
# ANNUAL REPORT

## FY 2020

HTTPS://WWW.LEGIS.IOWA.GOV/OMBUDSMAN/

**This annual report about the exercise of the Office of Ombudsman functions during the 2020 fiscal year is submitted to the Iowa General Assembly and the Governor pursuant to Iowa Code section 2C.18.**

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# 50th Anniversary of the Ombudsman's Office

As a step in combatting the perilous impersonality of government and in giving citizens a renewed sense of direct participation in their government, the office of ombudsman should be established, subject to appointment by the Governor and confirmation by the Senate. The concept has a 160-year history of success, beginning in Sweden and recently under consideration in more than half of our fifty states. An ombudsman would serve as a channel for redressing individual grievances which are beyond the reach of present court procedures and leave many people voiceless. Additionally, the ombudsman would analyze grievances and seek better administration of public agencies. He would improve the performance of legislative functions through identification of recurring problems which may require corrective legislation. Finally, experience has shown that an ombudsman improves the morale of public servants and increases public confidence in them, by ventilating unfounded criticism and rejecting unfounded complaints.

Honorable Robert D. Ray
Governor of Iowa
First Inaugural Message
January 16, 1969

This year marks the 50th anniversary of the Iowa Office of Ombudsman. Iowans should be proud of the foresight of the late Governor Robert D. Ray in 1970 to create an office where their voices could be heard and their complaints adequately addressed. Due to the consistent support of the Legislature, our office has been making good government better ever since.

Governor Ray appointed Lawrence D. Carstensen as Iowa's first ombudsman, giving him the title of "Citizens' Aide." The office was initially financed with a grant from the federal Office of Economic Opportunity. In his "State of the State" message on January 10, 1972, Governor Ray made an eloquent argument for continuation of the office:

> I established a State Citizens' Aide office through an experimental operation funded by a federal grant. To continue this office requires a $56,000 appropriation. Iowa has been a pioneer in this significant field, which directly confronts the problem of an individual citizen's frustration in trying to pierce what is – to him – the faceless wall of public bureaucracy. The ombudsman is the people's hope for unraveling the red tape, for remedying the oversights, and repairing the injustices of governmental bodies. The bigger and more complex the processes of government become, the greater becomes the need for an ombudsman to help the ordinary citizen. Proof of the need here is provided by the constantly increasing volume of requests for help to which the Iowa Citizens' Aide's Office is responding. The soundness of the idea is no longer in question. Let us now give it a foundation of statutory permanence.

*(Continued on page 2)*

*(Continued from page 1)*

During the subsequent 1972 legislative session, the Iowa General Assembly debated HF 1291, the Iowa Citizens' Aide Act, which proposed funding the office with state money and transferring the Ombudsman from the governor's office to the legislative branch. Republican Cedar Rapids Representative Joan Lipsky, in her closing remarks on the bill, detailed all the ways the ombudsman had benefitted Iowans:

> Here is an opportunity to do something in truth for the little man, for the citizen who feels browbeaten by bureaucracy, bound in red tape, frustrated in his dealings with government …
>
> I would like to remind you that that there are no shortages of grievances against abuses of government. The roll call of action or inaction which gives rise to complaints are: injustice, failure to carry out legislative intent, unreasonable delay, administrative error, lack of courtesy, negligence, inadequate investigation, unfair policies, partiality, maladministration, unfairness, arbitrariness, arrogance, inefficiency, abuse of authority, discrimination, carelessness. We could go on with the list; you have all met and experienced it. How much more distasteful for the individual experiencing it.
>
> The true role of the citizens' aide is to supplement our existing institutions, our courts, this legislative body, our executive and administrative agencies. These institutions must all be strengthened and made more responsive to the grievances of our citizens. Here in this small bill … we have the opportunity to give the average citizen open access to inquiries, redressing of grievances and solution of problems.

The bill ultimately passed in the House by a vote of 70-27, and 30-20 in the Senate.

The intent of our government leaders to invest oversight authority in the office was clear. But it was not enough to avoid conflict and legal challenges in the years that followed by some agencies that did not want to succumb to accountability. Agencies have challenged our authority to interview witnesses and access records, relenting only when courts have compelled compliance with our requests. We have also had to clarify legislation in the face of other challenges to our investigative powers.

The numbers of cases and contacts to our office have grown considerably over the years. In its first year of operation in 1970-71, the office opened 1,185 cases. In fiscal year 2020, we fielded over 5,600 cases.

On any given day, it is almost impossible to predict what sort of complaints we are likely to receive, and in what numbers. We hear about fence disputes on rural acreages and access to state benefits; the condition of gravel roads and city sidewalks; decisions by police on the beat and by mayors at city hall. We even hear from people on the opposite sides of common disputes: zoning officials who are too permissive of messy neighbors, and others who enforce nuisance laws too zealously. New regulations and downturns in the economy tend to add to the flux of complaints; so does the day of the week and the weather.

Regardless of the subject, this much is certain: There is never a shortage of citizens' requests for information and help. And, as we always have, we stand ready to answer those calls.

I am confident that the Ombudsman's office will continue to be a voice for the voiceless for another 50 years.

*Kristie Hirschman, Ombudsman*

# Ombudsman's Message

## by Kristie Hirschman

**What a year…**

**COVID-19**

It has always been my belief that the importance of an ombudsman's office is even more apparent in times of crisis. This year was definitely no exception.

We handled a slew of complaints related to COVID-19, and I have dedicated a section of this report to some of those cases. I estimate that 10 to 15 percent of our complaints in the first six months of 2020 were COVID-related.

These complaints touched many aspects of government, at all levels. Most of the complaints were to be expected, such as those dealing with unemployment benefits, public meeting participation, access to social services, and disruptions caused by governments' mitigation efforts. Some complaints, however, came as a surprise – such as one we received on garbage collection. (See summary on Page 6.)

Generally, we found that government agencies took thoughtful and practical approaches to continuing operations while preventing the spread of the virus. There were exceptions, though, that prompted us to propose alternatives.

My special thanks goes to the thousands of government employees (including my staff!) who worked tirelessly under challenging conditions to provide services through the COVID outbreak … and after August's unexpected and damaging derecho.

**FY 2020 by the numbers**

My staff and I opened almost 5 percent more cases in fiscal year 2020 than the previous year. While that may not sound like much, it amounts to over 250 additional cases. It is also the sixth straight year our case numbers have grown. The most notable increases concerned the Iowa Department of Human Services (DHS), the Iowa Department of Corrections, Iowa Workforce Development, the Board of Parole, and municipal utilities.

Surprisingly, jail complaints were down for the first time in many years. I attribute the decline to a smaller population of inmates. Iowa's criminal-justice system made concerted efforts to reduce jail populations to minimize the spread of COVID-19.

We also issued two public critical reports this calendar year, both dealing with DHS: A Tragedy of Errors: An Investigation of the Death of Natalie Finn and Misplaced Trust: An Investigation of the Death of Sabrina Ray. Our work in both investigations was emotionally draining. Nevertheless, our findings led us to make 27 recommendations to improve Iowa's child-welfare system and the bulk of our recommendations were accepted. We are hopeful that DHS's receptive response will spur greater vigilance by caseworkers who monitor troubled families and in-home daycares. *(Continued on page 4)*

# Ombudsman's Message

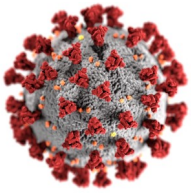
*(Continued from page 3)*

**What the Future Holds**

In looking to the future, it can be wise to reflect on the past. In his 1987 annual report, then-Ombudsman William Angrick noted on the 10th anniversary of his appointment a consistent problem with delays and backlogs among government agencies. He expressed concern about a widespread lack of resources that hampered officials' ability to get the job done.

I have worked for this office for 25 years, and I can confirm that resource issues have too frequently been a factor in cases we investigate. I wrote in my 2017 annual report column that there would be a terrible price to pay if agencies tasked with making life-saving decisions continued to go without adequate funding and manpower. The prescience of my prediction unfortunately proved to be accurate as it related to the Iowa Department of Human Services (DHS) and its oversight of the children profiled in our two recent public reports. We made recommendations in both investigations that DHS review its staffing adequacy in specific areas of its operation. But the problem certainly isn't unique to DHS. We have become aware of some county jails that sometimes use only one employee to monitor inmates – while they simultaneously handle dispatching duties. This, too, is a recipe for disaster.

As a society, we often fail to recognize the critical nature of many government services until something goes tragically wrong. Once again, I urge Iowa's city councils, county supervisors, and state agency directors to be proactive and to take ownership of their responsibilities. Do what is necessary to ensure that the vulnerable people who depend on your services can count on you. Never forget that your government is, in fact, their government.



## COVID-19 RELATED CASES

### Delayed Stimulus

Under the federal Coronavirus Aid, Relief, and Economic Security Act (CARES), each qualifying individual was entitled to a stimulus check of $1,200. The CARES Act allowed for the seizure of stimulus money if a person was behind on paying child support. Our office was contacted by a woman complaining that her stimulus check was being held for this reason. She said this was impossible, as her youngest child was 37 years old. The agency officials we contacted admitted the woman's case should have been closed. Within 24 hours of her call to our office, the woman was informed that her stimulus money would be refunded. We were surprised when the woman called us almost three weeks later to say she had still not received her check. We learned the agency had a 20-day wait period to allow for an adjustment from the Internal Revenue Service. The agency said her check was processed the previous week and should be on its way.

# COVID-19 RELATED CASES


## Unemployment Havoc

It is not surprising with the implementation of a number of COVID-19 unemployment programs that problems would arise. In fiscal year 2019, we had 18 unemployment complaints. In fiscal year 2020, we saw a 350 percent increase. A number of callers were behind on their bills and faced losing their homes. One caller admitted she was now living in her car. Due to the severity of the financial hardships people were facing, we prioritized reviewing unemployment claims.

We believed that in most cases, the source of the problem was likely just the sheer number of claims. The agency processed five million claims in six months. There was a short time frame for training temporary staff and significant software modifications that needed to be made. Many callers to our office expressed frustration with the differing answers they received every time they checked on the status of their claim. Our goal with most of these complaints was to get the complaint in front of agency officials for a review and a response. We found agency officials to be responsive to our inquiries, readily admitting when they were responsible for an error. Numerous calls to our office resulted in prompt review of the unemployment claims by the agency and issuance of benefits.

