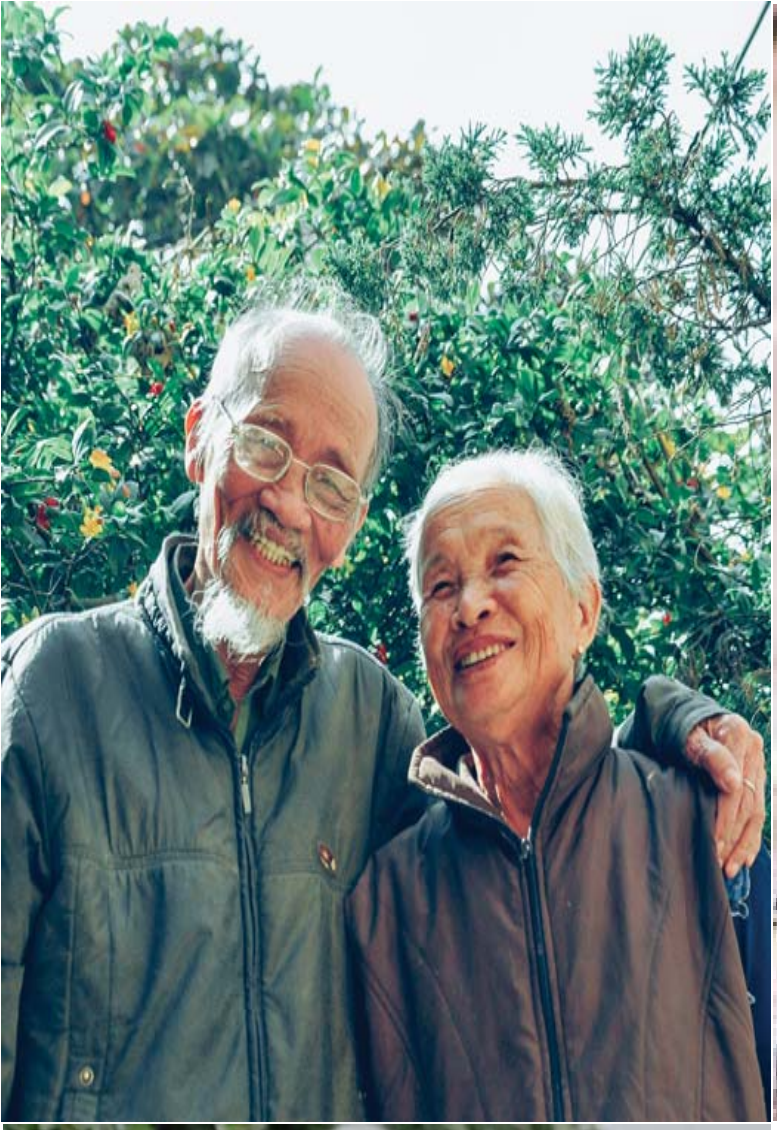

MANAGED CARE OMBUDSMAN PROGRAM

QUARTERLY REPORT

Year 4, Quarter 4
(January 1 - March 31, 2020)

Managed Care
OMBUDSMAN PROGRAM
A Division of the Office of the State Long-Term Care Ombudsman
866.236.1430 | ManagedCareOmbudsman@iowa.gov

EXECUTIVE SUMMARY

The Office of the State Long-Term Care Ombudsman's Managed Care Ombudsman Program advocates to resolve managed care issues on behalf of Medicaid managed care members who receive care in a health care facility, assisted living program, elder group home, or who are enrolled in one of the seven home and community-based services (HCBS) waiver programs. The waiver programs include: AIDS/HIV Waiver, Brain Injury Waiver, Children's Mental Health Waiver, Elderly Waiver, Health and Disability Waiver, Intellectual Disability Waiver and Physical Disability Waiver.

The Managed Care Ombudsman Program's monthly and quarterly report reports cases and complaints from the managed care members this Office serves. With the goal of accurately reflecting members served and those members' issues as opposed to the previous contacts reporting method.

For this reporting quarter, the office experienced a slight fluctuation of cases/complaints per month, with 56 individual member cases in January, 77 individual member cases in February, and 46 individual member cases in March.

