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 July 2016

DATE: Wednesday, August 10, 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 July 2016 Report.

The Managed Care Ombudsman Program serves 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 July, the Managed Care Ombudsman Program received 81 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 Access to preferred/necessary durable medical equipment, Change in care setting, and Service reduced, denied or terminated.

Medicaid Program

Most calls were related to the Elderly Waiver, the Iowa Health and Wellness Plan, and the Intellectual Disability Waiver. However, many contacts received were reported as "unknown" since the Managed Care Ombudsman was unable to verify the caller's Medicaid program.

Resolution Time

On average, it took six days to resolve an issue. Oftentimes, issues required the Managed Care Ombudsman to obtain additional information from another agency or organization necessary to resolve the issue. Therefore, the resolution time includes the time it took for those agencies and organizations to respond to the Managed Care Ombudsman with the necessary information.

Additional information can be found in the attached July 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: 07/2016

Number of Contacts[1]		81
Contact Categories[2]		
Access to Services/Benefits	Access to preferred/necessary durable medical equipment	18
	Access to preferred/necessary medication	1
	Prior authorization	6
	Provider/pharmacy/hospital not in network	3
	Service reduced, denied or terminated	16
	Transition services/coverage inadequate or inaccessible	4
	Transportation not available, timely or adequate	-
	Other service/coverage gap issue	-
	Other	-
Billing	Member charged improper cost sharing	6
	Other	6
Care Planning	Access to information or information sharing	-
	Care planning participation	-
	Change in care setting	17
	Discharge	4
	Level of care assessment	-
	Other	-
Customer Service	Care coordinator/case manager was rude or gave poor customer service	3
	MCO was rude or gave poor customer service	7
	Member has not received MCO card or other materials	-
	Provider/pharmacy was rude or gave poor customer service	-
	Scheduling	-
	Other	-
Eligibility	Member has lost eligibility status or was denied	5
	Member needs assistance with acquiring Medicaid eligibility information	4
	Member needs assistance with checking on application status	-
	Other	-
Enrollment	Disenrollment from MCO – good cause eligible	2
	Disenrollment from MCO – not good cause eligible	-
	Disenrollment from Medicaid program	-
	Selecting/changing MCO	3
	Other	-
Guardianship	Guardian not receiving information	-
	Guardianship documents not on file	-
	Unable to contact guardian	-
	Other	-
Other		3
N/A		5
Contacts Related to Grievances/ Appeals/Fair Hearings[3]	Grievances	1
	Appeals	13
	Fair Hearings	2
Contacts per MCO[4]	Amerigroup Iowa	16
	AmeriHealth Caritas	27
	UnitedHealthcare Plan of the River Valley	17

Program[5]	AIDS/HIV Waiver	-
	Brain Injury Waiver	-
	Children's Mental Health Waiver	9
	Dental	-
	Duals	-
	Elderly Waiver	27
	Fee for Service	-
	Habilitation	-
	Health & Disability Waiver	3
	HIPP	-
	Institutional Care	4
	Iowa Health & Wellness	11
	Intellectual Disability Waiver	10
	Medicare	-
	PACE	1
	Physical Disability Waiver	-
	QMB or SLMB	-
	Other	-
	N/A	2
	Unknown	10
Average Resolution Time[6]		6
Average Number of Entities Required for Resolution[7]		1
Referrals per Entity[8]	Department of Human Services	4
	Department of Inspections and Appeals	-
	Disability Rights Iowa	-
	Iowa Legal Aid	-
	LifeLong Links	1
	MCO	-
	Medicaid Fraud Control Unit	-
	Provider	-
	Senior Health Insurance Information Program	-
	State Ombudsman Office	2
	Other	1
Service(s) Provided to Contact[9]	Grievance assistance	-
	Appeals assistance	-
	Fair hearing assistance	-
	Advocacy	20
	Education and information	16
	Investigation	26
	Outreach	-
	Referral	8
	Other	-
	N/A	-
Service(s) Provided to Stakeholders[10]	Community education	3
	Information and consultation	31
	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.