OFFICE OF THE
State Long-Term Care
Ombudsman

Managed Care Ombudsman Executive Summary

FFY 2022

(Oct 1, 2021 – Sept 30, 2022)

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.

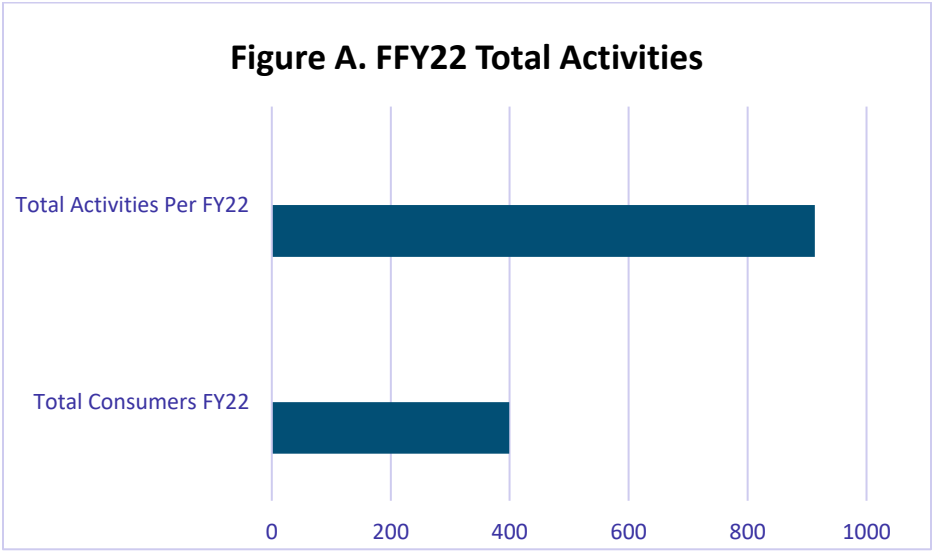
The Federal Fiscal Year (FFY22) executive summary contains a compilation of member issues (i.e., activities) brought to the attention of the OSLTCO from October 1, 2021 through September 30, 2022. This summary fulfills the requirements of HF 2460 regarding the OSLTCO's advocacy and assistance for managed 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 total of members affected based on monthly reports. Part II provides an annual total of complaint(s) resolution by provider, based on quarterly reports, Part III provides trends tracked and Part IV provides community partnerships, outreach and potential program improvements.

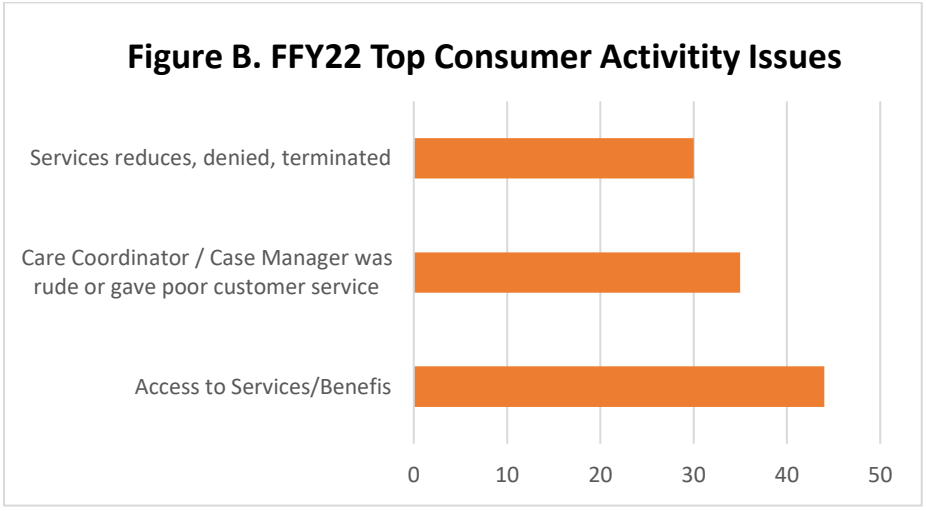
PART I

ANNUAL COMPILATION of COMPLAINT(s)/MEMBERS AFFECTED

During Federal Fiscal Year 2022 (FFY22) Managed Care Ombudsman processed over 900 new complaints from members which resulted in new investigations and advocacy. The overall volume of activities, and the number of consumers served for FY22, can be seen here in **Figure A.**



