FOR IMMEDIATE RELEASE

METRO EAST HUMAN RIGHTS AUTHORITY
REPORT OF FINDINGS
HRA CASE # 15-070-9020
MOLINA HEALTHCARE OF ILLINOIS

INTRODUCTION

The Metro East Regional Human Rights Authority (HRA) has concluded its investigation of a complaint involving the Integrated Care Program of Molina Healthcare of Illinois (Molina). Molina is a healthcare plan, also known as a Managed Care Organization, which provides services to seniors and persons with disabilities. According to their website, Molina is a multi-state healthcare organization which arranges for the delivery of healthcare services and offers health information management solutions to nearly five million individuals and families who receive their care through Medicaid, Medicare and other government-funded programs in 15 states.

The allegations being investigated are: 1) a service consumer is not obtaining medical services that she thought she would receive, including eyeglasses, Meals on Wheels and disposable undergarments; 2) a case manager wants to arrange for hospice for a consumer even though the consumer has received no information that her condition warrants hospice; 3) a case manager speaks to a consumer in a derogatory manner that makes the individual feel incompetent; 4) a consumer attempted to complain but the absence of follow-up to the complaint indicates that the grievance process is inadequate. If substantiated, these allegations would represent violations of Illinois Medicaid requirements, the Medical Patient Rights Act, the Public Aid Code and Molina policies.

METHODOLOGY

To pursue the investigation, the HRA Coordinator interviewed the consumer. In addition, the HRA team discussed, with consent, the details of the complaint with the Molina case manager during a regularly scheduled HRA meeting. On a separate occasion, an HRA team met with and interviewed the case manager and program manager. The HRA also obtained and reviewed the Molina Patients' Rights and Responsibilities Booklet, the Welcome to Molina Handbook, policies and procedures on Molina's website, and the Illinois Department of Healthcare and Family Services Managed Care Manual. In addition, the HRA Coordinator researched Illinois rules and regulations governing Managed Care organizations which showed that Molina is governed by the Illinois Department of Healthcare and Family Services. Relevant rules are detailed in the Managed Care Manual for Medicaid Providers.

FINDINGS

According to the Illinois Department of Healthcare and Family Services Managed Care Manual for Medicaid Providers, "the Integrated Care Program (ICP) was implemented in May of 2011. ICP is a program for Seniors and Persons with Disabilities who are eligible for the Medicaid program, but not eligible for Medicare. This care delivery system brings together an Enrollee's Providers as an integrated care team to provide a more coordinated medical approach and keep the Enrollee healthier. Integrated care focuses on all of the factors that can affect a person's health and well-being and puts a plan in place to manage all the Enrollee's health needs, whether those needs are physical, behavioral or social."

The first complaint indicated that the consumer failed to receive services she requested and was entitled to according to her plan, the first of which was an eye exam and new eyeglasses. According to Molina's website, one eye exam is covered per year and one pair of eyeglasses is covered in a two-year period, which is in accordance with Medicaid standards. The consumer also requested Meals on Wheels from the Molina case manager. Meals are not listed as a provided service in the Molina handbook or on their website; however Meals on Wheels is available in the consumers' area for a charge of $15.00 a week. Transportation services were provided as per the case manager and consumer and the consumer used those services to go to the grocery store and pharmacy. The consumer also inquired about disposable undergarments, which is a covered service although a supportive diagnosis is required in order for the garments to be considered medically necessary, according to the case manager. The case manager reports that in her many encounters with the consumer, she never admitted to having incontinence issues although the case manager suspected that there were such issues.

The second part of the complaint indicated that the case manager wanted to arrange for Hospice care for the consumer although the consumer had received no information that her condition warranted Hospice. The case manager and consumer each reported that the consumer saw a Nurse Practitioner (NP) in March of 2015 for a new patient exam. Both the patient and case manager stated that the NP reviewed radiological images and hospital reports that were performed during a previous hospital admission and that she informed the patient that she had multiple suspicious lesions throughout her body, including her adrenal glands, lungs, ovaries and breast which would indicate possible metastatic cancer. The consumer stated that the NP told her that there was nothing that could be done for her and she should go home and prepare to die. The consumer was upset by this and refused to go back to see the NP. According to the Medical Patient's Rights Act, "it is the right of each patient to care consistent with sound nursing and medical practices, …to receive information concerning his or her condition and proposed treatment, and to refuse any treatment." The consumer was informed of her diagnosis by the NP and Hospice services were offered. The consumer, by her own admission to the HRA, refused to return to the NP and refused to accept Hospice care, which is her right as a consumer. The case manager stated that she offered to come to her home to discuss her diagnosis and to explain the details of Hospice care, although the consumer was not interested.