For example, in early June we received a call from a man who was denied unemployment benefits in January. When he called us, he had recently been let go from another job. He filed a new claim online, but a month later, he was told his account was locked due to his pending January claim. Agency staff he spoke with, however, failed to tell him that he would be eligible for unemployment if he had earned 10 times his weekly benefit amount of $414 since the January decision. We forwarded a copy of the man's May paystub to the agency. They immediately removed the lock on his claim and said the man would have his unemployment benefits within a week.

In another case, a woman told us that she had been fired for excessive absences. Her absences were due to having been quarantined by her doctor because of COVID-19 exposure by a family member. Since her employer was contesting her unemployment claim, a fact-finding hearing needed to take place, but six weeks had passed without any notice of her hearing. We contacted the agency and they told us that they would mail the woman a notice of her hearing date that day. We were surprised, then, when we called the woman one month later and learned she still had not received anything from the agency. We contacted the agency again and they apologized, admitting they had failed to send the notice as promised. An agency official said he would call the woman before the end of the day to discuss the reasons behind her separation from her last employer.

Another man called us to complain he had not been able to file his weekly claims because there was a problem with his user name and password. The agency said it was fixed, but he told us he still could not access his account. He claimed the agency had quit responding to the messages he left attempting to resolve this problem. We brought this issue to the agency's attention and they immediately contacted the man and resolved his complaint.

# COVID-19 RELATED CASES

## Who's Better Equipped?

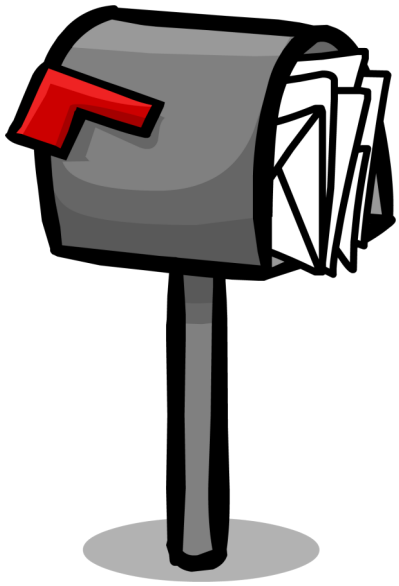
Shortly after the COVID-19 pandemic gripped Iowa and the rest of the nation, we fielded complaints that several Iowa cities had stopped collecting garbage and recycling. Instead, the cities reportedly told residents to haul their own garbage and recycling to centralized locations in their communities. We questioned the logic and safety of such decisions since residents were being told at the time not to make unnecessary trips out of their homes.

After we inquired with the cities, they each explained that they had suspended solid waste collection due to worker safety concerns. To us, that begged the question: Was it safer for trained employees with better personal protective equipment to collect garbage and recycling, or should average citizens assume the risk and responsibility?

In researching the matter, we learned that state public health officials did not recommend suspension of solid waste collection. Instead, they urged taking proper precautions, social distancing as much as possible, and being flexible if workers fell ill. Likewise, the federal Occupational Safety and Health Administration did not recommend stopping waste collection. They recommended following proper safety protocols and using personal protective equipment.

After reviewing the matter, we concluded that suspension of curbside trash collection went against social-distancing and stay-at-home recommendations issued at the time by state and federal public health officials. We also concluded that it was safer for trained city workers with superior protective gear to collect trash during the pandemic.

The complaints were substantiated and the Ombudsman issued formal recommendations that the cities should resume solid waste collection consistent with state and federal guidance. The cities did not immediately accept the Ombudsman's recommendations, though it's our understanding that trash and recycling collection eventually resumed as normal.



## Mail Delays

A jail inmate called to complain that his outgoing mail was being held in an open box in a room normally reserved for confidential meetings between inmates and their attorneys. He believed the mail should be stored in a more secure area. Jail administration advised us that the Centers for Disease Control and Prevention (CDC) projected that COVID -19 could survive on paper for three to five days. For this reason, the mail was being quarantined to "limit the spread [of COVID-19] in a responsible manner." The Jail conceded that even though the room had limited access, there could be confidentiality issues. As a result of our contact, they moved the mail to a more secure area.

# COVID-19 RELATED CASES

## Public Hearings in the Age of COVID-19

The onset of COVID-19 in early March created havoc for local governments accustomed to doing official business in the open.

Medical professionals who were fearful of transmitting a new and burgeoning disease suggested a halt to in-person gatherings; yet Iowa's Open Meetings Law contemplates an open-door policy when city councils and boards of supervisors meet to decide official business.

Some governments handled the challenge better than others. One county in western Iowa decided to hold its annual budget hearings on social media, which prompted a complaint to our office from a citizen who feared this would discourage public input on a planned tax increase. We understood the risk of having board-room meetings as usual, but also recognized that many citizens don't have the know-how or equipment to participate in online meetings.

We asked the citizen to make his complaint to a different state agency that polices violations of the Open Meetings and Open Records laws. Unfortunately, an agency representative suggested that a violation had to take place before the agency could act. To that point, the agency had instructed governments to make their meetings accessible to the public, but had not said anything about the public's ability to voice their opinions in public hearings.

We were adamant that the issue should be addressed before it became a problem and immediately placed a call to the county auditor. The auditor, who acts as clerk in supervisors' meetings, was receptive to alternative meeting arrangements. We suggested that the meeting be held telephonically, if possible, so it would be easier for the public to participate in the process. He discussed the matter with supervisors and the county's information-technology expert, who was able to arrange a conference-call meeting that allowed 150 people to participate simultaneously from the safety of their homes.

The governor's office now emphasizes that boards who hold public hearings electronically must provide a means for public participation.

*"So the Ombudsman works! I greatly appreciate you. I got more done talking to you in a half day than I have got done in three months talking to the agency."*

Unemployment Complainant

*"I wanted to inform you how greatly I appreciate your help. I sincerely do and I want to thank you for what you've done, and the expertise plus the extra effort you made yesterday."*

Unemployment Complainant

# HUMAN SERVICES

## Extra Effort: A Feel-Good Story from the Ombudsman

There was no mistake made by the agency in the following story. While our job is to point out problems, we don't always take the opportunity to highlight the good work government officials do. In this case, agency staff went above and beyond expectations to resolve a problem. We do not normally name agencies in our annual report case summaries but I am making an exception here, as I feel it is important to give credit where credit is deserved.

Out of necessity, I answered phones during the opening weeks of the COVID-19 pandemic. When I picked up the phone late one afternoon, I found a woman who spoke very little English; her primary language was Swahili. I was having a very difficult time overcoming the communication barrier when the woman put her darling 7-year-old daughter on the phone to translate. Her daughter said her mom was trying to tell me that she had received important mail but her daycare had not. In order to determine what mail her mom had actually received, I asked the young girl to read what was at the very top of the page. She said she could not read very well, but she could spell it. The first two words she spelled were "Kim Reynolds." At this point, I was confident the letter was from a state agency, and I suspected it involved a day care assistance application.

I kept the endearing young girl on the phone while I used my cell phone to contact Cassie, a Department of Human Services' (DHS) employee who is often our first point of contact on inquiries. Cassie was able to determine that the family had a pending day care assistance application that was denied because DHS needed more information. She provided a toll-free DHS number the family could call to resolve the problem. Cassie said DHS staff at that number would also have access to a translator.

I (correctly) assumed the toll-free number would initially be answered by an automated system, requiring the caller to select from a number of options. I had concerns that the young girl and her mother would not be able to traverse this obstacle, so I called the toll-free number using the conference call feature on my phone to include the young girl and her mother on the call. After about 30 minutes on hold, a DHS employee by the name of Jodi answered. She quickly had a translator join us on the call. Through the translator, Jodi was able to figure out that DHS needed proof of employment and documentation of the hours the mother worked in order to complete the daycare assistance application. The mother said she would take a picture of her paystub and text it to my personal cell phone.

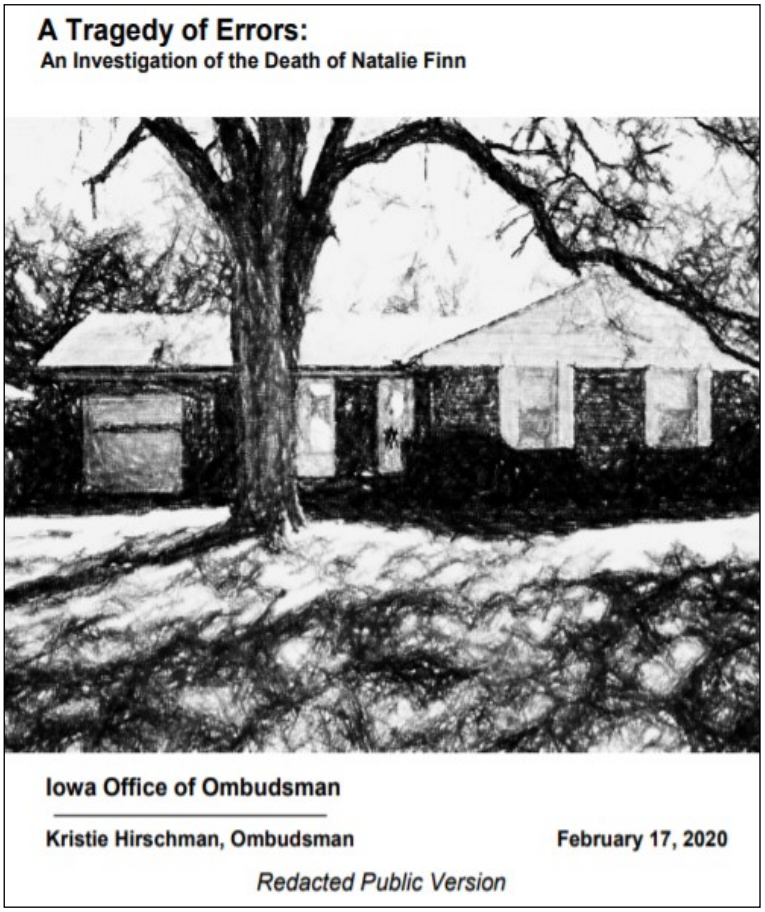
When I had not received a text by the next day, I contacted Jodi again. Jodi promised to follow up with the family. She also said she would go to their house and get it herself if she had to; her supervisor offered to do the same. Later that day, Jodi emailed me to say that, thanks once again to the young daughter's translations, she would personally go to the family's home after work to pick up the necessary information to complete the application process.

