Office of the State Long-Term Care
OMBUDSMAN
Established within the Iowa Department on Aging

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Executive Summary

The Office of the State Long-Term Care Ombudsman (OSLTCO), through the Managed Care Ombudsman Program (MCOP), advocates for managed care members who receive long-term services and supports (LTSS) in health care facilities or through one of the seven home and community-based (HCBS) waiver programs.

The MCOP assists these managed care members with understanding their rights regarding services, care and access to managed care. The MCOP does not advocate for managed care members who are not in a health care facility or who do not receive LTSS under one of the seven HCBS waivers. In addition, the MCOP does not advocate for providers.

This executive summary is submitted to fulfill the requirements of HF 2460 regarding the OSLTCO's advocacy and assistance for managed care members who are in a health care facility or who receive LTSS under one of the seven HCBS waiver. This executive summary summarizes member issues brought to the attention of the OSLTCO for the time period of October 1, 2017 through September 30, 2018.

I. Member Issues

The OSLTCO has received a total of 2,792 contacts regarding managed care from October 1, 2017 to September 30, 2018. Contacts were made with the OSLTCO by telephone and email. Members, their legal decision makers, and caregivers were the source of contacts with the OSLTCO. The following table identifies the total contacts received by month and the three issues most frequently raised by those contacting the OSLTCO. The number of contacts reported is representative of the number of times MCOP was contacted; it does not represent the number of complaints made to the MCOP.

Months	Total Contacts	Most Frequently Raised Issues
October 2017	318	• Service reduced, denied or terminated • Care planning participation • Access to information or information sharing
November 2017	223	• Transition services/coverage inadequate or inaccessible • Selecting/changing MCO • Services reduced, denied or terminated
December 2017	173	• Service reduced, denied or terminated • Care coordinator/case managed was rude or gave poor customer service • Care planning participation
January 2018	273	• Change in care setting • Transition services/coverage inadequate or inaccessible • Care planning participation
February 2018	225	• Service reduced, denied or terminated • Access to preferred/necessary durable medical equipment • Discharge
March 2018	214	• Level of care assessment • Service reduced, denied or terminated • Care planning participation
April 2018	211	• Care planning participation • Level of care assessment • Service reduced, denied or terminated
May 2018	213	• Care planning participation • Service reduced, denied or terminated • Level of care assessment
June 2018	250	• Service reduced, denied, terminated • Level of care assessment • Care planning participation
July, 2018	209	• Service reduced, denied or terminated • MCO was rude or gave poor customer service • Care planning participation
August 2018	316	• Service reduced, denied, or terminated • Care planning participation • MCO was rude or gave poor customer service
September 2018	167	• Service reduced, denied or terminated • Access to Services/Benefits-CCO/CDAC • Care planning participation

Most of the contacts the OSLTCO received were from Elderly Waiver managed care members or someone contacting the MCOP on their behalf.

In April 2018, MCOP began distilling additional information from the contacts that had been reported previously. The MCOP now tracks information on the type and number of complaints that managed care members, or someone acting on a managed care member's behalf, present to the MCOP for assistance. This data is reflected in the table below.

Month	Complaint	Members Affected
April	Services reduced, denied or terminated	23
	Care planning	4
	Eligibility	4
	Service coverage gap issues	2
	Case manager rude or poor customer service	1
	Change in care setting	1
	Level of care assessments	1
	Case manager not getting paid	1
	Provider not in network	1
	Transition services/coverage inadequate/inaccessible	1
	Transportation	1
May	Services reduced, denied or terminated	17
	Care planning	12
	Level of care assessments	10
	Access to preferred/necessary durable medical equipment	7
	Care coordinator/case manager was rude or gave poor customer service	5
	Member needs assistance with acquiring eligibility information	5
	Other service/coverage gap issue	5
	Access to information sharing	4
	Change in care setting	4
	Member has lost eligibility status or was denied	4
	Scheduling	4
June	Services reduced, denied or terminated	24
	Level of care assessment	13
	Care coordinator/case manager was rude or gave poor customer service	9
	Access to preferred/necessary durable medical equipment	6
	Care planning participation	5
	Other access to services/benefits issue	5
	Other	4

Month	Complaint	Members Affected
	Other billing issue	4
	Member needs assistance with acquiring eligibility information	4
	MCO was rude or gave poor customer service	3
	Other service/coverage gap issue	3
	Scheduling	3
	Transition services/coverage inadequate or inaccessible	3
	Change in care setting	2
	Access to preferred/necessary medication	1
	Disenrollment from MCO - good cause eligible	1
	Disenrollment from Medicaid program	1
	Guardian not receiving information	1
	Provider/pharmacy/hospital not in network	1
	Member has not received MCO materials	1
	Member has lost eligibility status or was denied	1
	N/A	1
	Transportation not available, timely or adequate	1
July	Services reduced, denied or terminated	22
	MCO was rude or gave poor customer service	8
	Access to preferred/necessary durable medical equipment	7
	Care coordinator/case manager was rude or gave poor customer service	7
	Care planning participation	7
	Level of care	7
	Other access to services/benefits issue	6
	Member needs assistance with acquiring Medicaid eligibility information	4
	Access to information or information sharing	3
	Access to preferred/necessary medication	3
	Other billing issue	3
	Discharge	2
	Home/vehicle modifications	2
	Provider/pharmacy/hospital not in network	2
	Transportation not available, timely or adequate	2
	Change in care setting	2
	Other service/coverage gap issue	2
	Disenrollment from MCO - good cause eligible	1
	Member needs assistance checking on application status	1
	N/A	1
	Other	1
	Transition services/coverage inadequate or inaccessible	1
August	Services reduced, denied or terminated	27

