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: Deanna Clingan-Fischer, State Long-Term Care Ombudsman

SUBJECT: Managed Care Ombudsman Program Monthly Report for December 2016

DATE: Thursday, January 12, 2016

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 December 2016 Report.

The Managed Care Ombudsman Program serves as an 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 which include AIDS/HIV, Brain Injury, Children's Mental Health, Elderly, Health and Disability, Intellectual Disability, and Physical Disability Waiver Programs.

Contacts and Main Issues
During the month of December, the Managed Care Ombudsman Program received 181 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 were:

1. Service reduced, denied or terminated – Members who have chronic and complex health care needs have reported a reduction in needed services. In one such example, a member requiring 24/7 support experienced a reduction in their supervision services; thus, the member no longer received the 24/7 support necessary for their diagnosis.
2. Guardianship documents not on file – Legal representatives of members are experiencing difficulty with communicating with MCOs on behalf of their loved one due to guardianship papers not being transferred from Iowa Medicaid Enterprise (IME) to the respective MCO, thus preventing legal representatives from participating in the care planning process for their loved one.
3. Transition services/coverage inadequate or inaccessible – Members continue to report issues with obtaining waiver services upon returning home from receiving skilled care in a facility.

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

Resolution Time
On average, it took 13 business days to resolve an issue. The issues reported to the Managed Care Ombudsman Program have increased in complexity and oftentimes impact processes and policies at a systemic level.

Additional information can be found in the attached December 2016 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: 12/2016

Number of Contacts[1]		181
Contact Categories[2]		
Access to Services/Benefits	Access to preferred/necessary durable medical equipment	13
	Access to preferred/necessary medication	2
	Prior authorization	-
	Provider/pharmacy/hospital not in network	-
	Service reduced, denied or terminated	65
	Transition services/coverage inadequate or inaccessible	25
	Transportation not available, timely or adequate	4
	Other service/coverage gap issue	18
	Other	7
Billing	Member charged improper cost sharing	8
	Other	-
Care Planning	Access to information or information sharing	7
	Care planning participation	2
	Change in care setting	7
	Discharge	15
	Level of care assessment	10
	Other	-
Customer Service	Care coordinator/case manager was rude or gave poor customer service	1
	MCO was rude or gave poor customer service	6
	Member has not received MCO card or other materials	-
	Provider/pharmacy was rude or gave poor customer service	-
	Scheduling	-
	Other	4
Eligibility	Member has lost eligibility status or was denied	2
	Member needs assistance with acquiring Medicaid eligibility information	7
	Member needs assistance with checking on application status	-
	Other	2
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	29
	Unable to contact guardian	-
	Other	-
Other		2
N/A		14
Contacts Related to Grievances/ Appeals/Fair Hearings[3]	Grievances	7
	Appeals	7
	Fair Hearings	18
Contacts per MCO[4]	Amerigroup Iowa	12
	AmeriHealth Caritas	116
	UnitedHealthcare Plan of the River Valley	34

Program[5]	AIDS/HIV Waiver	-
	Brain Injury Waiver	11
	Children's Mental Health Waiver	2
	Dental	-
	Duals	21
	Elderly Waiver	46
	Fee for Service	-
	Habilitation	6
	Health & Disability Waiver	35
	HIPP	-
	Institutional Care	-
	Iowa Health & Wellness	-
	Intellectual Disability Waiver	33
	Medicare	4
	PACE	-
	Physical Disability Waiver	-
	QMB or SLMB	-
	Other	-
	N/A	-
	Unknown	21
Average Resolution Time[6]		13
Referrals per Entity[8]	Department of Human Services	-
	Department of Inspections and Appeals	-
	Disability Rights Iowa	1
	Iowa Compass	-
	Iowa Legal Aid	1
	LifeLong Links	-
	MCO	1
	Medicaid Fraud Control Unit	-
	Provider	-
	Senior Health Insurance Information Program	3
	State Ombudsman Office	-
	Other	4
Service(s) Provided to Contact[9]	Grievance assistance	-
	Appeals assistance	-
	Fair hearing assistance	-
	Advocacy	47
	Education and information	5
	Investigation	134
	Referral	9
	Other	-
	N/A	-
Service(s) Provided to Stakeholders[10]	Community education	2
	Information and consultation	4
	Technical assistance	8
	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]*Average Number of Entities Required for Resolution:* Average number of entities required to resolve the issue.
[8]*Referrals Made to Entities:* Referrals made to external organizations that provide services beyond the scope of the program.
[9]*Services Provided to Contact:* Services provided to the contact who may be the member, family member or their authorized representative
[10]*Services Provided to Stakeholder(s):* Service 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.