



MANAGED CARE
OMBUDSMAN PROGRAM
QUARTERLY REPORT

Year 3, Quarter 1
(April 1 - June 30, 2018)

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 who receive care in a health care facility, assisted living program, or 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 slight fluctuation of contacts per month, with 211 contacts in April, 213 in May and 250 in June.

The issues identified for the first quarter are the primary issues addressed in April, May and June 2018. The Office works with a variety of stakeholders who are necessary to address and resolve issues, and does so through 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 1-Year 3 of Medicaid managed care, members reported the following primary issues:

1. Services are being reduced, denied or terminated for members needing long-term services and supports. Members reported reductions or denials in their HCBS waiver services in their homes or assisted living programs. This often affected consumer directed attendant care (CDAC) and consumer choice options (CCO) service hours. In response to reduction in services, members are requesting formal appeals and fair hearings to access the services they feel are necessary for their health and safety.
2. New annual level of care assessments required by the MCOs for some members are resulting in changes to members' services that do not meet their health care needs, with or without a change in the member's health.
3. Members are requesting assistance in connecting with their case manager for level of care assessment meetings and care planning meetings in order to arrange for or continue services that meet their needs. Members are also reporting concerns, including a lack of care planning and inadequate notification of a change in services.

The report that follows includes an overview of the first programmatic quarter of Year 3 (April, May and June 2018), as well as an update on the program, community partnerships and outreach efforts and administrative activities.

For further information, please contact the Managed Care Ombudsman Program at (866) 236-1430 or managedcareombudsmanprogram@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 2018.

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
- Level of care assessment
- Care planning participation

Program

During Year 3, Quarter 1, the majority of calls received came from members enrolled in the Elderly Waiver, Intellectual Disability Waiver and Brain Injury Waiver programs.

Waiver members experienced challenges when completing new level of care assessments implemented by their MCO. A Medicaid managed care member faced reductions in approved services after completing a level of care assessment that did not support the member's overall health needs. The Managed Care Ombudsman supported the member by requesting a review of the level of care assessment and by being present during the care planning meeting to advocate for the member.

Grievances/Appeals/Fair Hearings

The Managed Care Ombudsman Program attempts to resolve issues informally in an effort to expedite resolution. For Year 3, Quarter 1, the Managed Care Ombudsman Program received 18 contacts regarding a grievance and 68 regarding an appeal. There have been 24 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
April	211	<ol style="list-style-type: none"> Care planning participation Level of care assessment Service reduced, denied or terminated 	7 days	<ol style="list-style-type: none"> Elderly Waiver Intellectual Disability Waiver Brain Injury Waiver 	Amerigroup: 26 United: 155 FFS: 27	Grievances: 8 Appeals: 23 Fair Hearings: 1
May	213	<ol style="list-style-type: none"> Care planning participation Service reduced, denied or terminated Level of care assessment 	6 days	<ol style="list-style-type: none"> Elderly Waiver Intellectual Disability Waiver Health & Disability Waiver 	Amerigroup: 43 United: 152 FFS: 2	Grievances: 3 Appeals: 20 Fair Hearings: 11
June	250	<ol style="list-style-type: none"> Service reduced, denied or terminated Level of care assessment Care planning participation 	8 days	<ol style="list-style-type: none"> Intellectual Disability Waiver Elderly Waiver Dual Eligibility 	Amerigroup: 46 United: 179 FFS: 10	Grievances: 7 Appeals: 25 Fair Hearings: 12
Q1 Total	674	<ol style="list-style-type: none"> Service reduced, denied or terminated Level of care assessment Care planning participation 		<ol style="list-style-type: none"> Elderly Waiver Intellectual Disability Waiver Brain Injury Waiver 	Amerigroup: 115 United: 486 FFS: 39	Grievances: 18 Appeals: 68 Fair Hearings: 24

TABLE 1: QUARTER 1 CONTACT DATA (APRIL, MAY AND JUNE 2018)

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. Level of Care Assessment and Care Planning.** MCOs have transitioned to using their own internal processes of completing level of care assessments for their Medicaid members receiving long-term supports and services. Many members have voiced concerns over the new processes and the outcomes not supporting their health care needs, leading to a review of the overall assessment.
- 2. CDAC and CCO Reductions.** Members faced reductions or denials for their lawn and snow removal services. Many times, the member did not receive a formal letter of notification placing the member at risk of losing their provider, services and their right to appeal.
- 3. Case Manager Issues.** Communication issues continued between case managers and the members. Members reported that the case managers are still communicating they are overloaded. Members reported having to wait longer lengths of time between visits and having their calls returned.
- 4. Delays.** Delays in the time between becoming eligible for a waiver and being assessed by the MCO continued. Members also experienced delays in assignment to case managers, completion of level of care assessments and receipt of services in the home.
- 5. Digital On-Boarding for UHC.** United Healthcare River of the Valley (UHC) transitioned to digital on-boarding of all members. This process, as explained by UHC, includes an introduction letter explaining online access to member notifications and any process in which UHC would have sent a formal letter of information or notification in the past. Members may still request a handbook to be mailed to them, if needed.
- 6. 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 MCOs, and approved bids by the assigned MCO created more barriers. These barriers continued to affect the quality of life for the member.

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 and discuss and to address collective concerns expressed.

The Managed Care Ombudsman presented at the Patient-Centered Health Advisory Council and met with Easter Seals (Rural Solutions and Assistive Technology Center) to discuss the program's ability to assist members and distribute Managed Care Ombudsman materials.

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>.

