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: Cynthia Pederson, State Long-Term Care Ombudsman

SUBJECT: Managed Care Ombudsman Program Monthly Report for January 2018

DATE: Thursday, February 1, 2018

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 2018 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 in January 2018 were:

1. Change in care setting - Members are experiencing challenges when wanting to remain in their homes with their HCBS provider. In these instances, Managed Care Ombudsmen advocated for members to continue to receive the services necessary in maintaining their health and safety bases off their level of care needs.
2. Transition services/coverage inadequate or inaccessible - During the transition of switching to a new MCO, members were unable to access or receive medically necessary services. Managed Care Ombudsmen assisted members by contacting the MCO and advocating for services to be reinstated for the member promptly.
3. Care planning participation - Members lacked information needed to communicate with their new case manager during the transition to a new MCO or to Fee-for-Service coverage. The delay in connecting with their case manager made it challenging for members to obtain all the services necessary to maintain their quality of life in their home.

Medicaid Program

Most calls were related to the Intellectual Disability Waiver, the Elderly Waiver, and the Brain Injury Waiver.

Resolution Time

On average, it took 12 business days to resolve an issue.

Additional information can be found in the attached January 2018 Report. For further information, please contact the Managed Care Ombudsman Program by phone at 866-236-1430 or email at managedcareombudsman@iowa.gov.

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866.236.1430 | ManagedCareOmbudsman@iowa.gov

Managed Care Ombudsman Program Monthly Report

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

DATE: 01/2018

Number of Contacts[1]		273
Contact Categories[2]		
Access to Services/Benefits	Access to preferred/necessary durable medical equipment	20
	Access to preferred/necessary medication	-
	Home/vehicle modifications	7
	Prior authorization	12
	Provider/pharmacy/hospital not in network	18
	Service reduced, denied or terminated	27
	Transition services/coverage inadequate or inaccessible	57
	Transportation not available, timely or adequate	5
	Other service/coverage gap issue	6
	Other	17
Billing	Member charged improper cost sharing	1
	Other	-
Care Planning	Access to information or information sharing	14
	Care planning participation	53
	Change in care setting	65
	Discharge	2
	Level of care assessment	47
	Other	-
Customer Service	Care coordinator/case manager was rude or gave poor customer service	17
	MCO was rude or gave poor customer service	4
	Member has not received MCO card or other materials	-
	Provider/pharmacy was rude or gave poor customer service	-
	Scheduling	-
	Other	-
Eligibility	Member has lost eligibility status or was denied	-
	Member needs assistance with acquiring Medicaid eligibility information	18
	Member needs assistance with checking on application status	8
	Other	-
Enrollment	Disenrollment from MCO – good cause eligible	8
	Disenrollment from MCO – not good cause eligible	-
	Disenrollment from Medicaid program	-
	Selecting/changing MCO	6
	Other	1
Guardianship	Guardian not receiving information	-
	Guardianship documents not on file	9
	Unable to contact guardian	-
	Other	-
Other		2
N/A		10
Contacts Related to Grievances/ Appeals/Fair Hearings[3]	Grievances	23
	Appeals	11
	Fair Hearings	-
Contacts per MCO[4]	Amerigroup Iowa	45
	AmeriHealth Caritas	-
	UnitedHealthcare Plan of the River Valley	188
	Fee for Service	26

Program[5]	AIDS/HIV Waiver	-
	Brain Injury Waiver	35
	Children's Mental Health Waiver	-
	Dental	-
	Duals	1
	Elderly Waiver	49
	Habilitation	2
	Health & Disability Waiver	10
	HIPP	10
	Institutional Care	3
	Iowa Health & Wellness	12
	Intellectual Disability Waiver	86
	Medicare	-
	PACE	-
	Physical Disability Waiver	4
	QMB or SLMB	-
	Traditional Medicaid	30
	Other	3
	N/A	-
	Unknown	25
Average Resolution Time[6]		12
Referrals per Entity[7]	Department of Human Services	11
	Department of Inspections and Appeals	-
	Disability Rights Iowa	2
	Iowa Compass	-
	Iowa Legal Aid	4
	LifeLong Links	1
	MCO	7
	Medicaid Fraud Control Unit	-
	Provider	-
	Senior Health Insurance Information Program	-
	State Ombudsman Office	7
	Other	1
Service(s) Provided to Contact[8]	Grievance assistance	9
	Appeals assistance	6
	Fair hearing assistance	-
	Advocacy	115
	Education and information	23
	Investigation	143
	Referral	21
Service(s) Provided to Stakeholders[9]	Community education	-
	Information and consultation	9
	Technical assistance	5
	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 per Entity:* Referrals made to external organizations that provide services beyond the scope of the program.
[8]*Service(s) Provided to Contact:* Services provided to the contact who may be the member, family member or their authorized representative.
[9]*Service(s) Provided to Stakeholders:* 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.