Quarterly Report from the HHS Ombudsman Managed Care Assistance Team 1st Quarter FY 2019

As Required by

Section 531.0213 of the

Government Code

Office of the Ombudsman

July 2019

TEXAS
Health and Human Services

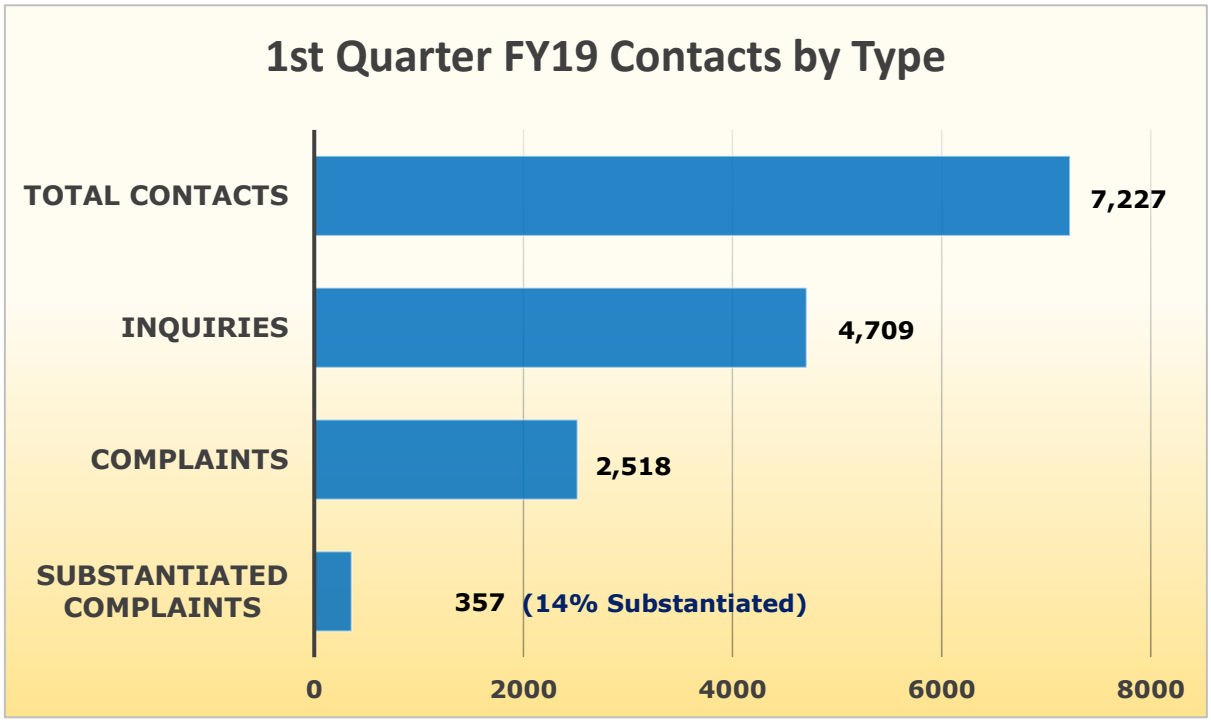
Table of Contents

Executive Summary

In accordance with Government Code Chapter 531, Section 531.0213(d)(5), the Health and Human Services Commission is required to collect and maintain statistical information on a regional basis regarding calls received by the Ombudsman Managed Care Assistance Team (OMCAT) and publish quarterly reports that: list the number of calls received by the region; identify trends in delivery and access problems; identify recurring barriers in the Medicaid system; and indicate other problems identified with Medicaid managed care.

The data provided in this report is exclusive to contacts received by OMCAT and does not include contacts received by any other areas within Health and Human Services (HHS).

OMCAT received 7,227 contacts during the first quarter of fiscal year 2019; of these contacts, 2,518 were complaints and 4,709 were inquiries. OMCAT resolved 2,514 complaints and 4 were still being worked into the second quarter of fiscal year 2019. Of the complaints that were resolved, 357 were substantiated, 392 were unsubstantiated, and 1,765 were unable to be substantiated (e.g. there was not enough evidence to make a determination as to whether agency policy or expectations were violated).



The most common reasons for complaints received by consumers during the first quarter of fiscal year 2019 were related to:

- Access to prescriptions,
- Medicaid eligibility and recertification,
- Third Party Resources,
- Balance billing issues, and
- Access to long term services and supports (LTSS).

This report contains recommendations to mitigate issues related to consumer access to prescriptions and outdated or erroneous third-party resources. These are the two most frequent and ongoing barriers to care that drive Medicaid managed care consumers to contact OMCAT. Often these issues happen in conjunction. If a pharmacy shows erroneous insurance information, then the authorization for the medication is held up until that insurance is removed from the system since other insurance must be billed first before Medicaid can pay. Prescriptions are the only Medicaid benefit where the payment must be guaranteed before they can be provided.

