OFFICE OF THE
State Long-Term Care
Ombudsman

Managed Care Ombudsman
Executive Summary

FY 2021
(Oct 1, 2020 – Sept 30, 2021)

EXECUTIVE SUMMARY

The Office of the State Long-Term Care Ombudsman (OSLTCO) administers the Managed Care Ombudsman Program (MCOP) to advocate and resolve managed care issues for Medicaid managed care members. These members live in health care facilities, assisted living programs, elder group homes, or other qualifying long-term services, supports (LTSS) environments. Qualifying Members are enrolled in one of the seven home and community-based services (HCBS) waiver programs: AIDS/HIV Waiver, Brain Injury Waiver, Children's Mental Health Waiver, Elderly Waiver, Health and Disability Waiver, Intellectual Disability Waiver and Physical Disability Waiver.

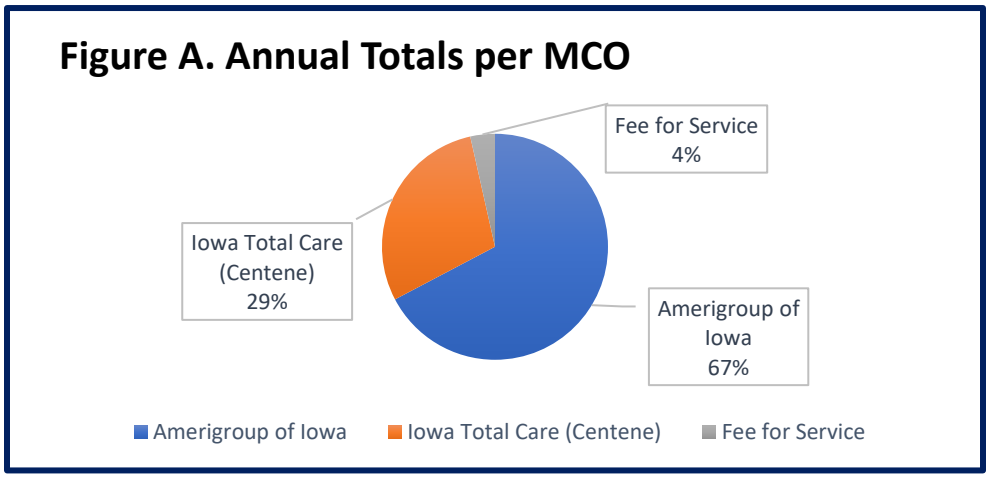
MCOP assists qualified managed care members with understanding their rights to services, care and access concerns. Services provided are more than complaint resolution or assistance with filing a grievance, appeal or fair hearing. The MCOP provides education, information, consultation, technical assistance and making referrals to ensure members have the information needed to make informed decisions regarding their care. The Managed Care Ombudsman Program networks with other advocacy and provider groups, associations, organizations and agencies to coordinate the provision of assistance to members when needed resources extend beyond the Managed Care Ombudsman's scope. MCOP does not advocate for providers or people who do not receive LTSS services under one of the HCBS waiver programs.

The Federal Fiscal Year (FFY21) executive summary contains a compilation of member issues (i.e., activities) brought to the attention of the OSLTCO from October 1, 2020 through September 30, 2021. This summary fulfills the requirements of HF 2460 regarding the OSLTCO's advocacy and assistance for managed care members who are in a health care facility or who receive LTSS under one of the HCBS waivers.

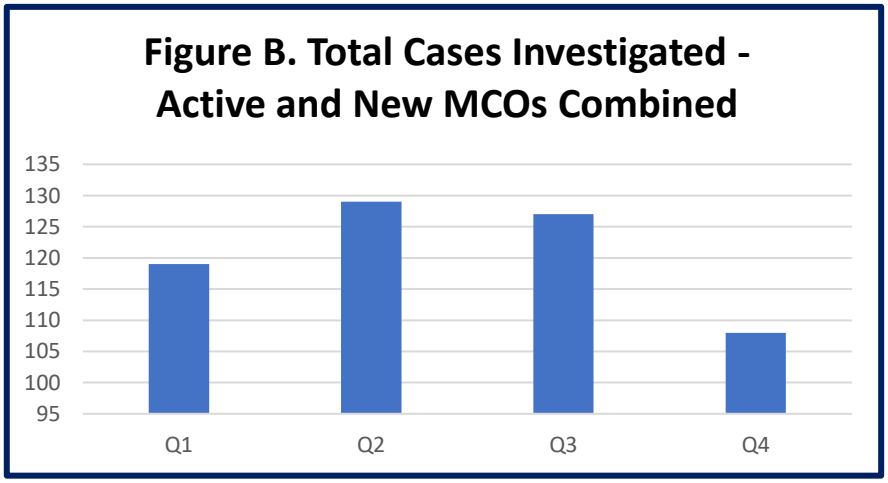
The executive summary includes four distinctive parts. Part I provides an annual compilation of member issue cases based on FFY21 monthly reports. Part II provides details of prevailing issues, based on quarterly reports, Part III provides trends tracked and Part IV provides community partnerships and outreach as well as potential program improvements.