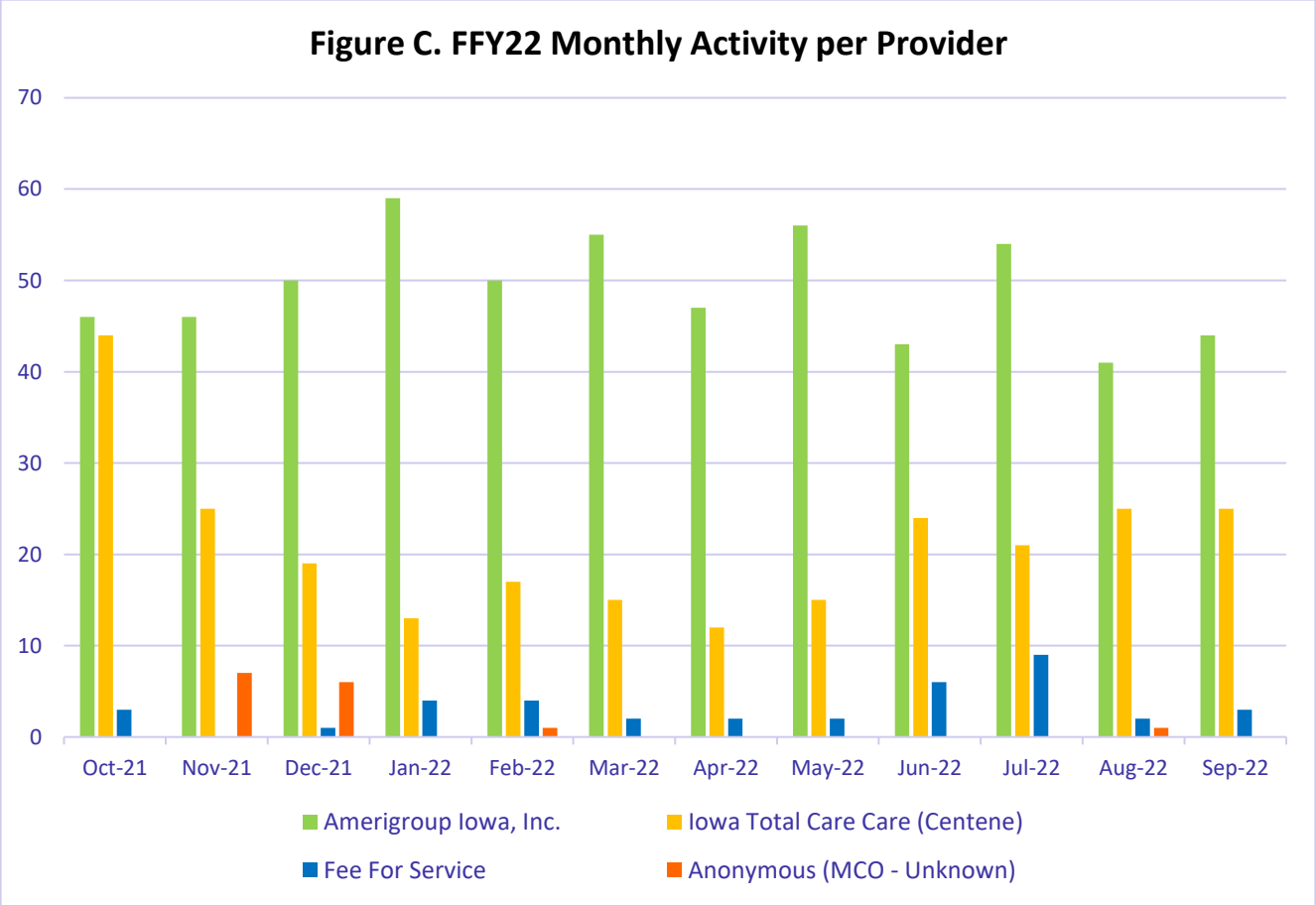
The top three (3) issues received in FFY22, depicted below in **Figure B,** were primarily associated with 1) access to services/benefits; 2) Care Coordinator/Case Manager was rude or provided poor customer service; and 3) services were reduced, denied, terminated. Data was tracked and reported monthly and quarterly.



