



My Ombudsman

MassHealth Health Plans

Presented By

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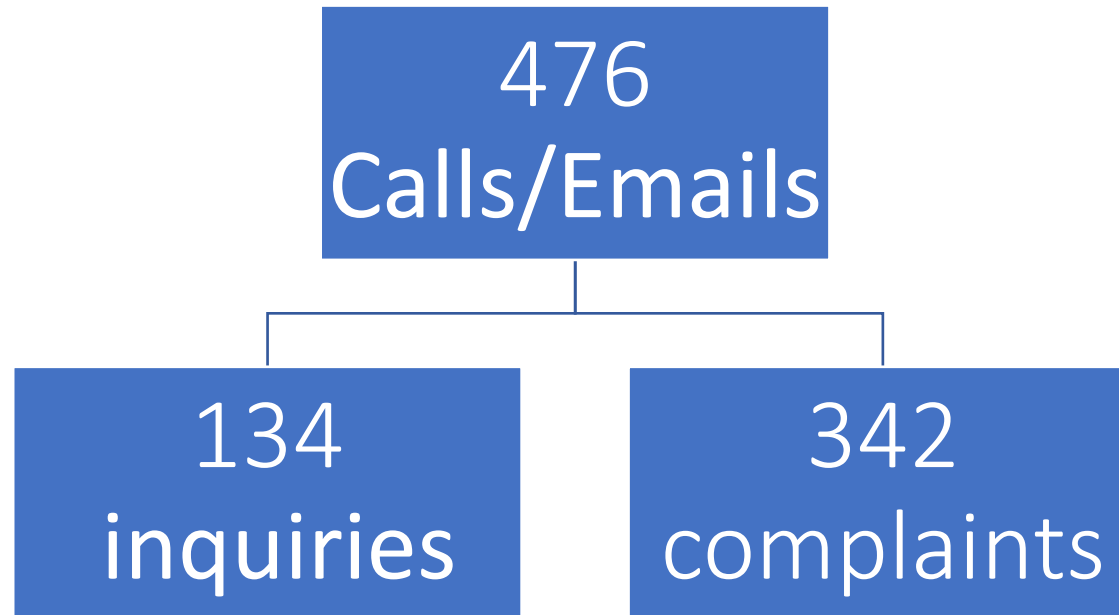
May 14, 2024

