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 June 2017

DATE: Thursday, July 6, 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 June 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 June, the Managed Care Ombudsman Program received 466 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 June 2017 were:

1. Service reduced, denied or terminated – Members reported a reduction in their HCBS waiver services, putting them at risk of entering a long-term care facility unnecessarily.
2. Access to information or information sharing – Members reported not receiving written notice when their services are reduced, denied or terminated. While MCO case managers may provide verbal notification to members when there is a change in their care, written notification is required when services are reduced, denied or terminated.
3. Care planning participation – Members, particularly those on the Elderly Waiver, have reported concerns with the possibility of their case manager changing as members want to be active participants in changes in their care plan and changes in care providers.

Medicaid Program

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

Resolution Time

On average, it took 13 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. Appeals continue to escalate to the fair hearing level with the State, when appropriate.

Additional information can be found in the attached June 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: 06/2017

Number of Contacts[1]		466
Contact Categories[2]		
Access to Services/Benefits	Access to preferred/necessary durable medical equipment	12
	Access to preferred/necessary medication	15
	Home/vehicle modifications	6
	Prior authorization	16
	Provider/pharmacy/hospital not in network	-
	Service reduced, denied or terminated	292
	Transition services/coverage inadequate or inaccessible	23
	Transportation not available, timely or adequate	6
	Other service/coverage gap issue	10
	Other	22
Billing	Member charged improper cost sharing	10
	Other	2
Care Planning	Access to information or information sharing	104
	Care planning participation	42
	Change in care setting	26
	Discharge	16
	Level of care assessment	17
	Other	-
Customer Service	Care coordinator/case manager was rude or gave poor customer service	13
	MCO was rude or gave poor customer service	22
	Member has not received MCO card or other materials	-
	Provider/pharmacy was rude or gave poor customer service	-
	Scheduling	1
	Other	1
Eligibility	Member has lost eligibility status or was denied	4
	Member needs assistance with acquiring Medicaid eligibility information	21
	Member needs assistance with checking on application status	-
	Other	2
Enrollment	Disenrollment from MCO – good cause eligible	1
	Disenrollment from MCO – not good cause eligible	-
	Disenrollment from Medicaid program	2
	Selecting/changing MCO	2
	Other	-
Guardianship	Guardian not receiving information	-
	Guardianship documents not on file	12
	Unable to contact guardian	-
	Other	-
Other		14
N/A		4
Contacts Related to Grievances/ Appeals/Fair Hearings[3]	Grievances	15
	Appeals	184
	Fair Hearings	27
Contacts per MCO[4]	Amerigroup Iowa	120
	AmeriHealth Caritas	274
	UnitedHealthcare Plan of the River Valley	61

Program[5]	AIDS/HIV Waiver	-
	Brain Injury Waiver	39
	Children's Mental Health Waiver	1
	Dental	-
	Duals	29
	Elderly Waiver	137
	Fee for Service	-
	Habilitation	-
	Health & Disability Waiver	32
	HIPP	-
	Institutional Care	16
	Iowa Health & Wellness	-
	Intellectual Disability Waiver	101
	Medicare	10
	PACE	-
	Physical Disability Waiver	75
	QMB or SLMB	-
	Other	-
	N/A	1
	Unknown	27
Average Resolution Time[6]		13
Referrals per Entity[7]	Department of Human Services	5
	Department of Inspections and Appeals	-
	Disability Rights Iowa	6
	Iowa Compass	-
	Iowa Legal Aid	1
	LifeLong Links	1
	MCO	8
	Medicaid Fraud Control Unit	-
	Provider	-
	Senior Health Insurance Information Program	-
	State Ombudsman Office	2
	Other	1
Service(s) Provided to Contact[8]	Grievance assistance	-
	Appeals assistance	23
	Fair hearing assistance	4
	Advocacy	245
	Education and information	40
	Investigation	339
	Referral	22
Service(s) Provided to Stakeholders[9]	Community education	1
	Information and consultation	11
	Technical assistance	3
	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 their 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.