Managed Care Ombudsman Program Quarterly Report

1st Quarter, Year 2 - Apr/May/Jun 2017

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

With the second year of managed care in full swing, the Managed Care Ombudsman continues to assist managed care members with their concerns. This quarterly report marks the first quarter of the second year of managed care.

Contacts to the program remained consistent over the course of the quarter. The issues identified for the quarter are the primary issues that were addressed in April, May, and June 2017. Services reduced, denied or terminated and Access to information or information sharing were two issues that remained consistent throughout the quarter.

During Quarter 1-Year 2 of managed care, members reported the following primary issues:

1) Services are being reduced, denied or terminated particularly for members that receive care in their home through a home and community-based services (HCBS) waiver program. In response to the change in services, members are moving more consistently through the formal appeal and state fair hearing processes.

2) Access to information or information sharing has been a challenge for members. Members continue to report not receiving written notice before services or prescriptions are reduced or denied. Written notification informs members of their right to appeal the change in their care and the process for doing so should they desire to appeal the MCO decision. The requirement of notifying members of a reduction, denial or termination of a service or prescription drug is an important consumer protection provision and enables members to participate and make decisions about the direction of their care.

3) MCO was rude or gave poor customer service was another primary issue reported by members throughout the quarter. During this quarter, members reported having issues with their MCO not returning phone calls, providing inaccurate information or not being helpful when assistance from the MCO was sought. Responsive and supportive customer service can enhance the members' experience and allow the members and MCOs to work in a collaborative fashion.

The enclosed report includes an overview of the first programmatic quarter of year two (April, May, June 2017) as well as an update on systemic trends, community partnerships and outreach efforts, and administrative activities.

For further information, please contact the Office of the State Long-Term Care Ombudsman Legislative Liaison Lynzey Kenworthy at lynzey.kenworthy@iowa.gov.

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 April, May, and June 2017. This is the first quarter of the second year of managed care.

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:

- Service reduced, denied or terminated
- Access to information or information sharing
- MCO was rude or gave poor customer service

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 State Ombudsman's Office) to resolve the issue.

The average resolution time to resolve an issue fluctuated throughout the quarter. The program continues to observe more members moving through the formal MCO appeal and state fair hearing processes.

Program

During Quarter 1 of Year 2 of managed care, the majority of calls received came from members enrolled in the Elderly Waiver, Intellectual Disability Waiver, and the Physical Disability Waiver programs.

A member received a reduction in their CDAC services that enabled them to live independently in their own home. The Managed Care Ombudsman Program guided the member through the appeal and fair hearing process by working with the member, Disability Rights Iowa, and their MCO. The hearing was ruled in in favor of the member and his CDAC services were restored at the necessary level.

Grievances/Appeals/Fair Hearings

The Managed Care Ombudsman Program attempts to resolve issues informally in an effort to expedite resolution. For Quarter 1-Year 2, the Managed Care Ombudsman Program received 36 contacts regarding a grievance and 456 regarding an appeal. There have been 70 contacts regarding a state 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
April	448	1. Service reduced, denied, terminated 2. Other 3. Care planning participation	20 days	1. Intellectual Disability Waiver 2. Elderly Waiver 3. Brain Injury Waiver	Amerigroup = 61 AmeriHealth = 247 United = 124	Grievances = 4 Appeals = 136 Fair hearings = 11
May	439	1. Service reduced, denied, terminated 2. Access to info/info sharing 3. MCO was rude or gave poor customer service	8 days	1. Elderly Waiver 2. Intellectual Disability Waiver 3. Physical Disability Waiver	Amerigroup = 63 AmeriHealth = 256 United = 95	Grievances = 17 Appeals = 136 Fair hearings = 32
June	466	1. Service reduced, denied, terminated 2. Access to info/info sharing 3. Care planning participation	13 days	1. Elderly Waiver 2. Intellectual Disability Waiver 3. Physical Disability Waiver	Amerigroup = 120 AmeriHealth = 274 United = 61	Grievances = 15 Appeals = 184 Fair hearings = 27
Qtr 1/Y2 Total	1,353	1. Services reduced, denied, terminated 2. Access to info/info sharing 3. MCO was rude or gave poor customer service		1. Elderly Waiver 2. Intellectual Disability Waiver 3. Physical Disability Waiver	Amerigroup = 244 AmeriHealth = 777 United = 280	Grievances = 36 Appeals = 456 Fair hearings = 70

TABLE 1: QUARTER 1/Year 2 CONTACT DATA (APRIL, MAY, JUNE 2017)

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) Members Remain in the Appeals/Fair Hearing Processes - Members have reported that after receiving a favorable determination by an administrative law judge during their fair hearing to maintain their services at the requested level, their MCO continues to deny or reduce those requested services upon the expiration of the administrative law judge's decision. Members must then start the appeal process over again with their MCO to obtain those services at the requested level. If the MCO upholds their decision, the member can then request a fair hearing at the state level and go through the lengthy process again. This keeps the member in the appeal process. In some cases, members have reported having to start the appeal process over again after 60 days.

2) Written Notification - Members continue reporting not receiving written notifications 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. Instead, members are learning of the changes through their provider providing that service. Members have been reporting this issue since July 2016.

3) Provider Payment Reductions Impacting Members - Members, particularly those receiving care through an HCBS waiver, have reported being discharged by their provider as a result of the provider receiving reduced reimbursement rates to care for them. As a result, members are left with having to find a new provider to receive their necessary care. In some cases, members have had challenges with finding alternate providers to provide care.

A Medicaid member receiving care through an HCBS waiver had their services abruptly reduced due to the provider discharging the member. The Managed Care Ombudsman Program advocated for the member and their family by contacting the MCO to discuss the discharge and abrupt reduction of services. The MCO reached out to the provider right away and resolved the issue. The member was able to resume services right away.

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, when possible, in various forums and work groups on a regular basis to inform discussion and to address collective concerns expressed.

The Managed Care Ombudsman Program has presented at various work groups 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
April	2	198	-	80
May	3	54	-	-
June	1	-	-	-
Qtr 1/Year2 Total	6	252	0	80

TABLE 2: QUARTER 1/Year 2 OUTREACH DATA (APRIL, MAY, JUNE 2017)

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/state-long-term-care-ombudsman/managed-care-ombudsman-program.

ADMINISTRATIVE UPDATE

The first quarter of the second year of managed care has brought administrative changes as well as new resources. As a result of the 2017 legislative budget, the Office of the State Long-Term Care Ombudsman has had to reassess its financial position and projections, altering office operations in our inability to fill existing vacancies. Working within these new constraints, the mission of the Office remains the same.

The Managed Care Ombudsman Program released the How to be Your Own Best Advocate Guide, a tool intended to serve as an educational resource for members and their caregivers or loved ones to reference when in need of general information about the complex and ever-changing world of managed care. The guide is intended to provide general guidance and information and should not be used as a substitute for legal advice. Each MCO may have specific processes and requirements regarding various topics. Therefore, referencing your MCO Member Handbook is recommended.

If interested in staying connected to the program to receive updates on managed and deadline reminders, please send an email to managedcareombudsman@iowa.gov to be added to the distribution list.

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