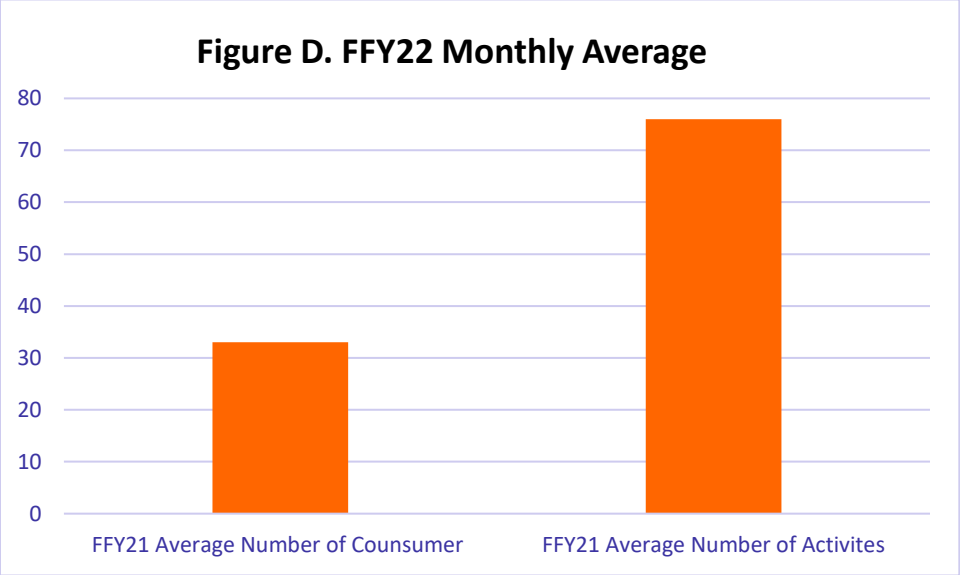
The majority of complaints were from three primary waiver sources and persisted over the following frequency.

WAIVER	FREQUENCY
Elderly Waiver	12/12 months
Brain Injury Waiver	11/12 months
Intellectual Disability Waiver	10/12 months

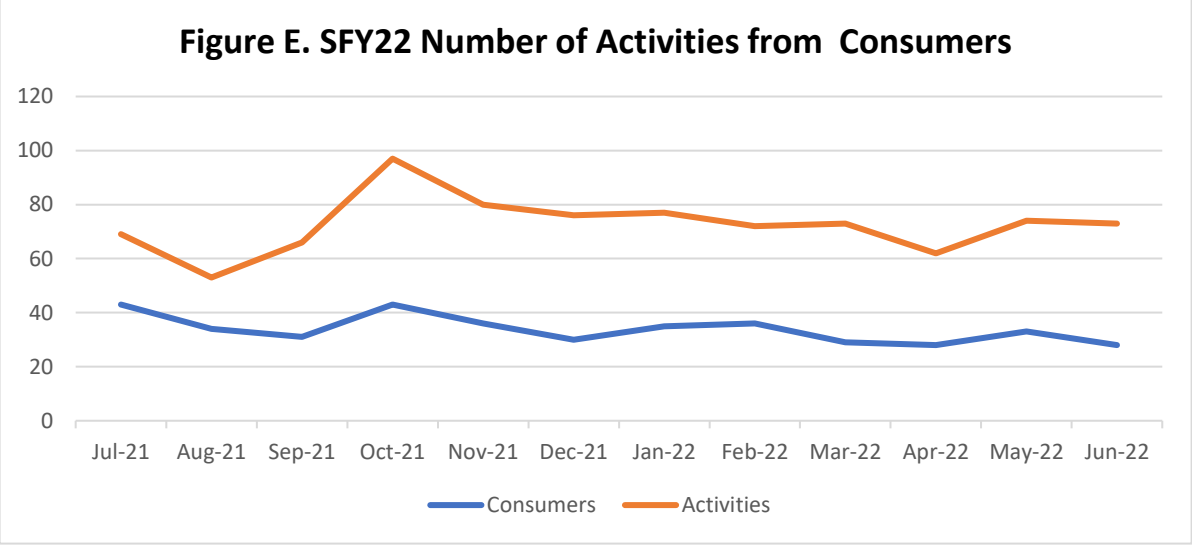
Providers associated with consumer issues are tracked the same as for Fee-for-Service providers and consumers who wish to keep their provider anonymous. The two providers in FFY22 were **Amerigroup Iowa, Inc**., totaling 591 consumer issues and **Iowa Total Care (Centene)** with the second highest number of 255 consumer issues. Data from consumers being serviced by **Fee-for-Service** providers resulted in 35 activities and **Anonymous (MCO-Unknown)** resulted in 15 activities as seen here in **Figure C.**



The monthly average of total activities handled was 76 per month for an average of 33 members per month as depicted here in **Figure D. FFY22 Monthly Average**.



