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**TO:** Iowa Department of Human Services  
**CC:** Centers for Medicare and Medicaid Services  
**FROM:** Deanna Clingan-Fischer  
**SUBJECT:** Managed Care Ombudsman Program Monthly Report for August 2016  
**DATE:** Wednesday, September 7, 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 August 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 August, the Managed Care Ombudsman Program received 130 contacts through phone and email. Oftentimes, multiple issues were addressed in one call. This number does not reflect 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 Prior authorization, Change in care setting, and Care coordinator/case manager was rude or gave poor customer service.

#### **Medicaid Program**

Most calls were related to the Intellectual Disability Waiver, the Elderly Waiver, and the Children's Mental Health Waiver. However, many of the 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 seven days to resolve an issue. Oftentimes, issues required the Managed Care Ombudsman to obtain additional information from other agencies and organizations necessary to resolve the issue. Therefore, the resolution time includes the time it took for those agencies and organizations to provide that information.

Additional information can be found in the attached August 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](mailto:lynzey.kenworthy@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: \_\_\_\_\_

Number of Contacts <sup>1</sup>		
<b>Contact Categories<sup>2</sup></b>		
Access to Services/Benefits	Access to preferred/necessary durable medical equipment	
	Access to preferred/necessary medication	
	Prior authorization	
	Provider/pharmacy/hospital not in network	
	Service reduced, denied or terminated	
	Transition services/coverage inadequate or inaccessible	
	Transportation not available, timely or adequate	
	Other service/coverage gap issue	
Other		
Billing	Member charged improper cost sharing	
	Other	
Care Planning	Access to information or information sharing	
	Care planning participation	
	Change in care setting	
	Discharge	
	Level of care assessment	
	Other	
Customer Service	Care coordinator/case manager was rude or gave poor customer service	
	MCO was rude or gave poor customer service	
	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	
	Member needs assistance with acquiring Medicaid eligibility information	
	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	
	Other	
Guardianship	Guardian not receiving information	
	Guardianship documents not on file	
	Unable to contact guardian	
	Other	
Other		
N/A		
Contacts Related to Grievances/ Appeals/Fair Hearings <sup>3</sup>	Grievances	
	Appeals	
	Fair Hearings	
Contacts per MCO <sup>4</sup>	Amerigroup Iowa	
	AmeriHealth Caritas	
	UnitedHealthcare Plan of the River Valley	

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

<sup>1</sup>Number of Contacts: Total Number of contacts received via phone and email.

<sup>2</sup>Contact Categories: Reason contact was made to the program. "Other" is used for issues not listed. "N/A" is used for issues unknown.

<sup>3</sup>Contacts Related to Grievances/Appeals/Fair Hearings: Contacts concerning filing or filed grievances/appeals/fair hearings.

<sup>4</sup>Contacts per MCO: Contacts received regarding the respective MCO.

<sup>5</sup>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.

<sup>6</sup>Average Resolution Time: Average number of days required for resolution.

<sup>7</sup>Average Number of Entities Required for Resolution: Average number of entities required to resolve the issue.

<sup>8</sup>Referrals Made to Entities: Referrals made to external organizations that provide services beyond the scope of the program.

<sup>9</sup>Services Provided to Contact: Services provided to the contact who may be the member, family member or their authorized representative

<sup>10</sup>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.