Managed Care Ombudsman Program Quarterly Report

3rd Quarter - Oct/Nov/Dec 2016

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

Since the transition of Iowa's Medicaid program to managed care, the Office of the State Long-Term Care Ombudsman (office) has been serving as the independent advocate for Medicaid managed care members that receive care in a health care facility or are enrolled in one of the seven home and community-based services (HCBS) waiver programs. The office provides:

- An access point for complaints and concerns about enrollment, access to covered services, and other related matters;
- Education on members' grievance and appeal rights, the state fair hearing process, member rights and responsibilities, and additional resources;
- Assistance (without representation), upon request, in navigating the grievance and appeal process and appealing adverse benefit determinations made by a managed care organization to a state fair hearing;
- Review and oversight of long-term services and supports (LTSS) program data to assist the State Medicaid Agency with identifying and resolving systemic issues.

As an advocate, our approach is to ensure assistance is accessible and provided in a consumer-friendly and timely manner. Meeting with the member where they are in the process in seeking resolution to their issue is an important element in our approach. Our office also provides ongoing feedback from consumers and providers to the State Medicaid Agency to help monitor program operations, ensuring efficiencies are made where possible in the overall system and that members receive help when they need it most.

During Quarter 3 of managed care, members reported the following primary issues:

1) Transitioning between care settings continues to be a prevalent issue. Those that receive HCBS services in their home have reported losing their waiver services simply due to needing care in a skilled facility for a brief period of time. This requires the member to reapply for Medicaid and waiver services, which then means the State Medicaid Agency must devote administrative resources to processing the application and conducting a level of care assessment when the member's financial and medical status have not changed.

2) Members have reported a reduction in hours for the services for which they are eligible. In one such example, a member requiring 24/7 support experienced a reduction in their supervision services; thus, the member no longer received necessary support for their diagnosis and was a danger to themselves and others.

3) Members have reported issues with obtaining vehicle and home modifications that enable them to remain independent in their home. Without these modifications, members are at risk of returning to a nursing facility as a result.

This report includes an overview of the third programmatic quarter (October, November, December), as well as an update on systemic trends, community partnerships and outreach efforts and administrative activities.

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 October, November, and December 2016.

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:

- Transition services /coverage inadequate or inaccessible
- Change in care setting
- Access to preferred/necessary durable medical equipment

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 increased as more issues moved through the formal MCO appeal and state fair hearing processes.

Program

During the third quarter of managed care, the majority of calls received came from members enrolled in the Elderly Waiver, Intellectual Disability Waiver, and the Health and Disability Waiver programs.

The Managed Care Ombudsman assisted and provided support to a member and their guardians through both the appeal and state fair hearing processes. The administrative law judge (ALJ) ruled in favor of the member which ensured the member received the vehicle modification necessary for the member to be transported safely to and from medical appointments as well as support the member to be involved in the community.

Grievances/Appeals/Fair Hearings

The Managed Care Ombudsman Program attempts to resolve issues informally in an effort to expedite resolution. For Quarter 3, the Managed Care Ombudsman Program received 21 contacts regarding a grievance and 17 regarding an appeal. There have been 18 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
October	152	1. Change in care setting 2. Transition services inadequate/ inaccessible 3. Other service gap/coverage issue	5 days	1. Elderly Waiver 2. Children's Mental Health Waiver 3. Health & Disability Waiver	Amerigroup = 31 AmeriHealth = 67 United = 23	Grievances = 12 Appeals = 8 Fair hearings = 0
November	181	1. Transition services inadequate/inaccessible 2. Change in care setting 3. Access to preferred/necessary DME	12 days	1. Elderly Waiver 2. Intellectual Disability Waiver 3. Brain Injury Waiver	Amerigroup = 28 AmeriHealth = 106 United = 24	Grievances = 2 Appeals = 2 Fair hearings = 0
December	181	1. Service reduced, denied, terminated 2. Guardianship documents not on file 3. Transition services inadequate/inaccessible	13 days	1. Elderly Waiver 2. Health & Disability Waiver 3. Intellectual Disability Waiver	Amerigroup = 12 AmeriHealth = 116 United = 34	Grievances = 7 Appeals = 7 Fair hearings = 18
Qtr 3 Total	514	1. Transition services inadequate/inaccessible 2. Change in care settings 3. Access to preferred/necessary DME		1. Elderly Waiver 2. Health & Disability Waiver 3. Intellectual Disability Waiver	Amerigroup = 71 AmeriHealth = 289 United = 81	Grievances = 21 Appeals = 17 Fair hearings = 18