The third complaint indicated that the case manager speaks to the consumer in a derogatory manner that makes the individual feel incompetent. The Molina Case Manager reported that their phone conversations were lengthy and pleasant although the consumer did express that she was unhappy with certain aspects of the care plan that the Case Manager was establishing and refused

to sign the document. She was unhappy that a family meeting with her cousin was suggested to help mend their relationship. The HRA coordinator spoke with the consumer on multiple occasions, during which the consumer never indicated that she was spoken to in a derogatory manner by the case manager although she did indicate on multiple occasions that she was unhappy with the information and services she was receiving. Molina assigned a new case manager to the consumer when one became available in the area.

The final complaint stated that when a consumer attempted to complain, there was no follow-up which indicated that the grievance process is inadequate. There is no record of a formal grievance being filed by the consumer as per the program manager?. According to the case manager, the consumer did call Molina and complain about the healthcare aide that was assigned to her and employed by an outside agency. The complaint stated that the aide refused to take out the trash without being provided gloves and refused to dust due to having allergies. The Molina Case Manager called the aide's employer and relayed the complaint. The consumer had also called the agency. The employee was replaced on two separate occasions and the consumer continued voice have multiple complaints regarding each aide that was assigned to her. The healthcare aide's duties included transporting the consumer to the grocery store and pharmacy, as well as assisting with light housework four hours weekly. Both the consumer and case manager stated that the agency accommodated the consumer's schedule by changing the hours in which the aide assisted the consumer.

MANDATES/REGULATIONS

According to Molina's Member Handbook:

Molina's Vision Benefits: *To help keep your eyes healthy, Molina Healthcare covers one eye exam per year for all members. We also cover one pair of eyeglasses (frames and lenses) every two years.*

Transportation: *To help you get the care you need, Molina Healthcare can provide you a ride if you need it.We cover transportation if needed to and from medical appointments, medical equipment providers and WIC offices. We also cover trips to the pharmacy to pick up a prescription right after a medical appointment. Medical appointments include trips to:*

- *A PCP or provider visit*
- *A clinic*
- *A hospital*
- *A therapy or behavioral health appointment*

According to Molina's Healthcare Membership Rights and Responsibilities;

As a member of Molina Healthcare, you have the following rights:

To receive information about your health including available treatment options and alternatives regarding cost or benefit coverage. Information must be presented in a manner appropriate to your condition and ability to understand.

To participate in decisions regarding your healthcare, including the right to refuse treatment.

To be informed of your right to a fair hearing and to file grievances and appeals. You have the right to appeal Molina Healthcare's decisions. You have the right to have someone speak for you during the grievance.

To make decisions concerning your medical care, including a clear and precise statement of any *limitation regarding the implementation of advanced directives as a matter of conscience.*

To exercise these rights without negatively affecting how you are treated by Molina Healthcare, Molina Healthcare's providers or the HFS.

According to the Illinois Department of Healthcare and Family Services Managed Care Manual for Medicaid Providers certain services are explained as follows:

Integrated Care Program (ICP): *The Integrated Care Program (ICP) was implemented in May of 2011. ICP is a program for Seniors and Persons with Disabilities who are eligible for the Medicaid program, but not eligible for Medicare. This care delivery system brings together an Enrollee's Providers as an integrated care team to provide a more coordinated medical approach and keep the Enrollee healthier. Integrated care focuses on all of the factors that can affect a person's health and well-being and puts a plan in place to manage all the Enrollee's health needs, whether those needs are physical, behavioral or social.*

Elderly Waiver: *The Elderly Waiver is for those people 60 years or older that live in the community. It is also known as the Aging Waiver or the Community Care Program (CCP).*

What's Covered

Adult Day Service, including transportation

Emergency Home Response

Homemaker

Adult Day Service (also known as Adult Day Health)
This service is a daytime community-based program for adults not living in Supported Living Facilities. Adult Day Service provides a variety of social, recreational, health, nutrition and related support services in a protective setting. Transportation to and from the center as well as lunch, are included as part of this service.