I have no doubt that local and state government officials often go the extra mile to resolve problems. Please accept my thanks for your often unappreciated efforts.

*Kristie Hirschman, Ombudsman*

# HUMAN SERVICES - Public Reports

We issued a public report in February which concluded that another tragedy like the death of teenager Natalie Finn could happen unless Iowa's child-protection workers are given the resources and support they need.




The 160-page report detailed our office's investigation into how the Department of Human Services (DHS) handled child abuse reports about Natalie Finn and her siblings. The 16-year-old girl was emaciated when emergency responders were called to her adoptive family's West Des Moines home in 2016. She died a few hours later at a local hospital.

We found that 14 child abuse reports had been made to DHS on behalf of the Finn children. The first three were made between 2005 and 2009. DHS's records for those three reports were scant or non-existent, due to the agency's policies for maintaining child abuse records. The lack of any meaningful records prevented us from reaching conclusions on the appropriateness of DHS's responses to those three abuse reports. The report criticized those record-retention policies, stating that they hinder DHS workers' ability to identify patterns of abuse.

Much of the report focused on DHS's responses to five child abuse reports made against the family from November 2015 to May 2016. Of those five abuse reports, the first four were rejected by DHS intake staff – meaning those reports were not assigned to field staff for investigation. We concluded that three of those abuse reports should have been accepted for investigation. Included were two abuse reports, made six months apart, from school officials who described Natalie as "starving" and "very thin." Intake staff did not document those descriptions and both abuse reports were rejected.

In reviewing policies in other states, we found that intake workers in Tennessee are required to read their written narrative back to anyone who makes a child abuse report by telephone. Had such a policy been in effect at DHS's child abuse intake unit in 2015-2016, the report stated, "it may have allowed reporters in the Finn case to point out significant errors and omissions, and may have resulted in several intakes being accepted instead of being rejected."

The common concern among the five people who made child abuse reports from November 2015 to May 2016 was that Natalie was not getting enough food at home. *(Continued on page 10)*

*(Continued from page 9)*

But no pattern was noticed until the fifth report, when a DHS worker took a step others did not and reviewed the four prior abuse reports about the Finn family. DHS intake workers are trained to check relevant histories for all abuse reports. The May 31, 2016, abuse report was also the only one of the five that was accepted for investigation. We found a number of serious missteps with how that investigation was handled by field staff: key witnesses were never identified or interviewed; the case was plagued by procedural irregularities; and the case was allowed to languish for extensive periods of time.

According to the report, child abuse call volumes and accepted intakes had increased significantly since Natalie's death. This resulted in a 36 percent increase to field workers' average caseloads from 2016 to 2018. Fortunately, additional funding for field staff was approved in 2019. We also found that the increased call volume was also straining DHS's centralized child abuse intake unit, where the number of intake workers had not increased since 2011.

"Although DHS received funding for the current fiscal year to hire additional field staff, I believe employees remain overworked, especially those in the intake unit," Ombudsman Kristie Hirschman said in the report. "I am seriously concerned that the recent budget increase is insufficient, especially in light of the increasing numbers of abuse reports and investigations since Natalie's death."

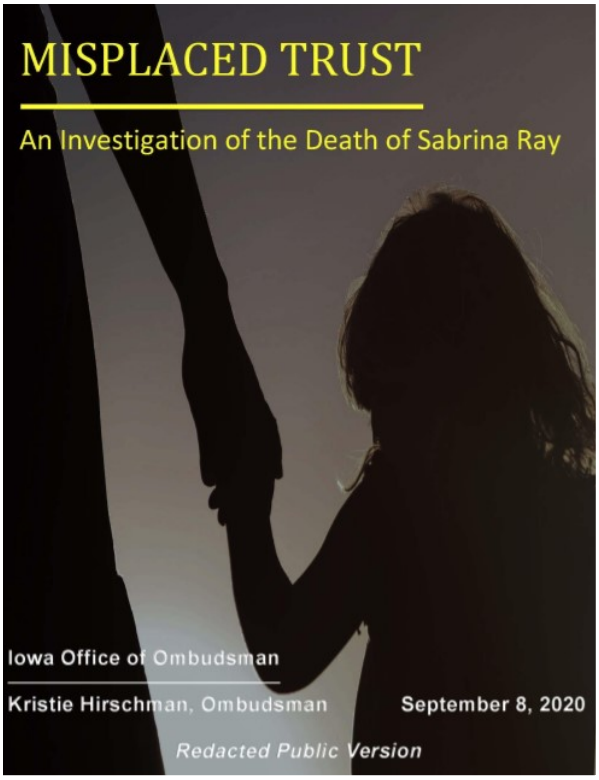
We made 14 recommendations to DHS. Included were recommendations that the agency:

- Conduct a systemic review of the agency's child abuse intake unit operations in light of the Ombudsman's findings.
- Modify its administrative rules to increase the retention period for child abuse intakes and assessments.
- Develop a policy for all intakes received by phone requiring intake workers to read their written narrative of the reporter's statements back to the caller before the conclusion of the call.
- Provide training and written guidance on legal tools available to field workers when faced with resistance from parents.
- Provide training and resources for intake and field staff impacted by secondary trauma, decision fatigue, and other job-related stress.

We also asked the Iowa Legislature to re-evaluate its expectations for the Child Fatality Review Committee and other oversight bodies responsible for reviewing child deaths. The Committee has never convened since it was established in 2000 following the death of 2-year-old Shelby Duis.

According to the report, DHS implemented some systemic changes during our investigation. In response to the report, DHS officials accepted 11 of the 14 recommendations. "This was a tragic case," DHS Director Kelly Garcia wrote. "The Finn children should never have had to endure the treatment they received."

"We will learn from this and improve the safety net DHS provides to Iowa's children," she added. "Some of the work to improve the Department's response began immediately, but a large part of the Department's ongoing efforts will focus on finding better ways to support our team so they can better support the families we serve." The full report can be viewed at https://www.legis.iowa.gov/Ombudsman/




Our second major child death investigation involved the horrific abuse and starvation of a 16-year-old girl in 2017. In a report issued on September 8, 2020, we found that Sabrina Ray's death might have been prevented if DHS workers and contractors had been more diligent and communicated better with one another.

Sabrina was in foster care with Marc and Misty Ray, and was later adopted in 2012. The Rays adopted three other children and fostered a total of 23. The parents also ran an in-home daycare.

DHS had received 11 child abuse reports against the Rays between 2010 and 2015. Several of the allegations lodged against the Rays reported that Sabrina looked extremely thin and unhealthy. It was also alleged that the Rays and others living in the home beat and belittled their adopted children and foster children. None of the 11 abuse reports was founded by DHS staff. Our report found that many of the allegations could have been handled with more vigor, and with greater skepticism of the Rays' explanations.

Some DHS workers noted during their assessments that Sabrina appeared thin, but in interviews with the Ombudsman, they acknowledged a lack of training in recognizing malnutrition. One worker in 2015 checked to see whether Sabrina had visited a doctor about her condition, but closed her investigation before she received a response.

The bedroom where Sabrina died revealed evidence of locks, alarms, and coverings on the doors and windows. However, we found that a DHS daycare inspector failed to check the bedroom just months before Sabrina's death because she misunderstood a policy requiring a complete examination of the house. On the few occasions when suspicious DHS workers discussed further investigation or monitoring of the Rays, there was no follow through. Even more troubling, one foster care contractor who made several abuse reports on behalf of foster children at the Ray home was silenced by her supervisors. She ultimately quit her job in frustration.

We concluded that there were plenty of official eyes and ears on this family; but when it came down to it, there was not sufficient communication among DHS officials. Our report made 13 recommendations to DHS to improve training, communication, and departmental protocols. Ten of the recommendations were accepted. Notably, DHS agreed to explore using medical professionals for consultation on cases. The agency also said it would take steps to ensure that welfare and child regulatory staff are alerted to any allegations of child abuse in the home.

In addition, we also encouraged DHS to ask state leaders for more money if it finds that its daycare licensing unit is understaffed. The full report can be viewed at https://www.legis.iowa.gov/Ombudsman/

# MANAGED MEDICAID

## "Exception to Policy" Confusion

A medical provider contacted our office because they received confusing information from a Managed Care Organization (MCO) and Iowa's Medicaid agency about a request for an "exception to policy."

An "exception to policy" can be used to request an item or service not otherwise covered by Medicaid. Iowa Code section 17A.9A allows Iowa agencies to grant waivers and variances from rule requirements. Prior to Medicaid being administered by the MCOs, exceptions to policy were processed by, and approved or denied by, the Medicaid agency.

Rule waivers and variance requests, as well as the status of requests made to executive branch agencies, can be reviewed on the Iowa Legislature's website at this link.

The provider in this case believed a Medicaid member needed RELiZorb, a single-use, digestive enzyme that helps break down fats. The provider knew RELiZorb was not a covered benefit under Medicaid, so she requested an exception to policy from the member's MCO.

The Medicaid member's MCO told the provider to request the exception to policy from the Medicaid agency. The Medicaid agency, in turn, told the provider that she needed to request the exception to policy from the MCO. The provider contacted our office to assist her in clearing up the confusion and to determine the appropriate process for requesting an exception to policy for the Medicaid member.

Our office contacted both the Medicaid agency and the MCO. The MCO admitted that the provider was incorrectly told by their staff to request the exception to policy from the Medicaid agency. The appropriate procedure is for the request to be initiated through the MCO, then if authorized, it is sent to the Medicaid agency for final approval. The complaint was substantiated against the MCO for erroneously advising the provider about the exception to policy process.

## Unfortunate Surgery Delay

Our office received a call from a woman whose surgery to alleviate severe back pain had been cancelled through no fault of her own. She had received a letter in May indicating she was going to be transferred from one Managed Care Organization (MCO) to another beginning on July 1. Her surgeon contacted her in late June to inform her they needed to hear from her new MCO before her July 11 surgery.