The report also highlights two issues identified during the first quarter of fiscal year 2019. The first was a trend identified in September 2018, regarding a Managed Care Organization's (MCO) pharmacy system that contained erroneous information of Medicare coverage for many of its consumers. The second issue identified in October 2018, involved a durable medical equipment (DME) provider that sent letters to its consumers on Medicaid and the Children's Health Insurance Program (CHIP) stating that an MCO would reduce their services by 50 percent. The report will discuss how OMCAT collaborated with the Managed Care Compliance Operations area (MCCO) within the Medicaid & CHIP Services Division to address these problems.

1. Introduction

Government Code Chapter 531, Section 531.0213(d)(5), directs OMCAT to publish quarterly reports that provide quantitative contact data, highlights trends, and identifies issues affecting Texans who receive or inquire about Medicaid benefits and services through HHS programs and their vendors.

The report provides high-level information regarding consumer inquiries and complaints reported to OMCAT during the first quarter of fiscal year 2019. It provides data and analysis of the contacts received by OMCAT, identifies barriers and problems with the managed care system, and provides recommendations to address the most frequent complaints. The report includes contacts from consumers on Fee for Service Medicaid, Medicaid managed care, and those who do not have any Medicaid benefits at the time of contacting OMCAT.

The contact data in this report provides analysis regarding:

- total number of inquiries and complaints received,
- types of inquiries and complaints received,
- top complaints by entity against which the complaints are made,
- number and types of inquiries and complaints by region and managed care delivery model,
- number of complaints resolved that were substantiated, and
- summaries of cases that illustrate relevant patterns or trends.

Background

Government Code 531.0171 requires the HHS Office of the Ombudsman to provide dispute resolution services for the health and human services system and perform consumer protection and advocacy functions related to health and human services. This assistance includes assisting a consumer or other interested person with raising a matter within the health and human services system that the person feels is being ignored, obtaining information regarding a filed complaint, and collecting inquiry and complaint data related to the health and human services system.

The Medicaid Managed Care helpline began operations on January 2, 2001, under a non-profit organization, Texas HEART, contracted by the Texas Department of Health. On September 1, 2007, HHSC transitioned the helpline into the HHS Office of the Ombudsman. The helpline was originally created during the 74th Texas Legislative Session through SB 601, which required HHSC to operate a helpline to assist consumers with urgent medical needs who experience barriers to receiving Medicaid and Medicaid managed care services.

OMCAT receives contacts from the public via a toll free helpline and an online submission form, which can be accessed at hhs.texas.gov/managed-care-help. Contacts are captured in the HHS Enterprise Administrative Report and Tracking System (HEART), a web-based system that tracks inquiries and complaints for a number of HHS programs. HEART tracks consumer specific information, consumer issues, regional and program data, as well as the findings and resolutions of OMCAT investigations.

Message from the Managed Care Ombudsman

This is the first of what will be an ongoing series of publicly available quarterly reports that OMCAT will be publishing on its website at hhs.texas.gov/managed-care-help.

This report offers our program an opportunity to identify and highlight trends and emergent issues reported by consumers who contact our office. The report contains regional data, Medicaid program specific data, as well as recommendations that the Office of the Ombudsman has for resolving problem trends. It should be noted that the data in this report only represents contacts received by OMCAT. Therefore, it will not include all Medicaid managed care complaints received by the agency, vendors, or MCOs during the quarter.

OMCAT is comprised of highly trained and experienced professionals who, collectively, possess 35 years of Medicaid managed care experience. As ombudsmen, staff educate consumers on their rights and responsibilities, help consumers navigate the Medicaid managed care system, and resolve complaints. OMCAT consumers investigate consumer complaints, determine compliance with state and agency rules and policies, determine if agency expectations were met, and provide recommendations for resolution with the goal of preventing future occurrences.

OMCAT welcomes feedback from stakeholders to improve this report in its ability to paint the picture of Medicaid consumer experiences.

OMCAT In Action

During the first quarter of fiscal year 2019, OMCAT identified a DME provider which mailed letters to its consumers stating an MCO would reduce consumers' Medicaid and CHIP benefits by 50 percent as of November 21, 2018. In this letter, the DME provider also encouraged its consumers to change health plans to avoid this reduction in services. OMCAT received numerous contacts from concerned consumers who used this DME company regarding this letter. OMCAT staff advised consumers that there would be no reduction in services and immediately notified Managed Care Compliance Operations (MCCO), the area at HHSC that has oversight of MCO contracts, of the letter. MCCO contacted the MCO, which then sent a cease and desist order to the DME provider.