Data are tracked and reported monthly. In **Figure E** below, **State Fiscal Year 2022 (SFY22 - July 1 2021 to June 30, 2022)** provides a broader visual scope of the number of member activities (top line) and number of consumers (bottom line) per month.



The activity reported in relation to consumer issues per quarter, revealed the following associated causes regarding the increases and decreases in issues or activity volume.

Quarter 1: Access to durable medical equipment (DME).
Quarter 2: Care Coordination, Change in Care Setting, Medications, and Dignity or Respect.
Quarter 3: Personal Hygiene, Environment, and Personal Property.
Quarter 4: Advocacy Investigation, Transition Services/Coverage Gap-inadequate or inaccessible.

In conclusion, attribution of increases and decreases are the result of both residual and emerging issues. Root cause analysis is incorporated into the Managed Care Ombudsman Program as part of the resolution process.

PART II

ANNUAL COMPILATION of QUARTERLY COMPLAINT(s) RESOLUTION/PROGRAM

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 as follows in Federal Fiscal Year 2022 (FFY22).

Quarter	Month/Year	Consumers Per Month	Activities Per Month
1	10/1/2021	43	97
	11/1/2021	36	80
	12/1/2021	30	76
2	1/1/2022	35	77
	2/1/2022	36	72
	3/1/2022	29	73
3	4/1/2022	28	62
	5/1/2022	33	74
	6/1/2022	28	73
4	7/1/2022	39	85
	8/1/2022	30	70
	9/1/2022	32	74

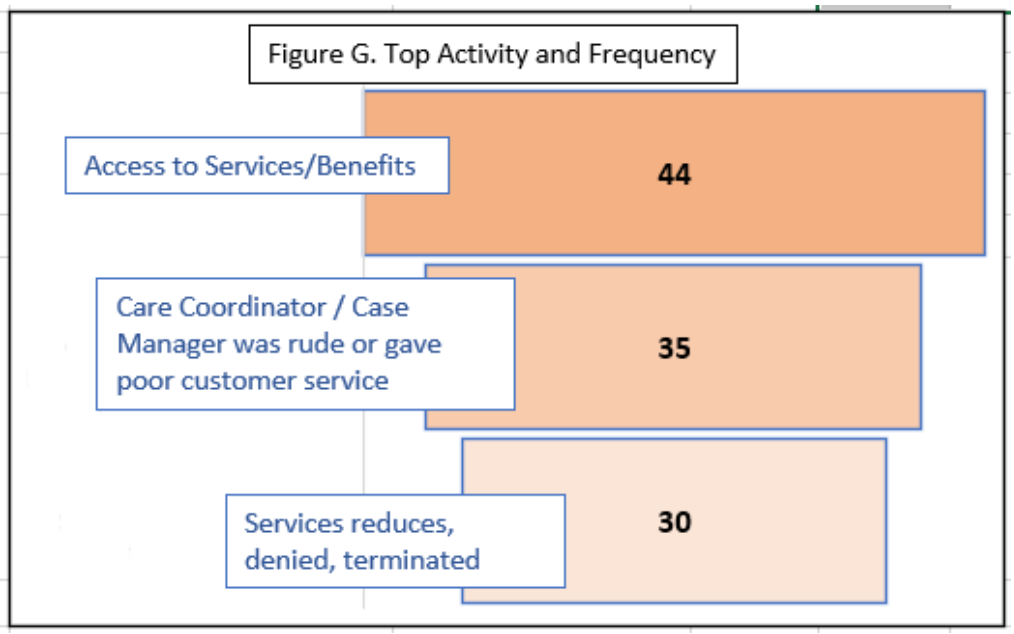
1. **Access to Services/Benefits**. Waiver members reported a lack of available providers. The lack of providers includes but is not limited to medical physicians, skilled care providers, transportation drivers, chore/homemaking providers and home modification providers. The lack of providers available 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. **Persistent in Q1; Q2; Q3; Q4.**