When she called the MCO, she discovered that, because of a system glitch, she had mistakenly been transferred to yet a different MCO. Her surgeon told her he did not take patients from that MCO. At that point, the state agency involved with MCOs reassigned her to an MCO the surgeon did deal with, but this transfer did not take place until August 1. Her surgery was rescheduled for August 29, but the new MCO still had to preauthorize her surgery. The MCO had received the preauthorization request on August 8. They had 14 business days to approve or deny the request but were running two days behind on their reviews. This meant her preauthorization would not be looked at until the day after her scheduled surgery. We asked the MCO if a review could be expedited in light of the fact the woman was guiltless in this whole debacle. The MCO responded to our inquiry the very same day and told us the procedure had been approved.

# MANAGED MEDICAID

## Individual CDAC Provider Complaints Increase; Nearly Half Are Substantiated

The Iowa Home and Community-Based Services (HCBS) Waiver programs are Medicaid programs that the federal government has set aside for "waived" rules. This gives Medicaid members more flexibility about how and where they receive services. The Waiver programs allow many people to remain in their own homes rather than being placed in institutions.

One of the services available to most HCBS Waiver members is Consumer Directed Attendant Care (CDAC). CDAC providers are paid to do things for members that members normally would do for themselves if they could such as getting in and out of bed, getting dressed, cooking, cleaning, and shopping.

Some CDAC providers work for private companies, but 2,443 individual providers are with Iowa's two Managed Care Organizations (MCOs). These individual providers care for individual members, often their own family members. Some individual providers live with the member as well. This means the CDAC provider pay can be income for the entire household, including the Medicaid member. Of the 300 individual CDAC providers that responded to a 2017 survey, 86.42% said they serve only one member and 67.91% of those said the member was a relative.

We received a total of 261 MCO complaints in Fiscal Year 2020. Of those, 100 were fully investigated by the end of the fiscal year. Thirty-three of those cases were substantiated, 16 of which involved CDAC providers. In other words, almost 50% of the cases we substantiated involved a CDAC provider.

The vast majority of the CDAC complaints involved delayed or incorrect payments. MCOs are allowed 30 days to pay claims according to their contracts with the Department of Human Services. Some of the substantiated complaints involved providers going unpaid well beyond 30 days. Others involved claims which were initially denied in error and had to be reprocessed. Yet others involved claims which were delayed due to case managers failing to timely schedule assessments, create service plans, and authorize services. One provider in particular went unpaid for months (even though the case manager knew the provider had been working for the member for many months) because the case manager delayed requesting an assessment and did not have a Care Plan meeting or a CDAC agreement signed with the provider.

Complaints also increased from individual CDAC providers because they were required to use a new form to file their claims. Many providers did not find out about the new form until their claim was denied. Other providers who submitted claims using the new form were repeatedly told by the MCO that the claim was not received. Several providers submitted multiple claims in multiple ways before the MCO finally acknowledged a claim was received.

*(Continued on page 14)*

# MANAGED MEDICAID

*(Continued from page 13)*

We also received complaints from individual CDAC providers who received conflicting and/or confusing information from MCO provider services. Providers were informed through an MCO "provider portal" that their claim was received and processed, but were later informed that their claims had not been received at all.

Of greatest concern was delay-of-payment complaints. The consequences of delays in payment can be severe. Members have reported that their providers quit or threatened to quit because they did not receive regular payment of their claims. Providers reported losing their homes, having their cars repossessed, and/or an inability to buy food and pay their bills. If the member lives with the provider, this means the member also risks losing a place to live, loss of transportation, and food shortages. Multiple providers told our office that, prior to Managed Care, they received regular payments each month within a week or two of submitting claims. Now, many providers complain about waiting nearly 30 days and sometimes longer.

Despite the 30-day claim payment timeframe allowed by contract, our office would like the MCOs to prioritize timely payments to individual CDAC providers. Individual CDAC providers are not a business, and these payments may be their only source of income. This means they often face disastrous consequences if payments are late. It is our hope that these issues can be resolved so that providers are paid correctly and promptly.

Another change looming on the horizon for individual CDAC providers is Electronic Visit Verification (EVV). Beginning January 1, 2021, individual CDAC providers will be required to participate in a process which uses electronic means to verify provider visits. Data will be collected during each visit, including the date of service, the daily duration of the service, the type of service performed, the location where the service is provided, and information about the service provider.

While EVV is a federal requirement, it is up to the MCOs to implement the process and train providers how to use it. Chaos ensued last year from a simple change in forms. Implementation of the EVV process is a much bigger and more challenging project for everyone involved. How will individual CDAC providers be notified about this requirement? Will providers quit rather than participate in this process? Will providers have the necessary technology, especially in rural areas? Will EVV streamline the claims process or add another layer of difficulty to be navigated by individual CDAC providers? Will individual CDAC providers be paid more quickly due to this process or will it be another barrier which lengthens payment of claims? Only time will tell, but we will be here to work through these problems with CDAC providers.

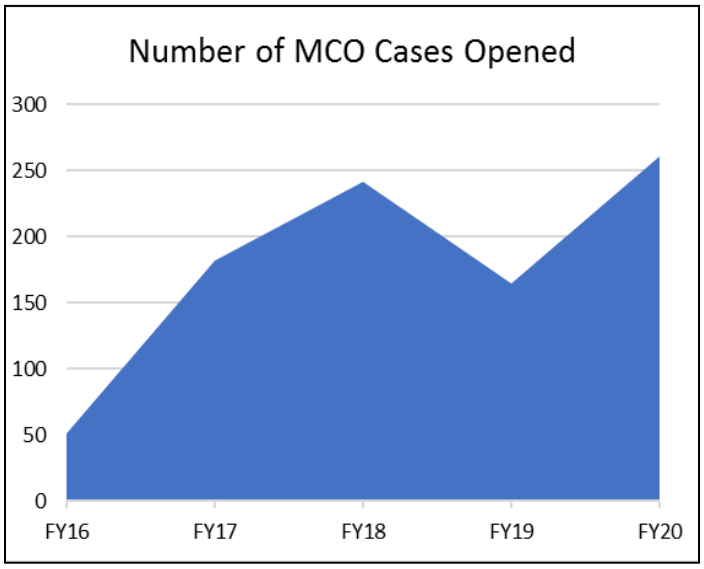
***"Thank you, Thank You, Thank you!!!!!!***

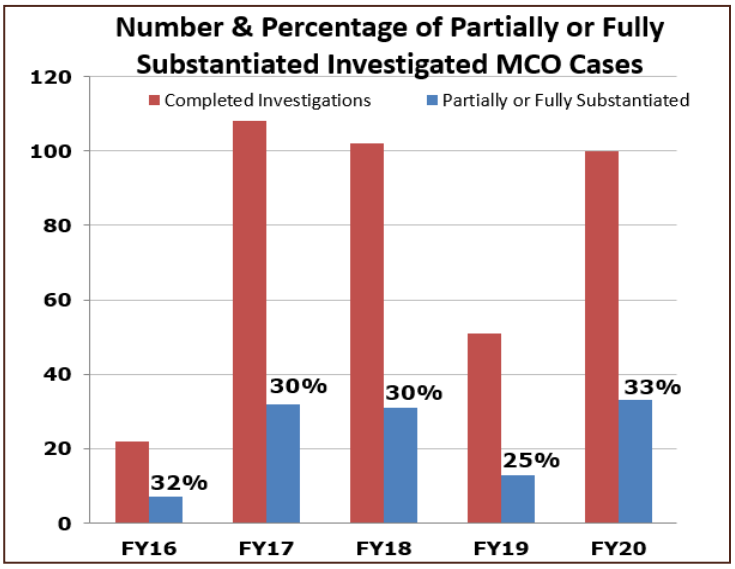
***Everything is so far so good for now.***

***YOU ARE THE BEST ."***

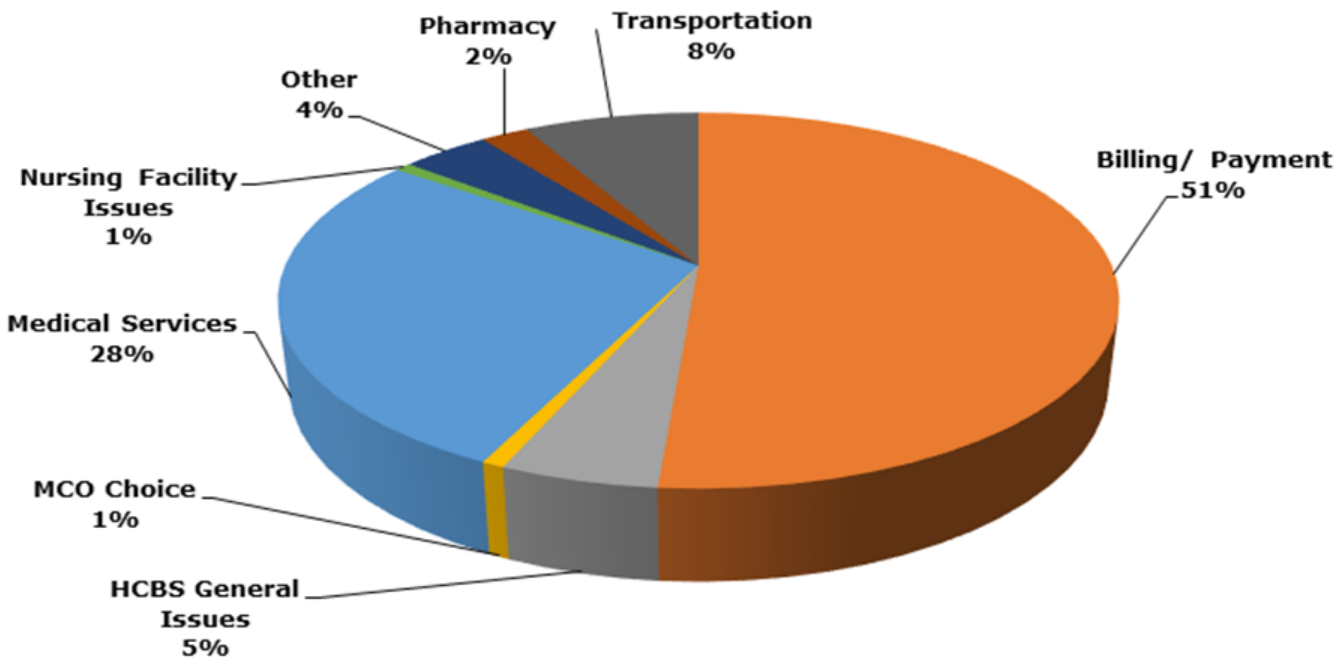
**Managed Care Complainant**

# MANAGED MEDICAID - Statistics




## MCO Cases by Category



# CORRECTIONS AND JAILS

## Understaffing Risks Inmate and Staff Safety


A former county jail inmate complained that jailers did not provide medical attention after a Taser was used on him. In the midst of reviewing the complaint, we identified problems with the jail's staffing and incident reporting practices.