PART I ANNUAL COMPILATION of MEMBER CASES

Total cases investigated by Managed Care Ombudsman to assist and advocate for members during Federal Fiscal Year 2021 (FFY21) totaled 483 from 787 activities. The case data depicted here are based off monthly reports and comprised the following numbers; Amerigroup of Iowa 325 cases, Iowa Total Care (Centene) 141, and Fee for Service came in at 17. The overall proportion of member cases per Managed Care Organization (MCO) in FFY21 is represented in **Figure A**.



Of the total 483 combined cases investigated in FFY21, **Figure B** demonstrates that the highest volume happened in Quarter 2 – January through March of 2021. The prevailing reasons are uncovered in Part II.

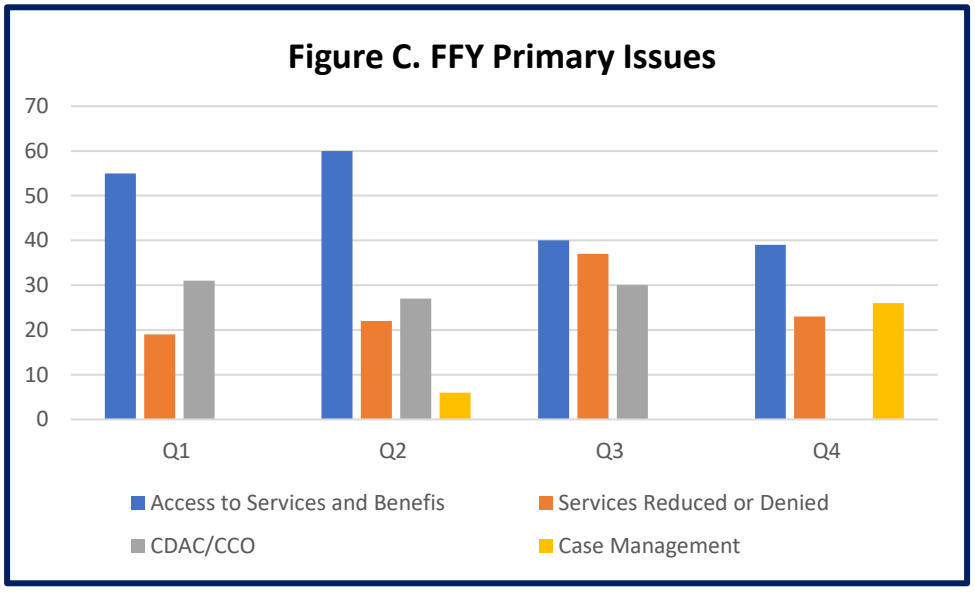


PART II ANNUAL COMPILATION of PREVAILING ISSUES

The Office works with a variety of essential stakeholders to help address and resolve issues. The Office deploys a variety of methods, including encouraging use of best practices; facilitating and coordinating communication with necessary parties; and referring to outside agencies as necessary. The numbers of complaints tracked showed the following slight fluctuations of individual member cases/complaints per quarter in Federal Fiscal Year 2021 (FFY21).

FFY21 Prevailing Issues per Quarter				
Issues	**Q1**	**Q2**	**Q3**	**Q4**
Access to services and benefits	x	x	x	x
Services reduced, denied or terminated	x	x	x	x
Access to durable medical equipment (DME)	x			
Notice of decision appeals and fair hearings		x		
Lack of approved consumer directed attendant care (CDAC) and consumer choice option (CCO) service hours			x	
Case management				x

The prevailing issues reported to the Managed Care Ombudsman Program by managed care members are identified in the chart above for each quarter of FFY21, based on activity volume. **Figure C** depicts the actual volume of these top significant issues per Quarter.



Access to Services and Benefits and *Services Reduced, Denied or Terminated* stand out as the predominant issues. Other issues, such as the lack of providers (i.e., medical physicians, skilled care providers, transportation drivers, chore/homemaking providers and home modification providers, etc.) had a direct impact on the members' overall health, as did the wait time members experienced for service benefits to be approved. Some members did not receive all services, for which they were approved. Members that need long-term services and supports reported reductions or denials in their HCBS waiver services in their homes or assisted living programs. This directly impacted attendant care (CDAC) and consumer choice options (CCO) service hours. Members reported delayed response time from case managers and a lack of support and understanding of their health care needs. Lack of understanding from newly assigned case managers, require the member to build new relationships and endure a lack of consistency and knowledge of their overall goals and health care needs. Of the 787 total cases, 405 were fully or partially resolved to the member's satisfaction. On average, 31 are actively in processed on a monthly basis[1].

