Managed Care Ombudsman Program Quarterly Report

2nd Quarter, Year 2 - July/August/Sept 2017

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
- Physical Disability Waiver

The goal of the Managed Care Ombudsman Program is to provide information about Medicaid managed care options and members' rights, serve as a resource for answers regarding managed care rules, and advocate for managed care members by investigating and attempting to resolve complaints made by, or on behalf of, members.

During Quarter 2-Year 2 of managed care, members reported the following primary issues:

1. Services being reduced, denied or terminated especially for members that receive care in their home through a home and community-based services (HCBS) waiver program. In response to this change in services, members are requesting formal appeals and state fair hearings to access the service level they feel is necessary.

2. Challenges accessing preferred/necessary durable medical equipment that enable members to remain safely independent in their home. Members have reported challenges, such as confusing processes, in working with their MCO to gain approval for durable medical equipment (DME). A portion of members reported denials in requests for DME and as a result are requesting an appeal and/or fair hearing. Members have also reported issues finding providers willing to provide approved durable medical equipment.

3. Limited access to information or information sharing for members to understand various processes that impact their ability to utilize waiver services, participate in the grievance, appeal or fair hearing process, or be actively engaged in their managed care experience.

The enclosed report includes an overview of the second programmatic quarter of year two (July, August, September 2017) as well as an update on systemic trends, 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 member issues on a monthly basis. For analysis purposes, this report provides a high-level overview of the data aggregated over the months of July, August, and September 2017.

Contacts

A 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 by month 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 may be 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 include:

- Services reduced, denied or terminated
- Access to preferred/necessary durable medical equipment
- Access to information or information sharing

Average Resolution Time

Resolution time begins when the Managed Care Ombudsman receives the issue and ends when the issue is resolved. Average resolution time is calculated each month by adding the resolution time for each issue together then 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 fluctuated throughout the quarter. The program continues to observe more members moving through the formal MCO appeal and state fair hearing processes.

Program

During Quarter 2-Year 2 of managed care, the majority of contacts came from members enrolled in the Intellectual Disability Waiver, the Brain Injury Waiver, and the Elderly Waiver.

A Medicaid member was new to a MCO and was in need of waiver services. The member was having challenges communicating with their case manager and contacted the Managed Care Ombudsman Program. A Managed Care Ombudsman was able to provide the member with communication suggestions and resources about advocating for themselves. The member then was able to fully communicate their needs to their case manager and receive the services needed to stay independent in their home.

Grievances/Appeals/Fair Hearings

The Managed Care Ombudsman Program attempts to resolve issues informally in an effort to expedite resolution. For Quarter 2-Year 2, the Managed Care Ombudsman Program received 51 contacts regarding a grievance and 315 regarding an appeal. There have been 169 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**
July	354	1. Service reduced, denied or terminated 2. Access to information or information sharing 3. Care planning participation	27 days	1. Intellectual Disability Waiver 2. Brain Injury Waiver 3. Elderly Waiver	Amerigroup = 81 AmeriHealth = 207 United = 56	Grievances = 19 Appeals = 121 Fair hearings = 40
August	468	1. Service reduced, denied or terminated 2. Access to preferred/necessary DME 3. Access to information or information sharing	27 days	1. Intellectual Disability Waiver 2. Brain Injury Waiver 3. Physical Disability Waiver	Amerigroup = 66 AmeriHealth = 268 United = 103	Grievances = 19 Appeals = 120 Fair hearings = 97
September	314	1. Service reduced, denied or terminated 2. Access to preferred/necessary DME 3. Home/vehicle modifications	13 days	1. Elderly Waiver 2. Brain Injury Waiver 3. Health & Disability Waiver	Amerigroup = 60 AmeriHealth = 151 United = 82	Grievances = 13 Appeals = 74 Fair hearings = 32
Qtr 2 Total	1,136	1. Service reduced, denied or terminated 2. Access to preferred/necessary DME 3. Access to information or information sharing		1. Intellectual Disability Waiver 2. Brain Injury Waiver 3. Elderly Waiver	Amerigroup = 207 AmeriHealth = 626 United = 241	Grievances = 51 Appeals = 315 Fair hearings = 169

TABLE 1: QUARTER 2-YEAR 2 CONTACT DATA (JULY, AUGUST, SEPTEMBER 2017)

TRENDS

In addition to tracking member issues on a monthly basis, the Managed Care Ombudsman Program documents and tracks trends discussed by members. The following discusses the issues and trends identified:

1. Consumer Directed Attendant Care (CDAC) Impacts – CDAC services are 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 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 choosing, barriers to using CDAC services as they would like, and perceived decreased flexibility within the service.

