KanCare Ombudsman Annual Report 2013

Since its creation, the Office of Ombudsman has served an important role as a resource to Kansas Medicaid consumers. The Ombudsman's office has been available to consumers, and has been able to respond to their inquiries and concerns in a timely and flexible manner. Phone calls were answered promptly and phone messages were returned within four hours. Consumer concerns became increasingly complex as the year progressed, requiring the Ombudsman to devote more time to the many calls received.

The work of the new Ombudsman's office for the first five to six months -- in addition to answering the many and varied questions, concerns -- was to create a network of relationships among KanCare's managed care organizations (MCOs), community service providers and state agencies to coordinate assistance for members who contact the Ombudsman's office.

The Ombudsman was deeply involved with various committees and workgroups throughout the year. Among those are:

1. KDADS Friends and Family Advisory Council and Communication/Education Subcommittee
2. I/DD Waiver Pilot Workgroup
3. KDADS Internal I/DD Workgroup
4. KDADS KanCare Weekly Workgroup
5. CMS Implementation Monitoring Meetings
6. HCBS Technical Workgroup

The Ombudsman presented at various forums throughout the year such as:

- Aging and Disability Resource Center
- Kansas Association for Independent Living
- Kansas Mental Health Coalition
- Kansas Council on Disability Concerns
- Families Together
- Kancare Consumer Tours
- KanCare Advisor News Bulletin articles written by Ombudsman
- Training of State Waiver managers and Quality Assurance staff

The Ombudsman actively participated in internal and external forums to enhance the visibility and understanding of KanCare, addressing the collective concerns and experiences of consumers. The Ombudsman has been accessible to Medicaid beneficiaries enrolled in KanCare throughout the year by phone, by presenting at workgroups and forums, via the KanCare Ombudsman website pages and has distributed the Ombudsman brochure and KanCare QuickStart brochures (specifically for the I/DD stakeholder population.

An Ombudsman assistant was hired in third quarter of FY 2013. This individual assisted with developing the Ombudsman log and the tools created to provide accurate reports. This addition to staff improved response time and concern resolution. The Ombudsman assistant is the liaison for the recently formed Friends and Family Advisory Council, which formed to create opportunities for parents, guardians and self-advocates to contribute their perspective on policies related to I/DD waiver services.

With the addition of the Ombudsman part-time assistant, the Ombudsman has been proactive in reaching out to stakeholder groups to enhance collaboration and facilitate the input of members. The Ombudsman has researched and collaborated with other concern-resolution resources to improve the function of this important member resource.

A web-based Ombudsman Contact Log was created and later refined for monitoring activity and trends throughout the year. It was later enhanced to include a breakdown by MCO, geography and category of Medicaid service.

Ombudsman Contact Log – 2013
(Phone calls only)

Issue/Concern	1st Qtr	2nd Qtr	3rd Qtr	4th Qtr	2013
Access to Providers (usually Medical)	11	11	8	8	38
Appeals, Grievance	3	16	10	7	36
Assessments	0	0	3	4	7
Billing	73	42	35	24	174
Change MCO	65	26	36	14	141
Dental	0	4	5	1	10
Durable Medical Equipment	0	3	7	5	15
Eligibility	42	25	70	33	170
Pharmacy	41	42	15	15	113
Reduction in hours of service	11	16	12	35	74
Transportation	11	9	3	6	29
Reason for call not disclosed	37	100	116	48	301
Returning your call	7	28	21	16	72
Thank you.	2	7	2	3	14
Unspecified	312	127	93	122	654
Total	615	456	436	341	1848

The focus of Ombudsman contact concerns for the first and third quarters (from the transportation line up) were billing, changing a member's MCO and eligibility determination. In the second quarter, the most frequent inquiries were in regard to pharmacy and billing, which were tied at the top, followed by changing MCOs and eligibility determination. In the 4th quarter reductions in hours of services moved to the top, followed by eligibility determination and billing.

Much of the utility of the Ombudsman's office is a result of the unique perspective gained through daily interactions among consumers, the state, the MCOs and many other stakeholder groups.

In summary, the Ombudsman has been a responsive resource for KanCare members. When members have concerns, they are being heard and addressed. With the addition of a part-time assistant, communication and statistical reporting of interactions and outcomes will be more timely and objectively documented.