In conclusion, attribution of persistent issues is the result of both residual and emerging issues. The Managed Care Ombudsman Program has little control over the root causes of issues but with a monthly average of 33.75 of fully or partially resolving issues to the member's satisfaction, it demonstrates consistent advocacy effort to bring satisfaction to MCO members.

For further information, please contact the Managed Care Ombudsman Program at (866) 236-1430 or https://www.iowaaging.gov/state-long-term-care-ombudsman/managed-care-ombudsman-program

[1] Managed Care Ombudsman monthly report data https://iowaaging.gov/state-long-term-care-ombudsman/managed-care-ombudsman-program/reports

PART III MANAGED CARE OMBUDSMAN PROGRAM TRENDS

The Managed Care Ombudsman Program documents and tracks program trends discussed by members. Similar to prevailing issues in Part I but broader in scope, trends identified in Federal Fiscal Year 2021 (FFY21) comprise nine (9) primary categories. The chart below shows **FFY21 Trends**. Categorical descriptions of trends follow and are organized in sequential order according to the chart. Trends may be based on persist or emerging issues.

FFY21 Trends				
Trends	**Q1**	**Q2**	**Q3**	**Q4**
Case Management	x			
Home and Vehicle Modification Barriers	x			
Transition Services/Coverage Gap	x	x	x	
Services Reduced, Denied or Terminated		x		
Transportation		x		
Appeal Process				x
Lack of Providers			x	x
Durable Medical Equipment (DME) Access	x		x	x
Consumer Directed Attendant Care (CDAC) and Consumer Choice Options (CCO)			x	x

1. **Case Management.** Case management issues are ongoing with poor communication from their case managers. Members share they have experienced a lack of case manager services when needed. Some of this is due to their lack of understanding about case manager obligations, when it comes to approving necessary services. **Persistent in Q1**.

2. **Home and Vehicle Modification Barriers**. Challenges regarding home and vehicle modifications are also a trend that members experienced this quarter. Members also reported lengthy periods to acquire the modification necessary to remain independent in their home from the point of applying for bids from available providers, to appealing denials. **Persistent in Q1.**

3. **Transition Services/Coverage Gap, inadequate or inaccessible**. Medicaid members report lengthy wait times when needing assistance with transitioning Medicaid programs and at times a lack of care planning, disruption in the continuity of care of the member creates a gap of services where the member does not receive the care they need, thus placing the member at risk. While members wait for assistance, with transitioning, they live in inadequate conditions because of lack of care planning, disruption in the continuity of care and other cascading issues caused primarily by inaccessibility. The transitional gap of services renders the member most

vulnerable during these times when the member does not receive the care they need, thus placing them at risk. This is an ongoing systemic issue and was most predominant in FFY21. **Persistent in Q1, Q2 and Q3.**

4. **Services Reduced, Denied or Terminated, for members needing long-term services and supports**. Members needing long-term services and supports reported reductions or denials in their HCBS waiver services in their homes or assisted living programs. Many times, these health services had been approved in the past. The unexpected change often affected consumer directed attendant care (CDAC) and consumer choice options (CCO) service hours. In response to reductions in services, members requested more formal appeals and fair hearings to gain access to the services they feel are necessary for their health and safety. **Persistent in Q2.**

5. **Transportation**. Transportation issues create challenges for many members trying to regularity attend scheduled medical appointments or access specialty healthcare visits. **Persistent in Q2**.

6. **Appeal Process**. Members have chosen to start the appeal process with their MCO for approval of those services necessary for the member to remain safe and healthy in their home. Members exercise their right to express dissatisfaction with their MCO through a grievance, or their disagreement with a decision about their health care, through an appeal and/or state fair hearing. The process remains confusing, intimidating and further delays access to care. **Persistent in Q4.**

7. **Lack of Providers**. Members have reported a lack of approved providers to choose from in order to receive health services. Reasons shared for lack of providers are that the MCO and/or the provider are not wanting to contract with one another. For members living in remote rural areas, this issue was more prevalent. The lack of providers includes medical physicians, transportation drivers and home modification providers as well as CDAC staff. **Persistent in Q3 and Q4**.

8. **Durable Medical Equipment (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. Members also reported having to wait for medically necessary equipment to be approved and then accessed. These barriers continue to affect the quality of life for the member. **Persistent in Q1, Q3 and Q4.**

9. **Consumer Directed Attendant Care (CDAC) and Consumer Choice Options (CCO), member impacts**. The Managed Care Ombudsman Program continues to receive a high number of complaints from members reporting dissatisfaction with changes affecting their CDAC services. Changes include service reductions or denials, and changes that impact the day to day use of CDAC services. Members were also concerned over their CDAC provider not receiving payment on time. Members have reported a lack of approved CDAC providers for members living in remote rural areas; this issue was more prevalent. Some members lost their providers due to non-payment for services rendered. **Persistent in Q3 and Q4.**

PART IV COMMUNITY PARTNERSHIPS AND OUTREACH | POTENTIAL AREAS FOR PROGRAM IMPROVEMENTS

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 collaborating with community stakeholders to connect members to resources beyond the Managed Care Ombudsman's scope.