In addition, CDAC providers and their members have reported continued issues with payment. While CDAC payment is not a specific member issue, members are often concerned about losing a trusted CDAC provider as a result of payment issues. In several instances, the CDAC provider may be a family member living with or contributing to the expenses of the member, which may create financial strain for the member.

2. Grievance, Appeal, and State Fair Hearing Processes – The Managed Care Ombudsman Program has shared previously that members are exercising their right to express dissatisfaction with their MCO through a grievance, or their disagreement with a decision about their care through an appeal and/or state fair hearing. While the steps for participating in these processes are included in a variety of member materials, the process remains confusing and intimidating for many members. Members specifically note confusion with the appeal and state fair hearing time frames and the ability to request continued benefits. The confusion can be exacerbated as members report being given conflicting and incorrect information by the MCO representatives tasked with accepting an appeal.

Members have the right to legal representation, but often do not have the resources to secure representation and non-profit legal organizations are not able to meet the full demand of requests. Members are increasingly engaging in the legal processes of appeals and state fair hearings without training or representation. When this occurs, members are expected to participate in the legal proceedings of a state fair hearing in front of an administrative law judge and opposing MCO attorney or representative. At best a member has a provider or advocate assisting them in these processes, but even those resources may be uniformed on legal proceedings.

A Medicaid member receiving waiver services received a notice from their MCO informing them of a reduction in their services which enabled the member to stay at home.
The Managed Care Ombudsman assisted the member and the family by working with Disability Rights Iowa and advocating for the member to keep their services in place throughout both an appeal and state fair hearing process. The member was able to maintain all their services medically necessary to ensure they were safe and all health needs were met in the home.

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.

The Managed Care Ombudsman Program has presented at various work groups and forums and distributed program materials. The table below identifies outreach efforts and total number of communication materials distributed:

Month	Presentations	Brochures	Bookmarks	Member Packets
July	-	700	-	251
August	2	1,475	-	550
September	0	1,475	-	550
Qtr 2 Total	2	3,650	-	1,351

TABLE 2: QUARTER 2-YEAR 2 OUTREACH DATA (JULY, AUGUST, SEPTEMBER 2017)

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

Throughout the quarter, the Managed Care Ombudsman Program worked with members, their representatives, advocates, each managed care organization (MCO), Iowa Medicaid Enterprise (IME) and other agencies to creatively and efficiently resolve complaints and issues. The program succeeds through the direct advocacy and support provided to members, as it creates an opportunity for improvement in the managed care experience. Often, members and their representatives communicate that they wish they had been aware of the Managed Care Ombudsman Program sooner.

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, available on the webpage. This form is internal to the Managed Care Ombudsman Program and is not shared with a member's MCO unless requested. Members and their representatives may complete the form to file a formal complaint with the program, and may request to be contact by a Managed Care Ombudsman.

In addition to being available by phone, email, and mail, the program has developed tools and resources with the goal of providing important, relevant and helpful information to those navigating the managed care system. These materials are available electronically on the Managed Care Ombudsman Program website, and are also available by request in hard copy.

Please share the Managed Care Ombudsman Program contact information and materials.

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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Managed Care Ombudsman Program Monthly Report

Per CMS Special Terms and Conditions, the monthly Managed Care Ombudsman Program data is provided below.