In this case, the primary complaint wound up being the least of our concerns. Even though jailers used a Taser on the complainant, he did not request medical attention after the incident, nor did he suffer any ill effects. We encouraged jail officials to review their policy and confer with their medical provider and the Taser manufacturer to help ensure that necessary safety precautions are taken after the devices are used.

What led up to the use-of-force incident wound up giving us the most concern. The complainant began to kick and elbow the door in his cell and was attempting to cover the camera in his cell. While his erratic behavior escalated, there was only one person working in the jail—a staff member who was cross-trained as a dispatcher and jailer. At this jail, a patrol deputy can be called if it becomes necessary to enter a cell. In this case, however, it took 15 minutes for a deputy to get to the jail while the inmate thrashed about his cell and risked serious injury.

State administrative rules require jails to have adequate personnel available on a 24-hour basis to respond to an emergency such as fires, assaults, suicide attempts, serious illnesses, or to preserve order "within a reasonable period of time." In this case, we did not think a 15-minute response time was reasonable given the complainant's reckless behavior. We also noted that it can take even longer for a deputy to get to an understaffed jail if they are responding to a different emergency elsewhere in the community. Aside from the health and safety implications, this unnecessarily exposes county taxpayers to significant financial risks.

We recommended that the jail should ensure that at least two jailers are in the facility at all times to respond to emergencies. The sheriff's office responded that they had been approved to hire two more full-time jailers, which should help.

We also found that the jail failed to file an incident report with the state jail inspector after force was used on the complainant. State rules require jails to notify the inspector within 24 hours of any death, attempted suicide, fire, escape, injury to staff or prisoners from assaults, use of force, or prisoner self-injuries. There were also nearly a dozen other instances in which this particular jail had failed to file timely incident reports with the jail inspector.

We recommended that the jail review and improve its reporting practices to ensure compliance with state jail standards. Jail officials pledged to follow the recommendation.

# CORRECTIONS AND JAILS

## Make Inquiries, Not Assumptions

After being denied payment for his work, a prison inmate contacted our office for assistance.

The inmate explained that when his work area was closed due to fire damage, he and others who worked with him were told to be available on their units in case they were needed. The inmates were told that they would still be paid. The inmate remained available for a month, but he was denied payment. In the inmate's grievance and two appeals, he provided the name of his work supervisor who had made the payment promise and the name of a staff witness who joked about it being nice to be on salary. The inmate also stated that several other inmates in the same situation were paid. He asked those reviewing his grievance to talk to the staff and review the payment records of the other inmates.

The responses the inmate received from the agency's three-step grievance process claimed there was no evidence to support his claims and that there was no work performed in the fire-damaged area during the dates he was requesting payment. He also was told that incarcerated individuals are paid for actual hours worked and no hours were documented for him. The final response stated his complaint had been thoroughly reviewed, and his appeal was denied.

These responses seemed too vague for the issue to have been thoroughly reviewed as claimed by the agency. Our office found it odd that out of the three denial responses, none mentioned whether the work supervisor or other staff had been questioned, nor did they state that any of the other inmate workers' records had been reviewed. This led us to review the other workers' pay records— we confirmed they had received payment. We shared this finding with the deputy warden and asked him to speak with the staff that told the inmates they would be paid.

Less than 24 hours later, the deputy warden reported to us that the inmate would be paid $101.76. We then contacted all staff who had a role in reviewing the inmate's grievance to inform them that we need to know inmates will get a fair and thorough review. We said that at a minimum, inquiries should be made of staff directly involved. The agency agreed that they should review, inquire, and investigate grievances properly. They said on occasion they "miss the boat," but when they do, if they are made aware of it, they are willing to fix it.


## Lack of Timely Medication Refills

A wife called about her husband having to go a month without his medications while he sat in a county jail. Our office contacted the jail and obtained a list of medications the husband allegedly received. The wife confirmed her husband normally took the listed medications, but the list included several he claimed he had not received. The husband was transferred to prison soon after the wife contacted our office. We reviewed the medical information that the county sent to the prison and were able to confirm the husband went without his thyroid and blood pressure medication for a month.

The problem appeared to be that the jail had failed to refill the husband's outside prescriptions once they had expired. We told the jail administrator and the sheriff that once an offender's prescription refills expire, the jail is obligated to get more medication. The jail administrator and sheriff agreed with our findings.

# CORRECTIONS AND JAILS

## Inmate Denied Timely Decontamination

An inmate complained he was "choking and burning" for nearly an hour because prison staff refused to allow him to shower after they had "sprayed" him with "vapor gas." The chemical agent was Oleoresin Capsicum (OC) and vapor is a term for the delivery method of the chemical agent.

The inmate questioned the legality of exposing someone to OC for kicking their cell door. He also believed the use of force was excessive. He said he was not harming himself or others. The prison's records indicated the inmate had been repeatedly kicking his cell door in a violent/destructive manner. He was given several directives to stop or chemical agents would be used. When he did not stop kicking his door, a short burst of OC was dispensed into his cell to deter him from continuing the perceived destructive action.

Our office did not substantiate the inmate's claim of misuse or excessive force because the inmate's actions could have caused property damage or injury to himself. He had been given specific orders to cease the action and warned what would occur if he did not. There was never any dispute that the inmate had been kicking the door.

Additionally, the inmate claimed he was not allowed to decontaminate with a shower in a timely manner after OC exposure.

Agency policy states that when a person is exposed to OC, they shall be given the opportunity to shower as soon as possible unless evidence will be destroyed. In this case, there was no concern about preserving evidence, so decontamination should have been offered once the inmate complied with being restrained.

According to the records provided to our office, our best calculation was approximately 42 minutes had elapsed from the time the inmate was exposed to OC to the time he was allowed to decontaminate. The explanation the deputy warden gave for this delay was that it takes time to get officers relieved from their assigned posts and assemble an extraction team. However, the deputy warden also said, "The Incarcerated Individual can comply to be restrained with handcuffs at any time in which he would be immediately removed from the cell and decontaminated."

Our office reviewed nine staff reports documenting the incident. There were three officers who had direct contact with the inmate prior to him being moved from his cell. There were no written records or video that indicated the inmate continued to be destructive after he had been exposed to the OC. There were no written records or video evidence that he was violent or a threat to anyone after he was sprayed with OC. There were also no written records or video indicating he was ever given the opportunity to be restrained and removed from the OC contaminated cell until approximately 42 minutes after being OC exposed.

It is our opinion that the inmate should have been asked to comply with being restrained and moved from the cell within minutes after the OC was used and had taken effect.

We substantiated this portion of his complaint and shared our findings with prison administration.

# CORRECTIONS AND JAILS

## Counselor Determined to Have Inmate Discharge

An inmate could not gain his counselor's support for his release despite the fact he had received no disciplinary reports in two years, was assigned to the highest privilege level, completed treatment, held a good prison job, and paid down his restitution. He contacted our office hoping we could find out why.

After we reviewed the inmate's records on the prison database, we too were puzzled. The inmate's release plan only mentioned positive accomplishments and he had already served two years on a work release revocation. The counselor had also staff-initiated him for release a year earlier. Regardless of all of this, it appeared he was now heading toward serving his full sentence. We contacted the deputy warden and asked what the inmate would need to do to gain staff support. We received a lengthy response that highlighted the inmate's previous lack of success on work release 28 months earlier, but still no explanation as to why staff would not support his release.

It is our view that support for release should be based on behavior and programming while incarcerated. After we issued a rebuttal to their rationale for failing to support release, the deputy warden said the counselor would consider placement at a work release facility. Within just a few days, two work release facilities said they would be willing to accept the inmate. Three days later, a release plan was completed supporting his release.

## Brrrrrrrr……

On a Friday afternoon in December, we received a phone call from an elderly man in prison. He was assigned to the infirmary and said all of the rooms for inmates were very cold. He needed two blankets just to stay warm. He said one of the staff told him a few weeks before that they had put in a work order to fix the problem, but nothing ever happened. He added that the head nurse had once brought in space heaters, but they broke the electrical circuit and could not be used anymore.

He said he discussed this situation earlier in the day with a staff member and they promised to check into it. We told the inmate we would wait until the following week to give prison officials a chance to act. The man called us again the next Monday and said nothing had been done. He told us it was even colder due to worsening weather.

We emailed the warden, asked him to check into this, and let us know what he found. The warden responded the next day, stating that a computer had been giving a false temperature reading. "A defective valve was discovered and has been replaced," the warden wrote. "The matter is resolved."

When the elderly man called us back, he said the temperature in his room had risen from 61 degrees to 71 degrees. "So it's good now," he said, and he thanked us for helping to get the problem resolved.

# CORRECTIONS AND JAILS

## Out of State, Out of Mind

We've all heard the phrase "out of sight, out of mind." Well, one prison inmate who was on an Interstate Compact transfer could coin a new phrase: "out of state, out of mind." The inmate felt forgotten when he was transferred out of state to serve his prison sentence. He could not get updated release plans or support for release, despite having gone 14 years without a disciplinary report. An Interstate Compact transfer is when an inmate from one state is accepted into another state for correctional supervision. Though interstate compact inmates reside out of state, Iowa retains responsibility to maintain the inmates' files and to develop accurate release plans.

