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, Interim State Long-Term Care Ombudsman

SUBJECT: Managed Care Ombudsman Program Monthly Report for August 2017

DATE: Wednesday, September 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 August 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 August, the Managed Care Ombudsman Program received 468 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 August 2017 were:

1. Service reduced, denied or terminated – Members needing long-term services and supports reported reductions or denials in their HCBS waiver services. In response to reductions in services, members have decided to move through the appeal and fair hearing processes to maintain these services.
2. Access to preferred/necessary durable medical equipment – Members reported denials of requests for durable medical equipment as well as challenges in the process of seeking a prior authorization.
3. Access to information or information sharing – Members reported issues obtaining information from their MCO to understand various processes that impact their ability to utilize waiver services.

Medicaid Program

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

Resolution Time

On average, it took 27 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 August 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: 08/2017

Number of Contacts[1]		468
Contact Categories[2]		
Access to Services/Benefits	Access to preferred/necessary durable medical equipment	84
	Access to preferred/necessary medication	4
	Home/vehicle modifications	41
	Prior authorization	-
	Provider/pharmacy/hospital not in network	8
	Service reduced, denied or terminated	224
	Transition services/coverage inadequate or inaccessible	28
	Transportation not available, timely or adequate	6
	Other service/coverage gap issue	5
	Other	8
Billing	Member charged improper cost sharing	-
	Other	1
Care Planning	Access to information or information sharing	78
	Care planning participation	39
	Change in care setting	10
	Discharge	-
	Level of care assessment	18
	Other	-
Customer Service	Care coordinator/case manager was rude or gave poor customer service	46
	MCO was rude or gave poor customer service	10
	Member has not received MCO card or other materials	-
	Provider/pharmacy was rude or gave poor customer service	9
	Scheduling	-
	Other	-
Eligibility	Member has lost eligibility status or was denied	26
	Member needs assistance with acquiring Medicaid eligibility information	-
	Member needs assistance with checking on application status	3
	Other	1
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	-
	Guardianship documents not on file	-
	Unable to contact guardian	6
	Other	-
Other		24
N/A		8
Contacts Related to Grievances/ Appeals/Fair Hearings[3]	Grievances	19
	Appeals	120
	Fair Hearings	97
Contacts per MCO[4]	Amerigroup Iowa	66
	AmeriHealth Caritas	268
	UnitedHealthcare Plan of the River Valley	103

Program[5]	AIDS/HIV Waiver	-
	Brain Injury Waiver	79
	Children's Mental Health Waiver	-
	Dental	-
	Duals	-
	Elderly Waiver	63
	Fee for Service	-
	Habilitation	-
	Health & Disability Waiver	56
	HIPP	1
	Institutional Care	6
	Iowa Health & Wellness	-
	Intellectual Disability Waiver	97
	Medicare	-
	PACE	-
	Physical Disability Waiver	73
	QMB or SLMB	-
	Other	4
	N/A	1
	Unknown	53
Average Resolution Time[6]		27
Referrals per Entity[7]	Department of Human Services	8
	Department of Inspections and Appeals	-
	Disability Rights Iowa	6
	Iowa Compass	2
	Iowa Legal Aid	5
	LifeLong Links	2
	MCO	3
	Medicaid Fraud Control Unit	-
	Provider	-
	Senior Health Insurance Information Program	3
	State Ombudsman Office	9
	Other	3
Service(s) Provided to Contact[8]	Grievance assistance	-
	Appeals assistance	23
	Fair hearing assistance	48
	Advocacy	218
	Education and information	43
	Investigation	271
	Referral	28
Service(s) Provided to Stakeholders[9]	Community education	2
	Information and consultation	13
	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.