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 February 2017

DATE: Wednesday, March 8, 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 February 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 February, the Managed Care Ombudsman Program received 355 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 services that enable members to remain independent in their home as well as hours to their consumer directed attendant care (CDAC) services and reductions in members' community choice options (CCO) budgets which impacts the amount and duration of services the member may receive. Members have also reported a reduction, denial or termination of services that were initially approved through a prior exception to policy or were provided through the Money Follows the Person (MFP) program due to providers' inability to provide such services under a reduced contracted rate.
2. Care planning participation – Members reported concerns about AmeriHealth's notice of changing case management as many members have had a longstanding relationship with their case managers for years. Thus, potential changes in case management may be disruptive to Iowa's most vulnerable population.
3. Change in care setting – In conjunction with members' services being reduced, denied or terminated, members are experiencing issues with maintaining their current residence or securing new placement due to providers not accepting reduced reimbursement rates for members that require higher level of care which is oftentimes more costly.

Medicaid Program

Most calls were related to the Intellectual Disability Waiver, the Elderly Waiver, and the Brain Injury Waiver, which remains consistent with previous months.

Resolution Time

On average, it took 22 business days to resolve an issue. 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 February 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: 02/2017

Number of Contacts[1]		355
Contact Categories[2]		
Access to Services/Benefits	Access to preferred/necessary durable medical equipment	21
	Access to preferred/necessary medication	31
	Prior authorization	-
	Provider/pharmacy/hospital not in network	-
	Service reduced, denied or terminated	124
	Transition services/coverage inadequate or inaccessible	28
	Transportation not available, timely or adequate	2
	Other service/coverage gap issue	22
	Other	1
Billing	Member charged improper cost sharing	4
	Other	3
Care Planning	Access to information or information sharing	31
	Care planning participation	106
	Change in care setting	76
	Discharge	48
	Level of care assessment	-
	Other	-
Customer Service	Care coordinator/case manager was rude or gave poor customer service	35
	MCO was rude or gave poor customer service	46
	Member has not received MCO card or other materials	-
	Provider/pharmacy was rude or gave poor customer service	21
	Scheduling	-
	Other	-
Eligibility	Member has lost eligibility status or was denied	25
	Member needs assistance with acquiring Medicaid eligibility information	4
	Member needs assistance with checking on application status	16
	Other	3
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	36
	Guardianship documents not on file	20
	Unable to contact guardian	-
	Other	3
Other		7
N/A		11
Contacts Related to Grievances/ Appeals/Fair Hearings[3]	Grievances	28
	Appeals	4
	Fair Hearings	5
Contacts per MCO[4]	Amerigroup Iowa	34
	AmeriHealth Caritas	243
	UnitedHealthcare Plan of the River Valley	60

Program[5]	AIDS/HIV Waiver	-
	Brain Injury Waiver	45
	Children's Mental Health Waiver	-
	Dental	-
	Duals	26
	Elderly Waiver	57
	Fee for Service	-
	Habilitation	7
	Health & Disability Waiver	12
	HIPP	-
	Institutional Care	13
	Iowa Health & Wellness	-
	Intellectual Disability Waiver	130
	Medicare	5
	PACE	-
	Physical Disability Waiver	14
	QMB or SLMB	-
	Other	5
	N/A	1
	Unknown	44
Average Resolution Time[6]		22
Referrals per Entity[8]	Department of Human Services	13
	Department of Inspections and Appeals	-
	Disability Rights Iowa	-
	Iowa Compass	-
	Iowa Legal Aid	-
	LifeLong Links	-
	MCO	5
	Medicaid Fraud Control Unit	-
	Provider	-
	Senior Health Insurance Information Program	1
	State Ombudsman Office	12
	Other	6
Service(s) Provided to Contact[9]	Grievance assistance	-
	Appeals assistance	-
	Fair hearing assistance	-
	Advocacy	206
	Education and information	70
	Investigation	167
	Referral	32
	Other	-
	N/A	-
Service(s) Provided to Stakeholders[10]	Community education	3
	Information and consultation	16
	Technical assistance	6
	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.