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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 September 2016
DATE: Monday, October 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 September 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 September, the Managed Care Ombudsman Program received 188 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 community or transitioning back to Iowa from out-of-state placement or finding appropriate placement once discharged from jail or the hospital. Members have reported residing in a hospital for over 30 days due to delayed care placement.
2. Member has lost eligibility status or was denied – Members enrolled in the Elderly Waiver have been losing their waiver services when they receive skilled care to address a temporary health care need in a facility and then return home. Once home, members are having difficulty with accessing necessary waiver services due to losing their eligibility status as result of their temporary stay in a skilled facility. This has resulted in receiving delayed necessary services at home that members require to maintain quality of life.
3. Other under Access to Services/Benefits – 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.

Medicaid Program

Most calls were related to the Elderly Waiver and Dual eligibles (i.e., individuals who are enrolled in both Medicare and Medicaid). However, many contacts received were reported as “unknown” since the Managed Care Ombudsman Program was unable to verify the caller’s Medicaid program.

Resolution Time

On average, it took eleven 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 September 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.

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 ¹		
Contact Categories²		
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 ³	Grievances	
	Appeals	
	Fair Hearings	
Contacts per MCO ⁴	Amerigroup Iowa	
	AmeriHealth Caritas	
	UnitedHealthcare Plan of the River Valley	

Program⁵	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		
Average Resolution Time⁶		
Referrals per Entity⁸	Department of Human Services	
	Department of Inspections and Appeals	
	Disability Rights Iowa	
	Iowa Compass	
	Iowa Legal Aid	
	Lifelong Links	
	MCO	
	Medicaid Fraud Control Unit	
	Provider	
	Senior Health Insurance Information Program	
	State Ombudsman Office	
Other		
Service(s) Provided to Contact⁹	Grievance assistance	
	Appeals assistance	
	Fair hearing assistance	
	Advocacy	
	Education and information	
	Investigation	
	Referral	
	Other	
N/A		
Service(s) Provided to Stakeholders¹⁰	Community education	
	Information and consultation	
	Technical assistance	
	Training	

¹Number of Contacts: Total Number of contacts received via phone and email.

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

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

⁴Contacts per MCO: Contacts received regarding the respective MCO.

⁵Program: 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.

⁶Average Resolution Time: Average number of days required for resolution.

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

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

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

¹⁰Services 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.