Standard Operating Procedures

Hotline Unit

July 2014

HHSC Office of the Ombudsman
Hotline Operational Procedures

Purpose:
The purpose of these processes is to document the operational methods utilized by Ombudsman Office Hotline staff in referring and resolving complaints and inquiries.

- Ensure excellent customer service by providing accurate resources, general information, agency policies, agency programs and inquiries.

- Educate clients and non-clients with agency procedures, policies, and complaint escalation processes.

Definitions:
- **Complaint** - defined as any expression of dissatisfaction.
- **Inquiry** - defined as any request for information regarding services, programs or other assistance needed.
- **Issue** - Any matter handled by OO, either complaint or inquiry.
- **Urgent Issue** – Any matter that relates to Access to Care or a customer who insists on speaking to a person immediately.
- **Access to Care** – customer has actual health or life-threatening immediacy or emergency.

Acronyms:
- **OO** – Office of the Ombudsman
- **SS** – Special Services
- **CCEA** – Center for Consumer and External Affairs
- **HHSC** – Health and Human Services Commission
- **CRS** – Complaint Resolution Specialist
- **PS** – Program Specialist
- **MMCH** – Medicaid Managed Care Helpline

Calls		
Method Received	**Process**	**Time Frame**
1-800-252-9330 **Texas Works Line** **1-888-834-7406** **Customer Service**	• Handle incoming calls through 1-888-834-7406, 1-800-252-9330, 1-877-787-8999 and TDD machine. • Greet customer, allow customer to explain their issue(s), determine nature of call, and log basic customer information into HEART. • Verify that customer is someone to whom information can be	Call is handled immediately upon receipt.

Line **1-877-787-8999** **Ombudsman Line**	released. If customer is not a party to which information can be released then request to speak with client on the case if present at time of call. If client is not available then assist with general information (non-case specific information). If customer is requesting case specific information, inform customer that legal documentation confirming authorized representation (e.g. form H1826) must be faxed to the OO and the customer's issue will be escalated to the Complaint and Resolution staff upon receipt at which time the customer will be contacted for additional assistance. • Research client's case in TIERS eligibility system. • Determine if issue can be resolved by providing information on the client's case or with a referral to 2-1-1, local office, other governmental program, or private sector if necessary. • If the client's issue is related to accessing care through their Medicaid managed care health plan and the client has **not** already contacted their health plan, refer the client to their Medicaid Managed care health plan. • If the issue is **not** related to accessing care through client's Medicaid managed care plan **and** client has already contacted 2-1-1, local office, or other division and not had their issue adequately resolved, then escalate the call. • Complete HEART entry. When entering the brief summary, use the template below: Issue: Findings: Resolution: **Example:** Issue: Client called to check status of SNAP application mailed on June 23rd. Findings: No SNAP application found in portal but found CMA application that doesn't indicate SNAP Resolution: Informed SNAP not indicated on app, only CMA. Will need to resubmit app for SNAP and informed of different ways to apply: 2-1-1, SSP, or local office. **Note: Manual Process When HEART is Down** • If HEART is down, document the call on the manual HEART tracking form and data enter/create the assignment when HEART is back up. The manual HEART tracking form is located at Manual HEART tracking forms.	
Escalation Process		
Method Received	**Process**	**Time Frame**
Transferring Customer's Issue to MMCH staff	• If the client's issue is related to accessing care through their Medicaid managed care health plan and the client has already contacted their health plan, then transfer the caller to the Medicaid Managed Care Helpline queue (x1017813 for English and x1017814 for Spanish (release any translators on the line)).	Immediately upon identifying escalation

Transferring Customer's Issue to SS staff	• Hotline agents will send all escalations including telephone calls to the SS Mailbox, except urgent/access to care issues, or if client insists on speaking with someone to escalate their issue.
	• Hotline will use the following script when escalating a client's issue through HEART to the SS mailbox, "I am escalating your issue to our complaint resolution team. You will be contacted within five business days by a member of that team with an update or resolution". Hotline will then provide the caller with the tracking number.
	• Hotline will need to ensure that the clients issue is well documented so that CRs can begin working the client issue based on the information in HEART.
	• CRs would need to contact the caller within 5 business days of receipt of the issue.
	• Issues sent to the SS mailbox will be assigned to CRs on a round robin basis by Administrative staff.
	• When a client calls about an **open assignment** and wants to speak with someone and
	  • the CR is in attendance but not answering their phone, the Hotline agent should try to get the caller in touch with the CR queue (or CHIP queue if the call is CHIP related).
	  • the CR is not in attendance, then the Hotline Agent should try to get the caller in touch with the CR's buddy. If the buddy is unavailable, the caller should be transferred to the CR queue, if they do not want to leave a voice message.
	• When a client calls about an **open assignment** and the CR that is working it does not answer (or is absent) and the client is transferred to the CR queue (or CHIP queue if CHIP issue), buddy, or SS PS, then the Hotline agent will assign the **Follow-up** HEART entry to the CR, buddy, or PS who took the call and **keep the new HEART entry open**. This will allow the new CR or PS credit for taking the call. The CR or PS who took the call will follow the steps below before closing the new HEART assignment:
	• Document the steps taken to address the concern in the new HEART assignment
	• Copy and paste the resolution documentation from the new HEART assignment to the original HEART assignment and upload any new emails/documents in the original assignment.
	• Create a relationship to the original HEART assignment.
	• If an email or online submission is received within 10 days of a **closed HEART assignment** and has to do with the same issue, Hotline agent will assign the issue to the CR who handled the closed HEART entry previously (like we do with phone calls).
	
