OFFICE OF THE
State Long-Term Care
Ombudsman

Managed Care Ombudsman Quarterly Report

Year 7, Quarter 4

(Jan 1 - Mar 31, 2023)

EXECUTIVE SUMMARY

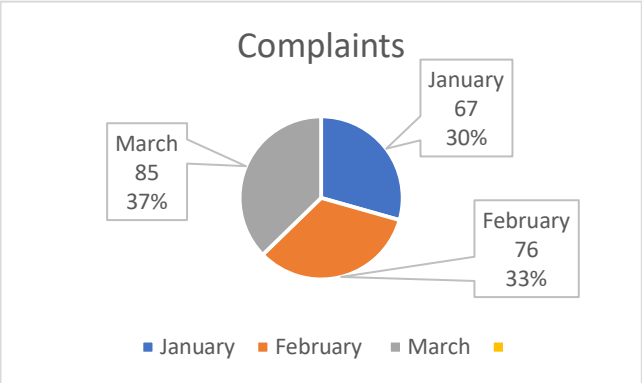
The Office of the State Long-Term Care Ombudsman's Managed Care Ombudsman Program advocates to resolve managed care issues on behalf of Medicaid managed care members. These members include people who receive care in a healthcare facility, assisted living program, elder group home, or who are enrolled 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 fourth programmatic quarter of Year 7 (January, February and March of 2023), as well as an update on the program, community partnerships, outreach efforts and administrative activities. During Quarter 4 -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. **Services Reduced, denied or terminated** Members needing 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.

3. **Access to durable medical equipment (DME)** Members reported problems with accessing durable medical equipment. Members experienced denials when trying to obtain DME, prescribed and recommended by their physician. This resulted in members filing for appeals and/or fair hearings requests. 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. These kinds of problems can result in ongoing physical mobility issues, hampering independence, diminishing physical strength and affecting ones' mental outlook on being self-determined.



For this reporting quarter, the Office experienced a fluctuation of individual member complaints per month, as follows: 67 in January, 76 in February and 85 in March, totaling 228. This was nearly a 16% increase from the previous Quarter 3 which totaled 196. 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. **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.

2. **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.

3. **Discharge** Medicaid members have been discharged without a discharge plan in place at times. This leads to a gap in services for the member and inadequate transitions from one residence to another. Many times, the member loses eligibility for waiver benefits and in-home services or they are placed in a facility which was not of their choice.

The Quarter 4 complaint totals comprised 61% who were Amerigroup members, 35% who were members with Iowa Total Care, 3% were from Fee-for-Service members and 2% had no associated MCO. The program opened 40 new cases and closed 12. Most of the cases opened were managed care members that were served by the Elderly Waiver, Intellectual Disability Waiver, and 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.

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