Emergency Home Response (also known as Personal Emergency Response System)
This electronic equipment allows members 24-hour access to help in an emergency. The equipment is connected to your phone line to call the response center and/or other forms of assistance once the help button is pressed.

Homemaker
In-home caregiver hired through an agency. The caregiver helps with housekeeping items such as meal preparation, shopping, light housekeeping and laundry. The caregiver can also help with hands-on personal care items such as personal hygiene, bathing, grooming and feeding.

The Illinois Department of Healthcare and Family Services Managed Care Manual for Medicaid Providers (Page 25) states the following with regard to enrollee grievances and appeals:

Each Health Plan is required to have an Enrollee Grievance and Appeals policy and procedures established to ensure that actions taken against participants are supported by policy, administrative code and law. The Department serves as a check and balance for managed care companies to make sure participants are receiving covered service to which they are entitled. Medicaid Health Plans are required to establish internal Grievance and Appeals procedures under which Medicaid Enrollees, or an authorized

representative acting on their behalf, may make a Complaint, challenge the denial of coverage of, or payment for, covered services. Health Plan Enrollees receive these policies and procedures when they first enroll with the Health Plan in their Enrollee Handbook. The Grievance and Appeals procedures are also listed on each Health Plan's website.

The Illinois Public Aide Code (305 ILCS 5/3-13), Aid to the Aged, Blind or Disabilities, states:

Declaration of responsibilities: *It is the position of this State that the Federal Government should meet its obligation to provide financial aid to those aged, blind or disabled persons eligible under Article III hereof so as to assure those persons a standard of living compatible with health and well-being, including any supplementary aid program provided to meet special or emergency needs, and it is the position of this State that the Federal Government should meet its obligation to provide continuing supplemental nutritional aid for such persons through the Federal Food Stamp Program or through full reimbursement for expenditures made in lieu of such Food Stamp Program.*

With regard to medical services, the Public Aid Code (305 ILCS 5/5-5) requires:

The Illinois Department, by rule, shall determine the quantity and quality of and the rate of reimbursement for the medical assistance for which payment will be authorized, and the medical services to be provided, which may include all or part of the following: (1) inpatient hospital services; (2) outpatient hospital services; (3) other laboratory and X-ray services; (4) skilled nursing home services; (5) physicians' services whether furnished in the office, the patient's home, a hospital, a skilled nursing home, or elsewhere; (6) medical care, or any other type of remedial care furnished by licensed practitioners; (7) home health care services; (8) private duty nursing service; (9) clinic services; (10) dental services, including prevention and treatment of periodontal disease and dental caries disease for pregnant women, provided by an individual licensed to practice dentistry or dental surgery; for purposes of this item (10), "dental services" means diagnostic, preventive, or corrective procedures provided by or under the supervision of a dentist in the practice of his or her profession; (11) physical therapy and related services; (12) prescribed drugs, dentures, and prosthetic devices; and eyeglasses prescribed by a physician skilled in the diseases of the eye, or by an optometrist, whichever the person may select; (13) other diagnostic, screening, preventive, and rehabilitative services, including to ensure that the individual's need for intervention or treatment of mental disorders or substance use disorders or co-occurring mental health and substance use disorders is determined using a uniform screening, assessment, and evaluation process inclusive of criteria, for children and adults; for purposes of this item (13), a uniform screening, assessment, and evaluation process refers to a process that includes an appropriate evaluation and, as warranted, a referral; "uniform" does not mean the use of a singular instrument, tool, or process that all must utilize; (14) transportation and such other expenses as may be necessary; (15) medical treatment of sexual assault survivors, as defined in Section 1a of the Sexual Assault Survivors Emergency Treatment Act, for injuries sustained as a result of the sexual assault, including examinations and laboratory tests to discover evidence which may be used in criminal proceedings arising from the sexual assault; (16) the diagnosis and treatment of

sickle cell anemia; and (17) any other medical care, and any other type of remedial care recognized under the laws of this State, but not including abortions, or induced miscarriages or premature births, unless, in the opinion of a physician, such procedures are necessary for the preservation of the life of the woman seeking such treatment, or except an induced premature birth intended to produce a live viable child and such procedure is necessary for the health of the mother or her unborn child. The Illinois Department, by rule, shall prohibit any physician from providing medical assistance to anyone eligible therefor under this Code where such physician has been found guilty of performing an abortion procedure in a willful and wanton manner upon a woman who was not pregnant at the time such abortion procedure was performed. The term "any other type of remedial care" shall include nursing care and nursing home service for persons who rely on treatment by spiritual means alone through prayer for healing.

