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 September 2017

DATE: Friday, October 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 September 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 September, the Managed Care Ombudsman Program received 314 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 September 2017 were:

1. Service reduced, denied or terminated – Members needing long-term services and supports reported reductions or denials in their HCBS waiver services. Several contacts were related specifically to a reduction in CDAC hours.
2. Access to preferred/necessary durable medical equipment – Members reported denials of requests for durable medical equipment. In response to denials, members have decided to pursue the appeal and fair hearing processes to obtain approval for durable medical equipment.
3. Home/vehicle modifications – Denials are being issued for home and vehicle modifications which are medically necessary for members to safely access areas of their home.

Medicaid Program

Most calls were related to the Elderly Waiver, the Brain Injury Waiver, and the Health and 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 frequently moving 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 September 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: 09/2017

Number of Contacts[1]		314
Contact Categories[2]		
Access to Services/Benefits	Access to preferred/necessary durable medical equipment	61
	Access to preferred/necessary medication	4
	Home/vehicle modifications	49
	Prior authorization	-
	Provider/pharmacy/hospital not in network	3
	Service reduced, denied or terminated	90
	Transition services/coverage inadequate or inaccessible	12
	Transportation not available, timely or adequate	5
	Other service/coverage gap issue	7
	Other	10
Billing	Member charged improper cost sharing	6
	Other	-
Care Planning	Access to information or information sharing	31
	Care planning participation	24
	Change in care setting	9
	Discharge	-
	Level of care assessment	10
	Other	20
Customer Service	Care coordinator/case manager was rude or gave poor customer service	5
	MCO was rude or gave poor customer service	4
	Member has not received MCO card or other materials	1
	Provider/pharmacy was rude or gave poor customer service	20
	Scheduling	-
	Other	-
Eligibility	Member has lost eligibility status or was denied	5
	Member needs assistance with acquiring Medicaid eligibility information	-
	Member needs assistance with checking on application status	25
	Other	-
Enrollment	Disenrollment from MCO – good cause eligible	-
	Disenrollment from MCO – not good cause eligible	-
	Disenrollment from Medicaid program	-
	Selecting/changing MCO	1
	Other	-
Guardianship	Guardian not receiving information	-
	Guardianship documents not on file	-
	Unable to contact guardian	3
	Other	1
Other		5
N/A		12
Contacts Related to Grievances/ Appeals/Fair Hearings[3]	Grievances	13
	Appeals	74
	Fair Hearings	32
Contacts per MCO[4]	Amerigroup Iowa	60
	AmeriHealth Caritas	151
	UnitedHealthcare Plan of the River Valley	82

Program[5]	AIDS/HIV Waiver	8
	Brain Injury Waiver	49
	Children's Mental Health Waiver	2
	Dental	-
	Duals	9
	Elderly Waiver	97
	Fee for Service	-
	Habilitation	6
	Health & Disability Waiver	40
	HIPP	2
	Institutional Care	5
	Iowa Health & Wellness	-
	Intellectual Disability Waiver	38
	Medicare	-
	PACE	-
	Physical Disability Waiver	18
	QMB or SLMB	4
	Other	6
	N/A	-
	Unknown	27
Average Resolution Time[6]		13
Referrals per Entity[7]	Department of Human Services	3
	Department of Inspections and Appeals	-
	Disability Rights Iowa	5
	Iowa Compass	-
	Iowa Legal Aid	5
	LifeLong Links	-
	MCO	9
	Medicaid Fraud Control Unit	-
	Provider	-
	Senior Health Insurance Information Program	1
	State Ombudsman Office	8
	Other	3
Service(s) Provided to Contact[8]	Grievance assistance	-
	Appeals assistance	31
	Fair hearing assistance	16
	Advocacy	144
	Education and information	62
	Investigation	129
	Referral	27
Service(s) Provided to Stakeholders[9]	Community education	-
	Information and consultation	8
	Technical assistance	6
	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.