The issues identified for this fourth quarter are the primary managed care member issues addressed in January, February and March 2020. The Office works with a variety of stakeholders who are necessary to address and resolve issues. During Quarter 4-Year 4 of Medicaid managed care, the primary issues reported to the Managed Care Ombudsman Program by managed care members continued to be that same as reported last quarter and included:

1. Access to Services/Benefits. Waiver members reported a lack of available providers contracted with their Managed Care Organizations as well as a lack of staff available within certain provider agencies. The lack of providers available to members had a direct impact to the members' overall health service benefits. As such members were approved for services yet did not receive all services for which they were approved.

2. Members are reporting issues with their case management. Members continue to experience delayed response time from case managers and a lack of support and understanding of their health needs. At times members were assigned new case managers against the members wishes at times, requiring the member to build new relationships and endure a lack of consistency and understanding of their overall goals and health care needs.

3. Services reduced, denied or terminated for members needing long-term services and supports. Members reported reductions or denials in their HCBS waiver services in their homes or assisted living programs. This often affected consumer directed attendant care (CDAC) and consumer choice options (CCO) service hours. In response to reduction in services, members are filing grievances, formal appeals and fair hearings to access the services they feel are necessary for their health and safety.

The report that follows includes an overview of the fourth programmatic quarter of Year 4 (January, February and March 2020), as well as an update on the program, community partnerships and outreach efforts and administrative activities.

For further information, please contact the Managed Care Ombudsman Program at (866) 236-1430 or managedcareombudsmanprogram@iowa.gov.

MEMBER ASSISTANCE

Members per MCO[1] in process January 2020	Amerigroup Iowa	40
	Iowa Total Care	13
	UnitedHealthcare Plan of the River Valley	1
	Fee for Service	2
Referrals per Entity[2]	Department of Human Services	3
	Department of Inspections and Appeals	-
	Disability Rights Iowa	8
	Iowa Compass	-
	Iowa Legal Aid	-
	LifeLong Links	-
	MCO	1
	Medicaid Fraud Control Unit	-
	Provider	1
	Senior Health Insurance Information Program	-
	State Ombudsman Office	5
	Other	1
Grievances/Appeals/Fair Hearings	Grievance assistance	5
	Appeals assistance	4
	Fair Hearing assistance	2

Members per MCO[1] in process February 2020	Amerigroup Iowa	65
	Iowa Total Care	10
	UnitedHealthcare Plan of the River Valley	1
	Fee for Service	1
Referrals per Entity[2]	Department of Human Services	2
	Department of Inspections and Appeals	-
	Disability Rights Iowa	5
	Iowa Compass	-
	Iowa Legal Aid	-
	LifeLong Links	-
	MCO	7
	Medicaid Fraud Control Unit	-
	Provider	1
	Senior Health Insurance Information Program	1
	State Ombudsman Office	-
	Other	3
Grievances/Appeals/Fair Hearings	Grievance assistance	5
	Appeals assistance	3
	Fair Hearing assistance	-

1 Members per MCO: Due to the MCO transition some of the managed care members are duplicated.

2 Referrals per Entity: Referrals made to external organizations that provide services beyond the scope of the program.

MEMBER ASSISTANCE

Members per MCO[1] in process March 2020	Amerigroup Iowa	39
	Iowa Total Care	7
	UnitedHealthcare Plan of the River Valley	-
	Fee for Service	-
Referrals per Entity[2]	Department of Human Services	-
	Department of Inspections and Appeals	-
	Disability Rights Iowa	8
	Iowa Compass	1
	Iowa Legal Aid	2
	LifeLong Links	1
	MCO	-
	Medicaid Fraud Control Unit	-
	Provider	-
	Senior Health Insurance Information Program	-
	State Ombudsman Office	-
	Other	-
Grievances/Appeals/Fair Hearings	Grievance assistance	1
	Appeals assistance	6
	Fair Hearing assistance	1

1 Members per MCO: Due to the MCO transition some of the managed care members are duplicated.

2 Referrals per Entity: Referrals made to external organizations that provide services beyond the scope of the program.

The Managed Care Ombudsman Program would like to remind manged care members that their managed care organization may have a value add program that could provide the member with a cell phone. Please contact your case manager for additional information.