The Public Aid Code (305 ILCS 5/5-5a) addresses waivers for home and community based services as follows:

The Department shall apply for a waiver from the United States Health Care Financing Administration to allow payment for home and community-based services under this Article.

The Department, in cooperation with the Department on Aging, the Department of Human Services and any other relevant State, local or federal government agency, may establish a nursing home pre-screening program to determine whether the applicant, eligible for medical assistance under this Article, may use home and community-based services as a reasonable, lower-cost alternative form of care. For the purpose of this Section, "home and community-based services" may include, but are not limited to, those services provided under subsection (f) of Section 3 of the Rehabilitation of Persons with Disabilities Act and Section 4 of the Illinois Act on the Aging. (Source: P.A. 99-143, eff. 7-27-15.)

According to the Medical Patient Rights Act (410 ILCS 50/3):

The following rights are hereby established:

(a) The right of each patient to care consistent with sound nursing and medical practices, to be informed of the name of the physician responsible for coordinating his or her care, to receive information concerning his or her condition and proposed treatment, to refuse any treatment to the extent permitted by law, and to privacy and confidentiality of records except as otherwise provided by law. (Source: P.A. 98-1046, eff. 1-1-15.)

The Illinois Administrative Code (89 Ill. Admin. Code 140.2) that governs medical assistance programs and states:

a) Under the Medical Assistance Programs, the Department pays participating providers for necessary medical services, specified in Section 140.3 through 140.7 for:

1) persons eligible for financial assistance under the Aid to the Aged, Blind or Disabled-State Supplemental Payment (AABD-SSP) and Temporary Assistance to Needy Families (TANF) programs (Medicaid-MAG); …

7) persons eligible for medical assistance under the Aid to the Aged, Blind or Disabled (AABD) program who reside in specified Supportive Living Facilities (SLFs), as described at 89 Ill. Adm. Code 146, Subpart B; …

b) "Necessary medical care" is that which is generally recognized as standard medical care required because of disease, disability, infirmity or impairment.

c) The Department may impose prior approval requirements, as specified by rule, to determine whether the medical care is necessary and eligible for payment from the Department in individual situations. Such requirements shall be based on recommendations of technical and professional staff and advisory committees.

d) When recipients are entitled to Medicare benefits, the Department shall assume responsibility for their deductible and coinsurance obligations, unless the recipients have income and/or resources available to meet these needs. The total payment to a provider from both Medicare and the Department shall not exceed either the amount that Medicare determines to be a reasonable charge or the Department standard for the services provided, whichever is applicable.

e) The Department shall pay for services and items not allowed by Medicare only if they are provided in accordance with Department policy for recipients not entitled to Medicare benefits.

f) The Department may contract with qualified practitioners, hospitals and all other dispensers of medical services for the provision and reimbursement of any and all medical care or services as specified in the contract on a prepaid capitation basis (i.e., payment of a fixed amount per enrollee made in advance of the service); volume purchase basis (i.e., purchase of a volume of goods or services for a price specified in the contract); ambulatory visit basis (i.e., one comprehensive payment for each visit regardless of the services provided during that visit) or per discharge basis (i.e., one comprehensive payment per discharge regardless of the services provided during the stay). Such contracts shall be based either on formally solicited competitive bid proposals or individually negotiated rates with providers willing to enter into special contractual arrangements with the State.

g) The Department may require that recipients of medical assistance under any of the Department's programs exercise their freedom of choice by choosing to receive medical care under the traditional fee for service system or through a prepaid capitation plan or under one of the other alternative contractual arrangements described in subsection (f) of this Section. The categories of recipients who may choose or be assigned to an alternative plan will be specified in the contract. Recipients required to make such a choice will be notified in writing by the Department. If a recipient does not choose to exercise his/her freedom of choice, the Department may assign that recipient to a prepaid plan. Under such a plan, recipients would obtain certain medical services or supplies from a single source or limited source. The Department will notify recipients in

writing if they are assigned to a prepaid plan. Recipients enrolled in or assigned to a prepaid plan will receive written notification advising them of the services which they will receive from the plan. Covered services not provided by the plan will be reimbursed by the Department on a fee for service basis. Recipients will receive a medical eligibility card, which will apply to such services.

