MANAGED CARE OMBUDSMAN PROGRAM QUARTERLY REPORT

Year 4, Quarter 3
(October 1 - December 31, 2019)

Managed Care
OMBUDSMAN PROGRAM
A Division of the Office of the State Long-Term Care Ombudsman

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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, or elder group home, or who are enrolled in one of the seven home and community-based services (HCBS) waiver programs, which 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.

Beginning January 1, 2019 the reporting format for the Managed Care Ombudsman Program monthly reports changed. The Managed Care Ombudsman now reports cases and complaints from the managed care members this Office serves. This reporting method more accurately reflects members served and those members' issues as opposed to the previous contacts reporting method.

The issuance of this quarterly report was significantly delayed due to a change in the federal reporting system for long-term care ombudsman programs which impacted the Managed Care Ombudsman Program's ability to compile figures and run reports. We apologize for any inconvenience this delay has caused and do not anticipate these types of delays in the future.

For this reporting quarter, the office experienced a slight fluctuation of cases/complaints per month, with individual member cases 63 in October, 55 in November and 59 in December.

The issues identified for this third quarter are the primary managed care member issues addressed in October, November and December 2019. The Office works with a variety of stakeholders who are necessary to address and resolve issues. The Office does so through a variety of methods, including encouraging use of best practices; facilitating and coordinating communication with necessary parties; and referring to outside agencies as necessary. During Quarter 3-Year 4 of Medicaid managed care, members reported the following primary issues:

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 third programmatic quarter of Year 4 (October, November and December 2019), 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

Category	Item	Count
Members per MCO[1] in process October 2019	Amerigroup Iowa	40
	Iowa Total Care	22
	UnitedHealthcare Plan of the River Valley	4
	Fee for Service	-
Referrals per Entity[2]	Department of Human Services	3
	Department of Inspections and Appeals	2
	Disability Rights Iowa	11
	Iowa Compass	1
	Iowa Legal Aid	10
	LifeLong Links	1
	MCO	1
	Medicaid Fraud Control Unit	-
	Provider	-
	Senior Health Insurance Information Program	-
	State Ombudsman Office	11
	Other	4
Grievances/Appeals/Fair Hearings	Grievance assistance	3
	Appeals assistance	2
	Fair Hearing assistance	1

Category	Item	Count
Members per MCO[1] in process November 2019	Amerigroup Iowa	34
	Iowa Total Care	18
	UnitedHealthcare Plan of the River Valley	1
	Fee for Service	1
Referrals per Entity[2]	Department of Human Services	1
	Department of Inspections and Appeals	-
	Disability Rights Iowa	2
	Iowa Compass	-
	Iowa Legal Aid	-
	LifeLong Links	-
	MCO	1
	Medicaid Fraud Control Unit	-
	Provider	1
	Senior Health Insurance Information Program	-
	State Ombudsman Office	1
	Other	-
Grievances/Appeals/Fair Hearings	Grievance assistance	3
	Appeals assistance	1
	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.

MEMBER ASSISTANCE

Members per MCO[1] in process December 2019	Amerigroup Iowa	40
	Iowa Total Care	16
	UnitedHealthcare Plan of the River Valley	2
	Fee for Service	1
Referrals per Entity[2]	Department of Human Services	-
	Department of Inspections and Appeals	1
	Disability Rights Iowa	3
	Iowa Compass	-
	Iowa Legal Aid	-
	LifeLong Links	-
	MCO	2
	Medicaid Fraud Control Unit	-
	Provider	-
	Senior Health Insurance Information Program	-
	State Ombudsman Office	5
	Other	2
Grievances/Appeals/Fair Hearings	Grievance assistance	-
	Appeals assistance	1
	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.

A Intellectual Disability Waiver Member received a Notice of Decision from their MCO without appeal or grievance information. When the guardian tried to assist the member by calling the MCO, they were told guardianship papers were not found. The Managed Care Ombudsman Program worked with the member's MCO, IME and guardians to ensure a new case manager was assigned as requested and guardianship papers were accessible. Once the proof of guardianship was uploaded, the guardians were able to file a grievance and support the member. A new case manager contacted the family and assisted with the care planning necessary for CDAC, SCL , Day HAB and Respite services to continue ensuring the member did not experience a gap in health services.