Due to the COVID-19 pandemic, many states have applied for and been granted waivers from some CMS requirements related to managed care. You can find information regarding these waivers on the DHS website, and Informational Letter 2127-MC-FFS-CVD.

Complaint(s) Resolution by Program Type

Amerigroup Iowa January, February and March	Fully or partially resolved to Member's satisfaction			Not resolved to Member's satisfaction			No action needed or appropriate			Open			**Total**
	J	F	M	J	F	M	J	F	M	J	F	M	
AIDS/HIV Waiver											2		2
Brain Injury Waiver			4							8		3	15
Children's Mental Health Waiver													
Dental													
Duals	1									1			2
Elderly Waiver		43	7							7	10	3	70
Habilitation		1								1	4		6
Health & Disability Waiver	6	12	1							5	3	6	33
HIPP													
Institutional Care													
Iowa Health & Wellness													
Intellectual Disability Waiver	6	36	12						2	22	14	6	98
Medicare													
PACE													
Physical Disability Waiver	2	3									3	7	15
QMB or SLMB													
Traditional Medicaid													
Other	3	1	10							3	3	5	25
N/A													
Unknown													
TOTAL:	18	96	34	0	0	0	0	0	2	47	39	30	266

UnitedHealthcare Plan of the River Valley January, February and March	Fully or partially resolved to Member's satisfaction			Not resolved to Member's satisfaction			No action needed or appropriate			Open			**Total**
	J	F	M	J	F	M	J	F	M	J	F	M	
AIDS/HIV Waiver													
Brain Injury Waiver													
Children's Mental Health Waiver													
Dental													
Duals													
Elderly Waiver													
Habilitation													
Health & Disability Waiver													
HIPP													
Institutional Care													
Iowa Health & Wellness													
Intellectual Disability Waiver													
Medicare													
PACE													
Physical Disability Waiver													
QMB or SLMB													
Traditional Medicaid													
Other			1								1		2
N/A													
Unknown													
TOTAL:	0	0	1	0	0	0	0	0	0	0	1	0	2

Complaint(s) Resolution by Program Type

Fee for Service January, February and March	Fully or partially resolved to Member's satisfaction			Not resolved to Member's satisfaction			No action needed or appropriate			Open			Total
	J	F	M	J	F	M	J	F	M	J	F	M	
AIDS/HIV Waiver													
Brain Injury Waiver													
Children's Mental Health Waiver													
Dental													
Duals													
Elderly Waiver													
Habilitation													
Health & Disability Waiver													
HIPP													
Institutional Care													
Iowa Health & Wellness													
Intellectual Disability Waiver			3										3
Medicare													
PACE													
Physical Disability Waiver													
QMB or SLMB													
Traditional Medicaid													
Other		5			1			1		5			12
N/A													
Unknown													
TOTAL:	0	5	3	0	1	0	0	1	0	5	0	0	15

Iowa Total Care January, February and March	Fully or partially resolved to Member's satisfaction			Not resolved to Member's satisfaction			No action needed or appropriate			Open			Total
	J	F	M	J	F	M	J	F	M	J	F	M	
AIDS/HIV Waiver													
Brain Injury Waiver		5											5
Children's Mental Health Waiver													
Dental													
Duals													
Elderly Waiver										2			2
Habilitation													
Health & Disability Waiver	3	3								3	3	2	14
HIPP													
Institutional Care													
Iowa Health & Wellness													
Intellectual Disability Waiver													
Medicare													
PACE													
Physical Disability Waiver												3	3
QMB or SLMB													
Traditional Medicaid		1									7		8
Other	2	4							1	2			9
N/A													
Unknown									-				
TOTAL:	5	13	0	0	0	0	0	0	1	7	10	5	41

COMPLAINTS & CASES

JANUARY

In January the Managed Care Ombudsman Program worked on complaints from 56 individual members. Out of the 46 active cases, 15 are newly opened. The top complaint from managed care members in January was in regard to Access to Services/Benefits (22 members). Additional complaints include:

