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 October 2016

DATE: Tuesday, November 8, 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 October 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 October, the Managed Care Ombudsman Program received 152 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. Change in care setting – Members are experiencing difficulty with transitioning between settings such as from a nursing facility returning home or to the community largely due to the inability in locating placement that can adequately meet the member's needs. Members have also reported difficulty with facilities maintaining admission of members transitioning from private pay to Medicaid status or facilities not accepting new Medicaid members due to lack of reimbursement from MCOs.
2. Transition services/coverage inadequate or inaccessible – Members have reported concern with maintaining their CDAC providers and losing their services due to the lack of payment to their CDAC providers and challenging documentation processes required by the MCOs.
3. Other service/coverage gap issue – Members have reported issues with obtaining necessary home and vehicle modifications that enable members to remain independent.

Medicaid Program

Most calls were related to the Elderly Waiver and the Children's Mental Health Waiver as well as the Health and Disability Waiver.

Resolution Time

On average, it took five 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 October 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: 10/2016

Number of Contacts[1]		152
Contact Categories[2]		
Access to Services/Benefits	Access to preferred/necessary durable medical equipment	10
	Access to preferred/necessary medication	2
	Prior authorization	-
	Provider/pharmacy/hospital not in network	-
	Service reduced, denied or terminated	12
	Transition services/coverage inadequate or inaccessible	27
	Transportation not available, timely or adequate	5
	Other service/coverage gap issue	20
	Other	19
Billing	Member charged improper cost sharing	1
	Other	8
Care Planning	Access to information or information sharing	4
	Care planning participation	13
	Change in care setting	30
	Discharge	1
	Level of care assessment	12
	Other	-
Customer Service	Care coordinator/case manager was rude or gave poor customer service	-
	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	1
	Other	-
Eligibility	Member has lost eligibility status or was denied	12
	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	-
	Unable to contact guardian	-
	Other	-
Other		-
N/A		18
Contacts Related to Grievances/ Appeals/Fair Hearings[3]	Grievances	12
	Appeals	8
	Fair Hearings	-
Contacts per MCO[4]	Amerigroup Iowa	31
	AmeriHealth Caritas	67
	UnitedHealthcare Plan of the River Valley	23

Program[5]	AIDS/HIV Waiver	-
	Brain Injury Waiver	1
	Children's Mental Health Waiver	19
	Dental	-
	Duals	9
	Elderly Waiver	33
	Fee for Service	8
	Habilitation	-
	Health & Disability Waiver	18
	HIPP	-
	Institutional Care	-
	Iowa Health & Wellness	10
	Intellectual Disability Waiver	2
	Medicare	-
	PACE	-
	Physical Disability Waiver	-
	QMB or SLMB	-
	Other	-
	N/A	-
	Unknown	1
Average Resolution Time[6]		5
Referrals per Entity[8]	Department of Human Services	3
	Department of Inspections and Appeals	-
	Disability Rights Iowa	1
	Iowa Compass	7
	Iowa Legal Aid	1
	LifeLong Links	2
	MCO	8
	Medicaid Fraud Control Unit	-
	Provider	-
	Senior Health Insurance Information Program	-
	State Ombudsman Office	-
	Other	1
Service(s) Provided to Contact[9]	Grievance assistance	1
	Appeals assistance	-
	Fair hearing assistance	-
	Advocacy	71
	Education and information	30
	Investigation	52
	Referral	16
	Other	-
	N/A	8
Service(s) Provided to Stakeholders[10]	Community education	5
	Information and consultation	1
	Technical assistance	18
	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.