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 July 2018

DATE: Tuesday, August 7, 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 July 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 July, the Managed Care Ombudsman Program received 209 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 July 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. MCO was rude or gave poor customer service – Members reported concerns and questions regarding conflicts of interest with internal case management and the level of care assessment process. Members also discussed issues regarding having to wait longer periods of time to reach someone and to seek resolution.
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 Health and Disability Waiver and the Brain Injury Waiver.

Resolution Time

On average, it took nine 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 July 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: 07/2018

Number of Contacts[1]		209
Contact Categories[2]		
Access to Services/Benefits	Access to preferred/necessary durable medical equipment	22
	Access to preferred/necessary medication	4
	Home/vehicle modifications	24
	Prior authorization	-
	Provider/pharmacy/hospital not in network	21
	Service reduced, denied or terminated	69
	Transition services/coverage inadequate or inaccessible	2
	Transportation not available, timely or adequate	4
	Other service/coverage gap issue	2
	Other	23
Billing	Member charged improper cost sharing	-
	Other	13
Care Planning	Access to information or information sharing	8
	Care planning participation	37
	Change in care setting	14
	Discharge	3
	Level of care assessment	27
	Other	-
Customer Service	Care coordinator/case manager was rude or gave poor customer service	23
	MCO was rude or gave poor customer service	41
	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	6
	Member needs assistance with checking on application status	4
	Other	-
Enrollment	Disenrollment from MCO – good cause eligible	3
	Disenrollment from MCO – not good cause eligible	-
	Disenrollment from Medicaid program	-
	Selecting/changing MCO	-
	Other	-
Guardianship	Guardian not receiving information	-
	Guardianship documents not on file	-
	Unable to contact guardian	-
	Other	-
Other		3
N/A		1
Contacts Related to Grievances/ Appeals/Fair Hearings[3]	Grievances	3
	Appeals	42
	Fair Hearings	10
Contacts per MCO[4]	Amerigroup Iowa	37
	AmeriHealth Caritas	-
	UnitedHealthcare Plan of the River Valley	158
	Fee for Service	8

Program[5]	AIDS/HIV Waiver	-
	Brain Injury Waiver	21
	Children's Mental Health Waiver	1
	Dental	3
	Duals	8
	Elderly Waiver	16
	Habilitation	-
	Health & Disability Waiver	54
	HIPP	4
	Institutional Care	2
	Iowa Health & Wellness	-
	Intellectual Disability Waiver	67
	Medicare	-
	PACE	-
	Physical Disability Waiver	14
	QMB or SLMB	-
	Traditional Medicaid	3
	Other	13
	N/A	-
	Unknown	3
Average Resolution Time[6]		9
Referrals per Entity[7]	Department of Human Services	1
	Department of Inspections and Appeals	-
	Disability Rights Iowa	20
	Iowa Compass	-
	Iowa Legal Aid	7
	LifeLong Links	-
	MCO	1
	Medicaid Fraud Control Unit	-
	Provider	-
	Senior Health Insurance Information Program	-
	State Ombudsman Office	1
	Other	-
Service(s) Provided to Contact[8]	Grievance assistance	3
	Appeals assistance	3
	Fair hearing assistance	4
	Advocacy	164
	Education and information	8
	Investigation	154
	Referral	20
Service(s) Provided to Stakeholders[9]	Community education	-
	Information and consultation	-
	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 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 209 contacts reported on page 1 resulted in the Managed Care Ombudsman Program working on complaints from 54 individual members (27 members were affected by more than one issue). The top complaint received this month was in regard to services reduced, denied or terminated (22 members). Additional complaints included:

MCO was rude or gave poor customer service (8 members)
Access to preferred/necessary durable medical equipment (7 members)
Care coordinator/case manager was rude or gave poor customer service (7 members)
Care planning participation (7 members)
Level of care (7 members)
Other access to services/benefits issue (6 members)
Member needs assistance with acquiring Medicaid eligibility information (4 members)
Access to information or information sharing (3 members)
Access to preferred/necessary medication (3 members)
Other billing issue (3 members)
Discharge (2 members)
Home/vehicle modifications (2 members)
Provider/pharmacy/hospital not in network (2 members)
Transportation not available, timely or adequate (2 members)
Change in care setting (2 members)
Other service/coverage gap issue (2 members)
Disenrollment from MCO – good cause eligible (1 member)
Member needs assistance checking on application status (1 member)
N/A (1 member)
Other (1 member)
Transition services/coverage inadequate or inaccessible (1 member)

		Amerigroup Iowa	UnitedHealthcare Plan of the River Valley	Fee for Service	Total
Complaint(s) by Program Type	AIDS/HIV Waiver	-	-	-	0
	Brain Injury Waiver	3	3	-	6
	Children's Mental Health Waiver	1	-	-	1
	Dental	-	1	-	1
	Duals	1	2	-	3
	Elderly Waiver	4	4	-	8
	Habilitation	-	-	-	0
	Health & Disability Waiver	2	9	1	12
	HIPP	-	-	1	1
	Institutional Care	-	1	-	1
	Iowa Health & Wellness	-	-	-	0
	Intellectual Disability Waiver	3	11	1	15
	Medicare	-	-	-	0
	PACE	-	-	-	0
	Physical Disability Waiver	-	1	-	1
	QMB or SLMB	-	-	-	0
	Traditional Medicaid	-	2	1	3
	Other	-	2	-	2
	N/A	-	-	-	0
	Unknown	-	-	-	0
	TOTAL:	14	36	4	54