# MANAGED CARE OMBUDSMAN PROGRAM

# QUARTERLY REPORT

Year 3, Quarter 2
(July 1 - September 30, 2018)

Managed Care
OMBUDSMAN PROGRAM
*A Division of the Office of the State Long-Term Care Ombudsman*
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# 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 fluctuation of contacts per month, with 209 contacts in July, 316 in August and 167 in September.

The issues identified for the second quarter are the primary issues addressed in July, August and September 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 2-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 reductions in services, members are requesting formal appeals and fair hearings to access the services they feel are necessary for their health and safety.

2. Members are needing support during care planning participation. New and existing Medicaid members requested assistance for yearly assessment and care plan meetings. Members reported they feel their health needs are not being individually addressed. Members also reported they were unaware of who their case manager would be or how often they were to have meetings.

3. Members are experiencing poor customer service from their MCO. Members reported an overall lack of communication and information sharing between case managers, supervisors, assessors and the review team members. Members report in members and their families feeling there is a conflict of interest among the care team and within the MCO which prevents seamless transitions, continuity of care and timely healthcare services rendered.

The report that follows includes an overview of the second programmatic quarter of Year 3 (July, August and September 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 July August and September 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
- Care planning participation
- MCO was rude or gave poor customer service

Program

During Year 3, Quarter 2, the majority of calls received came from members enrolled in the Intellectual Disability Waiver,  Health and Disability Waiver and Elderly Waiver programs.

The Managed Care Ombudsman advocated for a Medicaid member on the Health and Disability Waiver who was in need of durable medical equipment for over three years. While working with the legal guardian and the MCO through an appeal, the MCO approved the waiver funds to be used for the medical equipment which was being requested. The denial was overturned and the member received approval to obtain the necessary durable medical equipment for the member to continue to receive services in their home.

## Grievances/Appeals/Fair Hearings

The Managed Care Ombudsman Program attempts to resolve issues informally in an effort to expedite resolution. For Year 3, Quarter 2, the Managed Care Ombudsman Program received 33 contacts regarding a grievance and 77 regarding an appeal. There have been 20 contacts regarding a fair hearing during this quarter.

The table below shows a side-by-side comparison of the data discussed for this quarter.

| Month | Number of Contacts | Top Three Issues | Average Resolution Time | Program | Contacts per MCO | Contacts Related to Grievances/Appeals/ Fair Hearings |
|---|---|---|---|---|---|---|
| **July** | 209 | 1. Service reduced, denied or terminated<br>2. MCO was rude or gave poor customer service<br>3. Care planning participation | 9 days | 1. Intellectual Disability Waiver<br>2. Health and Disability Waiver<br>3. Brain Injury Waiver | Amerigroup: 37<br>United: 158<br>FFS: 8 | Grievances: 3<br>Appeals: 3<br>Fair Hearings: 4 |
| **August** | 316 | 1. Service reduced, denied or terminated<br>2. Care planning participation<br>3. MCO was rude or gave poor customer service | 10 days | 1. Intellectual Disability Waiver<br>2. Health and Disability Waiver<br>3. Elderly Waiver | Amerigroup: 83<br>United: 217<br>FFS: 16 | Grievances: 21<br>Appeals: 42<br>Fair Hearings: 14 |
| **Sept** | 167 | 1. Service reduced, denied or terminated<br>2. Access to Services/ Benefits - CCO/ CDAC<br>3. Care planning participation | 25 days | 1. Elderly Waiver<br>2. Intellectual Disability Waiver<br>3. Health and Disability Waiver | Amerigroup: 48<br>United: 116<br>FFS: 3 | Grievances: 9<br>Appeals: 32<br>Fair Hearings: 2 |
| **Q2 Total** | 692 | 1. Service reduced, denied or terminated<br>2. Care planning participation<br>3. MCO was rude or gave poor customer service | | 1. Intellectual Disability Waiver<br>2. Health and Disability Waiver<br>3. Elderly Waiver | Amerigroup: 168<br>United: 491<br>FFS: 27 | Grievances: 33<br>Appeals: 77<br>Fair Hearings: 20 |

**TABLE 1: QUARTER 2 CONTACT DATA (JULY, AUGUST AND SEPTEMBER 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. CDAC and CCO Impacts. Consumer Directed Attendant Care and Consumer Choice Options, are choices available to Medicaid members who are eligible for one of the home and community-based services (HCBS) waiver programs and is a service frequently used by HCBS waiver members. The Managed Care Ombudsman Program had a high number of contacts from members reporting a dissatisfaction with changes made to their CDAC services. Changes include service reductions or denials, and also changes that impact the day to day use of CDAC services. Members reported issues accessing the CDAC provider of their choice barriers to using CDAC services they would like, and perceived decreased flexibility within the service. Members were also concerned over their CDAC provider not receiving payment on time. Medicaid members have reported CCO budgets have not been completed on time, affecting the members ability to schedule staff to provide services needed.

2. Lack of Providers. Members have reported a lack of approved CDAC providers as well as an overall lack of providers accessible to the members to provide services. For members living in remote rural areas, this issue was more prevalent.