h) The Department may enter into contracts for the provision of medical care on a prepaid capitation basis from a Health Maintenance Organization (HMO) whereby the recipient who chooses to receive medical care through an HMO must stay in the HMO for a certain period of time, not to exceed six months (the enrollment period). Upon written notice, the recipient may choose to disenroll from such an HMO at any time within the first month of each enrollment period. The Department will send the recipient a notice at least 30 days prior to the end of the enrollment period, which gives the recipient a specified period of time in which to inform the Department if the recipient does not wish to re-enroll in the HMO for a new enrollment period. The recipient may then disenroll at the end of the enrollment period only if the recipient responds to the notice and indicates in writing a choice to disenroll. Failure to respond to the notice will result in automatic re-enrollment for a new enrollment period. Recipients shall also be allowed to disenroll at any time for cause. (Source: Amended at 38 Ill. Reg. 12141, effective May 30, 2014)

CONCLUSION

The complaint indicating that the consumer failed to receive covered services is **not substantiated**. Meals are not a covered service under the Aging Waiver Program, although the consumer is able to request Meals on Wheels from the local service provider at a cost of $15.00 per week. This information was obtained by the HRA Coordinator and relayed to the consumer who stated that she was unable to afford the cost. Molina denies that the consumer ever requested Meals on Wheels; if she had, the Case Manager explained that she would have called and arranged for Meals on Wheels to be delivered at the consumer's expense. According to the Public Aid Act, the Federal Government should meet its obligation to provide continuing supplemental nutritional aid for the aged through the Federal Food Stamp Program, and this consumer did receive a Link Card. With regard to the eyeglasses, the consumer reported to the HRA that she saw an eye doctor while on Molina, who recommended that she have cataract surgery prior to obtaining new eye glasses as the surgery would change her vision and the strength of the eyeglasses would need to be altered. One pair of glasses is covered every 2 years according to the Molina Handbook and eye exams are covered annually. With regard to the disposable undergarments, Molina claims that the consumer did not request that item and, in fact, denied having incontinence. The caseworker recalled suspecting that the consumer was suffering incontinence due to conditions observed in the consumer's home and asked the consumer on multiple occasions but she denied having any issues. The consumer also denied having incontinence issues when the HRA Coordinator interviewed her. She stated that she was entitled to the product because her neighbor receives them.

The complaint indicating that the case manager wanted to arrange for Hospice care although the consumer had not received notification that her condition warrants Hospice is **not substantiated.** In multiple conversations with the HRA Coordinator, the consumer claimed that the NP informed her that her condition was terminal. The Case Manager called the NP on behalf of the

patient and confirmed that she did recommend Hospice services. The Case Manager offered to come to the consumer's home to talk to her about her diagnosis and explain Hospice services but the consumer, understandably upset by this news, was unwilling to allow the caseworker to come and speak with her. The Case Manager suggested to the consumer that she speak with a psychologist about her situation and the consumer agreed. The Case Manager set up the appointment and the consumer cancelled the appointment without rescheduling.

Regarding the allegation that the case manager was rude, the HRA was unable to confirm this but a new case manager was assigned when the consumer voiced dissatisfaction with her care plan.

The final complaint that states the grievance process is inadequate when a consumer attempted to complain but there was no follow-up is **not substantiated**. There is no record of a formal grievance or complaint being filed by the consumer against Molina but Molina did report worker concerns to the provider agency that subsequently changed the worker. Molina's Grievance Policy, (governed by the Illinois Department of Healthcare and Family Services Managed Care Manual for Medicaid Providers) is included in the Molina Handbook that is supplied to all new enrollees. It clearly outlines the reasons a consumer may file a grievance and provides examples of possible grievances. It also explains how to file a grievance by phone, fax or mail, and explains that a consumer may request assistance in filing a grievance.

SUGGESTIONS

The HRA would like to encourage Molina to provide additional assistance to case managers experiencing difficulties within their caseloads. This assistance could come in the form of a Clinical Review Team that meets periodically with case managers to review current caseloads and address issues they or their consumers may be experiencing. The HRA acknowledges that the Case Manager was trying to assist the consumer with her needs, although she appeared overwhelmed by the complexity of the consumer's situation. The HRA members (many of which are healthcare professionals) offered multiple suggestions to the Case Manager on how she could proceed with helping the consumer, some of which were acted upon by the Case Manager.