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 August 2018

DATE: Thursday, September 6, 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 August 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 August, the Managed Care Ombudsman Program received 316 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 2018 were:

1. Service reduced, denied or terminated – Members needing long-term services and supports contacted the Managed Care Ombudsman Program regarding reductions or denials in their HCBS waiver services.
2. Care planning participation – New and existing Medicaid members requested assistance for their upcoming yearly assessment and care planning meetings. Members reported they feel their health needs are not being individually addressed. Members also reported they were unaware of who their case manager was or how often they would have meetings.
3. MCO was rude or gave poor customer service – Members reported an overall lack of communication and information sharing between case managers, supervisors, assessors and review team members. This resulted in members and their families feeling there is a conflict of interest among the care team within the MCO which prevents seamless transitions and timely healthcare services rendered.

Medicaid Program

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

Resolution Time

On average, it took 10 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 August 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: 08/2018

Number of Contacts[1]		316
Contact Categories[2]		
Access to Services/Benefits	Access to preferred/necessary durable medical equipment	26
	Access to preferred/necessary medication	5
	Home/vehicle modifications	8
	Prior authorization	2
	Provider/pharmacy/hospital not in network	2
	Service reduced, denied or terminated	133
	Transition services/coverage inadequate or inaccessible	10
	Transportation not available, timely or adequate	-
	Other service/coverage gap issue	18
	Other	33
Billing	Member charged improper cost sharing	7
	Other	8
Care Planning	Access to information or information sharing	19
	Care planning participation	42
	Change in care setting	9
	Discharge	2
	Level of care assessment	27
	Other	-
Customer Service	Care coordinator/case manager was rude or gave poor customer service	20
	MCO was rude or gave poor customer service	37
	Member has not received MCO card or other materials	-
	Provider/pharmacy was rude or gave poor customer service	11
	Scheduling	-
	Other	5
Eligibility	Member has lost eligibility status or was denied	8
	Member needs assistance with acquiring Medicaid eligibility information	9
	Member needs assistance with checking on application status	28
	Other	-
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	1
	Guardianship documents not on file	-
	Unable to contact guardian	-
	Other	-
Other		2
N/A		1
Contacts Related to Grievances/ Appeals/Fair Hearings[3]	Grievances	21
	Appeals	42
	Fair Hearings	14
Contacts per MCO[4]	Amerigroup Iowa	83
	AmeriHealth Caritas	-
	UnitedHealthcare Plan of the River Valley	217
	Fee for Service	16

Program[5]	AIDS/HIV Waiver	-
	Brain Injury Waiver	55
	Children's Mental Health Waiver	2
	Dental	-
	Duals	6
	Elderly Waiver	58
	Habilitation	-
	Health & Disability Waiver	59
	HIPP	3
	Institutional Care	-
	Iowa Health & Wellness	-
	Intellectual Disability Waiver	90
	Medicare	-
	PACE	-
	Physical Disability Waiver	14
	QMB or SLMB	-
	Traditional Medicaid	15
	Other	14
	N/A	-
	Unknown	-
Average Resolution Time[6]		10
Referrals per Entity[7]	Department of Human Services	4
	Department of Inspections and Appeals	3
	Disability Rights Iowa	19
	Iowa Compass	5
	Iowa Legal Aid	7
	LifeLong Links	4
	MCO	1
	Medicaid Fraud Control Unit	-
	Provider	-
	Senior Health Insurance Information Program	-
	State Ombudsman Office	3
	Other	-
Service(s) Provided to Contact[8]	Grievance assistance	3
	Appeals assistance	6
	Fair hearing assistance	1
	Advocacy	292
	Education and information	23
	Investigation	216
	Referral	30
Service(s) Provided to Stakeholders[9]	Community education	-
	Information and consultation	1
	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 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 316 contacts reported on page 1 resulted in the Managed Care Ombudsman Program working on complaints from 75 individual members (35 members were affected by more than one issue). The top complaint received this month was in regard to services reduced, denied or terminated (27 members) . Additional complaints included:

Care planning participation (11 members)
MCO was rude or gave poor customer service (11 members)
Level of care (7 members)
Member needs assistance checking on application status (7 members)
Other service/coverage gap issue (6 members)
Access to preferred/necessary durable medical equipment (6 members)
Other access to services/benefits issue (6 members)
Access to information or information sharing (5 members)
Care coordinator/case manager was rude or gave poor customer service (5 members)
Access to preferred necessary medication (4 members)
Other billing issue (4 members)
Member needs assistance with acquiring Medicaid eligibility information (3 members)
Home/vehicle modifications (3 members)
Change in care setting (2 members)
Discharge (2 members)
Provider/pharmacy/hospital not in network (2 members)
Transition services/coverage inadequate or inaccessible (2 members)
Other customer service issue (1 member)
Guardian not receiving information (1 member)
Member charged improper cost sharing (1 member)
Member has lost eligibility status or was denied (1 member)
N/A (1 member)
Other (1 member)

		Amerigroup Iowa	UnitedHealthcare Plan of the River Valley	Fee for Service	Total
Case(s) by Program Type	AIDS/HIV Waiver	-	-	-	0
	Brain Injury Waiver	3	6	-	9
	Children's Mental Health Waiver	-	1	-	1
	Dental	-	-	-	0
	Duals	2	1	-	3
	Elderly Waiver	8	10	-	18
	Habilitation	-	-	-	0
	Health & Disability Waiver	2	10	-	12
	HIPP	-	-	1	1
	Institutional Care	-	-	-	0
	Iowa Health & Wellness	-	-	-	0
	Intellectual Disability Waiver	2	17	1	20
	Medicare	-	-	-	0
	PACE	-	-	-	0
	Physical Disability Waiver	-	2	-	2
	QMB or SLMB	-	-	-	0
	Traditional Medicaid	2	3	2	7
	Other	-	2	-	2
	N/A	-		-	0
	Unknown	-		-	0
	TOTAL:				75