Managed Care
OMBUDSMAN PROGRAM
A Division of the Office of the State Long-Term Care Ombudsman

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TO: Iowa Department of Human Services

CC: Centers for Medicare and Medicaid Services

FROM: Deanna Clingan-Fischer, State Long-Term Care Ombudsman

SUBJECT: Managed Care Ombudsman Program Monthly Report for January 2017

DATE: Thursday, February 9, 2017

The Office of the State Long-Term Care Ombudsman is required by the Centers for Medicare and Medicaid Services (CMS) to report data from the Managed Care Ombudsman Program on a monthly basis. Attached is the January 2017 Report.

The Managed Care Ombudsman Program serves as the independent advocate for Medicaid managed care members receiving care in a health care facility as well as members enrolled in one of the seven home and community-based services (HCBS) waivers.

Contacts and Main Issues

During the month of January, the Managed Care Ombudsman Program received 273 member contacts through phone and email. This number does not reflect the total contacts received from all stakeholders including providers as this report only discusses member-specific issues. Oftentimes, multiple issues were addressed in one call with a member. The top three issues addressed were:

1. Service reduced, denied or terminated – Members have reported reductions in hours to their community choice options (CCO) program, a program that empowers members to direct their own care and budget. Members have also frequently reported a reduction in hours for their waiver services. As a result, several members have changed their MCO due to not being able to receive needed care.
2. MCO was rude or gave poor customer service – Members reported difficulty with filing a grievance with their MCO, receiving incorrect phone numbers to file a grievance, long wait times once obtaining the correct phone number, loss of documentation such as CDAC provider information. In one such case, a member reported that a representative from their MCO threatened to remove the member's services and treatment, exhibited unprofessional behavior and made unprofessional statements such threatening to remove legal guardianship of a member.
3. Other service/coverage gap issue – In conjunction with members' services being reduced, denied or terminated, members continue to experience a lack of continuity of care when receiving skilled care in a facility for a brief period of time and losing their services upon returning home.

Medicaid Program

Most calls were related to the Elderly Waiver, the Intellectual Disability Waiver, and those that were dually eligible for Medicare and Medicaid.

Resolution Time

On average, it took 29 business days to resolve an issue which is a significant increase from December's resolution time of 13 days. The issues reported to the Managed Care Ombudsman Program are moving more frequently through the formal appeal processes with the MCOs. Several appeals have escalated to the fair hearing level with the State.

Additional information can be found in the attached January 2017 Report. For further information, please contact the Office of the State Long-Term Care Ombudsman Legislative Liaison Lynzey Kenworthy at lynzey.kenworthy@iowa.gov.

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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: 01/2017

Number of Contacts[1]		273
Contact Categories[2]		
Access to Services/Benefits	Access to preferred/necessary durable medical equipment	17
	Access to preferred/necessary medication	9
	Prior authorization	-
	Provider/pharmacy/hospital not in network	-
	Service reduced, denied or terminated	99
	Transition services/coverage inadequate or inaccessible	16
	Transportation not available, timely or adequate	18
	Other service/coverage gap issue	30
	Other	18
Billing	Member charged improper cost sharing	17
	Other	3
Care Planning	Access to information or information sharing	-
	Care planning participation	19
	Change in care setting	29
	Discharge	5
	Level of care assessment	3
	Other	-
Customer Service	Care coordinator/case manager was rude or gave poor customer service	11
	MCO was rude or gave poor customer service	45
	Member has not received MCO card or other materials	-
	Provider/pharmacy was rude or gave poor customer service	4
	Scheduling	-
	Other	-
Eligibility	Member has lost eligibility status or was denied	20
	Member needs assistance with acquiring Medicaid eligibility information	-
	Member needs assistance with checking on application status	19
	Other	2
Enrollment	Disenrollment from MCO – good cause eligible	-
	Disenrollment from MCO – not good cause eligible	-
	Disenrollment from Medicaid program	-
	Selecting/changing MCO	-
	Other	-
Guardianship	Guardian not receiving information	-
	Guardianship documents not on file	11
	Unable to contact guardian	-
	Other	-
Other		4
N/A		6
Contacts Related to Grievances/ Appeals/Fair Hearings[3]	Grievances	17
	Appeals	18
	Fair Hearings	14
Contacts per MCO[4]	Amerigroup Iowa	67
	AmeriHealth Caritas	145
	UnitedHealthcare Plan of the River Valley	46

Program[5]	AIDS/HIV Waiver	-
	Brain Injury Waiver	17
	Children's Mental Health Waiver	1
	Dental	-
	Duals	20
	Elderly Waiver	98
	Fee for Service	1
	Habilitation	12
	Health & Disability Waiver	18
	HIPP	-
	Institutional Care	-
	Iowa Health & Wellness	-
	Intellectual Disability Waiver	89
	Medicare	1
	PACE	-
	Physical Disability Waiver	10
	QMB or SLMB	-
	Other	2
	N/A	-
	Unknown	3
Average Resolution Time[6]		29
Referrals per Entity[8]	Department of Human Services	5
	Department of Inspections and Appeals	-
	Disability Rights Iowa	1
	Iowa Compass	2
	Iowa Legal Aid	-
	LifeLong Links	1
	MCO	4
	Medicaid Fraud Control Unit	-
	Provider	1
	Senior Health Insurance Information Program	2
	State Ombudsman Office	2
	Other	5
Service(s) Provided to Contact[9]	Grievance assistance	2
	Appeals assistance	-
	Fair hearing assistance	-
	Advocacy	115
	Education and information	43
	Investigation	166
	Referral	15
	Other	-
	N/A	2
Service(s) Provided to Stakeholders[10]	Community education	-
	Information and consultation	11
	Technical assistance	2
	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]*Average Number of Entities Required for Resolution:* Average number of entities required to resolve the issue.
[8]*Referrals Made to Entities:* Referrals made to external organizations that provide services beyond the scope of the program.
[9]*Services Provided to Contact:* Services provided to the contact who may be the member, family member or their authorized representative
[10]*Services Provided to Stakeholder(s):* Service 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.