Managed Care Ombudsman Quarterly Report

Year 7, Quarter 2

(July 1 – Sept. 30, 2022)

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. These members include people who receive care in a healthcare facility, assisted living program, 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.

For this reporting quarter, the Office experienced a fluctuation of individual member cases/complaints per month, as follows: 39 in July, 30 in August and 32 in September.

The issues identified for the second quarter are primary managed care member issues addressed in July, August and September 2022. The Office works with a variety of essential stakeholders to help address and resolve issues. The Office deploys 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 2 -Year 7 of Medicaid managed care; members reported the following primary issues:

1. Access to Services/Benefits. Waiver members reported a lack of available providers. The lack of providers includes medical physicians, skilled care providers, transportation drivers, chore/homemaking providers and home modification providers. The lack of providers available to members had a direct impact on the members' overall health, as did the wait time members experienced for service benefits to be approved. Some members did not receive all services, for which they were approved.

2. CDAC and CCO Impacts. Consumer Directed Attendant Care and Consumer Choice Options, are choices available to Medicaid 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 changes that impact the day to day use of CDAC services. Members were also concerned over their CDAC provider not receiving payment on time. Members have reported a lack of approved CDAC providers for members living in remote rural areas; this issue was more prevalent. Some members have lost their providers due to the provider not being paid for services rendered.

3. Case Management. Case management issues are ongoing with poor communication from their case managers. Members share they have experienced a lack of case manager services when needed. Some of this is due to their lack of understanding about case manager obligations, when it comes to approving necessary services.

The report that follows includes an overview of the second programmatic quarter of Year 7 (July, August and September 2022), as well as an update on the program, community partnerships, outreach efforts and administrative activities.

For further information, please contact the Managed Care Ombudsman Program at (866) 236-1430 or https://www.iowaaging.gov/state-long-term-care-ombudsman/managed-care-ombudsman-program

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. Transition services/coverage gap, inadequate or inaccessible. Medicaid members report lengthy wait times when needing assistance with transitioning Medicaid programs and at times a lack of care planning, disruption in the continuity of care of the member creates a gap of services where the member does not receive the care they need, thus placing the member at risk.

2. Lack of Providers. Members have reported a lack of approved providers to choose from in order to receive health services. Reasons shared for lack of providers are that the MCO and/or the provider are not wanting to contract with one another. For members living in remote rural areas, this issue was more prevalent. The lack of providers includes medical physicians, transportation drivers and home modification providers as well as CDAC staff.

3. DME Access. Medicaid members experienced denials when trying to obtain durable medical equipment (DME) prescribed and recommended by their physician. Members reported the lack of contracted providers willing to work with the MCO's, and approved bids by the assigned MCO created more barriers. Members also reported having to wait for medically necessary equipment to be approved and then accessed. These barriers continue to affect the quality of life for the member.

4. Services reduced, denied or terminated for members needing long-term services and supports. Members that need long-term services and supports, reported reductions or denials in their HCBS waiver services in their homes or assisted living programs. Many times these health services had been approved in the past. The unexpected change often affected consumer directed attendant care (CDAC) and consumer choice options (CCO) service hours. In response to reductions in services, members request more formal appeals and fair hearings to gain access to the services they feel are necessary for their health and safety.

5. Home and Vehicle Modification barriers. Members reported lengthy periods to acquire the modification necessary to remain independent in their home from the point of applying for bids from available providers, to appealing denials.

6. DME Access Medicaid members experienced denials when trying to obtain durable medical equipment (DME) prescribed and recommended by their physician. Members reported they received denials, even when the members' care team had included medical recommendations as to why the member would require DME as a medical necessity. This resulted in members filing for appeals and/or fair hearings requests. Members reported a lack of providers willing to work with the MCOs, which created more barriers for members. These barriers continued to affect the quality of life for members.

COMMUNITY PARTNERSHIPS AND OUTREACH

Advocacy is more than complaint resolution or assistance with filing a grievance, appeal or fair hearing. It includes providing education, information, consultation, technical assistance or making a referral to the appropriate entity to ensure members have the information needed to make informed decisions regarding their care, in addition to partnering with community stakeholders to connect members to resources beyond the Managed Care Ombudsman's scope.

The Managed Care Ombudsman Program networks with other advocacy and provider groups, associations, organizations and agencies to coordinate the provision of assistance to members. The Managed Care Ombudsman Program also participates, when possible, in various forums and work groups on a regular basis to inform, discuss and to address collective concerns expressed by members.

Additionally, 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
https://www.iowaaging.gov/state-long-term-care-ombudsman/managed-care-ombudsman-program

The Managed Care Ombudsman Program as well as the State Long Term Care Ombudsman Program invites all LTSS members and their providers to visit our social media sites. You can find information by checking out our Facebook and Instagram pages.

https://www.facebook.com/profile.php?id=100076034146712

https://www.instagram.com/iowa_ltc_ombudsman/