	• When a client calls about their **closed HEART assignment** and it is within 10 days, we transfer the call to the previous CR's voice mail or to the SS queue (if client does not want to leave a message). Hotline will create a new HEART, mark it as a follow-up and keep the new HEART entry **open**. This helps ensure that an entry is open for further action to be	

	taken. Note: The CR or PS will be required to document in the new HEART entry and create a relationship to the original assignment. This will ensure the CR will receive credit for taking the call. **Note: Manual Process When HEART is Down** • If an issue is escalated to a CR while HEART is down, the CR is responsible for entering the call.	
Emails		
Method Received	**Process**	**Time Frame**
Clientmember.resolution@hhsc.state.tx.us Provider.resolution@hhsc.state.tx.us Medicaid@hhsc.state.tx.us Contact@hhsc.state.tx.us	• Team Lead will monitor receipt of emails throughout the day. • Team Lead will then prioritize and filter emails so that correspondence received from the following sources are reviewed and immediately assigned to Special Services Unit: o Legislative o External Relations Division o Emails addressed to Executive Commissioner ▪ All emailed correspondence addressed to the EC or other Commissioner will be forwarded to Nancy Raumaker, if appropriate, and also cc Elisa Hendricks. ▪ The following statement will be used when routing documents to Nancy. *"This correspondence was received at the Ombudsman Office and addressed to the Executive Commissioner. I am forwarding this correspondence for your review and assignment. Please let me know if you have any questions."* o USDA/FNS o Federal Inquiries (i.e., CMS, ACF) • All emails identified as belonging to Special Services Unit will be forwarded by email to ombuds_specserv@hhsc.state.tx.us for assignment to a CR. • All other emails will be assigned to designated Hotline staff for their review and handling (this task is round robin on a daily basis). o Hotline Analyst will do HEART inquiry to verify assignment has not already been completed recently. o Emails identified as complaints which need to be assigned to a CR will be entered into HEART and assigned to Special Services Unit (ensuring the ***Email Assignee*** box is checked). o Hotline Analyst will respond to email and either provide information or refer consumer to appropriate area for resolution. o Hotline Analyst will create HEART entry and will upload email and any attachments.	Email is handled within 24 hours of receipt or next business day, if submitted on weekend or holiday.

Online Submission Form	• Team Lead will designate Hotline staff as part of Email Queue in HEART.
	• HEART will automatically assign online submissions to member of the Email Queue on round robin basis.
	• Once HEART assignment is received the Hotline agent will do the following:
	  ○ Change the ***Received by*** name from Online Submission Form, - to their name.
	  ○ Change the ***Status*** from New Escalation to either Open or Closed.
	  ▪ Ensure the ***Email Assignee*** box is checked if you are escalating submission to Special Services Unit.
	  • TIP – after saving the HEART entry go into the Generate-View Email tab to ensure an email was sent to ombuds_specserv@hhsc.state.tx.us
	  ○ Document thoroughly in the ***Narrative*** (not brief summary). Keep in mind this information maybe on the email sent to the Special Services Unit.	

Staff Responsibilities	
Staff Person	**Responsibilities**
Hotline Analyst	• Hotline Analysts will handle incoming calls from the Customer Service Texas Works, and Ombudsman hotlines. • Hotline Analysts will escalate complex calls that require further research to the Special Services staff or MMCH staff. • Respond to correspondence from the email boxes and online submission. • Maintain accurate data entry in HEART database • Participate in special projects such as the HEART Workgroup or Ombudsman • Activity Planning Committee • Attend trainings and present at staff meetings • Provide MMCH and Receptionist support when necessary.
Team Lead	• Provide guidance with complex issues, serve as subject matter expert • Ensure phone coverage – monitor queues and assigned skillsets • Assign emails from the email boxes • Assign and track OTIs • Track leave requests and variations in schedules • Assist with establishing procedures • Assist with weekly, monthly and Civil Rights daily reports • Monitor quality on calls and adherence to procedures and schedules • Identify resources needed for staff to perform all duties • Generate and share reports regarding staff performance • Provide general supervisory functions • Train new staff and continue to develop and provide refresher training • Facilitate and lead projects • Assist staff with technical issues, including computer and telecom equipment

