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 June 2018

DATE: Tuesday, July 3, 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 June 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 June, the Managed Care Ombudsman Program received 250 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 2018 were:

1. Service reduced, denied or terminated – Members needing long-term services and supports reported reductions or denials in their HCBS waiver services.
2. Level of care assessment – Members required assistance requesting a review of their level of care assessment to better support their needs.
3. Care planning participation – New and existing Medicaid members requested assistance for their upcoming yearly assessment and care planning meetings.

Medicaid Program

Most calls were related to the Intellectual Disability Waiver, the Elderly Waiver and members with Dual eligibility.

Resolution Time

On average, it took eight business days to resolve an issue. The issues reported to the Managed Care Ombudsman Program are moving more frequently through the formal appeal and state fair hearing processes, which increases average resolution time.

Additional information can be found in the attached June 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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Managed Care Ombudsman Program Monthly Report

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

DATE: 06/2018

Number of Contacts[1]		250
Contact Categories[2]		
Access to Services/Benefits	Access to preferred/necessary durable medical equipment	21
	Access to preferred/necessary medication	5
	Home/vehicle modifications	-
	Prior authorization	-
	Provider/pharmacy/hospital not in network	2
	Service reduced, denied or terminated	84
	Transition services/coverage inadequate or inaccessible	20
	Transportation not available, timely or adequate	3
	Other service/coverage gap issue	7
	Other	19
Billing	Member charged improper cost sharing	-
	Other	12
Care Planning	Access to information or information sharing	20
	Care planning participation	31
	Change in care setting	15
	Discharge	-
	Level of care assessment	65
	Other	-
Customer Service	Care coordinator/case manager was rude or gave poor customer service	35
	MCO was rude or gave poor customer service	26
	Member has not received MCO card or other materials	2
	Provider/pharmacy was rude or gave poor customer service	-
	Scheduling	7
	Other	-
Eligibility	Member has lost eligibility status or was denied	5
	Member needs assistance with acquiring Medicaid eligibility information	15
	Member needs assistance with checking on application status	-
	Other	-
Enrollment	Disenrollment from MCO – good cause eligible	3
	Disenrollment from MCO – not good cause eligible	-
	Disenrollment from Medicaid program	7
	Selecting/changing MCO	-
	Other	-
Guardianship	Guardian not receiving information	1
	Guardianship documents not on file	-
	Unable to contact guardian	-
	Other	-
Other		6
N/A		1
Contacts Related to Grievances/ Appeals/Fair Hearings[3]	Grievances	7
	Appeals	25
	Fair Hearings	12
Contacts per MCO[4]	Amerigroup Iowa	46
	AmeriHealth Caritas	-
	UnitedHealthcare Plan of the River Valley	179
	Fee for Service	10

Program[5]	AIDS/HIV Waiver	-
	Brain Injury Waiver	25
	Children's Mental Health Waiver	2
	Dental	-
	Duals	30
	Elderly Waiver	41
	Habilitation	15
	Health & Disability Waiver	19
	HIPP	9
	Institutional Care	-
	Iowa Health & Wellness	-
	Intellectual Disability Waiver	60
	Medicare	-
	PACE	-
	Physical Disability Waiver	20
	QMB or SLMB	5
	Traditional Medicaid	6
	Other	12
	N/A	-
	Unknown	6
Average Resolution Time[6]		8
Referrals per Entity[7]	Department of Human Services	5
	Department of Inspections and Appeals	-
	Disability Rights Iowa	16
	Iowa Compass	-
	Iowa Legal Aid	2
	LifeLong Links	1
	MCO	3
	Medicaid Fraud Control Unit	-
	Provider	-
	Senior Health Insurance Information Program	-
	State Ombudsman Office	6
	Other	-
Service(s) Provided to Contact[8]	Grievance assistance	7
	Appeals assistance	1
	Fair hearing assistance	12
	Advocacy	178
	Education and information	9
	Investigation	173
	Referral	25
Service(s) Provided to Stakeholders[9]	Community education	1
	Information and consultation	7
	Technical assistance	1
	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.

Complaints by Recipient

The data reported on pages 1 and 2 of this report provides detailed information about all of the contacts made to the Managed Care Ombudsman Program over the course of the month. The number of contacts reported is representative of the number of times the Managed Care Ombudsman Program is contacted; it does not represent the number of complaints made to the Managed Care Ombudsman Program.

This month, the 250 contacts reported on page 1 resulted in the Managed Care Ombudsman Program working on complaints from 61 individual members (30 members were affected by more than one issue). The top complaint received this month was in regard to services reduced, denied or terminated (24 members). Additional complaints included:

- Level of care assessment (13 members)
- Care coordinator/case manager was rude or gave poor customer service (9 members)
- Access to preferred/necessary durable medical equipment (6 members)
- Care planning participation (5 members)
- Other access to services/benefits issue (5 members)
- Access to information or information sharing (4 members)
- Other (4 members)
- Other billing issue (4 members)
- Member needs assistance with acquiring eligibility information (4 members)
- MCO was rude or gave poor customer service (3 members)
- Other service/coverage gap issue (3 members)
- Scheduling (3 members)
- Transition services/coverage inadequate or inaccessible (3 members)
- Change in care setting (2 members)
- Access to preferred/necessary medication (1 member)
- Disenrollment from MCO - good cause eligible (1 member)
- Disenrollment from Medicaid program (1 member)
- Guardian not receiving information (1 member)
- Provider/pharmacy/hospital not in network (1 member)
- Member has not received MCO materials (1 member)
- Member has lost eligibility status or was denied (1 member)
- N/A (1 member)
- Transportation not available, timely or adequate (1 member)

Complaint(s) by Program Type

AIDS/HIV Waiver	-
Brain Injury Waiver	6
Children's Mental Health Waiver	1
Dental	-
Duals	6
Elderly Waiver	12
Habilitation	2
Health & Disability Waiver	5
HIPP	2
Institutional Care	-
Iowa Health & Wellness	-
Intellectual Disability Waiver	17
Medicare	-
PACE	-
Physical Disability Waiver	1
QMB or SLMB	1
Traditional Medicaid	2
Other	1
N/A	-
Unknown	5
TOTAL:	61