OSLTCO Update:
Managed Care Ombudsman Program

Health Policy Oversight Committee

December 13, 2016

Office of the State Long-Term Care
OMBUDSMAN
Established within the Iowa Department on Aging

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Executive Summary

In July 2015, the Office of the State Long-Term Care Ombudsman (OSLTCO) became the advocate for Medicaid managed care members who receive long-term services and supports in health care facilities or through one of the seven home and community-based waiver programs.

In response to that charge, the OSLTCO created the Managed Care Ombudsman Program to formalize and promote our advocacy role related to the rights and needs of Medicaid managed care members receiving care in a health care facility such as nursing homes, assisted living programs (ALP), elder group homes, or intermediate care facilities for the intellectually disabled (ICF/ID) as well as members enrolled in one of the seven home and community-based services (HCBS) waiver programs. This equates to serving just under 57,000 members receiving long-term services and supports (LTSS) or approximately 10 percent of the total Medicaid managed care population.

Since the transition to managed care, the Office has been addressing member concerns and issues, and tracking and monitoring systemic issues affecting members at large. Over the course of the year, the Office has been meeting with the Iowa Medicaid Enterprise (IME), managed care organizations (MCO), and other community stakeholders through routine monthly meetings and as a member of the Medical Assistance Advisory Council (MAAC) to deliberate on these issues and to develop practical policy solutions.

House File 2460 directed the OSLTCO to regularly review Medicaid managed care as it relates to the Office's respective statutory duties and submit an executive summary of pertinent information regarding deliberations during the prior year relating to Medicaid managed care. This Executive Summary, in furtherance of that requirement, will provide: 1) a summary of the member and systemic issues brought to the attention of the Office since the initial launch date of Medicaid managed care on January 1, 2016; 2) an overview of the Office's programmatic and administrative efforts; 3) a list of considerations for process and policy improvement; and 4) issues to watch as the State progresses toward year two of implementation.

I. <u>Member Issues</u>

The Office has been assisting Medicaid members and tracking issues since the initial launch date of January 1, 2016. The Office has received a total of 1,337 contacts from January 1, 2016 to October 31, 2016. Contacts were made to the office by both telephone and email and by members or their caregivers. The following table identifies the total contacts received per month and the top issues addressed. Examples have been provided for further information.

Month	Total Monthly Contacts	Top Issue	Examples
January & February	405	• Members' MCO selection were not being recorded at IME • IME Member Services call center had a wait time of up to 2 hours • Members did not understand letters sent to them from IME • Provider directories were inconsistent between IME and the MCOs	• Members reported issues primarily related to member's MCO selection not being recorded, challenges with reaching someone at IME within a reasonable amount of time about their issue, understanding what is expected of them with the transition, and identifying providers contracted with each MCO to make informed MCO selections.
March	42	• Access to services/benefits • Enrollment • Other service/coverage gap issue	• Members had difficulty with accessing a type of provider or service in their area since their provider had yet to contract with an MCO, selecting an MCO or enrolling in Medicaid or a waiver program.
April	143	• Keeping their care coordinator or case manager • Access to services/benefits • Eligibility	• Members reported being pressured to change their case manager prior to the 6 month transition date, unable to access their provider due to being out of network, not receiving communication regarding their Medicaid application, and long wait times before being able to receive services once determined eligible.

May	89	• Access to services/benefits • Customer service • Care planning	• Members continued to report issues with selecting or changing their MCO, lengthy wait times to receive services once determined eligible, participating in their care plan, and CDAC enrollment and reimbursement.
June	107	• Change in care setting • Member lost eligibility or was denied • Transition services/coverage inadequate or inaccessible	• Members reported difficulty with transitioning from care settings and, upon returning home, losing their waiver services. Transitioning between care settings were reported as extremely challenging.
July	81	• Access to preferred/necessary DME • Change in care setting • Service reduced, denied or terminated	• Members experienced difficulty with obtaining necessary DME as prescribed by their provider, finding in-state placement while working with their MCO, and having service hours reduced.
August	130	• Prior authorizations (PA) • Change in care setting • Care coordinator/case manager was rude	• Members continued to experience issues with finding an appropriate care setting and with receiving communication regarding a PA that was submitted on their behalf. Members reported poor customer service from MCO representatives.
September	188	• Change in care setting • Member has lost eligibility status or was denied • Access to services/benefits – Other	• Members experienced difficulty with transitioning between settings such as from a hospital or nursing home back home or finding appropriate care placement. Members continued to report losing their waiver services upon returning home from receiving skilled nursing in a facility.

October	152	• Change in care setting • Transition services/coverage inadequate or inaccessible • Other service/coverage gap issue	• Members continue to experience difficulty with transitioning between care settings once discharged from a hospital or skilled care facility or finding appropriate care placement with facilities not accepting new Medicaid members due to lack of reimbursement. Provider reimbursement, particularly for CDAC providers, continues to be an issue. Members have also reported issues with obtaining home and vehicle modifications necessary to live independently in their home.