We reviewed the inmate's release plans and were troubled by a number of entries we found over the last decade. A 2010 release plan stated the inmate was housed in "supermax," long after the facility had dropped that title in 2003. The name of the facility had been changed in response to a lawsuit that condemned the name for its "inflammatory associations." We believed the phrasing used in his release plans also implied his ongoing housing in "supermax," which was inaccurate.

His 2010 release plan also included a statement that he had completed programs but did not internalize what he had learned. That particular statement was made four years earlier in 2006 by a counselor at the out-of-state prison. It further noted that he had been removed from programming and returned to "supermax." That move had actually occurred in 2003. No dates were provided with the incidents when they were placed in the release plans, though dates were documented in the out-of-state records. We believe these statements gave the false impression the inmate was currently having problems.

Several more recent release plans read identically, and appeared to have been cut-and-pasted, even though Iowa had classification reports from the other state documenting the inmate's progress. A 2013 release plan did not include information that the inmate had completed over 10 different programs and had been disciplinary report-free for almost nine years. His 2014 release plan also stated his need to demonstrate an appropriate behavioral pattern. This was absurd since he had been disciplinary report-free for over 10 years. In 2018, his release plan did finally state he had been discipline-free since 2004, but it also said he would remain in maximum custody. We felt Iowa had a duty to find out why he remained in maximum custody after having been discipline-free for 14 years.

According to agency policy, the primary case manager is responsible for maintaining an inmate's file. There did not seem to have been a file "maintained." There were only four classification reports from the other state saved in 19 years. That same policy described the supervision of cases from other states and mandates that progress reports be completed and scanned into the database twice a year. We found no similar language for Iowa offenders transferred to other states, but the expectation should be the same.

The agency said the handling of this inmate's case was not representative of their overall work. Regardless, it was a dreadful failure, that we believe contributed to a delay in the inmate receiving a parole.

*(Continued on page 21)*

# CORRECTIONS AND JAILS

*(Continued from page 20)*

For this reason, our office will monitor release plans for compact cases until we are comfortable these cases are being given the same quality of care that those housed in Iowa receive.

We also suggested to the agency that information in release plans should:

- Be reflective of behavior since the completion of the previous plan.
- Avoid slang, obsolete and/or inflammatory language.
- Include dates of incidents/observations.
- Avoid cutting and pasting content from the previous plan.
- Include recommendations based on behavior and programming requirements.

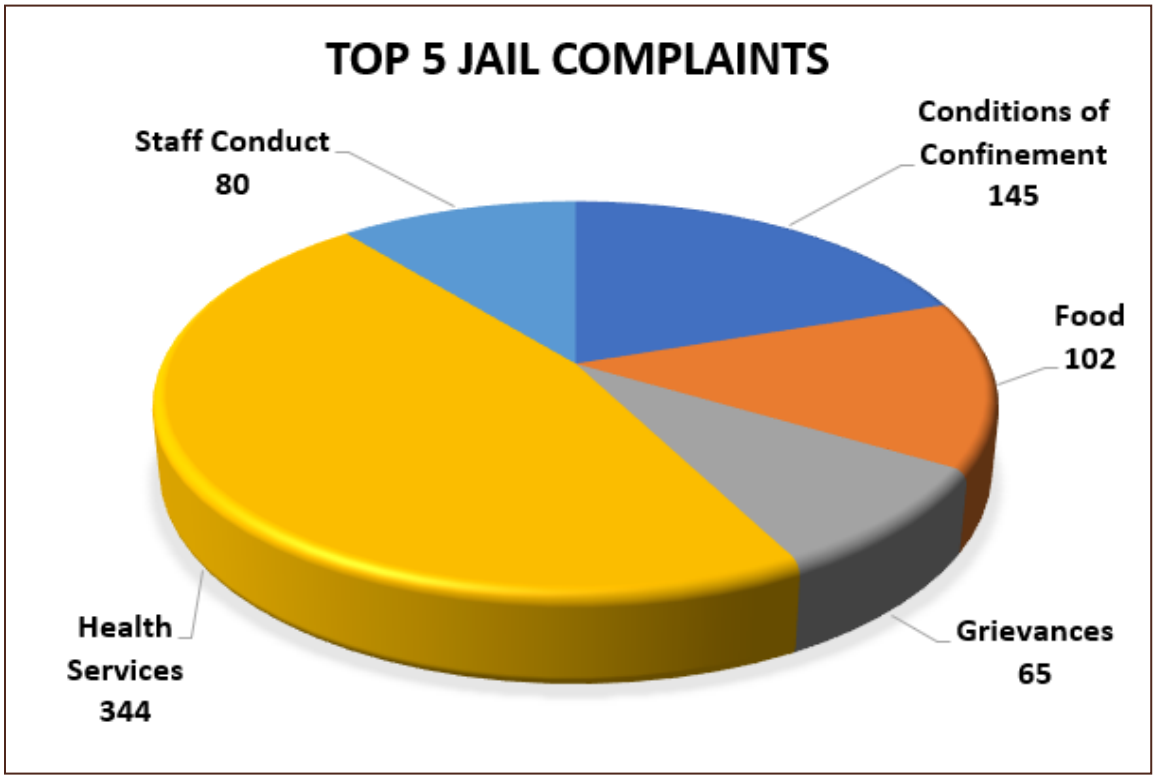
In addition, we suggested that the agency:

- Ensure progress reports are received from other states twice a year.
- Schedule a classification review with the offender annually, which the offender may participate in by phone or some other live electronic means, just as if the offender is in Iowa.
- Save all information received about the offender from the compact state in the database unless it is deemed confidential.

## Mail Thrown, Not Stored

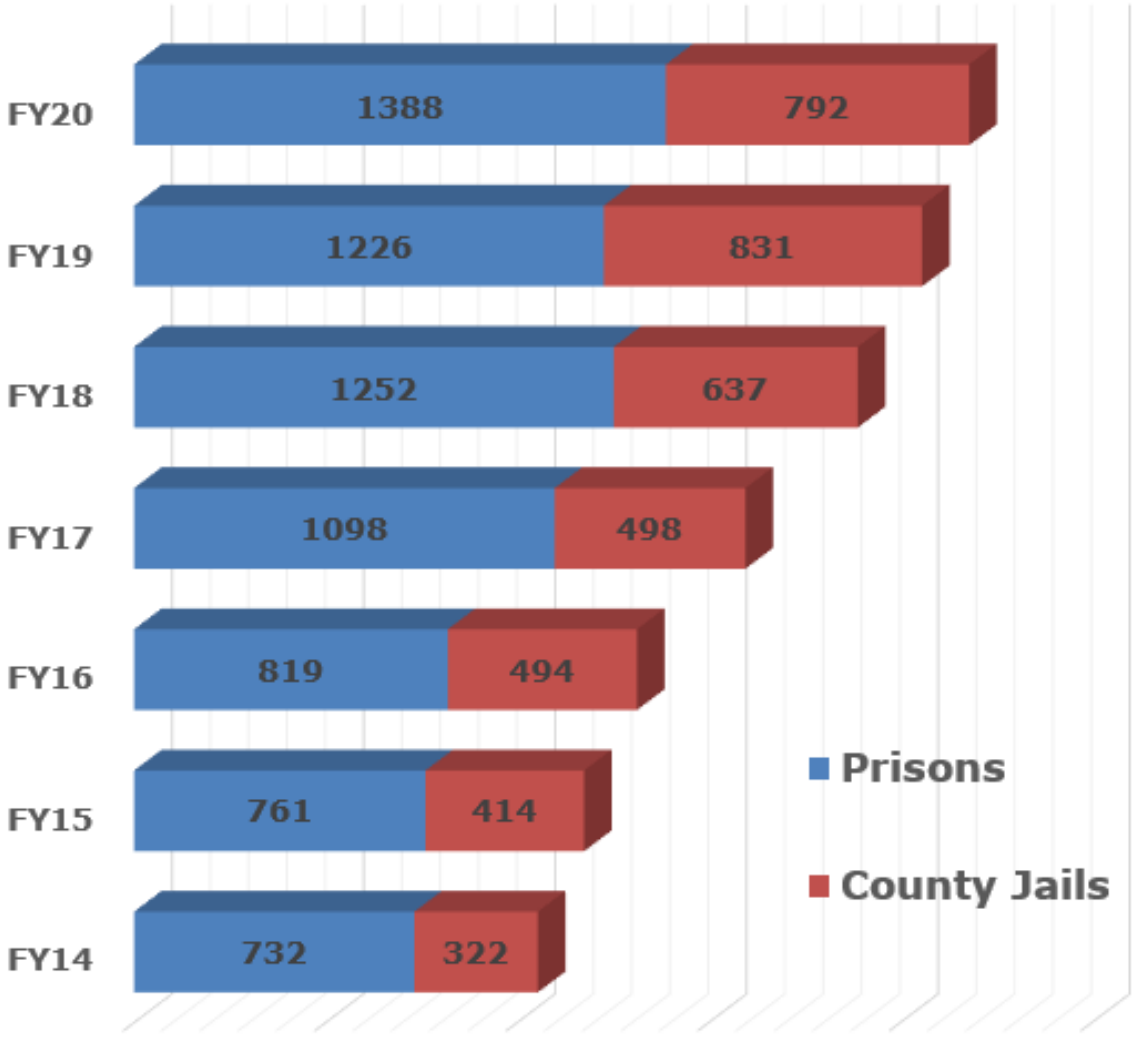
Multiple inmates under a mail restriction at one Iowa prison filed complaints with our office after they were told they must pay for mail to be sent back out, or have the mail thrown away. Prison policy requires that contraband items – items that are not specifically authorized by policy – be thrown away or mailed out. Since the mail would otherwise be allowed if the inmate had not been on a mail restriction, we do not believe it could now be considered contraband. We inquired with the deputy director and ultimately prison officials agreed to modify their practice and policy. Now when an inmate is on a mail restriction, his incoming mail is stored in their property until the restriction is lifted. We were told that this is in line with other prisons' procedures and practices.