A Medicaid member on the Elderly Waiver contacted the Office regarding gaps in receiving in-home services. The member had been waiting for several days after becoming MCO-enrolled. The Managed Care Ombudsman worked with other agencies and the member's assigned MCO in order to establish meetings for care planning necessary in setting up in-home services. Once the MCO connected with the member and established appropriate care assessments and care plans, the member was able to start receiving the in-home services needed in order to remain safe and healthy at home.

COMPLAINTS & CASES

APRIL

The data reported on page 3 of this report provides detailed information about all of the contacts made to the Managed Care Ombudsman Program over the course of the month. The number of contacts reported is representative of the number of times the Managed Care Ombudsman Program is contacted; it does not represent the number of complaints made to the Managed Care Ombudsman Program. In April, the 211 contacts reported on page 3 resulted in the Managed Care Ombudsman Program working on complaints from 40 individual members. The top complaint received in April was in regard to services reduced, denied or terminated (23 members). Additional complaints included:

- Care planning (4 members)
- Eligibility (4 members)
- Service coverage gap issues (2 members)
- Case manager rude or poor customer service (1 member)
- Change in care setting (1 member)
- Level of care assessments (1 member)
- Case manager not getting paid (1 member)
- Provider not in network (1 member)
- Transition services/coverage inadequate/inaccessible (1 member)
- Transportation (1 member)

MAY

The data reported on page 3 of this report provides detailed information about all of the contacts made to the Managed Care Ombudsman Program over the course of the month. The number of contacts reported is representative of the number of times the Managed Care Ombudsman Program is contacted; it does not represent the number of complaints made to the Managed Care Ombudsman Program. In May, the 213 contacts reported on page 3 resulted in the Managed Care Ombudsman Program working on complaints from 60 individual members (31 members were affected by more than one issue). The top complaint received in May was in regard to services reduced, denied or terminated (17 members). Additional complaints included:

- Care planning (12 members)
- Level of care assessments (10 members)
- Access to preferred/necessary durable medical equipment (7 members)
- Care coordinator/case manager was rude or gave poor customer service (5 members)
- Member needs assistance with acquiring eligibility information (5 members)
- Other service/coverage gap issue (5 members)
- Access to information sharing (4 members)
- Change in care setting (4 members)
- Member has lost eligibility status or was denied (4 members)
- Scheduling (4 members)

COMPLAINTS & CASES

- Transition services/coverage inadequate or inaccessible (4 members)
- Access to preferred/necessary medication (2 members)
- Home vehicle modification (1 member)
- Member has not received MCO materials (1 member)
- Provider/pharmacy/hospital not in network (1 member)
- Transportation (1 member)

JUNE

The data reported on page 3 of this report provides detailed information about all of the contacts made to the Managed Care Ombudsman Program over the course of the month. The number of contacts reported is representative of the number of times the Managed Care Ombudsman Program is contacted; it does not represent the number of complaints made to the Managed Care Ombudsman Program. In June, the 250 contacts reported on page 3 resulted in the Managed Care Ombudsman Program working on complaints from 61 individual members (30 members were affected by more than one issue). The top complaint received in June was in regard to services reduced, denied or terminated (24 members). Additional complaints included:

- Level of care assessment (13 members)
- Care coordinator/case manager was rude or gave poor customer service (9 members)
- Access to preferred/necessary durable medical equipment (6 members)
- Care planning participation (5 members)
- Other access to services/benefits issue (5 members)
- Other (4 members)
- Other billing issue (4 members)
- Member needs assistance with acquiring eligibility information (4 members)
- MCO was rude or gave poor customer service (3 members)
- Other service/coverage gap issue (3 members)
- Scheduling (3 members)
- Transition services/coverage inadequate or inaccessible (3 members)
- Change in care setting (2 members)
- Access to preferred/necessary medication (1 member)
- Disenrollment from MCO - good cause eligible (1 member)
- Disenrollment from Medicaid program (1 member)
- Guardian not receiving information (1 member)
- Provider/pharmacy/hospital not in network (1 member)
- Member has not received MCO materials (1 member)
- Member has lost eligibility status or was denied (1 member)
- N/A (1 member)
- Transportation not available, timely or adequate (1 member)

COMPLAINTS BY PROGRAM TYPE

Complaint	April	May	June
AIDS/HIV Waiver	-	-	-
Brain Injury Waiver	4	2	6
Children's Mental Health Waiver	3	3	1
Dental	-	-	-
Duals	4	5	6
Elderly Waiver	7	16	12
Habilitation	-	1	2
Health & Disability Waiver	4	7	5
HIPP	-	2	2
Institutional Care	-	-	-
Iowa Health & Wellness	-	-	-
Intellectual Disability Waiver	9	14	17
Medicare	2	-	-
PACE	-	-	-
Physical Disability Waiver	1	1	1
QMB or SLMB	-	-	1
Traditional Medicaid	2	3	2
Other	-	-	1
N/A	-	1	-
Unknown	3	5	5
Q1 Total	40	60	61

TABLE 1: QUARTER 1 COMPLAINTS BY TYPE (APRIL, MAY AND JUNE 2018)

UPCOMING EVENTS

Cross Training: Abuse in Later Life

Tuesday, Aug. 7 (8 a.m. - 5 p.m.)

Iowa Bankers Association | 8800 NW 62nd Ave. | Johnston, IA 50131

To register, contact Cheryl Ritter at the Iowa Attorney General's Office at (515) 281-7688 or cheryl.ritter@ag.iowa.gov. Registration deadline is Aug. 3, 2018.



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