Managed Care Ombudsman Program Quarterly Report

2nd Quarter - July/August/September 2016

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

Since the launch of managed care in Iowa, the Office of the State Long-Term Care Ombudsman's Managed Care Ombudsman Program has been advocating on behalf of Medicaid managed care members who receive care in a health care facility, assisted living program or elder group home, or 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
- Physical Disability Waiver

In addition to advocating on behalf of members, the Managed Care Ombudsman Program also provides education and information regarding managed care plans, services, care and processes, guidance with the grievance and appeals process, and complaint resolution for members needing assistance with resolving issues with their managed care plan or navigating the managed care system.

This report provides an update on the following items for the first programmatic quarter (July, August and September 2016):

- 2nd Quarter Overview
- Systemic Trends
- Community Partnerships and Outreach
- Managed Care Ombudsman Program Administrative Update

QUARTERLY OVERVIEW

The Managed Care Ombudsman Program is required to track issues on a monthly basis. For analysis purposes, this report provides a high-level overview of the data aggregated over the three months of July, August, and September 2016.

Contacts

The Managed Care Ombudsman is available by telephone, email and mail; however, most contacts made to the program are received via telephone. The total number of contacts fluctuates among months for various reasons, such as the approach of a deadline for members to change their managed care organization (MCO) without cause or the issuance of materials by Iowa Medicaid Enterprise (IME) that are difficult for members to understand.

Top Issues

There are nine major issue categories that the program tracks on a monthly basis (please refer to the Monthly Report for the categories). Each major category has subcategories that further define the issue. The most prevalent issues addressed during this quarter included:

- Change in care setting
- Member lost eligibility status or was denied
- Prior authorizations

Average Resolution Time

The resolution time begins when the Managed Care Ombudsman receives the issue and ends when the issue is resolved. The average resolution time is calculated each month by adding the resolution time for each issue together and dividing by the total number of issues handled that month. Oftentimes, the Managed Care Ombudsman must work with other agencies or organizations (i.e., IME, the member's MCO, the Office of the State Long-Term Care Ombudsman) to resolve the issue.

Many of the issues that came to the office during this quarter were systemic in nature, impacting multiple populations and members across the state and requiring resolution at the policy and systems level.

Program

Within the second quarter, the majority of calls received came from members enrolled or having issues with the Elderly Waiver program or the Intellectual Disability Waiver program. The program also received an increase in contacts regarding the Children's Mental Health Waiver as well as several contacts reported as Unknown (due to the inability to verify a member's program enrollment).

A Medicaid member needed assistance with finding placement upon returning to Iowa. The member experienced a severe heart attack and several strokes, paralyzing them from the neck down. The member's family sought assistance from the Managed Care Ombudsman with finding a facility within the state.

The Managed Care Ombudsman advocated with the member and their family to find placement. The Managed Care Ombudsman worked successfully with the MCOs on addressing the many challenges the member was experiencing in order to place the member in the least restrictive care setting that met their care needs and preferences here in Iowa.

Grievances/Appeals/Fair Hearings

The Managed Care Ombudsman Program attempts to resolve issues informally in effort to expedite issue resolution. For Quarter 2, the Managed Care Ombudsman Program received 14 contacts regarding a grievance and 24 regarding an appeal. There have been 2 contacts regarding a fair hearing during this quarter.

The table below shows a side-by-side comparison of the data discussed:

Month	Number of Contacts	Top Three Issues	Average Resolution Time	Program	Contacts per MCO	Contacts Related to Grievances/Appeals/ Fair Hearings
July	81	1. Access to DME 2. Change in care setting 3. Service reduced, denied, terminated	6 days	1. Elderly Waiver 2. IA Health & Wellness 3. Intellectual Disability Waiver	Amerigroup = 16 AmeriHealth = 27 United = 17	Grievances = 1 Appeals - 13 Fair hearings = 2
August	130	1. Prior authorizations 2. Change in care setting 3. Care coordinator gave poor customer service	7 days	1. Intellectual Disability Waiver 2. Elderly Waiver 3. Children's Mental Health Waiver	Amerigroup = 39 AmeriHealth - 60 United = 15	Grievances = 1 Appeals = 7 Fair hearings = 0
September	188	1. Change in care setting 2. Member lost eligibility status or was denied 3. Access to services/benefits Other	11 days	1. Elderly Waiver 2. Unknown 3. Duals	Amerigroup = 42 AmeriHealth = 90 United = 29	Grievances = 12 Appeals = 4 Fair hearings = 0
Qtr 2 Total	399	1. Change in care setting 2. Member lost eligibility status or was denied 3. Prior authorizations		1. Elderly Waiver 2. Intellectual Disability Waiver 3. Unknown	Amerigroup = 97 AmeriHealth = 177 United = 61	Grievances = 14 Appeals = 24 Fair hearings = 2

TABLE 1: QUARTER 2 CONTACT DATA (JULY, AUGUST, SEPTEMBER 2016)

SYSTEMIC TRENDS

In addition to tracking monthly member issues, the Managed Care Ombudsman Program documents and tracks systemic trends brought to the attention of the office. The following discusses the systemic trends identified:

1) Written Notification - Members have reported not receiving written notification from their MCO regarding a change in their care such as a reduction in hours of a particular service or denial of a previously authorized benefit or service and, instead, are learning of the changes through their provider providing that service. It is concerning that not only are members not being notified of a change in their service, benefits or authorizations which then disrupts the provision of care within their service plan that members depend on, but are then being denied the right to appeal the decision with the MCO since no formal written decision was issued and timeframes may have passed.

