OFFICE OF THE
State Long-Term Care
Ombudsman

Managed Care Ombudsman Quarterly Report

Year 7, Quarter 3

(Oct 1 - Dec 31, 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.

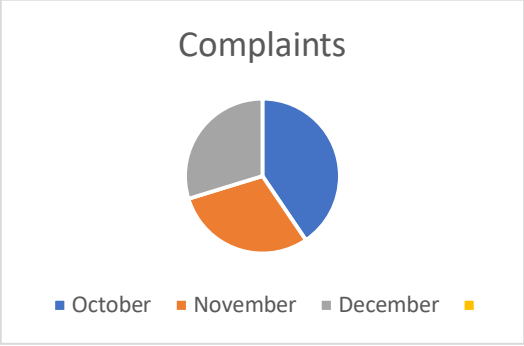
The report that follows includes an overview of the third programmatic quarter of Year 7 (October, November and December of 2022), as well as an update on the program, community partnerships, outreach efforts and administrative activities.

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 3 -Year 7 of Medicaid managed care; members reported the following primary issues:

1. **Access to Services/Benefits** Access to services or benefits are attributed to waiver members reporting a lack of available 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. These issues effect the members directly, resulting in members rights being ignored and de-valued.

2. **Care Coordinator / Case Manager was rude or gave poor customer service** Poor care coordination can disrupt the continuity of care where the member does not receive ongoing care, ultimately placing the member at risk. Poor customer service received from a case manager has a negative impact on members and a major barrier to being treated with dignity and respect - a fundamental right under the Older American's Act (OAA).

3. **Care Planning – related issues** Care planning issues vary from lack of care plans to care plans not being followed to the members' satisfaction. Members are negatively impacted when experiencing care planning issues that affect treatment plans, choices regarding alternatives and not being invited to participate in the care planning process. A lack of care planning or disruption in the continuity of care of the member creates a gap of services where the member does not receive the care they need ultimately placing the member at risk.



For this reporting quarter, the Office experienced a fluctuation of individual member complaints per month, as follows: 79 in October, 58 in November and 59 in December, totaling 196. This was nearly a 100% increase from the previous Quarter 2 which totaled 101. This may be partially attributed to the annual enrollment period.

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 to a new residence and/or Medicaid program. A lack of care planning or disruption in the continuity of care of the member creates a gap of services where the member does not receive the care they need ultimately placing the member at risk.

2. **Member Rights** Complaints include not being treated with dignity and respect, compromised privacy and confidentiality, not being included in one's own care planning process, decisions about treatment options and plans or alternatives are not open to the member. Member rights are violated when decisions on how to live, including when to go to bed, when to get up, what to eat, and other decisions of living are not considered. Members report discrimination, not being in control of personal belongings, unsecure personal possessions and the lack of freedom to pursue personal interests; all significant member rights. Some complains are due to not being able to express grievances without fear of reprisal. Members sometimes are not fully informed about services and costs. Members' rights are violated if they are restrained, abused or neglected.

3. **Consumer-directed Attendant Care and Consumer Choice Options** (CDAC and CCO) are choices available to Medicaid members who are eligible for one of the Home and Community-Based Services (HCBS). HCBS programs and services are frequently used by members. Members are frequently concerned over their CDAC provider not receiving payment on time. Lack of approved CDAC providers for members living in remote rural areas is more prevalent. Some members have lost their providers due to the provider not being paid for services rendered. Services are designed to help people do things that they normally would for themselves if they were able. Funding is limited and service providers are experiencing labor shortages.

The Quarter 3 complaint totals comprised 71% who were Amerigroup members, 23% who were members with Iowa Total Care, 3% were from Fee-for-Service members and 3% had no associated MCO. The program opened up 32 new cases and closed 11. Most of the cases opened were managed care members that were served by the Elderly Waiver, Intellectual Disability Waiver, Brain Injury and the Health and Disability Waiver.

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: Managed Care Ombudsman Program