

## NHeLP Model

**Member Advocate Requirements** -- The health plan must employ one or more member advocate(s), as specified in section 3(c) below, during the entire contract term. The member advocate(s) will work with enrollees, providers, and plan personnel to facilitate the provision of Medicaid benefits to enrollees; will be responsible for making recommendations to management on any changes needed to improve either the care provided or the way care is delivered; and must be in an organizational location within the health plan which provides the authority needed to carry out these tasks. The detailed requirements of the member advocate are listed below.

### 1. Qualifications of the member advocate(s):

The member advocate(s) must demonstrate substantial experience (at least 2 years) in health care, advocating for low-income populations. In addition, the member advocate(s) must have demonstrated sensitivity to the needs of people with disabilities and cultural sensitivity. Health plans may complete this requirement by submitting a policy description showing the qualifications they will require of the person who will fill this position.

The member advocate shall not have any conflict of interest, such as a financial interest in the health plan, that would affect the member advocate's ability to represent the interests of enrollees.

### 2. Functions of the member advocate(s):

- a. Ensure that members are informed of their rights and responsibilities.
- b. Assist members in filing complaints.
- c. Investigate, and resolve access and cultural sensitivity issues identified by health plan staff, State staff, providers, advocate organizations, and enrollees.
- d. Monitor complaints for purposes of identification of trends or specific problem areas of access and care delivery. An aspect of the monitoring function is the ongoing participation in the health plan grievance committee. Findings and reports should be made available to community advocates and consumers, if requested.
- e. Recommend policy and procedural changes to health plan management and the state Medicaid agency, including those needed to ensure and/or improve access to care and quality of care. Changes can be recommended for both internal administrative policies and for subcontracted providers.

At a minimum, the member advocate should report annual recommendations. A summary of the report should be made available to consumers, community advocates, and providers.

f. Act as the primary contact for consumer advocacy groups. Work with consumer advocacy groups on an ongoing basis to identify and correct barriers to access and quality concerns. If requested, the member advocate(s) should discuss problems with community advocates and report on the actions taken by the plan in response.

g. Act as the primary contact for local community based organizations (local governmental units, non-profit agents, etc.). Work with the local community based organizations on an ongoing basis to acquire knowledge and insight regarding the special health care needs of Medicaid enrollees.

h. Participate in local and statewide meetings with community advocates, consumers, and state representatives to discuss problems, potential solutions, and other findings.

i. Conduct ongoing analysis of internal health plan system functions, with health plan staff, as these functions affect access to medical care and quality of medical care.

j. Organize and provide ongoing training and educational materials for health plan staff and providers to enhance their understanding of the values and practices of all cultures with which the health plan interacts.

k. Provide ongoing input to health plan management on how changes in the health plan provider network will affect access to care, quality, and continuity of care. Participate in the development and coordination of policies to minimize any potential problems that could be caused by provider network changes. Assist in the development of adequate provider networks, with particular attention to serving special needs populations, including pediatric specialists.

l. Review and approve all health plan informing materials to be distributed to Medicaid enrollees for the purpose of assessing clarity and accuracy.

m. Assist enrollees and their authorized representatives in obtaining medical records.

### **3. Staff Requirements and Authority of the Member Advocate(s)**

a. The member advocate(s) must be located in the organizational structure so that the advocate has the authority to perform the functions and duties listed in (2)(a-m). b. The member advocate(s) shall have authority for facilitating and assuring access to all medically necessary services as stipulated in this Contract for each enrollee.

c. The health plan's application/bid requires the plan to state the staffing levels to perform the functions and duties listed in (2)(a-m) in terms of number of full and part time staff and total Full

Time Equivalents (FTEs) assigned to these tasks.

Health plans which plan to enroll between 10,000 - 15,000 enrollees Statewide must employ at least one full-time Advocate.

Health plans which plan to enroll more than 15,000 enrollees Statewide, or less than 10,000 enrollees Statewide are required to justify the adequacy of the staffing level proposed for these functions and duties.

