

September 29, 1998

Ombudsprograms and Member Advocates:
Consumer-Oriented Approaches to Problem-Solving
in Medicaid Managed Care

Prepared by National Health Law Program
Jane Perkins, Kristi Olson, and Lourdes Rivera
September 1998

Executive Summary

Ombudsprograms and plan-level member advocates generally are viewed as effective mechanisms for improving education, representation, problem resolution, and self-help for consumers enrolled in Medicaid managed care. Consumers and consumer advocates view these mechanisms as important safeguards of access and quality of care. Policy-makers, key opinion leaders, and health care plans see value in using ombudsprograms and member advocates as a source of information about how individual consumers are using their managed care plans. However, while the subject of much discussion, neither ombudsprograms nor member advocates are widely used mechanisms for giving voice to consumers enrolled in managed care.

There are a number of reasons ombudsprograms are approached with caution. To be successful, they require considerable funding, and the planning effort requires time and thought. Numerous decisions must be made regarding how the programs will be funded and how they will operate. To aggravate matters, these decisions often get caught up in politics -- as illustrated by the hotly debated and ultimately rejected recommendation before the President's Advisory Commission on Consumer Protection and Quality in the Health Care Industry to require state level ombudsprograms for managed care enrollees. States are anxious to implement managed care and are reluctant to commit to a project requiring more funding, further delay in implementation, and political tension.

This working paper answers some of the questions surrounding the use of ombudsprograms and member advocates in the Medicaid context, addressing questions such as: What is an ombudsprogram and a member advocate? What are the key decision points surrounding the

use of these consumer involvement mechanisms? Which states currently have programs serving Medicaid beneficiaries, and how have they addressed these key decision points? Recommendations for implementing these programs are made and discussed.

Ombudsprograms

An ombudsprogram is an entity which engages in impartial and independent investigation of individual complaints, advocates on behalf of consumers, and issues recommendations. Typically, the program does not have enforcement powers. According to the American Bar Association,

[t]he Ombudsman system is one of the institutions essential to a society under the Rule of Law, a society in which fundamental rights and human dignities are respected. Human rights are not protected simply by constitutions or legislation, by guarantees or speeches, by proclamations or declarations, but primarily by the availability of remedies. The Ombudsman system is one of the remedies which seeks to preserve human rights. [\(1\)](#)

Ombudsprograms for Medicaid managed care enrollees currently operate, either statewide or locally, in [California](#), Michigan, Minnesota, Oregon, Tennessee, Vermont and Wisconsin. These programs have been tailored to respond to specific state and local needs and funding capabilities, so it is difficult to draw general conclusions about them. Some patterns are surfacing, however.

While precise responsibilities vary, most ombudsprogram share similar overarching functions. They provide consumers with: education about managed care and health plan options; individual assistance with questions; patient advocacy and dispute resolution on behalf of individual plan members; and information gathering and reporting on how Medicaid managed care is working. Although the ombudsprograms receive requests for assistance through a combination of telephone and face-to-face encounters, most programs rely heavily on telephone assistance. The ombudsprograms uniformly are used to supplement, but not replace, in-plan grievances and state-level appeals.

Emphasis is placed on outreach to consumers to inform them of the existence of the program. The availability of the ombudsprogram and its services are advertised to managed care enrollees on their Medicaid cards, in flyers and on posters at welfare offices and at senior and

disability centers, through training events held for consumer and provider groups, and through media campaigns.

The funding and siting of ombudsprograms are mixed. To date, the primary funding source for these programs has been general state revenue and Medicaid budgets. There is growing interest in obtaining private foundation support for these activities. Other states are considering funding ombudsprograms through assessments on HMOs. As to siting, some programs are housed in state Medicaid agency offices or county agencies while others are situated in non-profit entities. For those programs not operated by the state, a state or county initiated request for proposal (RFP) process typically is used to select the entity that will serve as the ombudsprogram. Legal services offices have been the most frequent recipients of these contracts.

The following recommendations are made to assist with decision-making regarding the use of ombudsprograms to serve Medicaid managed care enrollees:

1. The ombudsprogram should be independent of both the state Medicaid agency and Medicaid-participating health plans.
2. The ombudsprogram should have clear goals and responsibilities, rules of program conduct, and the authority to implement these responsibilities.
3. The ombudsprogram should not assume responsibilities that have been designated to other participants in the managed care system.
4. The ombudsprogram should be tailored to serve the needs of Medicaid managed care beneficiaries.
5. The ombudsprogram should have adequate time and funding for planning and design. Input should be solicited from community organizations and beneficiaries during the planning and design phase.

6. The ombudsprogram should be adequately funded and available free of charge to Medicaid beneficiaries.

7. Staff should have knowledge/experience with Medicaid, managed care, the local health and social service system, and serving the needs of low-income populations. Staffing levels should be monitored on an ongoing basis to assure adequate staffing.

8. The ombudsprogram should have one central office that is respected and known to be competent and consumer-oriented.

9. The ombudsprogram should be well-advertised and readily accessible both by telephone and in-person.

10. Reports generated by the ombudsprogram should be publically available.

11. The ombudsprogram should be evaluated by an independent entity.

Member Advocates

A member advocate is a staff person hired by the health plan to serve as an advocate for Medicaid beneficiaries who are enrolled in that plan. The member advocate often is referred to as an "HMO advocate," a "Medicaid advocate," or a "patient advocate." Although sometimes referred to as an ombudsman, the member advocate is an employee of the health plan and lacks the independence of an ombudsprogram.

Delaware, Kentucky, Maine, Pennsylvania, Texas, West Virginia, and Wisconsin all require Medicaid-participating health plans to have member advocates. These requirements are not set forth by statute or regulation, but rather have been implemented pursuant to contracting specifications.

Because the titles and responsibilities of the member advocate vary among health plans and among states, the position is difficult to define with great precision. All member advocates share two critical characteristics, however. First, the member advocate is an employee of the health plan. And, second, the member advocate is expressly recognized as advocating for the consumer. The responsibilities of the member advocate generally include: solving access problems, assisting members in filing grievances, monitoring the resolution of grievances, reporting trends in grievance data, recommending policy changes, working with community groups, training plan staff on issues of cultural sensitivity, reviewing informational material for clarity and accuracy, and assisting members in obtaining medical records.

The following recommendations are made to assist with decision-making regarding the use of plan-level member advocates to serve Medicaid managed care enrollees:

1. Health plans should work with consumer groups in the health plan service area, and the ombudsprogram, if operating, to define the qualifications and responsibilities of the member advocate.
2. The member advocate function should not be perceived as an answer to, or substitute for, independent advocacy.
3. The ratio of member advocates to plan members should be sufficient to allow meaningful use of the service. When individuals with disabilities or special needs are included in mandatory enrollment, staffing should include a dedicated member advocate.
4. The responsibilities of the member advocate should be clearly stated and enrollee-oriented.
5. The program should be accessible and well advertised.
6. The member advocate should review and comment on policies of the plan and the state Medicaid agency.

Appendices A and B include model ombudsprogram and member advocate provisions developed by the National Health Law Program based on existing standards and interviews with a range of participants in Medicaid managed care programs. Appendix C lists existing state Medicaid managed care contract specifications for member advocates.

1. American Bar Association Administrative Law Section Ombudsman Committee, The Ombudsman (undated) (available from American Bar Association: New York, NY).

Full report available for \$15 from NHeLP's LA office (310) 204-6010.