Complaint(s) Resolution by Program Type

Amerigroup Iowa October, November and December	Fully or partially resolved to Member's satisfaction			Not resolved to Member's satisfaction			No action needed or appropriate			Open			Total
	O	N	D	O	N	D	O	N	D	O	N	D	
AIDS/HIV Waiver													
Brain Injury Waiver	2									2		6	10
Children's Mental Health Waiver												3	3
Dental													
Duals													
Elderly Waiver	3	16	5		1			4		21	2	1	53
Habilitation			2									2	4
Health & Disability Waiver			4							7	4	10	25
HIPP													
Institutional Care													
Iowa Health & Wellness													
Intellectual Disability Waiver	9	3	13	4						19	5	10	63
Medicare													
PACE													
Physical Disability Waiver			3							2			5
QMB or SLMB													
Traditional Medicaid													
Other	1	1	4							8	1	4	19
N/A													
Unknown													
TOTAL:	15	20	31	4	1	0	0	4	0	59	12	36	182

UnitedHealthcare Plan of the River Valley October, November and December	Fully or partially resolved to Member's satisfaction			Not resolved to Member's satisfaction			No action needed or appropriate			Open			Total
	O	N	D	O	N	D	O	N	D	O	N	D	
AIDS/HIV Waiver													
Brain Injury Waiver													
Children's Mental Health Waiver													
Dental													
Duals													
Elderly Waiver	1									1			2
Habilitation													
Health & Disability Waiver													
HIPP													
Institutional Care													
Iowa Health & Wellness													
Intellectual Disability Waiver				4			3			1			8
Medicare													
PACE													
Physical Disability Waiver													
QMB or SLMB													
Traditional Medicaid													
Other			1								1		2
N/A													
Unknown													
TOTAL:	1	0	1	4	0	0	3	0	0	2	1	0	12

Complaint(s) Resolution by Program Type

Fee for Service October, November and December	Fully or partially resolved to Member's satisfaction			Not resolved to Member's satisfaction			No action needed or appropriate			Open			**Total**
	O	N	D	O	N	D	O	N	D	O	N	D	
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													
N/A													
Unknown													
TOTAL:	0	0	3	0	0	0	0	0	0	0	0	0	3

Iowa Total Care October, November and December	Fully or partially resolved to Member's satisfaction			Not resolved to Member's satisfaction			No action needed or appropriate			Open			**Total**
	O	N	D	O	N	D	O	N	D	O	N	D	
AIDS/HIV Waiver													
Brain Injury Waiver		4								4			8
Children's Mental Health Waiver													
Dental													
Duals													
Elderly Waiver	4	3	7							7		6	27
Habilitation		2								2			4
Health & Disability Waiver			4							10	1	3	18
HIPP													
Institutional Care													
Iowa Health & Wellness		1									1		2
Intellectual Disability Waiver			9			1				3	3		16
Medicare													
PACE													
Physical Disability Waiver										4			4
QMB or SLMB													
Traditional Medicaid													
Other		9								4			13
N/A													
Unknown													
TOTAL:	4	19	20	0	0	1	0	0	0	34	5	9	92

COMPLAINTS & CASES

OCTOBER

In October the Managed Care Ombudsman Program worked on complaints from 63 individual members. Out of the 43 active cases, 23 are newly open. The top complaint from managed care members in October was in regard to Access to Services/Benefits (33 members). Additional complaints include:

All open cases:
Case Management (16 members) Access to Services/Benefits (22 members) Services reduced, denied or terminated (12 members) CCO & CDAC (7 members) Transition services/coverage gap, inadequate or inaccessible (7 members) Member Rights (15 members) Level of Care (10 members) NOD, Appeals, Fair Hearing (6 members) Complaints against provider (1 member) Eligibility & Enrollment (7 members) Care Planning (12 members) Access to durable medical equipment and medications (6 members) Discharge (2 members) Transportation (9 members) Home and vehicle modifications (2 members) Member Relations & Grievances (5 members) Guardianship (2 member) Network Adequacy (4 members) Exception to Policy (2 members)

Closed cases:
Case Management (7 members) Access to Services/Benefits (11 members) Services reduced, denied or terminated (5 members) CCO & CDAC (5 members) Transition services/coverage gap, inadequate or inaccessible (0 members) Member Rights (2 members) Level of Care (2 members) NOD, Appeals, Fair Hearing (1 member) Complaints against provider (3 members) Eligibility & Enrollment (1 member) Care Planning (1 member) Access to durable medical equipment and medications (4 members) Discharge (2 members) Transportation (7 members) Home and vehicle modifications (0 members) Member Relations & Grievances (4 members) Guardianship (0 members) Network Adequacy (2 members) Exception to Policy (0 members)

