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, State Long-Term Care Ombudsman

SUBJECT: Managed Care Ombudsman Program Monthly Report for September 2018

DATE: Friday, October 5, 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 September 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 September the Managed Care Ombudsman Program received 167 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 2018 were:

1. Service reduced, denied or terminated – Medicaid members needing long-term services and supports reported reductions or denials in their HCBS waiver 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.
3. Care planning participation – New and existing Medicaid members requested assistance for their upcoming yearly assessment and care plan meetings. Members reported they feel their health needs are not being individually addressed. Members also reported they were unaware of who their case manager was or how often they would have meetings.

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 September 2018 Report. For further information, please contact the Managed Care Ombudsman Program by phone at 866-236-1430 or email at managedcareombudsman@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: 09/2018

Number of Contacts[1]		167
Contact Categories[2]		
Access to Services/Benefits	Access to preferred/necessary durable medical equipment	6
	Access to preferred/necessary medication	2
	Home/vehicle modifications	13
	Prior authorization	9
	Provider/pharmacy/hospital not in network	9
	Service reduced, denied or terminated	52
	Transition services/coverage inadequate or inaccessible	1
	Transportation not available, timely or adequate	8
	Other service/coverage gap issue	10
	Other	44
Billing	Member charged improper cost sharing	1
	Other	1
Care Planning	Access to information or information sharing	9
	Care planning participation	22
	Change in care setting	13
	Discharge	7
	Level of care assessment	7
	Other	-
Customer Service	Care coordinator/case manager was rude or gave poor customer service	8
	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	21
	Other	-
Eligibility	Member has lost eligibility status or was denied	1
	Member needs assistance with acquiring Medicaid eligibility information	5
	Member needs assistance with checking on application status	-
	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	1
	Unable to contact guardian	-
	Other	-
Other		-
N/A		-
Contacts Related to Grievances/ Appeals/Fair Hearings[3]	Grievances	9
	Appeals	32
	Fair Hearings	2
Contacts per MCO[4]	Amerigroup Iowa	48
	AmeriHealth Caritas	-
	UnitedHealthcare Plan of the River Valley	116
	Fee for Service	3

Program[5]	AIDS/HIV Waiver	2
	Brain Injury Waiver	6
	Children's Mental Health Waiver	4
	Dental	-
	Duals	4
	Elderly Waiver	59
	Habilitation	1
	Health & Disability Waiver	22
	HIPP	-
	Institutional Care	-
	Iowa Health & Wellness	-
	Intellectual Disability Waiver	47
	Medicare	-
	PACE	-
	Physical Disability Waiver	21
	QMB or SLMB	-
	Traditional Medicaid	-
	Other	1
	N/A	-
	Unknown	-
Average Resolution Time[6]		25
Referrals per Entity[7]	Department of Human Services	1
	Department of Inspections and Appeals	-
	Disability Rights Iowa	6
	Iowa Compass	3
	Iowa Legal Aid	3
	LifeLong Links	-
	MCO	1
	Medicaid Fraud Control Unit	-
	Provider	-
	Senior Health Insurance Information Program	-
	State Ombudsman Office	1
	Other	-
Service(s) Provided to Contact[8]	Grievance assistance	3
	Appeals assistance	5
	Fair hearing assistance	2
	Advocacy	164
	Education and information	9
	Investigation	133
	Referral	6
Service(s) Provided to Stakeholders[9]	Community education	-
	Information and consultation	6
	Technical assistance	1
	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 167 contacts reported on page 1 resulted in the Managed Care Ombudsman Program working on complaints from 43 individual members (17 members were affected by more than one issue). The top complaint received this month was in regard to services reduced, denied or terminated (11 members). Additional complaints included:

Access to Services/Benefits-Other (8 members)
Home/vehicle modifications (5 members)
Care coordinator/case manager was rude or gave poor customer service (5 members)
Care planning participation (4 members)
Other service/coverage gap issue (4 members)
Access to information or information sharing (4 members)
Scheduling (3 members)
Member needs assistance with checking on application status (3 members)
Discharge (3 members)
Access to preferred/necessary durable medical equipment (2 members)
Prior authorization (2 members)
Provider/pharmacy/hospital not in network (2 members)
Level of care assessment (2 members)
MCO was rude or gave poor customer service (2 members)
Transportation not available, timely or adequate (2 members)
Transition services/coverage inadequate or inaccessible (1 member)
Member charged improper cost sharing (1 member)
Other billing issue (1 member)
Change in care setting (1 member)
Access to preferred/necessary medication (1 member)
Member has lost eligibility status or was denied (1 member)
Selecting/changing MCO (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	-	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:				43