All open cases:
Case Management (11 members) Access to Services/Benefits (18 members) Services reduced, denied or terminated (18 members) CCO & CDAC (14 members) Transition services/coverage gap, inadequate or inaccessible (6 members) Other/Member charged improper cost sharing or waiting on CDAC staff to be approved (2 members) Member Rights (13 members) Level of Care (12 members) NOD, Appeals, Fair Hearing (8 members) Complaints against provider (6 members) Eligibility & Enrollment (9 members) Care Planning (12 members) Access to durable medical equipment and medications (10 members) Discharge (5 members) Transportation (7 members) Home and vehicle modifications (1 member) Member Relations & Grievances (7 members) Guardianship (1 member) Network Adequacy (4 members) Prior Authorization (5 members) Exception to Policy (3 members)

Closed cases:
Case Management (5 members) Access to Services/Benefits (4 members) Services reduced, denied or terminated (1 member) CCO & CDAC (0 members) Transition services/coverage gap, inadequate or inaccessible (0 members) Other/Member charged improper cost sharing or waiting on CDAC staff to be approved (0 members) Member Rights (1 member) Level of Care (1member) NOD, Appeals, Fair Hearing (1 member) Complaints against provider (1 member) Eligibility & Enrollment (1 member) Care Planning (2 members) Access to durable medical equipment and medications (3 members) Discharge (1 member) Transportation (3 members) Home and vehicle modifications (1 member) Member Relations & Grievances (1 member) Guardianship (2 members) Network Adequacy (0 members) Prior Authorization (2 members) Exception to Policy (0 members)

FEBRUARY

In the month of February the Managed Care Ombudsman Program worked on complaints from 77 individual members. Out of the 39 active cases, 15 are newly opened. The top complaint from managed care members in February was in regard to Access to Services/Benefits (32 members). Additional complaints include:

All open cases:
Case Management (16 members) Access to Services/Benefits (15 members) Services reduced, denied or terminated (11 members) CCO & CDAC (12 members) Transition services/coverage gap, inadequate or inaccessible (5 members) Member Rights (6 members) Level of Care (9 members) NOD, Appeals, Fair Hearing (9 members) Complaints against provider (3 members) Eligibility & Enrollment (6 members) Care Planning (13 members) Access to durable medical equipment and medications (7 members) Discharge (5 members) Transportation (5 members) Home and vehicle modifications (1 member) Member Relations & Grievances (6 members) Guardianship (1 member) Exception to policy (4 members) Network Adequacy (3 members) Prior Authorization (1 member)

COMPLAINTS & CASES

Closed cases:
Case Management (14 members) Access to Services/Benefits (17 members) Services reduced, denied or terminated (9 members) CCO & CDAC (6 members) Transition services/coverage gap, inadequate or inaccessible (5 members) Member Rights (8 members) Level of Care (8 members) NOD, Appeals, Fair Hearing (5 members) Complaints against provider (5 members) Eligibility & Enrollment (8 members) Care Planning (8 members) Access to durable medical equipment and medications (6 members) Discharge (1 member) Transportation (8 members) Home and vehicle modifications (1 member) Member Relations & Grievances (4 members) Guardianship (0 members) Exception to policy (2 members) Network Adequacy (0 members) Prior Authorization (0 members)

MARCH

In March the Managed Care Ombudsman Program worked on complaints from 46 individual members. Out of the 31 active cases, 12 are newly opened. The top complaint from managed care members in March was in regard to Access to Services/Benefits (18 members). Additional complaints include:

All open cases:
Case Management (10 members) Access to Services/Benefits (14 members) Services reduced, denied or terminated (10 members) CCO & CDAC (8 members) Transition services/coverage gap, inadequate or inaccessible (3 members) Other/Covid-19 education and information (1 member) Member Rights (5 members) Level of Care (7 members) NOD, Appeals, Fair Hearing (8 members) Complaints against provider (2 members) Eligibility & Enrollment (6 members) Care Planning (10 members) Access to durable medical equipment and medications (6 members) Discharge (4 members) Transportation (2 members) Home and vehicle modifications (1 member) Member Relations & Grievances (7 members) Guardianship (1 member) Exception to Policy (4 members) Prior Authorization (0 members) Network Adequacy (2 members)