If people with disabilities are to be enrolled, the staffing should include at least one dedicated member advocate for people with disabilities in addition to the above provisions.

d. The member advocate staffing levels submitted in the health plan's application shall be maintained, and solely devoted to

e. The member advocate shall develop prior to contract signing, and shall maintain and modify as necessary, throughout the Contract term, a member advocate work plan, with time lines and activities specified.

4. No discriminatory or retaliatory action shall be taken by the health plan against any enrollee, employer, provider or other individual for disclosing information to the member advocate. **Del aware**

DELAWARE DEPARTMENT OF HEALTH AND SOCIAL SERVICES, REQUEST FOR PROPOSALS FOR MANAGED CARE ORGANIZATIONS [Effective Date: 11/95 - 11/96].

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## 5.9 MCO Medicaid Advocate

MCOs are required to employ a Medicaid Advocate to work with both Diamond State Health Plan clients and providers to facilitate the provision of benefits. This Advocate must be responsible for making recommendations to management on any changes needed to improve either the actual care provided or the manner in which the care is delivered. The person must be in an organizational location within the MCO which provides the authority needed to carry out

these tasks. This person must demonstrate substantial (at least two (2) years) experience in health care, working with low-income populations and demonstrated cultural sensitivity. MCOs may fulfill this requirement by submitting a position description which shows the qualifications they will require of the person who will fill this position. This Advocate will:

(a) Investigate and resolve access and cultural sensitivity issues identified by MCO staff, State staff, providers, advocate organizations, and clients

(b) Monitor MCO formal and informal grievances with the grievance personnel to look at trends or major areas of concern; discuss these reports with community advocates, if requested

(c) Coordinate with schools, community agencies and State agencies providing complementary services to DSHP clients

(d) Recommend policy and procedural changes to MCO management including those needed to ensure/improve client access to care and quality of care; changes can be recommended for both internal administrative policies and providers

(e) Function as a primary contact for client advocacy groups; work with these groups to identify and correct client access barriers

(f) Participate in local community organizations to acquire knowledge and insight regarding the special health care needs of clients

(g) Analyze systems functions through meetings with staff

(h) Organize and provide training and educational materials for MCO staff and providers to enhance their understanding of the values and practices of all cultures with which the MCOs interact

(i) Provide input to MCO management on how provider changes will affect client access and quality/continuity of care; develop/coordinate plans to minimize any potential problems

(j) Review all informing material to be distributed to clients

(k) Assist clients and authorized representatives obtain medical records[.]

## **Maine**

MAINE DEPARTMENT OF HUMAN SERVICES REQUEST FOR PROPOSAL FOR THE HMO CHOICE INITIATIVE (December 28, 1995).

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## **B. Member Services**

### **7. HMO Advocate**

The HMO must employ a[n] [sic] HMO Advocate who will work with both enrollees and providers to facilitate the provision of Medicaid benefits to enrollees. The Advocate must be responsible for making recommendations to management on any changes needed to improve either the care provided or the way the care is delivered. This person (or persons) must be in an organizational location within the HMO which provides the authority needed to carry out these tasks. Responsibilities should include the following:

- a. Investigate and resolve access and cultural sensitivity issues identified by HMO staff, Department staff, providers, advocacy organizations, and enrollees.
- b. Monitor formal and informal grievances with the grievance personnel to look at trends or major areas of concern. Discuss these reports with community advocates, if requested.
- c. Upon request, provide assistance or access to assistance for those enrollees who wish to file a formal written grievance but are unable to write such a grievance without assistance.
- d. Recommend policy and procedural changes to HMO management including those needed to ensure/improve enrollee access to care and quality of care.
- e. Primary contact for recipient advocacy groups. Work with these groups to identify and correct recipient access barriers.
- f. Coordinate with schools, community agencies and State agencies providing complementary services to HMO Choice Initiative enrollees.
- g. Participate in local community organizations to acquire knowledge and insight regarding the special health care needs of Medicaid enrollees.
- h. Analyze systems functions through various meetings with staff.
- i. Organize and provide training and educational materials for HMO staff and providers to enhance their understanding of the values and practices of all cultures with which the HMO interacts.
- j. Provide input to HMO management on how provider changes will affect enrollee access and

quality/continuity of care. Develop/coordinate plans to minimize any potential problems.

k. Review all informing material to be distributed to HMO Choice Initiative enrollees.

l. Assist enrollees and authorized representatives to obtain medical records.