II. Systemic Issues

The Office tracks and monitors issues that are systemic in nature, particularly those which impact multiple members and populations across the state, and works within the system to seek resolution. These issues are then highlighted in the Managed Care Ombudsman Program quarterly reports. The following issues have been pervasive since the launch of managed care and in some cases, existed prior to managed care but continue to require resolution:

a) Members are waiting 3 to 6 months to receive waiver services from the date of obtaining financial and medical eligibility approval by IME. This delay has resulted in the degradation of members' health which can lead to needing long-term care services in a facility setting and places additional financial strain on the member. This has also resulted in providers and facilities not being paid.

b) Members enrolled in a waiver who receive skilled care for 30 or more days have been losing their waiver services upon returning home and are required to go through the Medicaid application process again. This issue is particularly common among members enrolled in the Elderly Waiver program. Losing waiver services upon returning home from placement in a temporary skilled care facility has resulted in members accruing debt to providers or forgoing the services until their Medicaid application for waiver services is approved again. The re-application process appears to be an unnecessary step, as most members' financial and medical eligibility have not changed.

c) Providers have been receiving delayed reimbursement, inadequate reimbursement or no reimbursement at all since April 1st, 2016. As a result, many providers are refusing to accept new Medicaid members, reducing their case load and staff, and/or taking out business loans to remain solvent. This impacts not only the provision of care for members, but also provider network adequacy standards required by the Centers for

Medicare and Medicaid Services (CMS).

d) Members are not receiving a Notice of Action when a change in their service or covered benefit occurs or written prior authorization approval and denial letters for pharmaceuticals. As a result, members have been learning of the change in their care or benefit through their provider and are not given ample time to find an alternative to the service or benefit no longer provided. Additionally, without a written Notice of Action, the member does not have documentation of the decision or action taken by the MCO and, in many cases, does not then know of their rights to file an appeal or request a fair hearing as a result.

e) Members' grievances are not being documented and maintained in the MCO's system thus denying any record of such grievance being filed. As a result, the member's expression of dissatisfaction remains unacknowledged which circumvents the member's right to file a grievance and to receive written disposition of the resolution from the MCO.

f) There remains widespread miscommunication regarding various policies and procedures including the following:

   - Which party has authority to issue exceptions to policy (ETP): Prior to managed care, IME maintained authority to issue ETPs. This has caused confusion among members who need to request additional or other services and have caused delays in receiving those services due to not understanding the process.

   - Understanding of CDAC policies: Both members and providers have reported confusion regarding the ability for individuals to register and serve as an individual CDAC provider post June 30, 2016.

   Understanding of the role of the Managed Care Ombudsman Program: As the State's designated advocate for Medicaid managed care members receiving long-term services and supports (LTSS), the Office plays a unique role in advocating on behalf of members and in resolving issues within the system. There remains a lack of understanding regarding the specific role of the Managed Care Ombudsman Program, the broader role of the Office of the State Long-Term Care Ombudsman and the OSLTCO's ability to access documents and obtain confidential information with member consent in order to resolve issues among the MCOs. This lack of understanding has resulted in delayed issue resolution and interference of the work conducted by the Office.

III. <u>Policy and Process Considerations</u>

The following should be considered in reviewing the Medicaid managed care system:

a) **Improve communications within IME, among MCOs, and with Medicaid managed care members and their approved representative, and adopt consistent use of terminology.**

Oftentimes systems within an agency communicate in silos which frequently results in information not being shared with or transferred to the appropriate entity.

b) **Standardize claims submission processes.** Many providers have contracted with all three MCOs thus requiring them to understand and utilize three unique processes and procedures for submitting claims. This can be timely and expensive for small provider groups. Providers can only withstand not being paid for a period of time until they can no longer operate as a business entity and provide care to members.

c) **Create an advocacy ombudsman-type system for Medicaid members not served through the LTSS Managed Care Ombudsman Program.** The Office has received numerous contacts from populations outside the scope of the Office's authority. While the Office employs a policy that ensures all contacts receive a warm referral to the appropriate entity, the need for an advocate for the Medicaid population at large is evident. In 2015, the Office was required to convene a Health Consumer Ombudsman Alliance workgroup per Senate File 505 to develop a proposal for the establishment of a permanent coordinated system of independent consumer supports. The following were recommendations from that report:

   i. Develop a Medicaid Managed Care Information Program to assist Medicaid members in obtaining objective and unbiased information, counseling and options for enrollment,

   ii. Implement a statewide single point of entry to the system to facilitate seamless access to resources, supports, and assistance with issues related to health care services, coverage, access, and rights,

   iii. Expand the role of the advocacy ombudsman-type system to serve as an advocate for all Medicaid members, not just Medicaid managed care members receiving long-term services and supports,

   iv. Ensure capacity for legal advocacy for Medicaid members by expanding the current legal assistance network, and

   v. Establish a Health Consumer Ombudsman Alliance to identify gaps and discuss overall health care needs of Iowans and make recommendations to address issues encountered.

IV. <u>Issues to Watch</u>

1. Wait time for members to receive waiver services once determined financially and medically eligible for Medicaid
2. Loss of waiver services if a member on a waiver receives skilled care in a facility for a brief period of time and returns home without the ability to promptly resume their

waiver services even though their financial and medical status have not changed

3. Providers denying admission to new Medicaid residents and tenants at their facility or no longer taking on new Medicaid members or case work due to lack of or inadequate reimbursement

4. Provider network adequacy as providers continue to deny admission or caring for new Medicaid members

5. Options for care placement as members seek residency of their choice that meets their needs

6. Circumvention of member's rights