HHSC OFFICE OF THE OMBUDSMAN

Standard Operating Procedures

Medicaid Managed Care Helpline (MMCH)

December 2012

HHSC Office of the Ombudsman
Medicaid Managed Care Helpline Procedures

Purpose:
The purpose of these procedures is to document the operational methods utilized by Office of the Ombudsman Medicaid Managed Care Helpline in referring and resolving complaints and inquiries.

These procedures:

- Establish consistent processes for the intake, resolution, and referral of issues.
- Ensure excellent customer service by providing accurate information, resources, and referrals.
- Inform staff of how to educate clients on: navigating the Medicaid Managed Care system; their rights and responsibilities; Medicaid eligibility policies and complaint escalation procedures.

Definitions:
For the purposes of these procedures, the following terms and acronyms will be used:

- **Advocate** – helpline agent
- **Complaint** – any expression of dissatisfaction regarding services or programs, especially when a client experiences a barrier to accessing health care to which they are entitled
- **HEART** – Health and Human Services Enterprise Administrative Report and Tracking System
- **HHSC** – Health and Human Services Commission
- **Inquiry** – any request for assistance or information regarding services or programs
- **Issue** - Any matter handled by OO, either a complaint or inquiry
- **MMC** – Medicaid Managed Care
- **MMCH** – Medicaid Managed Care Helpline
- **MCO** – Managed Care Organization (Medicaid Managed Care Health Plan)
- **OO** - Office of the Ombudsman

Calls Received at 866-566-8989 MMCH Toll-Free or 866-222-4306 TDD Lines

Process	Details	Time Frame
Answer the call promptly and politely	• Greet the caller in a pleasant tone and with the standard greeting, "Thank you for calling the Medicaid Managed Care Helpline, this is _____."	Majority of issues are resolved the same day received.
Verify the caller	• Verify at least three pieces of biographical information with the caller prior to providing any information, even confirming if there is or is not a Medicaid case. ○ If the caller is not on the case and is calling on behalf of an adult (over 18), obtain permission from the adult on the case to speak with the caller.	
Actively listen	• Listen to the caller's concern, ask any probing questions and empathize with the caller.	
Check for open cases	• Check HEART to determine if an open issue exists. ○ If so, transfer the caller to the advocate handling the issue, if the advocate is available. If the advocate is not available, take a message for the advocate and advise the caller when to expect a return call. ○ If not, begin entering the demographic information in HEART as the caller explains the issue.	
Check appropriate electronic systems	• Use TIERS, Phoenix, and other appropriate systems, to ascertain the nature of call by asking probing questions, reviewing previous contact history, and verifying information.	
Transfer to Hotline if appropriate	• If the issue relates to eligibility or other HHS matter *not* related to a Medicaid service or benefit, and the caller has already contacted the appropriate resources (i.e. 2-1-1 and other HHS programs or toll-free lines), but still has a concern, the advocate may transfer the call to the main OO queue, extension 1017780 (Hotline). ○ The caller should be advised that he/she is being transferred to another line and their may be a brief hold time. The advocate should remain on the line and attempt to do a warm transfer.	Issues transferred are to be considered resolved the same day received and should be closed in HEART by MMCH.

	○ If, after holding for about 2 minutes, a Hotline agent does not answer the transfer, please report to a MMCH or Hotline team lead or manager.	
Research and provide appropriate resolution information Call pharmacies for most prescription issues	• If the issue relates to a Medicaid benefit or service and the client is already determine eligible for Medicaid, resolve the issue if possible, including: providing relative, accurate and reliable information and offering referrals to other help lines or agencies that could assist further with the client's issue. If the issue relates to a Medicaid service or benefit not contracted and coordinated by a health plan, the advocate should refer the caller to the appropriate resource. ○ Regarding prescription issues, *when possible* staff should contact the pharmacy in effort to assess why a prescription can not be filled. Staff may be able to educate the pharmacy and assist in getting the claim through; if not, staff may refer the caller to the health plan or Vendor Drug Regional Pharmacist as appropriate.	
Refer callers to their health plan and equip the caller to advocate for him or herself when appropriate Call the health plan on behalf of the caller or with the caller on the line when necessary	• If the issue relates to Medicaid Managed Care and is a responsibility of a health plan, the advocate should: ○ Refer the caller to the health plan and provide the health plan phone number if necessary. ○ Teach the caller to advocate for him/herself and advise the caller of what to ask for when calling the health plan, when appropriate or necessary. ○ Call the health plan for or with the caller when the caller does not seem prepared to call independently or indicates he/she has already made a diligent effort to coordinate with the health plan. ○ Advise the caller that they may experience several minutes of hold time while the plan is being contacted and then attempt to reach the health plan either via established contacts or the plan toll-free lines. • If callers are under duress or have already attempted resolution with the plan or other appropriate area, MMCH staff should contact appropriate parties on behalf of the client, and	