## **Texas**

TEXAS DEPARTMENT OF HEALTH, 1996 CONTRACT FOR SERVICES BETWEEN THE TEXAS DEPARTMENT OF HEALTH AND HMO [Effective Date: 4/23/96 - 8/31/97].

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## **Q. MEMBER ADVOCATE**

HMO shall provide Member advocacy services sufficient to serve its STAR Members. The Member advocate shall be physically located within the Service Area and is responsible for ensuring that Members are aware of their rights and responsibilities, the Grievance process, the health education and the prevention activities available to them which will include information related to support services offered outside HMO such as child nutrition, child abuse, parenting skills, stress control, exercise, smoking cessation, weight loss and healthy birth. This does not imply that HMO is responsible for the provision or payment of these additional non-medical services; however, care coordination does imply that sufficient referral and collaborative resources are available to meet the needs of Members. The advocate shall assist the Members in writing their Grievances and be responsible for monitoring the Grievance through HMO's grievance procedure until their issues have been resolved. The Member advocate shall file a report of his/her review and participation in the grievance procedure for each Grievance brought by a Member and a summary of each Grievance resolution, a copy of which shall be included in HMO's quarterly report. The advocate shall be responsible for making recommendations to management on any changes needed to improve either the care provided or the way the care is delivered.

## **West Virginia**

Bureau for Medical Services, West Virginia Department of Health and Human Resources, Request for Application (January 19, 1996).

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### **4.3.2 Medicaid Member Advocate**

The Member Services Department must employ a Medicaid Member Advocate. The Medicaid Member Advocate must be responsible for making recommendations to management on any changes needed to improve either the actual care provided or the manner in which the care is delivered. The person must be in a position within the MCP [Managed Care Plan] which provides the authority needed to carry out these tasks. This person must demonstrate substantial experience in health care, experience working with low-income populations and cultural sensitivity. . . . This advocate will:

- a) Investigate and resolve access and cultural sensitivity issues identified by MCP staff, State staff, providers, advocate organizations and recipients;
- b) Monitor MCP formal and informal grievances with the grievance personnel to look at trends or major areas of concern and discuss these reports with community advocates, if requested;
- c) Coordinate with schools, community agencies, local health departments, state health laboratories and state agencies providing complementary services to Medicaid enrollees;
- d) Recommend policy and procedural changes to MCP management including those needed to ensure and improve enrollee access to care and quality of care; changes can be recommended for both internal administrative policies and providers;



- e) Function as a primary contact for recipient advocacy groups and work with these groups to identify and correct recipient access barriers;
- f) Participate in local community organizations to acquire knowledge and insight regarding the special health care needs of recipients;
- g) Analyze systems functions through meetings with staff;
- h) Organize and provide training and educational materials for MCP staff and providers to enhance their understanding of the values and practices of all cultures with which the MCPs interact;
- i) Provide input to MCP management on how provider changes will affect enrollee access and quality/continuity of care; develop/coordinate plans to minimize any potential problems;
- j) Review all informing materials to be distributed to enrollees; and
- k) Assist enrollees and authorized representatives to obtain medical records.

## **Wisconsin**

Wisconsin Department of Health and Family Services, Draft Contract for Medicaid HMO Services [Effective Date: January 1998 - December 1999].