# CORRECTIONS AND JAILS - Statistics

# CORRECTIONS AND JAILS - Statistics

## NUMBER OF PRISON AND COUNTY JAIL COMPLAINTS



# LOCAL GOVERNMENT

## Not Getting What You Paid For

A central Iowa man appealing two property-tax assessments asked county officials for a record of all the time and cost they had incurred in pressing their case against him. A county attorney told the man the request would cost him about $75, which included an hour of legal review. The man bristled at the quote, but reluctantly agreed to pay it – only to find when the records arrived that they were not what he had requested. The man protested, but was told nothing could be done about the fee. We reviewed the man's request and the information he was given, and it was clear to us that there had been a misunderstanding. In speaking with the county assessor and detailing the terms of the man's request, the assessor agreed. In reality, the office had very few records to offer that were responsive to the man's request. The assessor admitted that his staff had not sought clarification on the specifics of the man's records request, and he offered the man a full refund.

## Lights Out Without Notice

A scared and frustrated citizen was referred to this office after her electricity was disconnected without notice on November 19. The citizen thought she was signed up for Low Income Home Energy Assistance Program, otherwise known as LIHEAP. We made an inquiry the same day and learned that the citizen had not applied for LIHEAP this heating season. As a result, she was not protected by the moratorium.

We noticed, however, that the city had not notified the customer before disconnecting her service. The city argued no notice was required under the citizen's payment agreement. We found this practice was contrary to Iowa Utility Board rules and the city's own policies, which are intended to allow a customer an opportunity to pay before disconnection. The customer applied anew for LIHEAP and was able to get reconnected the following day.

## Missing Words Create Confusion About Council Vacancy

When a city council member resigns his or her term early, Iowa law allows councils to either appoint a replacement or hold a special election for the empty seat. If a council chooses to make an appointment, it must publish a notice that informs the public it has a right to petition for an election instead.

We heard from a citizen in a small central Iowa town who knew that the council had a vacancy. The citizen saw the city's notice in the newspaper, but the notice had omitted a key part of the law pertaining to the timing of a petition. After reviewing the notice and the law, we agreed that the error could confuse voters about when a petition would be due.

We brought the omission to the attention of the mayor. Shortly thereafter, we received a call from the city attorney who acknowledged the mistake and asked for our proposal on a remedy. We suggested that the city re-run the notice to give citizens another chance to petition for an election if they wanted one. The city attorney seconded our suggestion, and the city ran a corrected notice.

# LOCAL GOVERNMENT

## Non-Utility Fines vs. Utility Services

A city required that all fees and fines one customer owed the city be paid before water service would be restored to their property. Residents of the property owed the city multiple fines related to their aggressive dog, which repeatedly got loose. The city eventually impounded and euthanized the dog. The residents were fined for violations of the city ordinances and billed for the costs to shelter and euthanize the dog.

Several months later, the residents' water was shut off due to non-payment. When they inquired about the total due to have the water reconnected, they were told all fines and fees associated with their dog must be paid before the water could be reconnected.

Our review of Iowa law and the city's ordinances showed the city was not permitted to require payment of non-utility fines before turning water back on. The city administrator agreed with our findings. The city permitted the residents to pay the past-due water bill amounts and reconnection fees to have water services restored. The city decided to pursue other avenues for the collection of the dog fines and agreed to enter into payment negotiations with the residents for those fines.

## Details Matter

A citizen in northeast Iowa alleged that city officials stole a work truck that was parked on his business property. The complainant further claimed that the city did not notify him of an alleged nuisance before they towed the truck, nor did they grant his request for a hearing so he could plead his case. The complainant's efforts to recover the truck were reportedly unsuccessful and although it had not been driven in quite some time, he claimed it was still worth at least $10,000.

We advised the complainant that we could not order the city to compensate him, but we could encourage them to negotiate to avoid a legal battle if we determined that something improper occurred.

We inquired with the city to learn more. The complainant and city officials agreed that notice of the illegally parked truck was served roughly five years earlier. However, the complainant reportedly spoke with the mayor at the time and was told "not to worry about it." Had city officials wanted to take further action under the ordinance cited at the time, they should have followed the abatement procedures outlined in their municipal code. City officials could not document that they had taken any further action.

When city officials eventually had the truck towed, they invoked a different ordinance than what had been cited five years earlier. They also could not prove that they had followed the law, which requires notification and the opportunity for a hearing.

We determined that the city had justification to tow the truck because it was parked on the public right of way for numerous years and appeared to lack current registration. However, city officials eventually acknowledged that they could not prove that they had followed their own ordinance or state law. Therefore, we encouraged city officials to contact the complainant to discuss compensation. Unfortunately, we later learned that discussions broke down and the complainant sued the city.

The lesson in this situation is that even if city officials identify a legitimate nuisance, they must follow their own ordinances and state law before they take enforcement action.

# LOCAL GOVERNMENT

## Uh, Remember That Bill You Never Paid …

## 15 Years Ago?!

Imagine how horrified you would be if you received an unexpected bill in the mail from the government for $5,000. That's what happened to a man in a small town in south-central Iowa last spring.

The letter said he owed the city money for unpaid water, sewer, and electric bills that dated back at least 15 years. The man's daughter explained to us that the bill was accumulated by his ex-wife after he had moved out of their apartment. The bill was apparently sent to him because his name was on the account and he still lived in town.

The man recalled that he had pleaded his case to the City Council on the unpaid bill years earlier—but had never heard anything back. He had assumed this meant the Council had forgiven the bill.

At our urging, the man again spoke to the Council about the circumstances of the case. The city, in response, said it could find no record of the Council's past decision and restated its intention to collect the bill through a seizure of the man's anticipated state tax refund.

We requested documentation from the city that would prove the amounts and the dates of the old bills. A city official explained that many of the records no longer existed. The official added that the city was attempting to collect on a host of bills that a previous city clerk had allowed to go unpaid for years. Cities typically shut off delinquent utility customers within a matter of weeks or months.

Although we understand that cities (especially small cities) rely on bill payments to maintain their utilities, we had serious reservations about the city attempting to collect a bill so old, and without evidence of the city's calculations. Our research of state laws suggested that municipal utility bills in Iowa might not be legally collectible after five years.

After considerable discussion with various authorities, the city grudgingly agreed to cease its collection efforts in the matter. Although we felt the resolution was fair to the customer, the case also highlighted the importance of recordkeeping and timely bill collection for cash-strapped city utilities.

# OTHER AGENCIES

## Our Mistake is Your Problem?

A certified public accountant called us in desperation after he was told nothing could be done to rectify a tax problem his client encountered through no fault of his own.

The accountant said he had mailed his client's tax bill on time, and in full. To his surprise, his client later received notice that the payment was never received, and he now owed penalties and interest. After the accountant complained, an internal investigation discovered that a bin of timely payments had been misplaced by state workers. However, despite the mistake, the state insisted that penalties and interest must be paid.

We shared this information with a supervisor who said he was befuddled by his staff's response. He said it had long been the agency's policy to waive penalties and interest under such circumstances. After some inquiries, the agency changed course on the matter and informed about 10 taxpayers that no additional payments would be needed.

We later heard from two other accountants who encountered similar problems. We referred them to the same agency supervisor to resolve their disputes.

## Licensing Board Dismisses Complaint Prematurely

It is common for our office to receive complaints against state boards when they decline to discipline licensed professionals for alleged malpractice or misbehavior. These boards have traditionally given considerable leeway to professionals such as doctors or engineers when the treatment or service they provide falls within a reasonable standard of care.

Because we are not trained in the various specialties overseen by these boards, we typically defer to the boards' judgments. But we usually try to ensure that the boards make a good-faith effort to investigate the complaints they receive and formulate a logical basis for their dismissal of complaints.

One such complaint came to our attention after a man claimed he was wrongly committed to a mental hospital for two days. In reviewing the details of the complaint, we understood why there could have been concerns about the man's mental health. However, the man later made arguments to a district court judge that the committal was unlawful – and the judge agreed with him. This meant that the committal should never have happened.

The man referenced this important court decision in his complaint to the state licensing board against the hospital worker that had him committed. But it appeared that the board did not read the decision before it dismissed the man's complaint.

*(Continued on page 28)*

# OTHER AGENCIES

*(Continued from page 27)*

We were concerned that the worker who sought the committal may never have learned that his actions were unlawful. During the course of our investigation, we also discovered that a second person had consented to the improper committal. We pressed the licensing board to reconsider its dismissal and to open an investigation of the second worker.

The board did ask a separate licensing board that had jurisdiction over the second worker to open an investigation. However, it said it was barred from reopening the complaint it had already closed, or from notifying the worker of the law on committals. We were dissatisfied with the board's response and asked it to rewrite its rules to allow such notifications in the future.

*"I am so relieved. I could just sit in a corner and cry in relief. It's been so stressful. You have restored my faith, you really have."*