Agenda

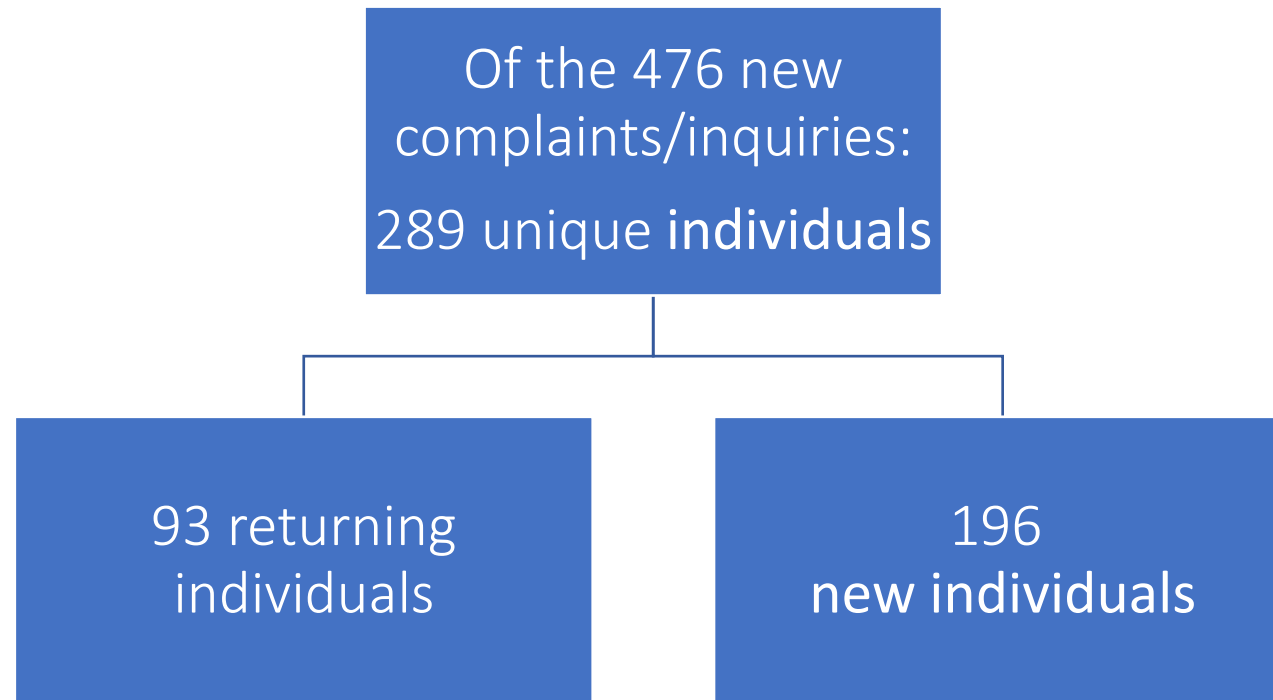


- Review of 2023 data for One Care plans
 - The themes and the details that emerged from our analysis of complaints that were closed in 2023
- Review of Q1 2024 data for One Care plans
 - The top themes that emerged from our analysis of complaints that were closed in Q1 2024
- Key Takeaways
- Questions/Comments

New Inquiry/Complaint Volume in 2023



Unique One Care Members Assisted in 2023



Analysis of Closed Complaints



What is a closed complaint?

- A complaint that has reached its conclusion after providing the member with the plan's resolution
- Member may be referred to a partner organization for further assistance
- Includes complaints that may have been opened in a different quarter

Why analyze closed complaints?

- Closed complaints provide understanding of the issue from beginning to end
- Closed complaints contain the most complete data, including demographics, resolution, and member satisfaction
- Open complaints may evolve over time

Call Subjects within Closed Complaints (2023)



Themes	Frequency
Benefits/Access	116
DME	57
Claim/Payment	35
Care Coordination/ Care Manager	33
LTSS	32
Pharmacy/Medication	22
Transportation	20
Physician/Hospital	15
CLAS/Accessibility	11
Home Health Agency	<10
Appeals/Grievance Process	<10
Behavioral Health	<10
Enrollment/Disenrollment	<10
Total	366

Top themes within closed complaints in 2023



Themes	Frequency
Denial of a benefit or service	64
Dissatisfaction with any general aspect of care	48
Problem finding an in-network provider	42
Delays in receiving an approved benefit or service	42
Problems with authorization process	33
Member received a bill or had to pay a co-pay	23
Member needed guidance or support initiating a benefit or service	21
Member reported insufficient/inadequate Care Coordination	18
Deaf and Hard-of-Hearing Accessibility Issues	11

Total number of closed complaints: 366

Denial of a benefit or service



The most common reasons for denials were administrative issues, lack of medical necessity, or the requesting of a non-covered benefit.



31% (20 out of 64) of the denials were related to dental services



The remaining denials were related to PCA (12), Medication (4), DME (4), Physical Therapy (2), Optical Services (2), and Other or unclear benefits or services.



44% (28 out of 64) the denials were resolved in the member's favor, 17% (11 out of 64) continued to be denied after the appeal, and 39% (25 out of 64) were inconclusive due to members being unreachable.

Key Takeaways from 2023 Denial of Benefit Themes



- The most common theme was related to members being denied for a benefit or service, and among those denials, members sought help with MYO regarding getting dental services approved the most.
- For this reason, MYO has recently updated its database to include “Dental” as a separate call subject, for better monitoring and analysis of Dental services-related cases that MYO receives.
- MYO places high priority to find a conclusive outcome to members’ denial cases, including reaching out to the member at least 3 times before determining the member unreachable.

Dissatisfaction with any general aspect of care



What did members report as being dissatisfied with?