Closed cases:
Case Management (5 members) Access to Services/Benefits (4 members) Services reduced, denied or terminated (2 members) CCO & CDAC (2 members) Transition services/coverage gap, inadequate or inaccessible (3 members) Other/Covid-19 education and information (0 members) Member Rights (1 member) Level of Care (1 member) NOD, Appeals, Fair Hearing (2 members) Complaints against provider (2 members) Eligibility & Enrollment (1 member) Care Planning (1 member) Access to durable medical equipment and medications (2 members) Discharge (0 members) Transportation (1 member) Home and vehicle modifications (1 member) Member Relations & Grievances (2 members) Guardianship (1 member) Exception to Policy (4 members) Prior Authorization (1 member) Network Adequacy (0 members)

MANAGED CARE OMBUDSMAN PROGRAM TRENDS

In addition to tracking member issues on a monthly basis, the Managed Care Ombudsman Program documents and tracks trends discussed by members. Issues and trends identified this quarter included:

1. Transportation issues created challenges for many members trying to attend regularly scheduled medical appointments or access specialty healthcare. Members reported safety concerns with new transportation providers showing up to provide transportation for the members, lacking knowledge of the members disabilities and challenges pertaining to mobility. Many providers sent drivers out with ill equipped vehicles which did not meet the members needs or provide a safe transportation ride . Members were not always able to utilize their provider of choice and experienced poor customer service.
2. Lack of Providers. Members have reported a lack of approved CDAC providers as well as an overall lack of providers accessible to the members to provide services. For members living in remote rural areas, this issue was more prevalent. The lack of providers includes medical physicians, skilled care providers, transportation drivers, chore/homemaking providers and home modification providers as well as CDAC staff. Some members have lost their providers due to the provider not being paid for services rendered.
3. Denials of durable medical equipment (DME). Medicaid members experienced denials when trying to obtain DME prescribed and recommended by their physician, resulting in members filing appeals and/or fair hearing requests. Members reported the lack of contracted providers willing to work with the MCOs, which created more barriers for members to receive DME.
4. COVID-19 Planning. Members reported concerns about the virus COVID-19 and the Department of Human Resources began to post resources for the public to access the latest information to help those in need being affected by the COVID-19 Pandemic.
5. Pandemic Waiver response. A COVID-19 Waiver was implemented for Medicaid members to gain access to home delivered meals, services and health care which otherwise might have been denied or limited.
6. Provider and Facility Nonpayment. Providers continue to report nonpayment or receive inadequate payment from the members assigned MCO. Some CDAC providers have had to find other means of employment to make ends meet and at times this has placed the member at risk in their home without staff or services which have been approved to meet the members level of care. Lack of payment and late payments, have had a direct impact on the amount of providers available to provide services necessary to adequately maintain a member's daily health requirements.
7. Prior authorization. The time for prior authorizations to be approved or resubmitted due to initial denials, lengthened wait times for the member to receive prescribed medications and medical care. Often PA's needed to be submitted more than once.
8. Medicaid members are filing more appeals due to denials regarding the need for more service hours to provide necessary support and care in the members home as well as denials pertaining to Durable Medical Equipment (DME).
9. Access to Services/Benefits. Members experienced additional stressful daily living conditions when they did not have any provider to assist and provide approved services such as daily chore services which include lawn care, snow removal and housecleaning. Without these services being completed the members reported they then lacked access to leaver their home and skilled care and direct care were at times blocked from going into the members home. A member received a city fine due to the inability to access lawn care.

MANAGED CARE OMBUDSMAN PROGRAM TRENDS

A managed care ombudsman advocated for a member on the Physical Disability Waiver program in obtaining DME in their home. The member was at risk without a voice activation device, life alert and phone landline. With the aide of the managed care ombudsman and support from the MCO and members physician, the member remained safe in their home with

ADDITIONAL MATERIALS

The Managed Care Ombudsman Program maintains a website with information regarding the program's services, informational materials and links to other resources. Electronic versions of communications materials and tools can be found at the Managed Care Ombudsman website. Additionally, How to Be Your Own Best Advocate: A Guide on How to Navigate Managed Care In Iowa is a resource for members.

UPCOMING EVENTS

Quarter 2 Annual Provider Training, All Topics
Locations: Cedar Rapids, Davenport, Des Moines, Dubuque, Sioux City, Waterloo
June 2020 (final date TBA), 9 am – 12 pm & 1 pm – 4 pm

Quarter 4 Session, Topic: Durable Medical Equipment (DME)
September 2020 (final date TBA)

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