DATE: 11/2017

Number of Contacts[1]		223
Contact Categories[2]		
Access to Services/Benefits	Access to preferred/necessary durable medical equipment	4
	Access to preferred/necessary medication	6
	Home/vehicle modifications	20
	Prior authorization	27
	Provider/pharmacy/hospital not in network	7
	Service reduced, denied or terminated	46
	Transition services/coverage inadequate or inaccessible	59
	Transportation not available, timely or adequate	10
	Other service/coverage gap issue	9
	Other	10
Billing	Member charged improper cost sharing	6
	Other	1
Care Planning	Access to information or information sharing	7
	Care planning participation	12
	Change in care setting	-
	Discharge	7
	Level of care assessment	9
	Other	2
Customer Service	Care coordinator/case manager was rude or gave poor customer service	9
	MCO was rude or gave poor customer service	5
	Member has not received MCO card or other materials	-
	Provider/pharmacy was rude or gave poor customer service	1
	Scheduling	-
	Other	-
Eligibility	Member has lost eligibility status or was denied	-
	Member needs assistance with acquiring Medicaid eligibility information	17
	Member needs assistance with checking on application status	3
	Other	5
Enrollment	Disenrollment from MCO – good cause eligible	-
	Disenrollment from MCO – not good cause eligible	-
	Disenrollment from Medicaid program	-
	Selecting/changing MCO	46
	Other	3
Guardianship	Guardian not receiving information	-
	Guardianship documents not on file	-
	Unable to contact guardian	-
	Other	-
Other		3
N/A		11
Contacts Related to Grievances/ Appeals/Fair Hearings[3]	Grievances	7
	Appeals	17
	Fair Hearings	16
Contacts per MCO[4]	Amerigroup Iowa	75
	AmeriHealth Caritas	119
	UnitedHealthcare Plan of the River Valley	66

Program[5]	AIDS/HIV Waiver	-
	Brain Injury Waiver	27
	Children's Mental Health Waiver	-
	Dental	-
	Duals	-
	Elderly Waiver	82
	Fee for Service	23
	Habilitation	-
	Health & Disability Waiver	22
	HIPP	-
	Institutional Care	7
	Iowa Health & Wellness	-
	Intellectual Disability Waiver	27
	Medicare	-
	PACE	-
	Physical Disability Waiver	6
	QMB or SLMB	-
	Other	1
	N/A	2
	Unknown	20
Average Resolution Time[6]		29
Referrals per Entity[7]	Department of Human Services	6
	Department of Inspections and Appeals	-
	Disability Rights Iowa	2
	Iowa Compass	1
	Iowa Legal Aid	-
	LifeLong Links	1
	MCO	7
	Medicaid Fraud Control Unit	-
	Provider	-
	Senior Health Insurance Information Program	1
	State Ombudsman Office	4
	Other	3
Service(s) Provided to Contact[8]	Grievance assistance	1
	Appeals assistance	1
	Fair hearing assistance	7
	Advocacy	97
	Education and information	30
	Investigation	111
	Referral	20
Service(s) Provided to Stakeholders[9]	Community education	3
	Information and consultation	6
	Technical assistance	-
	Training	-

[1]*Number of Contacts:* Total Number of contacts received via phone and email.
[2]*Contact Categories:* Reason contact was made to the program. "Other" is used for issues not listed. "N/A" is used for issues unknown.
[3]*Contacts Related to Grievances/Appeals/Fair Hearings:* Contacts concerning filing or filed grievances/appeals/fair hearings.
[4]*Contacts per MCO:* Contacts received regarding the respective MCO.
[5]*Program:* Type of program discussed during the contact. "Other" is used for programs beyond those captured in this report. "N/A" is used when the contact inquires about unrelated programs/issues. "Unknown" is used when the contact does not know the program they are enrolled with/inquiring about.
[6]*Average Resolution Time:* Average number of days required for resolution.
[7]*Referrals Made to Entities:* Referrals made to external organizations that provide services beyond the scope of the program.
[8]*Services Provided to Contact:* Services provided to the contact who may be the member, family member or their authorized representative.
[9]*Services Provided to Stakeholder(s):* Services provided to stakeholders, including but not limited to community organizations, advocacy organizations and MCOs.

Note: Total *Number of Contacts* may not equal total number of issues identified under *Contact Categories* due to the identification of multiple issues during one contact.

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Established within the Iowa Department on Aging

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Executive Summary

The Office of the State Long-Term Care Ombudsman (OSLTCO), through long-term care ombudsman/managed care ombudsman, advocates for concerns and rights of 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.