TABLE 1: QUARTER 3 CONTACT DATA (OCTOBER, NOVEMBER, DECEMBER 2016)

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) Written Notification - Members continue to report 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. It is concerning that not only are members not being notified of a change in their service, benefits or authorizations which then disrupts the provision of care within their service plan that members depend on, but are then being denied the right to appeal the decision with the MCO since no formal written decision was issued and timeframes may have passed.

2) Loss of Waiver Services - Members continue to experience challenges when returning home from receiving skilled care. Upon returning home, members are being notified of their loss of eligibility for waiver services when neither their financial nor medical status have changed. Loss of services require the member to reapply for Medicaid and forgo receipt of waiver services during the application process. Waiver services enable members to receive care in their home and remain independent. Without these services, members are at risk of returning to a skilled care facility or residing in a nursing home unnecessarily.

3) Provider and Facility Nonpayment - Since April, providers have been reporting nonpayment or insufficient payment from MCOs. As a result, providers are reducing their case loads or are no longer accepting new patients. Several providers have contacted the office indicating that if the payment issues are not resolved then closure is highly probable. Additionally, facilities are declining admission for new Medicaid members due to lack of payment from MCOs. These issues impact not only impact consumer options, but also the provider infrastructure and provider network adequacy standards as required by CMS.

4) Transitioning Between Care Settings - Members continue to experience challenges when transitioning between settings. For example, members have reported difficulty with finding timely care placement that meets their care needs once discharged from jail or a hospital.

5) Denials of durable medical equipment (DME) - During quarter 3, members have reported an increase in denials from their MCO to obtain necessary home and vehicle modifications. These modifications enable members to live independently and reside in their home, which aligns with the State's HCBS transition plan initiative.

6) System-wide inefficiencies - Since the launch of managed care, the office has received several complaints from members regarding system-wide issues that continue to persist. For example, members have reported updating their address with IME; however, their MCO does not have record of their new address resulting in members not receiving communication from their MCO. Members continue to report issues with filing guardianship documents with IME multiple times and those documents not transferring to their MCO. As a result, MCOs are not communicating with the guardian since they did not receive the guardianship documents from IME. Additionally, members have reported delays in the scheduling of their level of care (LOC) assessment. Delays in the LOC assessment delays the member's ability to receive waiver services and puts the member at risk of entering a facility unnecessarily.

The Managed Care Ombudsman assisted a member with acquiring transportation and waiver services in the home after being discharged from a facility. It was critical for the member to receive their weekly treatments for their health condition to maintain good health. The Managed Care Ombudsman worked diligently with the MCO and other entities to arrange and access necessary treatments as were deemed medically necessary.

The Managed Care Ombudsman assisted a member on the Elderly Waiver who did not have a guardian or any natural supports to aide in the process of obtaining their medications. The Managed Care Ombudsman worked with the pharmacy and the MCO closely to monitor the prescription approval and help the member receive the medications necessary in a timely manner.

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
October	4	67	0	105
November	4	200	0	100
December	2	0	0	0
Qtr 3 Total	**10**	**267**	**0**	**205**

TABLE 2: QUARTER 3 OUTREACH DATA (OCTOBER, NOVEMBER, DECEMBER 2016)

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 issues identified and addressed by the office during the third quarter of managed care remained consistent with issues identified since the launch of managed care. The office continues to meet with stakeholders including the State Medicaid Agency to creatively address these issues across the state such as revising outdated state administrative rules that no longer serve members to mitigate unnecessary issues, establish best practices, and improving the sharing of information regarding how best to navigate the managed care system.

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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