Happy Customer

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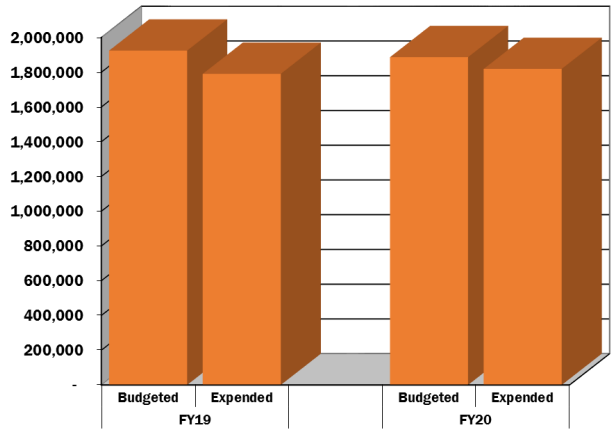
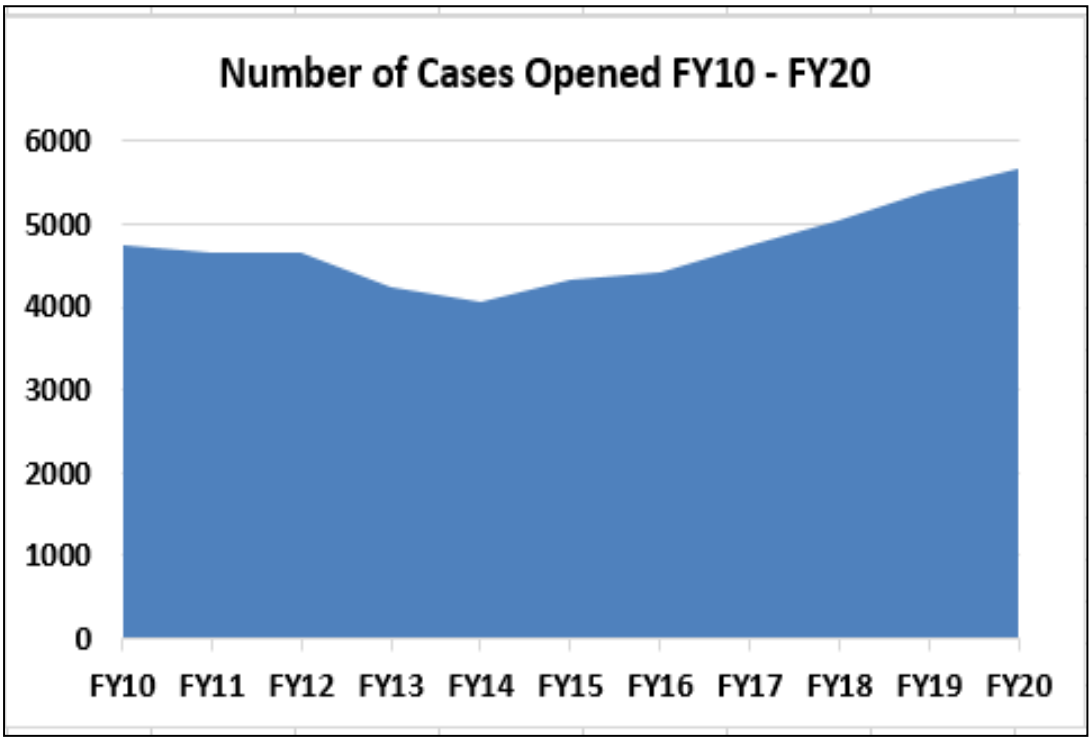
**Office of Ombudsman**

**FY19 and FY 20 Financial Information**

***Presented to meet the requirement that state government annual reports to the Legislature include certain financial information.***



# STATISTICS


Number of Cases Opened FY10 - FY20
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5000
4000
3000
2000
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0
FY10
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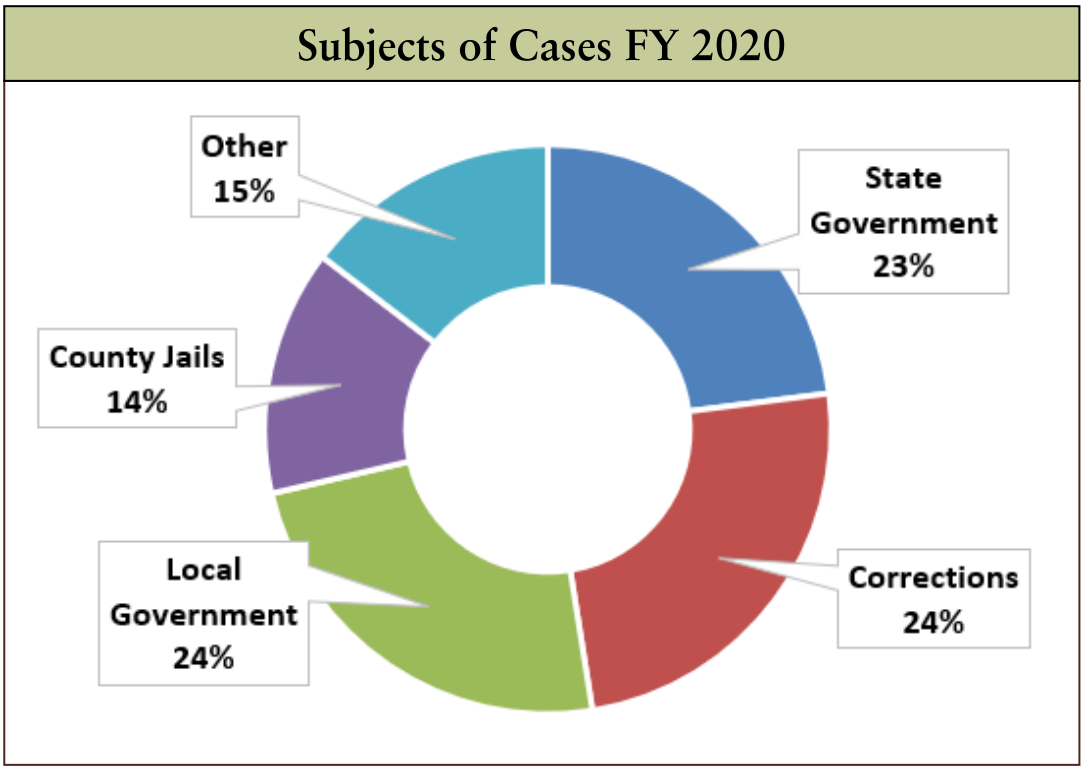
FY19
FY20


Subjects of Cases FY 2020
Other 15%
State Government 23%
County Jails 14%
Local Government 24%
Corrections 24%

| Agency | Jurisdictional Complaints | Information Requests | Non-Jurisdictional Cases | Total | Percentage of Total |
|---|---|---|---|---|---|
| **State Government** | | | | | |
| Administrative Services | 8 | 1 | 0 | 9 | 0.16% |
| Aging | 1 | 54 | 0 | 55 | 0.97% |
| Agriculture & Land Stewardship | 4 | 0 | 0 | 4 | 0.07% |
| Attorney General/Department of Justice | 10 | 7 | 0 | 17 | 0.30% |
| Auditor | 1 | 0 | 0 | 1 | 0.02% |
| Blind | 4 | 1 | 0 | 5 | 0.09% |
| Civil Rights Commission | 6 | 0 | 0 | 6 | 0.11% |
| College Aid Commission | 0 | 0 | 0 | 0 | 0.00% |
| Commerce | 8 | 4 | 0 | 12 | 0.21% |
| Corrections | 1348 | 40 | 0 | 1388 | 24.50% |
| County Soil & Water Conservation Districts | 0 | 0 | 0 | 0 | 0.00% |
| Cultural Affairs | 0 | 0 | 0 | 0 | 0.00% |
| Drug Control Policy | 0 | 0 | 0 | 0 | 0.00% |
| Economic Development | 0 | 1 | 0 | 1 | 0.02% |
| Education | 3 | 1 | 0 | 4 | 0.07% |
| Educational Examiners Board | 0 | 0 | 0 | 0 | 0.00% |
| Ethics and Campaign Disclosure Board | 0 | 0 | 0 | 0 | 0.00% |
| Executive Council | 0 | 0 | 0 | 0 | 0.00% |
| Human Rights | 1 | 0 | 0 | 1 | 0.02% |
| Human Services | 617 | 31 | 0 | 648 | 11.44% |
| Independent Professional Licensure | 3 | 0 | 0 | 3 | 0.05% |
| Inspections & Appeals | 17 | 4 | 0 | 21 | 0.37% |
| Institute for Tomorrow's Workforce | 0 | 0 | 0 | 0 | 0.00% |
| Iowa Communication Network | 0 | 0 | 0 | 0 | 0.00% |
| Iowa Finance Authority | 1 | 0 | 0 | 1 | 0.02% |
| Iowa Lottery | 1 | 0 | 0 | 1 | 0.02% |
| Iowa Public Employees Retirement System | 0 | 0 | 0 | 0 | 0.00% |
| Iowa Public Information Board | 3 | 0 | 0 | 3 | 0.05% |
| Iowa PBS | 0 | 0 | 0 | 0 | 0.00% |
| Law Enforcement Academy | 0 | 0 | 0 | 0 | 0.00% |
| Management | 1 | 2 | 0 | 3 | 0.05% |
| Municipal Fire & Police Retirement System | 0 | 0 | 0 | 0 | 0.00% |
| Natural Resources | 6 | 0 | 0 | 6 | 0.11% |
| Office of Ombudsman | 5 | 46 | 0 | 51 | 0.90% |
| Parole Board | 65 | 8 | 0 | 73 | 1.29% |
| Professional Teachers Practice Commission | 0 | 0 | 0 | 0 | 0.00% |
| Public Defense | 1 | 0 | 0 | 1 | 0.02% |
| Public Employees Relations Board | 0 | 0 | 0 | 0 | 0.00% |
| Public Health | 8 | 4 | 0 | 12 | 0.21% |
| Public Safety | 12 | 0 | 0 | 12 | 0.21% |
| Regents | 17 | 0 | 0 | 17 | 0.30% |
| Revenue & Finance | 33 | 5 | 0 | 38 | 0.67% |
| Secretary of State | 1 | 1 | 0 | 2 | 0.04% |
| State Fair Authority | 0 | 0 | 0 | 0 | 0.00% |
| State Government (General) | 130 | 51 | 0 | 181 | 3.20% |
| Transportation | 35 | 4 | 0 | 39 | 0.69% |
| Treasurer | 1 | 0 | 0 | 1 | 0.02% |
| Veterans Affairs Commission | 3 | 0 | 0 | 3 | 0.05% |
| Workforce Development | 63 | 8 | 0 | 71 | 1.25% |
| **State Government - non-jurisdictional** | | | | | |
| Governor | 0 | 6 | 16 | 22 | 0.39% |
| Judiciary | 0 | 12 | 140 | 152 | 2.68% |
| Legislature and Legislative Agencies | 0 | 5 | 19 | 24 | 0.42% |
| Governmental Employee-Employer | 0 | 2 | 6 | 8 | 0.14% |
| **Local Government** | | | | | |
| City Government | 599 | 25 | 0 | 624 | 11.02% |
| County Government | 1066 | 19 | 0 | 1085 | 19.15% |
| Metropolitan/Regional Government | 17 | 1 | 0 | 18 | 0.32% |
| Community Based Correctional Facilities/Programs | 383 | 19 | 0 | 402 | 7.10% |
| Schools & School Districts | 17 | 0 | 0 | 17 | 0.30% |
| **Special Projects** | | | | 33 | 0.58% |
| **Non-Jurisdictional** | | | | | |
| Non-Iowa Government | 0 | 11 | 81 | 92 | 1.62% |
| Private | 0 | 33 | 465 | 498 | 8.79% |
| **Totals** | **4499** | **406** | **727** | **5665** | **100.00%** |

# STAFF

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