relationships; or each county could contract for the services. What needs to happen, regardless of the model, is to build problem-solving and advocacy into the care delivery system and ensure that consumers know how to access advocacy services. They caution against setting up yet another bureaucracy, this time one of advocates.

Request for Information (RFI)

A Request for Information (RFI) was published in the Minnesota State Register in October 1997 to solicit information from community advocates and other stakeholders. DHS received four responses.

The Southeastern Minnesota Area Agency on Aging suggested that the statewide AAA network would be a viable network to use, if the Department is required to seek independent Ombudsman or prepayment coordinator services.

The Legal Services Advocacy Project believes that the Ombudsman for MHCP and the County Advocates need to be made independent of state and local government and health plans. They believe that there needs to be more formal coordination between the state Ombudsman and County Advocates. They believe that there is little data collection at either the state or county level regarding the complaints and phone calls, so that systemic issues are difficult to find, and the effectiveness of the current advocacy system is difficult to monitor and assess. They believe that an independent Ombudsman/Advocate would have:

- the ability to file annual reports with the legislature;
- the ability to prepare investigative reports when systemic problems occur;
- the ability to testify at the legislature on behalf of public program recipients;
- the possibility of better data collection; less susceptibility to political pressures within state/local government; and
- the ability to request needed resources to accomplish the ombudsman mission independent of DHS budget priorities.

The Minnesota Council of Health Plans has concerns about the impact that reorganization would have on enrollees. They believe that the close proximity of the Ombudsman to DHS managed care staffs who have program, policy and operational expertise is invaluable for the decisions affecting enrollees. They believe the current structure has worked effectively to ensure that enrollees receive assistance with their health care.

The Multiple Sclerosis Society said that there are already in existence multiple advocacy groups engaged in representing persons with specific disabilities, such as the MS Society, the ARC, and the National Alliance for the Mentally Ill. If reorganization occurs, thought should be given to contracting with these advocacy groups which already have the trust of the consumers they serve. They believe that persons with special needs require more assistance, which they are capable of delivering. They also have a communications network that alerts their community of constituents to the issues and works toward problem resolution.

Summaries of Simultaneous Reviews

Departments of Health and Commerce Report on Consolidation and Coordination of Health Care Consumer Assistance and Advocacy Offices

The Departments of Health and Commerce were directed to study and recommend to the Legislature the feasibility and desirability of consolidating and improving coordination of some or all existing state consumer assistance, ombudsperson, and advocacy activities (Laws of Minnesota 1997, Chapter 237, Section 19).

That study found that there is already significant activity by the three health-related state ombudsmen offices that work to improve coordination of efforts. They have a common brochure, cross-listings in the state directory, sharing of professional resources for case review, and joint staff training in common areas.

The report recommends that the cooperation among these three ombudsmen be more formalized, by the creation of an Office of Health Related Ombudsman Services. That Office would create a single point of entry for consumers through a toll-free telephone number, and centralization of training and resources. It also recommended moving toward one administrative structure, including eventual co-location of ombudsmen, but with each ombudsman maintaining a separate funding stream through its current budget.

Departments of Health and Department of Commerce Complaint Process Study

The Departments of Health and Commerce were directed, in consultation with the Consumer Advisory Board, to make recommendations on developing a complaint resolution process for health plan companies to make available for enrollees. (Laws of Minnesota 1997, Chapter 237, Section 20).

The report recommends the creation of a health care consumer advocacy and information office, organized within the structure of the Department of Health. This office would be available to any health care consumer in the state, including those covered by employer self-funded plans. While this would be a phone number that any consumer could call, the office would not attempt to duplicate services already being delivered through other resources. If a call came in from an MHCP Enrollee, for example, the call would be referred to the Ombudsman for MHCP.

Health Care Consumer Advisory Board Recommendations for a Complaint Resolution Process

The Health Care Consumer Advisory Board was directed by the Legislature to advise the Commissioners of Health and Commerce on the needs of health care consumers, how to better serve and educate consumers on health care concerns, and to recommend solutions to identified problems. The Board may also make recommendations to the Legislature on these issues. The Departments of Health and Commerce were directed to consult with the Health Care Consumer Advisory Board about the development of a complaint resolution process. (Laws of Minnesota 1997, Chapter 237, Sections 7 and 20).

Two of the Board's recommendations were: an advocacy program for all state health care consumers, independent from health plans and state agencies; and an appeal process independent from state agencies and private industry.

Proposed Models

Commissioner Model

The Ombudsman for MHCP would remain in DHS, but would report annually to the Commissioner. County Advocates would remain within each county, but reporting relationships would change comparably.

The Advantages to this model would be:

- Greater independence of the ombudsman and less conflict of interest concerns than with the current model.
- Ability to express concerns and offer suggestions to senior management without going through several intervening levels of management.
- Maintains the ease in accessing the public program information system, policy staff, Performance Measurement and Quality Improvement staff, systems support, operational staff.
- Maintain ability to resolve problems quickly and efficiently.
- No extra funding for administration.
- Local advocacy can be county-based or regional, with oversight and training by the ombudsman.
- Quick access to information about and input into decisions about managed care policy, operations, and contracts.
- Greater ease in outreach through bulletins & other information that is sent from state and county.

- The ombudsman and advocates will have easy access to information and reports generated about managed care enrollees through the DHS Executive Information system.

