MCO Access Grievances 2010-2012

From 2010-2012, MCOs reported a total of 15,660 member grievances.

52% of all grievances were related to MCO Administration (member materials, ID cards, benefit set dissatisfaction, MCO membership process and billing process).

The 2nd greatest % of grievances, 24%, were related to Access (inability to obtain a referral, delays in obtaining service, delays in appointment scheduling, excessive wait times, inability to obtain medical information, lack of availability of special services and inadequate geographic options).

As the grievance rate increased over the 3 year period, DHS requested an accounting from the health plan that was reporting the greatest percentage - 72% - of the grievances, with a focus on access-related grievances. The health plan responded that 33%-66% of their grievance volume is related to ID card changes, Primary Care Clinic (PCC) changes, name/address changes and formulary exception requests. Upon further investigation it was discovered:

In 2010, 23% of the plan's total grievances were related to access and
46% of the access grievances were related to pharmacy services and restricted recipient issues. Pharmacy-related grievances were due, in large part, to a change in pharmacy formulary, quantity limits or step therapy needed or the member not showing eligible in the Rx system on the 1st of the month. The health plan investigated each grievance and provided a timely response (acknowledging or substantiating/taking action) to the member. Restricted recipient (RR) grievances were about the enrollee wanting to go to a pharmacy other than the one they were restricted to or complaints about being on the restricted recipient program.
[It should be noted that during the 2010 Triannual Compliance Assessment (TCA), conducted in conjunction with the MDH QA Exam, DHS discovered that some of this health plan's written policies were not in compliance with the contract. The health plan developed a corrective action plan (CAP) and over the course of the following year, DHS and health plan resources were committed to developing accurate Policies and Procedures, which included accurate identification of grievances.]

In 2011, 21% of the plan's total grievances were related to Access and 83% of the access grievances were related to PCC/ID card/name and address changes, pharmacy services, professional medical services and restricted recipient issues. The professional medical service-related grievances were due to copay issues, services not covered or the member not being happy with the coverage level. Again, the plan investigated and provided a timely response to the member, taking action to correct the issue when grievance was substantiated. DHS will have further discussions with the plan to determine if the PCC/ID card and name/address changes were correctly logged as access grievances.

In 2012, 26.9% of the plan's total grievances were related to Access and 94% of the access grievances were related to PCC/IDcard/name and address changes, restricted recipient issues, pharmacy services and transportation services. The PCC/IDcard/name and address changes, restricted recipient issues and pharmacy services grievances were handled as noted above. The transportation-related grievances were due to the member not liking the vendor or driver, not being picked up on time, hold times (when calling the plan's transportation line) and same day

rides. The health plan monitors grievances monthly, noted the high number of transportation grievances and initiated a corrective action plan, adding staff and training.

At this point, although one health plan may be over-reporting or mis-logging some grievances, we could find no evidence that the managed care plans have inadequate provider networks, that enrollees are unable to access covered services through their health plans, that enrollees have difficulty or are unable to obtain referrals or medical information, or that the networks lack available special services. At certain times, and under certain circumstances there is evidence of possible delays in transportation service due to long hold times, possible delays in scheduling appointments due to a change in PCC/ID cards/name/address, and delays in obtaining pharmacy services when the health plan's pharmacy benefit manager doesn't have member enrollment information on the first day of the month. In my experience, however, I find that when managed care enrollees have difficulty accessing care or services, or they have a grievance (about anything other than a health plan action), enrollees are well-served by a well-defined managed care grievance process which provides intervention and assistance to enrollees and accountability to DHS.

DHS will continue to monitor and investigate MCO grievance rates, issues and outcomes; and continue to work with MCOs to continuously improve the identification, handling and reporting of grievances.

If PCG wants to update Appendix 1 (on page 23 of the PCG draft report) to better correlate with access grievance findings (above) which may be included in the final report, here is the 2010-2012 Access Grievance table. [The 2010-2012 Grievance System Summary information will be posted on the MN DHS website in July, 2013.]

| | Access Grievances | | |
|---|---|---|---|
| | 2010 | 2011 | 2012 |
| Blue Plus | 712 | 858 | 971 |
| HealthPartners | 169 | 210 | 258 |
| Henn Health | | | 6 |
| IMCare | 0 | 0 | 0 |
| MHP | 35 | 41 | 17 |
| Medica | 34 | 54 | 267 |
| PrimeWest | 3 | 3 | 2 |
| SCHA | 19 | 4 | 9 |
| UCare | 12 | 15 | 53 |

| | | | |
|---|---|---|---|
| **Total** | **984** | **1,185** | **1,583** |