	close the case in HEART after resolution is communicated to the caller. • Document all calls and resolution in HEART during the call. Close the HEART case at the end of the call, if the issue is resolved. • If an issue is more complex or the caller has already made an effort to coordinate with the appropriate resource, the advocate should intervene on behalf of the caller as necessary, by contacting parties who can assist with resolving the issue; this includes provider (i.e. doctor, medical equipment company, pharmacy, etc.) Coordination may involve conference calls with the caller and appropriate contact. Staff may also coordinate with HHS agency or contract staff (ie MAXIMUS, HPO_STAR_PLUS email box, Data Integrity mailboxes, etc). If the agent is not able to resolve the caller's complaint within the initial call: • Keep the case open in HEART until resolved. • Email, using secure email, established contacts who can resolve the issue (e.g. MCO's Member Advocate, MMCH's contact for the HHS agency that can correct the error on the client's Medicaid case, etc). ○ HMOs must resolve Member Complaints received by HHSC no later than the due date indicated on HHSC's notification form. HHSC will provide HMOs up to ten (10) Business Days to resolve such Complaints • Maintain contact with all involved parties until the client is able to access the needed care or the issue is fully resolved. • Enter all follow up efforts in HEART. • Alert the MMCH Team Lead or Manager if issues are not resolved effectively or timely. During all calls, advocates must: ○ Follow protocols to ensure confidential	When issues cannot be resolved immediately, staff will follow up and make every effort to resolve within 5 business days. Some issues cannot be resolved within 5 business days due to the complexity or number of parties that must be involved in order to resolve the issue. In addition, in some instances MCO contracts with HHSC allow for longer than 5 business days for issues to be resolved. The

Transferring Client's Issue to SS staff	information is released only after verification of whom they are speaking with and/or with consent to release information. Additional Expectations: ○ Assist other advocates when consumers call for status and assigned advocate is not available; advise the assigned advocate of the call ○ Notify team lead/supervisor of the status of open/pended cases if taking planned leave. Coordinating with Special Services: If the caller is inquiring an **ongoing open** HEART assignment, offer to transfer the call to the CR working the assignment. Inform the caller that if the CR is not available, they may leave a message. If the caller agrees, then warm transfer the call to the CR's extension. If the caller states they do not want to leave a message then attempt to warm transfer the call to the CR. If the CR is not available then warm transfer the call to the CR queue. (*follow the new issue escalation process above) • If the caller is inquiring about a **closed** HEART assignment, read notes in the HEART entry and inform client of prior resolution. If the caller does not agree with the resolution or continues to request to speak to the previous CR, route the call to the next available CR on queue. (*follow the same escalation process above)	overall goal is to resolve 90% of contacts within 10 business days.

Helpline Agents

Staff Person	Responsibilities
Advocates	• Answer the MMCH Toll-free line and TDD Line. • Follow-up on all ongoing cases. • Work a regular and predictable schedule • Adhere to OO and HHSC policies

Program Specialist

Staff Person	Responsibilities
Advocate Supervisor/Team Lead	• Be available to assist the intake staff in answering questions • Be responsible for the day-to-day direction of helpline activities (e.g. assignment of voice mail, staffing, trainings) • Monitor each advocate's time off of the phones (breaks, lunches, wrap up time) • Monitor 6 calls per month for each advocate and review those scores with them • Coach and counsel advocates on their work performance • Serve as Acting Manager in the absence of the Manager • Be responsible for other Special Assignments, as required • Coordinate leave requests to ensure there is adequate coverage

Manager

Staff Person	Responsibilities
Helpline Manager	• Serve as primary subject matter expert on Medicaid Managed Care policies • Serve as primary point of contact for the unit • Be responsible for all helpline operations: helpline equipment, IT support and staffing needs • Train, develop and evaluate employee performance • Report to the OO Director on call center performance as well as problem trends that are identified in the helpline's data entry system • Address inferior work performance and develop disciplinary action for staff members that fail to meet all work requirements • Develop training for helpline staff on new Medicaid policies and programs as well develop any refresher trainings when staffs need additional information on current Medicaid programs. • Approve leave requests • Approve any items to be purchased