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## **PP. MEDICAID HMO ADVOCATE REQUIREMENTS**

The HMO must employ a Medicaid HMO Advocate during the entire contract term. The Medicaid HMO Advocate is to work with both enrollees and providers to facilitate the provision of Medicaid benefits to enrollees; is responsible for making recommendations to management on any changes needed to improve either the care provided or the way care is delivered; and must be in an organizational location within the HMO which provides the authority needed to carry out these tasks. The detailed requirements of the Medicaid HMO Advocate are listed below:

### 1. Functions of the Medicaid HMO Advocate

a. Identification and resolution of access and cultural sensitivity issues identified by HMO staff, State staff, providers, advocate organizations, and recipients.

b. Monitoring formal and informal grievances with the grievance personnel for purposes of identification of trends or specific problem areas of access and care delivery. An aspect of the monitoring function is the ongoing participation in the HMO grievance committee.

c. Recommendation of policy and procedural changes to HMO management including those needed to ensure and/or improve recipient access to care and recipient quality of care. Changes can be recommended for both internal administrative policies and for subcontracted providers.

d. Act as the primary contact for recipient advocacy groups. Work with recipient advocacy groups on an ongoing basis to identify and correct recipient access barriers.

e. Act as the primary contact for local community based organizations (local governmental units, non-profit agencies, etc.). Work with the local community based organizations on an ongoing basis to acquired [sic] knowledge and insight regarding the special health care needs of Medicaid enrollees.

f. Participate in the Advocacy Program for Managed Care that is organized by the Department. Such participation includes the following: attendance, on an as needed basis, at the Regional

Forums chaired by a Department staff person, and at the semi-annual Statewide Forum; work with BHCF Managed Care staff person assigned to the HMO on issues of access to medical care and quality of medical care; work with the Enrollment Contractor staff persons on issues of access to medical care, quality of medical care, and enrollment/disenrollment; attendance, on an as needed basis, at bi-monthly Advocacy Team meetings, which will be attended by the BHCF Managed Care Staff, enrollment contractor staff, community based organizations, recipient service representatives from the Fiscal Agent, and HMO ombuds.

g. Ongoing analysis of internal HMO system functions, with HMO staff, as these functions affect recipient access to medical care and recipient quality of medical care.

h. Organization and provision of ongoing training and educational materials for HMO staff and providers to enhance their understanding of the values and practices of all cultures with which the HMO interacts.

i. Provision of ongoing input to HMO management on how changes in the HMO provider network will affect recipient access to medical care and recipient quality and continuity of care. Participation in the development and coordination of plans to minimize any potential problems that could be caused by provider network changes.

j. Review and approve all HMO informing material to be distributed to Medicaid enrollees for the purpose of assessing clarity and accuracy.

k. Provision of assistance to recipients and their authorized representatives for the purpose of obtaining medical records.

## **2. Staff Requirements and Authority of the Medicaid HMO Advocate**

a. The Medicaid HMO Advocate must be located in the organizational structure so that the Advocate has the authority to perform the functions and duties listed in (1)(a-k).

b. The Medicaid HMO Advocate shall have authority for facilitating and assuring access to all medically necessary services as stipulated in this Contract for each enrolled recipient.

c. The HMO Certification Application requires HMOs to state the staffing levels to perform the functions and duties listed in (1)(a-k) in terms of number of full and part time staff and total Full Time Equivalent (FTEs) assigned to these tasks.

HMOs which plan to enroll between 10,000 - 15,000 enrollees Statewide must employ at least one full-time Advocate.

HMOs which plan to enroll more than 15,000 enrollees Statewide, or less than 10,000 enrollees Statewide are required to justify the adequacy of the staffing level proposed for these functions and duties.

d. The Medicaid HMO Advocate staffing levels submitted in the HMO Certification Application shall be maintained, and solely devoted to the functions and duties listed in (1)(a-k) throughout the contract term.

e. The Medicaid HMO Advocate shall develop prior to contract signing, and shall maintain and modify as necessary, throughout the Contract term, a Medicaid HMO Advocacy work plan, with time lines and activities specified.