2. **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 Q4.**

3. Services reduced, denied or terminated for members needing long-term services and supports. 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. This often-affected 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 they feel are necessary for their health and safety. **Persistent in Q1; Q2; Q3.**

The most frequently reoccurring issue identified in every quarter of FFY22 was Access to Benefits. Over all, Medicaid managed care members reported the following primary issues: **See Figure G**. **Top Activity and Frequency**, depicts the top three areas where issues were addressed and resolved.



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

PART III

MANAGED CARE OMBUDSMAN PROGRAM TRENDS

In addition to tracking member issues on a monthly basis, the Managed Care Ombudsman Program documents and tracks program trends discussed by members. Issues and trends identified in Federal Fiscal Year 2022 (FFY22) are described in the following nine (9) categories and in which quarter/s those trends persist.

1. 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. **Persistent in Q1 and Q3**. 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. **Persistent in Q2 and Q4.**

2. 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 Q2 and Q3.** Members reported challenges when trying to reach their case manager during the transition to a new MCO. Members were not notified as to who their temporary case manager or point of contact would be during the transition period **Persistent in Q1**.

3. 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.**

4. 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**.

5. Consumer Directed Attendant Care (CDAC) and Consumer Choice Options (CCO) Impacts. are choices 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 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 Q1 and Q2.**

6. 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 Q3.**

7. Responses and Denials. Medicaid members receiving long term services and supports chose to file grievances with their MCO due to unsatisfactory responses and denials for a range of services. **Persistent in Q1.**

8. 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 Q4.**

9. Home and Vehicle Modification barriers. Members 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 Q4**.

PART IV

COMMUNITY PARTNERSHIPS, OUTREACH AND POTENTIAL 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.

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-care-ombudsman/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 tracks trends discussed by members, some of which inform program improvement. Those areas identified for Federal Fiscal Year 2022 (FFY22) included:

Increase knowledge of challenges to accessing services/benefits was a repeated concern from the previous fiscal year. Members identified issues with accessing providers for approved daily chore services such as providers including medical physicians, skilled care providers, transportation drivers, chore/homemaking providers and home modification providers. 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 continue to make providers aware of member issues.

Increase awareness of diminished access to Durable Medical Equipment (DME). Access trended down from FFY21. Medicaid Members experienced increased denials 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, and approved bids by the assigned MCO, which 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. The MCOP will increase awareness of issues as they are received.

Continue to track transition services/coverage gap, inadequate or inaccessible experienced an increase in FFY22. 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. These issues were especially persistent in Q1 and Q3 most likely associated with open enrollment periods. 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. During FFY21 members using the programs of the Intellectual Disability Waiver and the Elderly Waiver, most frequently resulted in a managed care member or someone acting on the managed care member's behalf, contacting the MCOP or requesting assistance from the MCOP. This ongoing systemic issue persisted in FY22 and will continue to be tracked and reported in FFY23.

Prepare for case management issue fluctuations which are ongoing and primarily symptomatic of poor communication from 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. The majority of specific issues related to case management service provision was persistent in Q2 and Q3. Members also reported challenges when trying to reach their case manager during the transition to a new MCO. Members were not notified as to who their temporary case manager or point of contact would be during the transition period. This issue trends down following certain times, as it was mostly attributed to systematic issues and persistent in Q1.

Monitor staff needed to serve members' call intake. Member needing long-term services and supports, caused by reported reductions or denials in their HCBS waiver services in their homes or assisted living programs, are more apt to call during certain months. This often times affected 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 they feel are necessary for their health and safety. These issues were especially persistent in Q1; Q2 and Q3 of FFY22. This situation impacts staff hours expended.

The Office of the State Long-Term Care Ombudsman experienced a reduction in workforce of a Managed Care Ombudsman half-time employee due to retirement. The current workforce is one FTE. The Managed Care Ombudsman Program will endeavor to sustain services to Medicaid Managed Members, potential members as well as track trends discussed by members, and the community at large to inform continual quality assurance and program improvement in FFY23.