Long-term care ombudsman/managed care ombudsman are charged with assisting recipients with understanding members' rights regarding services, care and access to managed care. Long-term care ombudsman/managed care ombudsman also provide advice and assistance to managed care members that wish to file complaints, grievances and appeals.

House File 2460 directed the OSLTCO to review Medicaid managed care as it relates to the OSLTCO's statutory duties and annually submit an executive summary of pertinent information. OSLTCO's statutory duties include advocacy and assistance for recipients of long-term supports and services provided by the Medicaid program. This Executive Summary contains a summary of the member issues brought to the attention of the OSLTCO for the time period of October 1, 2016 through September 30, 2017, as well as issues to watch.

I. Member Issues

The OSLTCO has received a total of 4,187 contacts regarding managed care from October 1, 2016 to September 29, 2017. Contacts were made with the OSLTCO by telephone and email. Members, their legal decision makers, and caregivers were the source of contacts with the OSLTCO. The following table identifies the total contacts received by month and the top three issues raised by those contacting the OSLTCO.

Months	Total Contacts	Top 3 Issues
October 2016	152	• Change in care setting • Transition services inadequate/inaccessible • Other service gap/coverage issue

Months	Total Contacts	Top 3 Issues
November 2016	181	• Transition services inadequate/inaccessible • Change in care setting • Access to preferred/necessary durable medical equipment
December 2016	181	• Service reduced, denied, terminated • Guardianship documents not on file • Transition services inadequate/ inaccessible
January 2017	273	• Services reduced, denied, terminated • MCO was rude or gave poor customer service • Other service gap/coverage issue
February 2017	355	• Service reduced, denied, terminated • Care planning participation • Change in care setting
March 2017	556	• Service reduce, denied, terminated • Care coordinator/case manager was rude/gave poor customer service • Care planning participation

Months	Total Contacts	Top 3 Issues
April 2017	448	• Service reduced, denied, terminated • Other • Care planning participation
May 2017	439	• Service reduced, denied, terminated • Access to information/information sharing • MCO was rude or gave poor customer service
June 2017	466	• Service reduced, denied, terminated • Access to information/information sharing • Care planning participation
July, 2017	354	• Service reduced, denied or terminated • Access to information/information sharing • Care planning participation

Months	Total Contacts	Top 3 Issues
August 2017	468	• Service reduced, denied, terminated • Access to preferred/necessary durable medical equipment • Access to information/information sharing
September 2017	314	• Service reduced, denied, terminated • Access to preferred/necessary durable medical equipment • Home/vehicle modifications

In addition to the issues in the table above, the OSLTCO tracked resolution times for issues reported to the OSLTCO by managed care members, or someone reporting on their behalf. Resolution times fluctuated from a low of 5 days in October 2016, to a high of 29 in January 2017.

Most of the contacts the OSLTCO received were from Elderly Waiver managed care members or someone reporting on their behalf.

II. Issues To Watch

CDAC providers and their members have reported continued issues with payment. While payment is not a specific member issue, members are often concerned about losing a trusted CDAD provider as a result of payment issues.

The OSLTCO noted an increase in the number of contacts from managed care members or someone reporting on their behalf regarding state fair hearings. For the months of October, November and December of 2016, the OSLTCO had 18 contacts regarding state fair hearings. For the months of July, August and September of 2017 the number of contacts regarding state fair hearings had increased to 169 contacts.

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Trends Regarding Transition from AmeriHealth Caritas
Federal Fiscal Year 2017 and Partial Federal Fiscal Year 2018

Month	Contacts Transition Services/Coverage Inadequate or Inaccessible	Contacts Selecting/Changing MCO
October 2016	27	0
November 2016	43	1
December 2016	25	0
January 2017	16	0
February 2017	28	0
March 2017	42	1
April 2017	16	0
May 2017	33	0
June 2017	23	2
July 2017	11	0
August 2017	28	0
September 2017	12	1
Total FFY17	**304**	**5**

October 2017	30	12
November 2017	59	46
Total FFY18	**89**	**58**