MANAGED CARE OMBUDSMAN PROGRAM

QUARTERLY REPORT

Year 3, Quarter 3

(Oct 1 - December 31, 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 slight fluctuation of contacts per month, with 148 contacts in October, 159 in November and 144 in December.

The issues identified for the third quarter are the primary issues addressed in October, November and December 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 3-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 effected 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 their upcoming 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. Access to preferred/necessary durable medical equipment. Waiver members reported having to wait for medically necessary durable equipment to be approved and accessed. Members have reported denials for requests of DME (Durable Medical Equipment), resulting in members filing appeals and/or fair hearing requests. Members have also reported a lack of DME providers contracted with the MCO's.

The report that follows includes an overview of the third programmatic quarter of Year 3 (October, November and December 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 reports issues on a monthly basis. For analysis purposes, this report provides a high-level overview of the data aggregated over the three months of October, November and December 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 when Medicaid members transition between Medicaid programs as well as from one MCO to another.

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
- Access to preferred/necessary durable medical equipment

Program

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

The Managed Care Ombudsman Program continues to assist members who experience their services reduced, denied or terminated. A Medicaid managed care member receiving services in his home, had filed for an appeal to maintain all services. The appeal was denied and the member then filed for a fair hearing. A few days before the fair hearing date, the MCO reinstated all of the members requested services. The Medicaid member was then able to remain in his home with the reinstated waiver services .

Grievances/Appeals/Fair Hearings

The Managed Care Ombudsman Program attempts to resolve issues informally in an effort to expedite resolution. For Year 3, Quarter 3, the Managed Care Ombudsman Program received 16 contacts regarding a grievance and 87 regarding an appeal. There have been 4 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
October	148	1. Service reduced, de nied or terminated 2. Access to Services/ Benefits-CCO/CDAC 3. Access to preferred/ necessary durable medical equipment	25days	1. Elderly Waiver 2. Intellectual Disability Waiver 3. Health and Disability Waiver	Amerigroup: 32 United: 107 FFS: 2	Grievances: 10 Appeals: 18 Fair Hearings: 1
November	159	1. Service reduced, denied or terminated 2. Access to information or information sharing 3. Care planning participation	30 days	1. Health and Disability Waiver 2. Intellectual Disability Waiver 3. Elderly Waiver	Amerigroup: 14 United: 137 FFS: 5	Grievances: 5 Appeals: 50 Fair Hearings: 2
December	144	1. Service reduced, denied or terminated 2. Care planning participation 3. Level of care assessment	25 days	1. Elderly Waiver 2. Intellectual Disability Waiver 3. Health and Disability Waiver	Amerigroup: 27 United: 116 FFS: 0	Grievances: 1 Appeals: 19 Fair Hearings: 1
Q3 Total	451	1. Service reduced, denied or terminated 2. Care planning participation 3. Access to preferred/ necessary durable medical equipment		1. Elderly Waiver 2. Intellectual Disability Waiver 3. Health and Disability Waiver	Amerigroup: 73 United: 360 FFS: 7	Grievances: 16 Appeals: 87 Fair Hearings: 4

TABLE 1: QUARTER 3 CONTACT DATA (OCTOBER, NOVEMBER AND DECEMBER 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 has a high number of contacts from members reporting 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 choosing, 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, effecting 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. 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 consistently receive verbal decisions not written decisions about a change in their care from their case manager or provider.

5. Level of Care Assessment and Care planning. Members are requesting new level of care assessments which would support their overall healthcare needs. Members are in disagreement with level of care assessment outcomes. Members feel there is a direct conflict of interest with the Managed Care Organization completing LOC assessments internally and providing internal Case Management.

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.

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.

The Managed Care Ombudsman Program advocated for a Medicaid member receiving benefits under the Elderly Waiver Program. The member had been approved for the Elderly Waiver yet waited several weeks to hear from an MCO. The Medicaid member and the guardian had not received their MCO materials and did not know who to contact to establish a care plan and receive in home services. Due to the advocacy of a Managed Care Ombudsman, the Elderly Waiver member was contacted by an MCO and their Case Manager. Level of Care and Care planning meetings were then completed.

COMPLAINTS & CASES

OCTOBER

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 October, the 148 contacts reported on page 3 resulted in the Managed Care Ombudsman Program working on complaints from 55 individual members. The top complaint received in October was in regard to services reduced, denied or terminated (12 members). Additional complaints included:

Access to Services/Benefits-Other (10 members)
Access to preferred/necessary durable medical equipment (8 members)
Access to information or information sharing (7 members)
Care planning participation (7 members)
Care coordinator/case manager was rude or gave poor customer service (6 members)
Transportation not available, timely or adequate (5 members)
Other service/coverage gap issue (5 members)
Level of care assessment (5 members)
MCO was rude or gave poor customer service (3 members)
Provider/pharmacy/hospital not in network (3 members)
Discharge (3 members)
Member needs assistance with acquiring Medicaid eligibility information (3 members)
Change in care setting (2 members)
Access to preferred/necessary medication (1 member)
Home/vehicle modifications (1 member)
Transition services/coverage inadequate or inaccessible (1 member)
Billing-Other (1 member)
Scheduling (1 member)
Member needs assistance with checking on application status (1 member)
Guardianship documents not on file (1 member)