- The most common complaints included members being dissatisfied with Care Coordination (11), Transportation (10), Hospitals/Physicians (9), and Home Health Services (7).
- The remaining members were dissatisfied with LTSS (2), Behavioral Health Services (1), Medication (1), and Other Benefits or services, such as dental providers (5).

Outcomes

- 56% (27 out of 48) of these complaints were resolved.
- The remaining were inconclusive, due to members becoming unreachable.

Problems finding an in-network provider



Subjects

- The most common provider search cases were related to: Dental (11) and Behavioral Health (8)
- The remaining cases were related to Eye doctor (5), PCP (5), Massage therapist (3), Other (6), Unclear (4)
- Most of the members were looking for guidance finding a provider in these areas, while the remaining had more specific issues such as preferred providers no longer taking insurance plans, not taking new patients, or not being available in their service area.

Outcomes

- 55% (23 out of 42) of these provider search cases were resolved.
- The remaining were inconclusive due to members becoming unreachable.

Delays in receiving an approved benefit or service



Reasons for Delays

- This theme includes DME (26), LTSS (6), Medication (3), and Home Health services (4) delays due to various reasons.
- Most prevalent reasons for the delays include insufficient communication with care coordinator, insufficient communication or miscommunication with vendors and providers, and members having difficulty finding vendors in-network.

Outcomes

- 83% (35 out of 42) of these complaints were resolved.
- The remaining were inconclusive, due to members being unreachable at any point during the case.

Problem with authorization process



Reasons

- Cases included authorization process issues for DME, LTSS, Medication, and Home Health service, etc, with LTSS and DME being the most prevalent subjects.
- Prevalent reasons for the issues included pre-requisites for seeking authorization, such as completion of an evaluation or assessment not met, and provider or vendor verbally refusing member's request for a DME, LTSS, or medication prior authorization.
- Other reasons included prior authorizations not sent due to provider's office or care team's delays, prior authorization having insufficient or inaccurate information.

Outcomes

- 70% (23 out of 33) of these complaints were resolved.
- The remaining were inconclusive, due to members becoming unreachable.

Member received a bill or had to pay a co-pay



Reasons

- In most of these cases, the member received a bill or had to pay a co-pay because the benefit or service wasn't covered, the bill was sent due to an administrative error, or the provider or vendor was out of network
- The remaining reasons included provider or vendor not having member's correct insurance information, providers refusing to send claims/other paperwork to the plan, and a gap in health insurance coverage.

Outcomes

- 83% (19 out of 23) of the cases were resolved by MYO.
- 13% (3 out of 23) were unresolved due to the member missing the deadline for the appeal, and 4% (1 out of 23) were inconclusive due to member being unreachable.

Member needed guidance or support initiating a benefit or service



Benefits or Services included:

- 62% of the cases were regarding members needing guidance or support initiating a DME request.
- The remaining cases were regarding getting started with Transportation, Care Coordination, Dental, Medication, or other: such as cardiac or pulmonary rehab services

Outcomes

- 62% (13 out of 21) of the cases were resolved by MYO.
- The remaining were inconclusive, due to members being unreachable at any point during the case.

Member reported Insufficient/Inadequate Care Coordination



Reasons

- Members reported that their care coordinators or care teams were unresponsive or difficult to contact (83%)
- Members also reported being unaware of care coordinator change.

Outcomes

- 67% (12 out of 18) of the cases were resolved by MYO.
- The remaining were inconclusive, due to members becoming unreachable.

Deaf/Hard-of-Hearing Accessibility Issues



Deaf/HOH Accessibility Issues

- Deaf and Hard-of-Hearing members reported needing help with arranging interpreter services for their appointments, making sure that an interpreter is available, and arranging in-person interpreters rather than video-remote interpreting.

Outcomes

- In 81% (9 out of 11) of these cases, member got the outcome they wanted, meaning that they were able to have an interpreter at their appointments.
- In the remaining cases, the members were unreachable.