COMMUNITY PARTNERSHIPS AND OUTREACH

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, discuss and to address collective concerns expressed by members.

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 are available at https://www.iowaaging.gov/state-long-term-careombudsman/managed-care-ombudsman-program

The Managed Care Ombudsman Program as well as the State Long Term Care Ombudsman Program invites all LTSS members and their providers to visit our social media sites. You can find information by checking out our Facebook and Instagram pages. https://www.facebook.com/profile.php?id=100076034146712 https://www.instagram.com/iowa_ltc_ombudsman/

POTENTIAL AREAS FOR PROGRAM IMPROVEMENT

The Managed Care Ombudsman Program continues to service members' advocacy needs, identify potential areas for program improvement by tracking trends and increase awareness. The data is published on a monthly and quarterly basis is shared with affiliates and program partners on a routine basis. During Federal Fiscal Year

2021 (FFY21), at the height of the COVID-19 Pandemic and recovery, the new State Long-Term Care Ombudsman instituted improving awareness and expanding the outreach potential of the Office.

The Managed Care Ombudsman Program (MCOP) will remain vigilant as a stop-gap resource to Medicaid members during transition. As Iowans struggled to recover from the 2020 COVID-19 Pandemic the most prevalent problem in FFY21 was the transitional gap of services. Gap in services renders the member most vulnerable during times when they do not receive the care they need, thus placing them at risk. Lengthy wait times contributing to lack of care planning disrupts the continuity of care of the member and creates a gap of services where the member does not receive the care they need, thus placing the member at risk. These issues were especially persistent in Q1, Q2 and Q3. Suspected of being associated open enrollment periods and attributed to the pandemic, the MCOP will remain focused.

The MCOP will increase awareness of issues related to Durable Medical Equipment (DME) and provide solutions, as they are received. Diminished access to Durable Medical Equipment (DME) is a problematic area where improvement is needed. Medicaid Members experienced increased denials or long waits for approval when trying to obtain equipment prescribed and recommended by their physician. Members reported the lack of contracted providers willing to work with the MCO's. These barriers continue to affect the quality of life for the member. The Office will continue to triage member calls for assistance and advocacy when acquiring DME.

Increase preparedness for issues and concerns with case management. The volume of case management issues can fluctuate at certain times of the year. Primarily symptomatic of poor communication from case managers, the MCOP helps members navigate the complexity of the system. When members share that they have experienced a lack of case manager services, careful investigation is needed to sort out the root cause. Sometimes it’s due to members’ lack of understanding about case manager obligations when it comes to approving necessary services. Members also reported challenges when trying to reach their case manager during the transition to a new MCO and/or were not notified as to who their temporary case manager or point of contact would be during the transition period. This issue trended down in the latter part of FFY21, as it was mostly attributed to systematic issues with enrollment, persistent in Q1. The MCO stays connected to Medicaid provider and case management network in an effort to be prepared to expedite resolutions for members.

Assure staff availability to serve member calls. Fluctuation in calls from members needing long-term services and supports, are many times caused by reported reductions or denials in HCBS waiver services in their homes or assisted living programs. Members are more apt to call during certain months which may be attributed to

Consumer Directed Attendant Care (CDAC) and Consumer Choice Options (CCO) service hours. In response to reductions in services, members request more formal appeals and fair hearings to gain access to the services which they feel are necessary for their health and safety. These issues were especially persistent in Q3 and Q4 of FFY21. The influx and decrease in calls of this nature is being monitored.

Inform affiliates about access services/benefits and explore ways to resolve root causes. Members identified issues with accessing providers for approved daily chore services. The lack of providers available to members had a direct impact on the members' overall health, as did the wait time members experienced for service benefits to be approved. Some members did not receive all services, for which they were approved. Members living in rural areas reported this as a more prevalent issue. The MCOP will support resolving member issues and provide referrals and advocacy as needed. This information will be tracked and trends shared through pre-approved channels.

Increase outreach by opening new media channels. During FFY21 the Office underwent rebranding, increased presence on social media (*Facebook*, *Instagram* and *.Gov*) to increase outreach overall. The Managed Care Ombudsman Program will endeavor to sustain outreach services to Medicaid affiliates. Medicaid Managed Members' and potential members issues will be aggregated, tracked and reviewed for trends. Non-biased information will be shared appropriately to grow public awareness and engage the managed care community at large, in an effort to to assure continual quality assurance and program improvement in FFY22.