NOVEMBER

In November the Managed Care Ombudsman Program worked on complaints from 55 individual members. Out of the 38 active cases, 7 are newly opened. One case was not captured in the previous November grids due to eligibility not determined at that time. The top complaint from managed care members in November was in regard to Access to Services/Benefits (29 members). Additional complaints include:

All open cases:
Case Management (16 members) Access to Services/Benefits (20 members) Services reduced, denied or terminated (14 members) CCO & CDAC (11 members) Transition services/coverage gap, inadequate or inaccessible (8 members) Member Rights (10 members) Level of Care (8 members) NOD, Appeals, Fair Hearing (5 members) Complaints against provider (3 members) Eligibility & Enrollment (6 members) Care Planning (15 members) Access to durable medical equipment and medications (8 members) Discharge (4 members) Transportation (4 members) Home and vehicle modifications (1 member) Member Relations & Grievances (7 members) Guardianship (0 members) Network adequacy (4 members) Prior Authorization (3 members) Exception to Policy (1 member)

COMPLAINTS & CASES

Closed cases:
Case Management (6 members) Access to Services/Benefits (9 members) Services reduced, denied or terminated (1 member) CCO & CDAC (1 member) Transition services/coverage gap, inadequate or inaccessible (1 member) Member Rights (3 members) Level of Care (4 members) NOD, Appeals, Fair Hearing (0 members) Complaints against provider (0 members) Eligibility & Enrollment (4 members) Care Planning (4 members) Access to durable medical equipment and medications (4 members) Discharge (0 members) Transportation (4 members) Home and vehicle modifications (0 members) Member Relations & Grievances (1 members) Guardianship (1 member) Network adequacy (1 member) Prior Authorization (1member) Exception to Policy (1 member)

DECEMBER

In December the Managed Care Ombudsman Program worked on complaints from 59 individual members. Out of the 38 active cases, 14 are newly opened. The top complaint from managed care members in December was in regard to Access to Services/Benefits (29 members). Additional complaints include:

All open cases:
Case Management (13 members) Access to Services/Benefits (19 members) Services reduced, denied or terminated (13 members) CCO & CDAC (7 members) Transition services/coverage gap, inadequate or inaccessible (5 members) Other/Lack of staff available within an agency (2 members) Member Rights (10 members) Level of Care (7 members) NOD, Appeals, Fair Hearing (3 members) Complaints against provider (6 members) Eligibility & Enrollment (3 members) Care Planning (12 members) Access to durable medical equipment and medications (13 members) Discharge (5 members) Transportation (6 members) Home and vehicle modifications (2 members) Member Relations & Grievances (8 members) Guardianship (2 members) Prior Authorization (6 members) Network Adequacy (3 members) Exception to Policy (2 members)

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

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. 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.

2. CDAC and CCO Impacts. CDAC and CCO are choices available to managed care members who are eligible for one of the home and community-based services (HCBS) waiver programs and is a service frequently used by HCBS waiver members. The Managed Care Ombudsman Program continues to receive a high number of complaints from members reporting dissatisfaction with changes affecting their CDAC services. Changes include service reductions or denials, and also changes that impact the day to day use of CDAC services. Members reported issues accessing new CDAC providers of their choosing, barriers to using CDAC services they would like, and perceived decreased flexibility within the service. Members were also concerned over their CDAC provider not receiving payment on time. Managed care members have reported CCO budgets have not been completed on time, effecting the members ability to schedule staff to provide services needed.

3. 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 who were strangers to the members, who did not understand the individual member needs, or did not have vehicles equipped for specific types of medical equipment. Members were not always able to utilize their provider of choice.

4. Guardianship issues. During the transitions between different MCOs, member information was not transferred over in a timely manner, which impacted the time frame for MCO contact with the member and/or guardian to establish healthcare meetings, assessments and overall services. Members report at times, decisions and changes were made without the guardians involvement and support.

5. 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.

6. 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.

MANAGED CARE OMBUDSMAN PROGRAM TRENDS

7. Prior authorization. Many prescriptions and medical services were requiring a prior authorization for the first time. 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.

A Medicaid member on the Intellectual Disability Waiver program lost eligibility due to a language barrier during the eligibility review process. The Managed Care Ombudsman Program worked with IME and the family to request an exception to policy to assist the member with getting back on the Intellectual Disability Waiver. The MCO has assisted with access to health services needed until the member is approved for the waiver again.

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

Quarterly Provider Training Sessions 2020
Quarter 2, Home- and Community-Based Services (HCBS) Waivers and Consumer-Directed Attendant Care (CDAC)
March 2020 (final date TBA), 9 am – 12 pm & 1 pm – 4 pm
Location: Mason City

Quarter 3 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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