Other themes within closed complaints in 2023



Themes	Count
Transportation Issues	<10
Member required assistance with the status of a prior authorization	<10
PCA staff payment issues	<10
Enrollment Issues	<5
Other themes	24
Insufficient data	23

Total number of closed complaints: 366

Recalling the Agenda



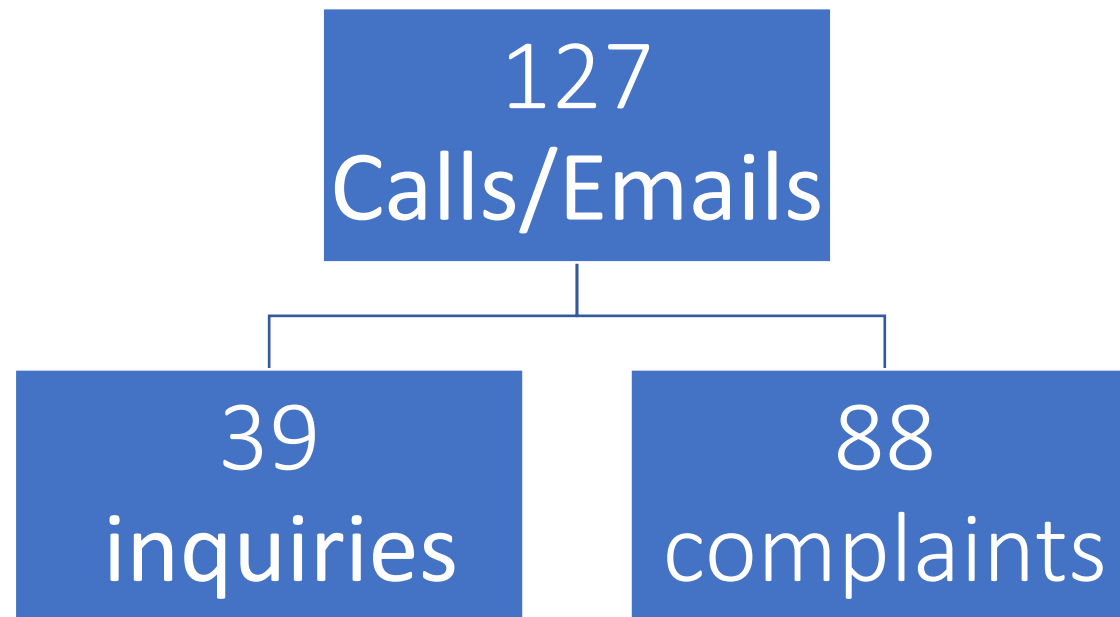
First part of the presentation

- Review of 2023 data for One Care plans
 - The themes and the details that emerged from our analysis of complaints that were closed in 2023