3. 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 MCO's, and approved bids by the assigned MCO created more barriers. These barriers continued to affect the quality of life for the member.

4. Scheduling. Members reported long delays in initially hearing from a case manager and case managers needing to reschedule meetings due to large case loads. At times, members would have family members travel to participate in the meetings, only to have the meeting rescheduled without much notice.

5. Case Manager Issues. Communication issues continue between case managers and members. Members are reporting their case managers are very busy and at times cannot meet with them when they need to speak with them.

6. Lack of Notice of Decisions. The Managed Care Ombudsman Program continuously serves members who have reported they did not receive 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 continue to receive a verbal decision, instead of a written decision from their case manager or provider.

# 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 to inform and discuss and to address collective concerns expressed.

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.

Medicaid members receiving waiver benefits experienced reductions to their in home services despite no change in their health. At times these members were not informed properly with any Notice of Decision, but instead were informed through their provider agency or CDAC provider without appeal instructions or information of their member rights. In this process, at times, providers were not paid on time and were not able to continue to provide services. The lack of contracted providers added to the members challenges in accessing services and contributed to gaps in services. The Managed Care Ombudsman advocated for these members by aiding in communication with the MCO and the member during care planning.

# COMPLAINTS & CASES

## JULY

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 July, the 209 contacts reported on page 3 resulted in the Managed Care Ombudsman Program working on complaints from 54 individual members. The top complaint received in July was in regard to services reduced, denied or terminated (22 members). Additional complaints included:

- MCO was rude or gave poor customer service (8 members)
- Access to preferred/necessary durable medical equipment (7 members)
- Care coordinator/case manager was rude or gave poor customer service (7 members)
- Care planning participation (7 members)
- Level of care (7 members)
- Other access to services/benefits issue (6 members)
- Member needs assistance with acquiring Medicaid eligibility information (4 members)
- Access to information or information sharing (3 members)
- Access to preferred/necessary medication (3 members)
- Other billing issue (3 members)
- Discharge (2 members)
- Home/vehicle modifications (2 members)
- Provider/pharmacy/hospital not in network (2 members)
- Transportation not available, timely or adequate (2 members)
- Change in care setting (2 members)
- Other service/coverage gap issue (2 members)
- Disenrollment from MCO - good cause eligible (1 member)
- Member needs assistance checking on application status (1 member)
- N/A (1 member)
- Other (1 member)
- Transition services/coverage inadequate or inaccessible (1 member)

## AUGUST

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 August, the 316 contacts reported on page 3 resulted in the Managed Care Ombudsman Program working on complaints from 75 individual members. The top complaint received in August was in regard to services reduced, denied or terminated (27 members). Additional complaints included:

- Care planning participation (11 members)
- MCO was rude or gave poor customer service (11 members)
- Level of care (7 members)
- Member needs assistance checking on application status (7 members)
- Other service/coverage gap issue (6 members)
- Access to preferred/necessary durable medical equipment (6 members)
- Other access to services/benefits issue (6 members)
- Access to information or information sharing (5 members)

# COMPLAINTS & CASES

- Care coordinator/case manager was rude or gave poor customer service (5 members)
- Access to preferred necessary medication (4 members)
- Other billing issue (4 members)
- Member needs assistance with acquiring Medicaid eligibility information (3 members)
- Home/vehicle modifications (3 members)
- Change in care setting (2 members)
- Discharge (2 members)
- Provider/pharmacy/hospital not in network (2 members)
- Transition services/coverage inadequate or inaccessible (2 members)
- Other customer service issue (1 member)
- Guardian not receiving information (1 member)
- Member charged improper cost sharing (1 member)
- Member has lost eligibility status or was denied (1 member)
- N/A (1 member)
- Other (1 member)

## SEPTEMBER

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 September, the 167 contacts reported on page 3 resulted in the Managed Care Ombudsman Program working on complaints from 43 individual members. The top complaint received in September was in regard to services reduced, denied or terminated (11 members). Additional complaints included:

- Access to Services/Benefits-Other (8 members)
- Home/vehicle modifications (5 members)
- Care coordinator/case manager was rude or gave poor customer service (5 members)
- Care planning participation (4 members)
- Other service/coverage gap issue (4 members)
- Access to information or information sharing (4 members)
- Scheduling (3 members)
- Member needs assistance with checking on application status (3 members)
- Discharge (3 members)
- Access to preferred/necessary durable medical equipment (2 members)
- Prior authorization (2 members)
- Provider/pharmacy/hospital not in network (2 members)
- Level of care assessment (2 members)
- MCO was rude or gave poor customer service (2 members)
- Transportation not available, timely or adequate (2 members)
- Transition services/coverage inadequate or inaccessible (1 member)
- Member charged improper cost sharing (1 member)
- Other billing issue (1 member)
- Change in care setting (1 member)
- Access to preferred/necessary medication (1 member)
- Member has lost eligibility status or was denied (1 member)
- Selecting/changing MCO (1 member)
- Guardianship documents not on file (1 member)