2) Communication/Understanding of Policies and Procedures - There is widespread confusion regarding various policies and procedures among members and providers. For example, the office has received several issues from members and providers regarding the misunderstanding of who is able to issue exceptions to policies (ETP) in order to make a request that goes beyond the scope of the member's program. There is also confusion regarding if individuals can still register as an individual consumer directed attendant care (CDAC) provider and how CDAC providers can successfully track and report for reimbursement. Additionally, members have reported issues with updating their address with IME and having that information being transferred to their MCO. As a result, members have reported not receiving information from their MCO.

3) Maintenance of Records - The office has received complaints from members who have attempted to file a an oral grievance or appeal and have discovered that the MCO did not maintain their record of the grievance or appeal. Lack of retaining records circumvents members' right to file a grievance or appeal and receive acknowledgment and disposition on the grievance or appeal filed.

4) Provider and Facility Nonpayment - Providers continue to report nonpayment or receive inadequate payment from MCOs. As a result, providers are reducing their case loads or are no longer accepting new patients. Additionally, facilities are declining admission for new Medicaid members due to lack of payment from MCOs. This may impact provider network adequacy standards.

5) Loss of Waiver Services - Members continue to experience challenges when returning home from receiving skilled care for 30 days or more. Upon returning home, the members are being notified of their loss of eligibility for waiver services when neither their financial nor medical status have changed. Loss of services require the member to reapply for Medicaid and forgo receipt of waiver services during the application process. Waiver services enable members who qualify to receive care in a facility to receive care in their home and remain independent. Without these services, members are at risk of residing in a facility.

6) Transitioning Between Care Settings - Members continue to experience challenges when transitioning between settings. For example, members have reported difficulty with finding timely care placement that meets their care needs once discharged from jail or a hospital. One such example includes a member who resided in a hospital for over 30 days due to the hospital's inability to reach the MCO to assist with finding placement.

A Medicaid member with a health condition that requires physician-directed care three times a week lost their Elderly Waiver services due to miscommunication and, as a result, lost their transportation to and from their appointments. Additionally, the member did not speak English. Without their services, the member's health was in jeopardy.

The Managed Care Ombudsman worked with the MCO to reinstate their services covered under the Elderly Waiver. With assistance from the Managed Care Ombudsman, the member now has access to transportation and is receiving their treatments necessary for their health condition.

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 and partnering with community stakeholders to connect members to resources beyond the Managed Care Ombudsman's programmatic scope.

The Managed Care Ombudsman Program has built a network 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 in various forums and workgroups on a regular basis to inform discussion and to address collective concerns expressed when possible.

The Managed Care Ombudsman Program has presented at various workgroups and forums and distributed program materials. The table below identifies programmatic outreach efforts and total number of communication materials distributed:

Month	Presentations	Brochures	Bookmarks	Member Packets
July	3	128	40	97
August	3	875	80	1,273
September	2	570	-	200
Qtr 2 Total	7	1,573	120	1,570

TABLE 2: QUARTER 2 OUTREACH DATA (JULY, AUGUST, SEPTEMBER 2016)

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 our communications materials and tools can be found on our website at https://www.iowaaging.gov/long-term-care-ombudsman/managed-care-ombudsman.

ADMINISTRATIVE UPDATE

The second quarter of managed care brought new endeavors. The Office of the State Long-Term Care Ombudsman hired an additional Managed Care Ombudsman. With two Managed Care Ombudsmen, the office is better able to meet the needs of members and provide timely issue resolution.

In response to the questions and issues received by the office and in an effort to better serve Iowans, the office has updated the webpage to include additional resources for members and providers. The tools and resources provided are made available free of charge with the goal of providing important, relevant, and helpful information to those navigating the managed care system.

The office values its partnerships with state agencies, MCOs, and organizations across the State. The office continues to work with stakeholders on addressing issues and concerns, and works to inform policy to improve practice by participating in various forums such as the Medical Assistance Advisory Council (MAAC), the U.S. Attorney General's Healthcare Fraud Task Force, and other routine touch base meetings with IME, LTSS providers, and other stakeholder venues.

If you are interested in staying in touch with the Managed Care Ombudsman Program and to be added to the distribution list, please submit your information online at:

https://www.iowaaging.gov/long-term-care-ombudsman/managed-care-ombudsman/stay-touch-managed-care-ombudsman-program

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