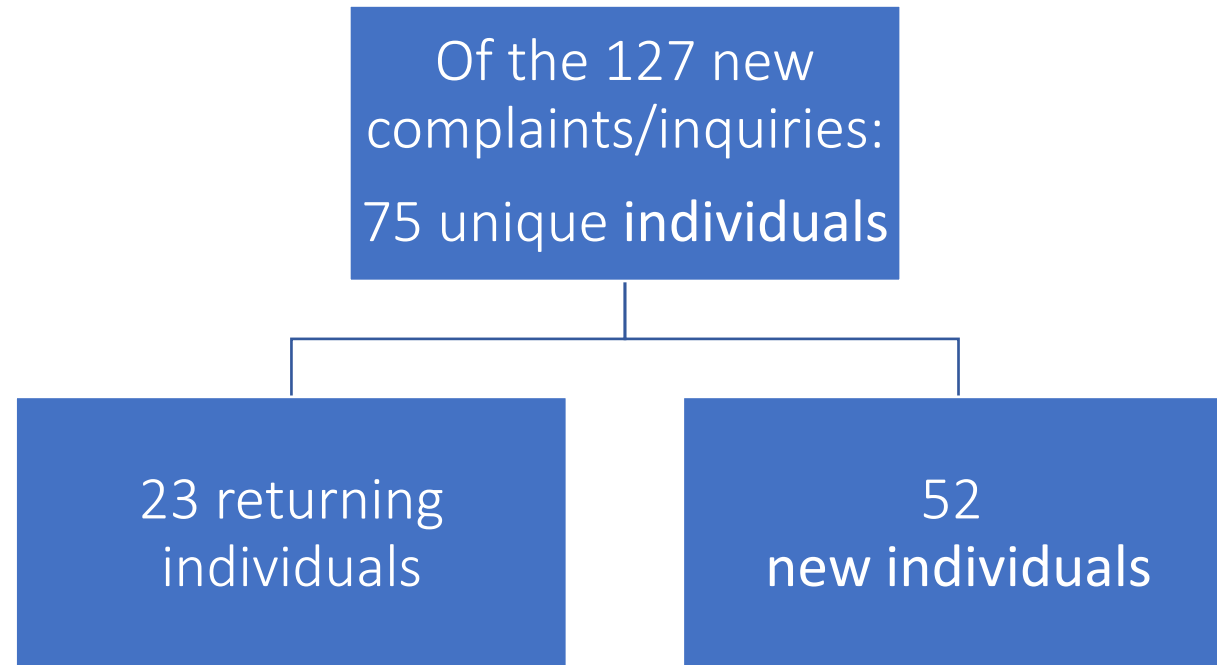
Second part of the presentation

- Review of Q1 2024 data for One Care plans
 - The top themes that emerged from our analysis of complaints that were closed in Q1 2024

New Inquiry/Complaint Volume in Q1 2024



Unique One Care Members Assisted in Q1 2024



Closed Complaints in Q1 2024: Call Subjects



Themes	Frequency
Benefits/Access	21
DME	12
LTSS	11
Care Coordinator/Care Manager	<10
Claim/Payment	<10
Pharmacy/Medication	<10
Appeals/Grievance Process	<10
Transportation	<10
CLAS/Accessibility	<10
Total	68



Top theme in Closed Complaints from Q1 2024

Themes	Frequency
Problem with authorization process	<10

Total number of closed complaints: 68

Problem with authorization process (Q1 2024 top theme)



Reasons

- Cases included authorization process difficulties for Physical therapy, DME, LTSS, Medication, and Home Health service, etc. with DME being the most prevalent subject.
- Reasons for the difficulties included pre-requisites for seeking authorization not met, (such as completion of evaluation or assessment for PCA services), and vendor, care team or provider's errors.

Outcomes

- 78% of these complaints were resolved.
- The remaining (2 complaints) were inconclusive, due to members being unreachable at any point during the case.



Takeaways from Q1 2024 top theme

- The most common theme was related to members experiencing issues with the authorization process due to various reasons:
 - Due to pre-requisites for seeking authorization not met, such as completion of evaluation or assessment for PCA services.
 - Due to vendor, provider or care team's errors, or provider not submitting claims to the insurance plan for payment.

Other themes in Q1 2024



Themes	Count
Insufficient/Inadequate Care Coordination	<10
Member needed guidance or support with initiating a request for a benefit or service	<10
Denial of a benefit or service	<10
Delays in receiving an approved benefit or service	<10
Dissatisfaction with any general aspect of care	<10
Problem finding an in-network provider	<5
Member required assistance with the status of a prior authorization	<5
PCA staff payment issues	<5
Member received bill from a provider or vendor or had to pay a co-pay	<5
Deaf/HOH Accessibility issues	<5
Other themes	<10

Total number of closed complaints: 68



Thank you!

Questions or comments?

Contact Us



My Ombudsman

Need help with your MassHealth benefits? We're here for you.

- **Phone:** 855-781-9898
- **Deaf/Hard of Hearing:** 339-224-6831
- **Email:** info@myombudsman.org
- **Web:** www.myombudsman.org
- Monday-Friday 9am-4pm
- We use an interpreter phone service for many other languages as needed
- Nosotros hablamos Español
- Nou pale Kreyol
- We use ASL