Attachment
Ombudsman Plan
Revised 2013 per Centers for Medicare and Medicaid Services(CMS) #11-W-00283/7;Special Terms and Conditions (STC) 42

Independent Consumer Supports (Ombudsman). To support the beneficiary's experience receiving medical assistance and long term services and supports in a managed care environment, the state shall maintain a permanent system of independent consumer supports (hereafter referred to as the Ombudsman) to assist enrollees in understanding the coverage model and in resolving problems regarding services, coverage, access and rights.

a. Core Elements of the Ombudsman.

i. *Organizational Structure*. The Ombudsman shall be autonomous to any KanCare MCO and the State Medicaid agency. If the Ombudsman operates within a sister state agency, the State shall establish protections such that no undue influence will be imposed that restricts the ability of the Ombudsman to perform all of the core functions. The organizational structure of the Ombudsman shall demonstrate transparency and collaboration with beneficiaries, MCOs, community based organizations, and state government.

ii. *Accessibility*. The services of the Ombudsman are available to all Medicaid beneficiaries enrolled in KanCare, with priority given to those receiving long-term services and supports (institutional, residential and community based). The Ombudsman must be accessible through multiple entryways (e.g., phone, internet, office) and must use various means (mail, phone, in person), as appropriate, to reach out to beneficiaries and/or authorized representatives through.

iii. *Functions*. The Ombudsman assists beneficiaries to navigate and access covered health care services and supports. The services of the Ombudsman help individuals understand the delivery system and resolve problems and concerns that may arise between the individual and a provider/payer. The following list encompasses the Ombudsman's minimum scope of activity. The Ombudsman:

1. Shall serve as an access point for complaints and concerns about access to services and other related matters when the beneficiary isn't able to resolve their concern directly with a provider or health plan
2. The Ombudsman shall help enrollees understand the state's Medicaid fair hearing process, grievance and appeal rights, and grievance and appeal processes provided by the health plan, and shall assist enrollees in navigating those processes and/or accessing community legal resources, if needed/requested.
3. The Ombudsman shall develop a protocol for referring unresolvable issues to the State Medicaid Agency and other state officials as necessary to ensure the safety and well-being of beneficiaries.
4. The Ombudsman shall develop and implement a program of training and outreach with KanCare MCOs, providers, and community based organizations to facilitate cross-organizational collaboration, understanding, and the development of system capacity to support

beneficiaries in obtaining covered plan benefits. The state shall track and report all such activities to the State Medicaid Agency and CMS, as specified in subparagraph v. of this STC.

5. The Ombudsman shall assist enrollees to understand and resolve billing issues, or notices of action.

iv. *Staffing and training*. The Ombudsman must employ individuals who are knowledgeable about the state's Medicaid programs; beneficiary protections and rights under Medicaid managed care arrangements; the health and support needs of persons with complex needs, including those with a chronic condition, disability, and cognitive or behavioral needs, and the community based systems that support them. In addition, the Ombudsman shall ensure that its services are delivered in a culturally competent manner and are accessible to individuals with limited English proficiency and people with disabilities. The state shall develop an access standard to measure the availability and responsiveness of the system to beneficiaries and others seeking support from the Ombudsman, and shall report compliance with this standard to CMS in its quarterly and annual reports, as specified in STC 77 and 78. The system shall be staffed sufficiently to address all requests for support consistent with this access standard.

v. The State and CMS will review the performance of the Ombudsman against this access standard and against the functions described in these STCs 12 months following approval of this demonstration. The State shall take any necessary corrective action to comply with this standard.

vi. *Data Collection and Reporting*. The Ombudsman shall include a robust system of data collection and reporting. The state shall include this data in all quarterly and annual reports to CMS as specified in STCs 77 and 78. The state shall also develop a mechanism for public reporting. At a minimum, the state shall collect and report on the following elements:

1) The date of the incoming request as well as the date of any change in status.

2) The volume and type (email, phone, verbal, etc.) of incoming request for assistance.

3) Time required for beneficiaries to receive assistance from the Ombudsman, including time from initial request to resolution.

4) The issue(s) presented in incoming requests for assistance.

5) The health plan (s) involved in the request for assistance, if any.

6) The geographic area where the beneficiary involved resides, if applicable.

7) Which 1915(c) waiver authority if applicable (ID/DD, PD, Aging, etc) the beneficiary receives services from.

8) The current status of the request for assistance, including actions taken to resolve.

9) The number and type of education and outreach events conducted by the Ombudsman.

10) System Enhancement. The Ombudsman shall generate periodic public reports that describe the functioning of the

Ombudsman and any enhancements to the program that the state makes. The first report will be submitted to CMS within 6 months of approval of the demonstration. Subsequent reports will be submitted to CMS within 6 months of the end of the calendar year.

11) Transparency and Stakeholder Involvement. The State shall assure transparency in the operation of the Ombudsman, including public reporting of all aggregate data and performance reports and changes made to improve the Ombudsman program. The State shall develop a mechanism to secure stakeholder input into the operation and performance of the Ombudsman and demonstrate inclusion of stakeholder input in its on-going operation, evaluation, and enhancement of the program.

b. The State will evaluate the impact of the Ombudsman program in the demonstration evaluation per STC 101.