## COMPLAINTS BY PROGRAM TYPE AND MANAGED CARE ORGANIZATION

| | | Amerigroup Iowa | UnitedHealthcare Plan of the River Valley | Fee for Service | Total |
|---|---|---|---|---|---|
| Complaint(s) by Program Type | AIDS/HIV Waiver | - | - | - | 0 |
| | Brain Injury Waiver | 3 | 3 | - | 6 |
| | Children's Mental Health Waiver | 1 | - | - | 1 |
| | Dental | - | 1 | - | 1 |
| | Duals | 1 | 2 | - | 3 |
| | Elderly Waiver | 4 | 4 | - | 8 |
| | Habilitation | - | - | - | 0 |
| | Health & Disability Waiver | 2 | 9 | 1 | 12 |
| | HIPP | - | - | 1 | 1 |
| | Institutional Care | - | 1 | - | 1 |
| | Iowa Health & Wellness | - | - | - | 0 |
| | Intellectual Disability Waiver | 3 | 11 | 1 | 15 |
| | Medicare | - | - | - | 0 |
| | PACE | - | - | - | 0 |
| | Physical Disability Waiver | - | 1 | - | 1 |
| | QMB or SLMB | - | - | - | 0 |
| | Traditional Medicaid | - | 2 | 1 | |
| | Other | - | 2 | - | 2 |
| | N/A | - | - | - | 0 |
| | Unknown | - | - | - | 0 |
| | **TOTAL:** | 14 | 36 | 4 | 54 |

| | | Amerigroup Iowa | UnitedHealthcare Plan of the River Valley | Fee for Service | Total |
|---|---|---|---|---|---|
| Case(s) by Program Type | AIDS/HIV Waiver | - | - | | 0 |
| | Brain Injury Waiver | 3 | 6 | - | 9 |
| | Children's Mental Health Waiver | - | 1 | | 1 |
| | Dental | - | - | | 0 |
| | Duals | 2 | 1 | - | 3 |
| | Elderly Waiver | 8 | 10 | - | 18 |
| | Habilitation | - | - | | 0 |
| | Health & Disability Waiver | 2 | 10 | - | 12 |
| | HIPP | - | - | 1 | 1 |
| | Institutional Care | - | - | | 0 |
| | Iowa Health & Wellness | - | - | | 0 |
| | Intellectual Disability Waiver | 2 | 17 | 1 | 20 |
| | Medicare | - | - | | 0 |
| | PACE | - | - | | 0 |
| | Physical Disability Waiver | - | 2 | | 2 |
| | QMB or SLMB | - | - | | 0 |
| | Traditional Medicaid | 2 | 3 | 2 | 7 |
| | Other | - | 2 | | 2 |
| | N/A | - | | - | 0 |
| | Unknown | - | | - | 0 |
| | **TOTAL:** | 19 | 52 | 4 | 75 |

## COMPLAINTS BY PROGRAM TYPE

| | | Amerigroup Iowa | UnitedHealthcare Plan of the River Valley | Fee for Service | Total |
|---|---|---|---|---|---|
| Complaint(s) by Program Type | AIDS/HIV Waiver | 1 | - | - | 1 |
| | Brain Injury Waiver | 2 | 1 | - | 3 |
| | Children's Mental Health Waiver | - | 2 | - | 2 |
| | Dental | - | - | - | 0 |
| | Duals | - | 1 | - | 1 |
| | Elderly Waiver | 5 | 6 | - | 11 |
| | Habilitation | - | 1 | - | 1 |
| | Health & Disability Waiver | 1 | 6 | - | 7 |
| | HIPP | - | - | - | 0 |
| | Institutional Care | - | - | - | 0 |
| | Iowa Health & Wellness | - | - | - | 0 |
| | Intellectual Disability Waiver | 3 | 9 | 2 | 14 |
| | Medicare | - | - | - | 0 |
| | PACE | - | - | - | 0 |
| | Physical Disability Waiver | - | 2 | - | 2 |
| | QMB or SLMB | - | - | - | 0 |
| | Traditional Medicaid | - | - | - | 0 |
| | Other | - | 1 | - | 1 |
| | N/A | - | - | - | 0 |
| | Unknown | - | - | | 0 |
| | **TOTAL:** | 12 | 29 | 2 | 43 |

GRAND TOTAL 172

# UPCOMING EVENTS

**Nursing Home Family & Ombudsman Engagement, Education, and Empowerment sessions**

With funding from the New York State Health Foundation, LTCCC is undertaking a special project to provide support for nursing home families and those who work with them. Their goal is to help families and ombudsmen understand residents' rights and how to organize and sustain effective family councils.

November 20: Making Your Voice Heard in the Nursing Home…and Beyond

December 18: Staffing: How to Find Out About Staffing in Your Facility & What it Means for Your Resident's Care & Quality of Life

Attend in Two Easy Ways:
1) To join the online meeting, go to: https://join.freeconferencecall.com/richardmollot.

2) To participate by phone, at the time of the program call (712) 770-4010. When prompted, enter the Access Code, 878277, followed by the pound (#) key.

Note: All program materials will be posted in the Learning Center at www.nursinghome411.org. To view the recording of the program, click on the YouTube button on our homepage.

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