Month	Complaint	Members Affected
	Care planning participation	11
	MCO was rude or gave poor customer service	11
	Level of care	7
	Member needs assistance checking on application status	7
	Other service/coverage gap issue	6
	Access to preferred/necessary durable medical equipment	6
	Other access to services/benefits issue	6
	Access to information or information sharing	5
	Care coordinator/case manager was rude or gave poor customer service	5
	Access to preferred necessary medication	4
	Other billing issue	4
	Member needs assistance with acquiring Medicaid eligibility information	3
	Home/vehicle modifications	3
	Change in care setting (2 members)	2
	Discharge	2
	Provider/pharmacy/hospital not in network	2
	Transition services/coverage inadequate or inaccessible	2
	Other customer service issue	1
	Guardian not receiving information	1
	Member charged improper cost sharing	1
	Member has lost eligibility status or was denied	1
	N/A	1
	Other	1
September	Services reduced, denied or terminated	11
	Access to Services/Benefits-Other	8
	Home/vehicle modifications	5
	Care coordinator/case manager was rude or gave poor customer service	5
	Care planning participation	4
	Other service/coverage gap issue	4
	Access to information or information sharing	4
	Scheduling	3
	Member needs assistance with checking on application status	3
	Discharge	3
	Access to preferred/necessary durable medical equipment	2
	Prior authorization	2
	Provider/pharmacy/hospital not in network	2
	Level of care assessment	2
	MCO was rude or gave poor customer service	2

Month	Complaint	Members Affected
	Transportation not available, timely or adequate	2
	Transition services/coverage inadequate or inaccessible	1
	Member charged improper cost sharing	1
	Other billing issue	1
	Change in care setting	1
	Access to preferred/necessary medication	1
	Member has lost eligibility status or was denied	1
	Selecting/changing MCO	1
	Guardianship documents not on file	1

In addition, the complaints presented are now being tracked by program type. This information is presented in the table below for April, May and June.

Complaint	April	May	June
AIDS/HIV Waiver	-	-	-
Brain Injury Waiver	4	2	6
Children's Mental Health Waiver	3	3	1
Dental	-	-	-
Duals	4	5	6
Elderly Waiver	7	16	12
Habilitation	-	1	2
Health & Disability Waiver	4	7	5
HIPP	-	2	2
Institutional Care	-	-	-
Iowa Health & Wellness	-	-	-
Intellectual Disability Waiver	9	14	17
Medicare	2	-	-
PACE	-	-	-
Physical Disability Waiver	1	1	1
QMB or SLMB	-	-	1
Traditional Medicaid	2	3	2
Other	-	-	1
N/A	-	1	-
Unknown	3	5	5
Q1 Total	**40**	**60**	**61**

COMPLAINTS BY TYPE (APRIL, MAY AND JUNE 2018)

And beginning with the data for July, August and September the complaints, by program type and MCO are reflected in the tables below.

	July	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	
	Other	-	2	-	2
	N/A	-	-	-	0
	Unknown	-	-	-	0
	TOTAL:	14	36	4	54

	August	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:	19	52	4	75

September		Amerigroup Iowa	UnitedHealthcare Plan of the River Valley	Fee for Service	Total
Complaint(s) by Program Type	AIDS/HIV Waiver	1	-	-	1
	Brain Injury Waiver	2	1	-	3
	Children's Mental Health Waiver	-	2	-	2
	Dental	-	-	-	0
	Duals	-	1	-	1
	Elderly Waiver	5	6	-	11
	Habilitation	-	1	-	1
	Health & Disability Waiver	1	6	-	7
	HIPP	-	-	-	0
	Institutional Care	-	-	-	0
	Iowa Health & Wellness	-	-	-	0
	Intellectual Disability Waiver	3	9	2	14
	Medicare	-	-	-	0
	PACE	-	-	-	0
	Physical Disability Waiver	-	2	-	2
	QMB or SLMB	-	-	-	0
	Traditional Medicaid	-	-	-	0
	Other	-	1	-	1
	N/A	-	-	-	0
	Unknown	-	-		0
	TOTAL:	12	29	2	43

II. Trends Tracked By The Managed Care Ombudsman Program October 1, 2017 to September 30, 2018

The most frequent reason that managed care members, or someone acting on the managed care member's behalf, contacted the MCOP, or requested assistance from the MCOP involved an issue with services being reduced, denied or terminated. The program that most frequently resulted in a managed care member or someone acting on the managed care member's behalf, contacting the MCOP or requesting assistance from the MCOP was the elderly waiver.