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 March 2017

DATE: Friday, April 7, 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 March 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 March, the Managed Care Ombudsman Program received 556 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 reported a denial or reduction in services that enable members to remain independent in their home. Several contacts were related specifically to a reduction in CDAC hours as well as reductions in home health or skilled nursing visits.
2. Care coordinator/case manager was rude or gave poor customer service – Members reported issues with communication between the member, their case managers, and their MCO. For example, members reported several instances where the case manager did not obtain all the necessary information from the member and, therefore, did not supply the MCO with accurate information. This has resulted in a reduction of services. The office also received several calls regarding issues with case managers not knowing what information needs to be submitted to the MCO or fully understanding the member's needs or responding to the member's needs as well as not full understanding the new managed care system and, instead, were trying to follow the previous Medicaid processes instituted prior to managed care. Additionally, members have reported not receiving consumer-focused customer service from the MCO.
3. Care planning participation – Members have reported concern with the change with AmeriHealth's case management and desired to maintain their existing case manager as many members have worked with their case managers for years. Members have also reported needing assistance with requesting an updated assessment from their MCO when there is a change in their care needs.

Medicaid Program

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

Resolution Time

On average, it took 17 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 March 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: 03/2017

Number of Contacts[1]		556
Contact Categories[2]		
Access to Services/Benefits	Access to preferred/necessary durable medical equipment	18
	Access to preferred/necessary medication	18
	Prior authorization	27
	Provider/pharmacy/hospital not in network	-
	Service reduced, denied or terminated	214
	Transition services/coverage inadequate or inaccessible	42
	Transportation not available, timely or adequate	9
	Other service/coverage gap issue	21
	Other	41
Billing	Member charged improper cost sharing	3
	Other	3
Care Planning	Access to information or information sharing	7
	Care planning participation	78
	Change in care setting	64
	Discharge	20
	Level of care assessment	14
	Other	5
Customer Service	Care coordinator/case manager was rude or gave poor customer service	89
	MCO was rude or gave poor customer service	35
	Member has not received MCO card or other materials	-
	Provider/pharmacy was rude or gave poor customer service	32
	Scheduling	-
	Other	3
Eligibility	Member has lost eligibility status or was denied	60
	Member needs assistance with acquiring Medicaid eligibility information	25
	Member needs assistance with checking on application status	-
	Other	4
Enrollment	Disenrollment from MCO – good cause eligible	15
	Disenrollment from MCO – not good cause eligible	-
	Disenrollment from Medicaid program	-
	Selecting/changing MCO	1
	Other	-
Guardianship	Guardian not receiving information	7
	Guardianship documents not on file	4
	Unable to contact guardian	2
	Other	-
Other		72
N/A		31
Contacts Related to Grievances/ Appeals/Fair Hearings[3]	Grievances	12
	Appeals	76
	Fair Hearings	8
Contacts per MCO[4]	Amerigroup Iowa	114
	AmeriHealth Caritas	252
	UnitedHealthcare Plan of the River Valley	156

Program[5]	AIDS/HIV Waiver	-
	Brain Injury Waiver	101
	Children's Mental Health Waiver	-
	Dental	-
	Duals	55
	Elderly Waiver	82
	Fee for Service	1
	Habilitation	5
	Health & Disability Waiver	88
	HIPP	3
	Institutional Care	11
	Iowa Health & Wellness	4
	Intellectual Disability Waiver	74
	Medicare	9
	PACE	-
	Physical Disability Waiver	38
	QMB or SLMB	23
	Other	13
	N/A	3
	Unknown	75
Average Resolution Time[6]		17
Referrals per Entity[7]	Department of Human Services	5
	Department of Inspections and Appeals	1
	Disability Rights Iowa	2
	Iowa Compass	2
	Iowa Legal Aid	3
	LifeLong Links	5
	MCO	7
	Medicaid Fraud Control Unit	-
	Provider	-
	Senior Health Insurance Information Program	1
	State Ombudsman Office	9
	Other	7
Service(s) Provided to Contact[8]	Grievance assistance	-
	Appeals assistance	3
	Fair hearing assistance	5
	Advocacy	391
	Education and information	66
	Investigation	307
	Referral	32
	Other	-
	N/A	9
Service(s) Provided to Stakeholders[9]	Community education	4
	Information and consultation	10
	Technical assistance	-
	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 Made to Entities:* Referrals made to external organizations that provide services beyond the scope of the program.

[8]*Services Provided to Contact:* Services provided to the contact, who may be the member, family member or an authorized representative.

[9]*Services Provided to Stakeholder(s):* 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.