NOVEMBER

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 November, the 159 contacts reported on page 3 resulted in the Managed Care Ombudsman Program working on complaints from 37 individual members. The top complaint received in November was in regard to services reduced, denied or terminated (16 members). Additional complaints included:

Access to information or information sharing (8 members)
Care planning participation (8 members)
Access to preferred/necessary durable medical equipment (3 members)
Access to Services/Benefits-Other (3 members)
Level of care assessment (3 members)

COMPLAINTS & CASES

MCO was rude or gave poor customer service (3 members)
Discharge (2 members)
Care Coordinator/case manager was rude or gave poor customer service (2 members)
Home/vehicle modifications (2 members)
Other service/coverage gap issue (2 members)
Transition services/coverage inadequate or inaccessible (2 members)
Provider/pharmacy/hospital not in network (1 member)
Selecting/changing MCO (1 member)
Guardianship documents not on file (1 member)
Member needs assistance with acquiring Medicaid eligibility information (1 member)
Member has lost eligibility status or was denied (1 member)
Member has not received MCO card or other materials (1 member)
Guardian not receiving information (1 member)
Change in care setting (1 member)
Member needs assistance with checking on application status (1 member)

DECEMBER

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 December, the 144 contacts reported on page 3 resulted in the Managed Care Ombudsman Program working on complaints from 42 individual members. The top complaint received in December was in regard to services reduced, denied or terminated (23 members). Additional complaints included:

Care planning (9 members)
Level of care assessment (7 members)
Access to information or information sharing (6 members)
Access to preferred/necessary durable medical equipment (3 members)
Transition services/coverage inadequate or inaccessible (3 members)
Access to Services/Benefits-Other (3 members)
Care coordinator/case manager was rude or gave poor customer service (2 members)
MCO was rude or gave poor customer service (2 members)
Change in care setting (2 members)
Discharge (2 members)
Home/vehicle modifications (1 member)
Provider/pharmacy/hospital not in network (1 member)
Transportation not available, timely or adequate (1 member)
Other service/coverage gap issue (1 member)
Member has not received MCO card or other materials (1 member)
Member needs assistance with acquiring Medicaid eligibility information (1 member)
Guardian not receiving information (1 member)

COMPLAINTS BY PROGRAM TYPE

OCTOBER		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	-	-		0
	Dental	-	-		0
	Duals	3	-	-	3
	Elderly Waiver	5	8	-	13
	Habilitation	-	3		3
	Health & Disability Waiver	1	6	-	7
	HIPP	-	-		0
	Institutional Care	-	-		0
	Iowa Health & Wellness	-	-		0
	Intellectual Disability Waiver	1	10	1	12
	Medicare	-	-		0
	PACE	-	-		0
	Physical Disability Waiver	-	5		5
	QMB or SLMB	-	-		0
	Traditional Medicaid	-	1		1
	Other	-	2		2
	N/A	-	1		1
	Unknown	-	4		4
	TOTAL:	13	41	1	55

*data may be incomplete due to data collection issues this reporting period

NOVEMBER		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	-	3		3
	Children's Mental Health Waiver	-	-		0
	Dental	-	1	1	2
	Duals	3	-	-	3
	Elderly Waiver	2	4	-	6
	Habilitation	-	2		2
	Health & Disability Waiver	2	8	-	10
	HIPP	-	-		0
	Institutional Care	-	-		0
	Iowa Health & Wellness	-	-		0
	Intellectual Disability Waiver	-	7		7
	Medicare	-	-		0
	PACE	-	-		0
	Physical Disability Waiver	-	2		2
	QMB or SLMB	-	-		0
	Traditional Medicaid	-	-		0
	Other	-	-		0
	N/A	-	-		0
	Unknown	1	-	-	1
	TOTAL:	8	28	1	37

COMPLAINTS BY PROGRAM TYPE

DECEMBER		Amerigroup Iowa	UnitedHealthcare Plan of the River Valley	Fee for Service	Total
Complaint(s) by Program Type	AIDS/HIV Waiver	-	-		0
	Brain Injury Waiver	1	3		4
	Children's Mental Health Waiver	-	-		0
	Dental	-	1	0	1
	Duals	1	1	-	2
	Elderly Waiver	2	10	-	12
	Habilitation	-	-		0
	Health & Disability Waiver	2	5	-	7
	HIPP	-	-		0
	Institutional Care	-	-		0
	Iowa Health & Wellness	-	-		0
	Intellectual Disability Waiver	1	12		13
	Medicare	-	1		1
	PACE	-	-		0
	Physical Disability Waiver	-	1		1
	QMB or SLMB	-	-		0
	Traditional Medicaid	-	-		0
	Other	-	1		1
	N/A	-	-		0
	Unknown	-	-	-	0
	TOTAL:	7	35	0	42
GRAND TOTAL		28	104	2	129

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