The concerns about this model are:

- Although lessened, there is still a potential for political or financial influence on ombudsman decision making or staffing.
- Continued distrust by community advocacy groups, due to perception of conflict of interest.

Interagency Transfer or Executive Transfer to the Ombudsman Office for Mental Health & Mental Retardation (MHMR).

This ombudsman's office is the largest of existing state ombudsman offices. This would be a logical transfer as the Ombudsman Office for MHMR is already an established state agency, and has administrative and staff support in place. The Ombudsman Office for MHMR assists a vulnerable population of Minnesota's health care recipients.

The Advantages of this model would be:

- Ombudsman staff would continue to have access to program information through the mainframe.
- It's Cost-effective: merges administrative costs of two or more offices - by co-location of ombudsman office space, staff and systems integration and cooperation.
- Shared expertise of ombudsmen.
- Perception of independence by community advocates.
- Could be broadened to include commercial managed care, which could meet the expectations of the Departments of Health and Commerce and the Health Care Consumer Advisory Board.

The Concerns about this model are:

- Each ombudsman office has a separate clientele it serves, with specific funding. The funding for the Ombudsman for MHCP includes federal dollars for MA and MinnesotaCare. If there aren't enough resources, there could be an erosion of services of one constituency, and a misuse of federal funds. This is of major concern if this office also takes on the enrollees of all commercial health plans without sufficient funding.

Status Quo

The Advantages of this model would be:

- The ombudsman and advocates have access to all welfare and health care information through the system.

- The ombudsman and advocates have easy access to state and county managed care policy, operational, contract and system staff, allowing them to resolve most problems quickly and efficiently.
- The ombudsman and advocates have the enforcement power of the contract behind them when negotiating/mediating with the plans, because of their close working relationship with contract management staff.
- Ombudsman and advocacy services are cost-effective, being part of an established administration.
- Ombudsman and advocacy will have easy access to information and reports generated about managed care enrollees through the DHS Executive Information system.

Concerns about this model are:

- Potential for conflicts of interest, particularly if a county purchases health care through county-based purchasing.

Independent Model -- State Ombudsman for Health Care

The Advantages of this model would be:

- This type of independence is perceived by community advocacy groups to eliminate conflicts of interest.
- Could be broadened to include commercial managed care, which could meet the expectations of the Departments of Health and Commerce and the Health Care Consumer Advisory Board.

Concerns about this model are:

- Added cost of funding separate office space, systems and support staff, and advocacy staff.
- More difficult to access timely information about changes to managed care policy, operations, contracting, and systems.
- Less opportunity to participate in managed care policy, operations and contract decision-making.

Regional Model -- State Ombudsman centrally located, Advocates at regional sites.

The Advantages of this model would be:

- Oversight of advocate activities.
- Centralized gathering of data - to identify trends and report to interested parties.
- Perceived independence of this model by community advocacy groups.
- Maintain local consumer access to assistance.

Concerns about this model are:

- Difficult to determine where ultimate accountability of the Ombudsman lies.
- Multiplies cost of administration by number of sites.

Recommendation

While the DHS understands the concerns of advocates on the need for independence of the Ombudsman and Advocacy offices, we believe that the necessary independence can be achieved without physically removing the Ombudsman and Advocates from the DHS or the County.

For the Office of Ombudsman for MHCP, a change in reporting relationships, so that the Ombudsmen report on an annual basis to the Commissioner of DHS, would provide the necessary distance and independence.

The Ombudsmen would still maintain the value of their internal connections: the ease of connection to the computer mainframe system; the extensive knowledge that comes only from close and regular connection with other staff working on the metamorphosis of managed care policy, operations, contracts and systems; the ability, because they are part of DHS, of having the power of the enforcement of the contract with the health plan behind them. All of this allows the Ombudsmen to provide effective one-on-one assistance for enrollees of MHCP. To disturb those relationships because of fears that conflict might occur flies in the face of the fact that the work the Ombudsmen do is effective and efficient because the relationships do exist.

The Department agrees with the position of the Departments of Health and Commerce that our Ombudsman's efforts should be well coordinated with the other health care ombudsmen's efforts. However, much has already been done on an informal basis to accomplish that, and much more can be done to formalize those efforts, including the establishment of telephone linkages for easier referral.

It is also clear, from the survey of enrollees, that any change that results in the removal of the Ombudsmen from the DHS would result in the need to replace those staff. The work necessary to solve each Enrollee's problem does now, and will continue, to require the involvement of DHS staff. Currently, this happens effectively because of the location of the Ombudsmen with the DHS staff who can help to resolve the managed care problem, whether it's a contract issue, a contract management issue, or a system or operational issue. In addition the continuous exchange of information and ideas between the Ombudsmen and the contract managers help to identify and resolve systemic issues and problems effectively and efficiently, which is difficult to achieve if these offices are physically separated.

Similarly, the DHS believes that County Advocates should remain located in the local agency. If a county chooses to purchase health care through county-based purchasing, the local agency can take similar steps to ensure that the county advocates remain independent from the county's purchasing program.

Phone Log Enrollee Survey

Ombudsman:_____ Date:_____

Name	Health Plan	I/C	Issue	County/State	Ind	No Preference

Informal Survey:
Would you be more comfortable calling a county or state office with a health plan problem? or an independent office with a health plan problem?

When you have a problem with your health plan or problems getting health care: would you be more comfortable or prefer calling a county or state office? or an independent office?