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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 October 2018

DATE: Thursday, November 15, 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 October 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 October, the Managed Care Ombudsman Program received 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 October 2018 were:

1. Service reduced, denied or terminated – Members needing long-term services and supports reported reductions or denials in their HCBS waiver services which enable members to remain independent in their home. Several contacts were related to a reduction in CDAC hours as well as reductions in home health or skilled nursing visits. In response to reductions in needed services, members have decided to move through appeal and fair hearing processes to maintain these services.
2. Access to Services/Benefits-CCO/CDAC – Medicaid members are reporting reductions of their services related to their CDAC and CCO provider access. Reported issues/concerns are; lack of approved CDAC providers, member budgets not completed on time, payment issues and lengthy wait times for providers to be approved to provide services. Members are experiencing difficulty with accessing additional necessary services or obtaining services that meet their new care needs as their health and care needs evolve over time.
3. Access to preferred/necessary durable medical equipment – Waiver members experienced challenges with long waiting periods for medically necessary equipment in their residence.

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

Resolution Time
On average, it took 25 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 October 2018 Report. For further information, please contact the Managed Care Ombudsman Program by phone at 866-236-1430 or email at managedcareombudsman@iowa.gov.

Managed Care
OMBUDSMAN PROGRAM

A Division of the Office of the State Long-Term Care Ombudsman

866.236.1430 | ManagedCareOmbudsman@iowa.gov

Managed Care Ombudsman Program Monthly Report

Per CMS Special Terms and Conditions, the monthly Managed Care Ombudsman Program data is provided below.

DATE: 10/2018

Number of Contacts[1]		148
Contact Categories[2]		
Access to Services/Benefits	Access to preferred/necessary durable medical equipment	23
	Access to preferred/necessary medication	2
	Home/vehicle modifications	5
	Prior authorization	-
	Provider/pharmacy/hospital not in network	13
	Service reduced, denied or terminated	36
	Transition services/coverage inadequate or inaccessible	3
	Transportation not available, timely or adequate	8
	Other service/coverage gap issue	13
	Other	33
Billing	Member charged improper cost sharing	-
	Other	4
Care Planning	Access to information or information sharing	16
	Care planning participation	19
	Change in care setting	5
	Discharge	7
	Level of care assessment	15
	Other	-
Customer Service	Care coordinator/case manager was rude or gave poor customer service	17
	MCO was rude or gave poor customer service	8
	Member has not received MCO card or other materials	-
	Provider/pharmacy was rude or gave poor customer service	-
	Scheduling	1
	Other	-
Eligibility	Member has lost eligibility status or was denied	-
	Member needs assistance with acquiring Medicaid eligibility information	7
	Member needs assistance with checking on application status	2
	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	-
	Guardianship documents not on file	1
	Unable to contact guardian	-
	Other	-
Other		-
N/A		-
Contacts Related to Grievances/ Appeals/Fair Hearings[3]	Grievances	10
	Appeals	18
	Fair Hearings	1
Contacts per MCO[4]	Amerigroup Iowa	32
	AmeriHealth Caritas	-
	UnitedHealthcare Plan of the River Valley	107
	Fee for Service	2

Category	Item	Count
Program[5]	AIDS/HIV Waiver	2
	Brain Injury Waiver	14
	Children's Mental Health Waiver	-
	Dental	-
	Duals	6
	Elderly Waiver	42
	Habilitation	5
	Health & Disability Waiver	22
	HIPP	-
	Institutional Care	-
	Iowa Health & Wellness	-
	Intellectual Disability Waiver	31
	Medicare	-
	PACE	-
	Physical Disability Waiver	16
	QMB or SLMB	-
	Traditional Medicaid	1
	Other	-
	N/A	1
	Unknown	8
Average Resolution Time[6]		25
Referrals per Entity[7]	Department of Human Services	2
	Department of Inspections and Appeals	-
	Disability Rights Iowa	3
	Iowa Compass	
	Iowa Legal Aid	3
	LifeLong Links	1
	MCO	1
	Medicaid Fraud Control Unit	-
	Provider	-
	Senior Health Insurance Information Program	1
	State Ombudsman Office	2
	Other	1
Service(s) Provided to Contact[8]	Grievance assistance	4
	Appeals assistance	3
	Fair hearing assistance	1
	Advocacy	131
	Education and information	23
	Investigation	88
	Referral	8
Service(s) Provided to Stakeholders[9]	Community education	1
	Information and consultation	1
	Technical assistance	2
	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 148 contacts reported on page 1 resulted in the Managed Care Ombudsman Program working on complaints from 55 individual members (22 members were affected by more than one issue). The top complaint received this month was in regard to services reduced, denied or terminated (12 members). Additional complaints included:

Access to Services/Benefits-Other (10 members)
Access to preferred/necessary durable medical equipment (8 members)
Access to information or information sharing (7 members)
Care planning participation (7 members)
Care coordinator/case manager was rude or gave poor customer service (6 members)
Transportation not available, timely or adequate (5 members)
Other service/coverage gap issue (5 members)
Level of care assessment (5 members)
MCO was rude or gave poor customer service (3 members)
Provider/pharmacy/hospital not in network (3 members)
Discharge (3 members)
Member needs assistance with acquiring Medicaid eligibility information (3 members)
Change in care setting (2 members)
Access to preferred/necessary medication (1 member)
Home/vehicle modifications (1 member)
Transition services/coverage inadequate or inaccessible (1 member)
Billing-Other (1 member)
Scheduling (1 member)
Member needs assistance with checking on application status (1 member)
Guardianship documents not on file (1 member)

		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	-	-	-	0
	Dental	-	-	-	0
	Duals	3	-	-	3
	Elderly Waiver	5	8	-	13
	Habilitation	-	3	-	3
	Health & Disability Waiver	1	6	-	7
	HIPP	-	-	-	0
	Institutional Care	-	-	-	0
	Iowa Health & Wellness	-	-	-	0
	Intellectual Disability Waiver	1	10	1	12
	Medicare	-	-	-	0
	PACE	-	-	-	0
	Physical Disability Waiver	-	5	-	5
	QMB or SLMB	-	-	-	0
	Traditional Medicaid	-	1	-	1
	Other	-	2	-	2
	N/A	-	1	-	1
	Unknown	-	4	-	4
	TOTAL:	13	41	1	55

*data may be incomplete due to data collection issues this reporting period