Managed Care Ombudsman Program Quarterly Report

4th Quarter, Year 2 - Jan/Feb/Mar 2018

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 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 the Physical Disability Waiver.

For this reporting quarter, the office experienced a slight fluctuation of contacts per month ranging from 273 contacts in January, 225 in February, and 214 in March.

The issues identified for the fourth quarter are the primary issues addressed in January, February and March 2018. Many of the issues continue to be throughout the year. The office works with a variety of stakeholders who are necessary to address and resolve issues that come to the office and do so through a variety of methods such as encouraging use of best practices, facilitating and coordinating communication with necessary parties and referring to outside agencies as necessary. During Quarter 4-Year 2 of managed care, members reported the following primary issues:

1. New level of care assessments required by the MCO for some members are resulting in changes to members' services that do not meet members' health care needs with or without a change in the member's health.

2. 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 the health and safety.

3. Members and guardians are not offered the opportunity to assist in the care planning participation and are reporting a lack of care planning prior to receiving notification of a change in service as well as delays in services being set up in the home once assigned with an MCO. Members also experienced a delay when newly eligible for Medicaid and waiver services implemented while trying to connect with their case manager to provide assessment and service plan coordination.

The enclosed report includes an overview of the fourth programmatic quarter of year two (January, February, March 2018) as well as an update on program, community partnerships and outreach efforts, and administrative activities.

For further information, please contact the Managed Care Ombudsman Program by phone at 1-866-236-1430 or email at 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 January, February, and March 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:

- Level of care assessment
- Service reduced, denied or terminated
- Care planning participation

Average Resolution Time

Resolution time begins when the Managed Care Ombudsman receives the issue and ends when the issue is resolved. For the months of January, February and March 2018 the average resolution time was nine days.

Program

During the fourth quarter - Year 2, the majority of calls received came from members enrolled in the Intellectual Disability Waiver program, the Brain Injury Waiver, and the Elderly Waiver programs.

Members faced changes to their services impacting their place of residence, access to providers and daily health services in the home. A Medicaid member receiving waiver services in her home previously approved by an MCO, faced a possible reduction of those services. The member was dependent on her care givers to provide the support necessary to remain in her home and not transition into a nursing facility. The Managed Care Ombudsman worked with the providers and the MCO to reassess the member's needs and maintain services in the home.

Grievances/Appeals/Fair Hearings

The Managed Care Ombudsman Program attempts to resolve issues informally in an effort to expedite resolution. For Quarter 4 - year 2, the Managed Care Ombudsman Program received 45 contacts regarding a grievance and 74 contacts regarding an appeal. There have been 13 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
January	273	1. Change in care setting 2. Transition services/coverage inadequate or inaccessible 3. Care planning participation	12 days	1. Intellectual Disability Waiver 2. Elderly Waiver 3. Brain Injury Waiver	Amerigroup = 45 United = 188 FFS = 26	Grievances = 23 Appeals = 11 Fair Hearings = 0
February	225	1. Service reduced, denied, or terminated 2. Access to preferred/necessary durable medical equipment 3. Discharge	5 days	1. Elderly Waiver 2. Intellectual Disability Waiver 3. Brain Injury Waiver	Amerigroup = 17 United = 177 FFS = 12	Grievances = 8 Appeals = 34 Fair hearings = 8
March	214	1. Level of care assessment 2. Service reduced, denied, or terminated 3. Care planning participation	10 days	1.Intellectual Disability Waiver 2. Brain Injury Waiver 3. Elderly Waiver	Amerigroup = 38 United = 148 FFS = 18	Grievances = 14 Appeals = 29 Fair hearings =5
Qtr 4 Total	712	1. Service reduced, denied, or terminated 2. Care planning participation 3. Level of care assessment	9 days	1. Intellectual Disability Waiver 2. Elderly Waiver 3. Brain Injury Waiver	Amerigroup = 100 United = 513 FFS = 56	Grievances = 45 Appeals = 74 Fair hearings = 13

TABLE 1: QUARTER 4 CONTACT DATA (JANUARY, FEBRUARY, MARCH 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. Amerigroup Ready to Accept Members:

Amerigroup notified the Iowa Department of Human Services (DHS) that the company had capacity to begin accepting new IA Health Link members. The small group of members who chose Amerigroup Iowa had been temporarily transitioned to Fee-for-Service coverage, and now would be assigned to Amerigroup Iowa effective March 1, 2018. It was also announced that new IA Health Link members will be able to choose Amerigroup for coverage effective May 1, 2018. Amerigroup announced changes regarding case management for members residing in facilities. Members will continue to be assigned to a case manager, however, the case manager will no longer be completing an annual level of care assessment. A level of care assessment will be completed by Amerigroup when there is a change in the member's level of care, reducing the number of visits from an Amerigroup case manager. The Managed Care Ombudsman Program experienced an increase in contacts related to members transitioning from FFS to Amerigroup who were expressing issues that affected their care planning, approved services and level of care outcomes.

2. Transportation Issues:

As a result of AmeriHealth Caritas leaving the state of Iowa, the Managed Care Ombudsman Program received an increase in calls and complaints related to the lack of transportation providers and a lack of communication between providers and the MCO. Due to the issues surrounding transportation, many members were not able to attend regularly scheduled medical appointments or access specialty healthcare. With an influx of newly contracted transportation providers, members reported safety concerns with individuals who were strangers to the members and who did not understand the individual member needs or did not have vehicles equipped for specific types of medical equipment.

3. Case Manager Issues:

Communication issues continued between case managers and the members. There was an increase of new case managers who need to set up appointments for assessments, establish service plan goals, and build relationships with members. This gap resulted in service reductions and denials. Members reported that the case managers were communicating they were overloaded. Members were at times denied new case managers due to a lack of case managers available for certain rural areas.

4. Delays:

Delays in the time between becoming eligible for a waiver and being assessed by the MCO continued. Members experienced a delay in assignment to case managers, level of care assessments being completed, and services being received in the home.

5. Budgets:

Individual budgets were not completed or approved on time, which delayed payments and services rendered to the members.

6. Guardianship Issues:

Guardianship issues continued. At times the guardian was not included in assessments or important meetings to initiate member needs. Guardianship documents were not transferred over right away for members while transitioning between MCOs. During the transitions from MCO to MCO and FFS, member information was not transferred over in a timely manner, which impacted the time frame for contact with the member and or guardian to establish healthcare meetings, assessments and overall services.

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, as well as 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 proving 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.

A representative for a Brain Injury Waiver member whose health services were facing a possible reduction, needed assistance with a level of care assessment review. A Managed Care Ombudsman provided advocacy by contacting the MCO and assisted with the coordination of all necessary supports in attendance. The Managed Care Ombudsman assisted in ensuring the members history and current needs were communicated. The case manager was able to document all information and maintain services.

ADMINISTRATIVE UPDATE

During Quarter 4-Year 2, the Managed Care Ombudsman Program worked with members, their representatives, advocates, MCO's, IME, DHS and other agencies to resolve member issues. These partnerships are critical in order to work collaboratively together for our members.

The Managed Care Ombudsman Program is accessible through a variety of means. Members and their representatives may contact the program by phone, email and mail. Another method of contact is the Managed Care Ombudsman Program Complaint Form which is available through an online form on the website. Once completed, the form is automatically submitted to the Managed Care Ombudsman Program email for review by a Managed Care Ombudsman. The Managed Care Ombudsman Program Complaint Form is available for download and may be submitted by mail, fax or email as well. The Program hopes that this continues to be a useful tool for members, their representatives, and advocates.

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

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