Contacts and Complaints

Contact Data Analysis - Total Contacts

OMCAT received 7,227 contacts in the first quarter of fiscal year 2019. Total contacts include general inquiries and complaints from consumers, legislative staff on behalf of consumers, and other stakeholders related to Medicaid benefits and services.

Inquiry Data Analysis

OMCAT received 4,709 inquiries in the first quarter of fiscal year 2019.

Top 10 Inquiries

The top ten inquiries listed below represent 65.6% (3,091) of the total number of inquiries received during the first quarter of fiscal year 2019.

Inquiry Reason	Count	Percent of Total
Verify Health Coverage	625	13.3%
Access to PCP/Change PCP	440	9.3%
Caller Disconnected/Did not Respond *	333	7.1%
Explanation of Benefits/Policy	329	7.0%
Apply for Health Coverage	316	6.7%
Access to Long Term Services and Supports (LTSS)	287	6.1%
Reporting Change	238	5.1%
Other/NA**	192	4.1%
Access to Adult Dental	168	3.6%
Change Plan	163	3.5%

*Inquiries described as caller disconnecting or not responding refer to calls where the consumer could not be heard on the line, the caller could not hear the OMCAT agent, or the call disconnected before the caller explained the issue. Disconnects were not due to known technical issues.

** Other/NA refers to inquiries that did not match already defined inquiry reasons.

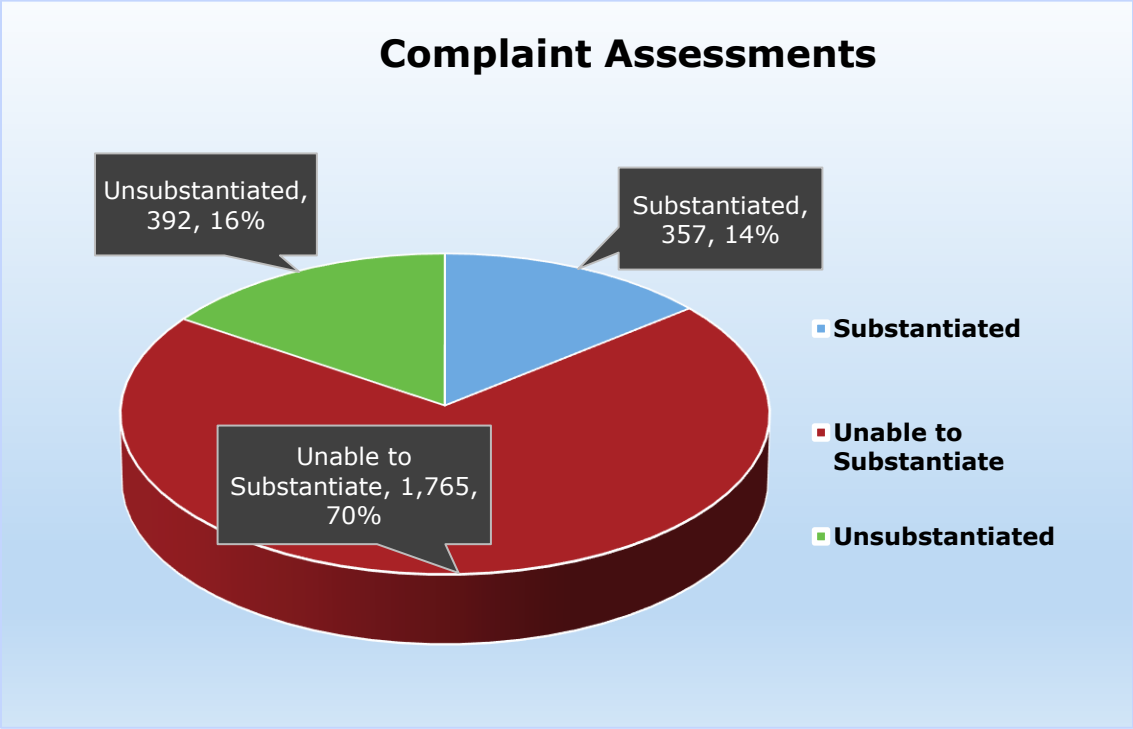
Complaint Data Analysis

OMCAT received 2,518 complaints in the first quarter of fiscal year 2019.

Substantiated Complaints (357)

OMCAT found 14 percent of consumer complaints substantiated during the first quarter of fiscal year 2019. Complaints include those received by consumers on Fee for Service Medicaid, Medicaid managed care, and by consumers applying for or whose Medicaid has lapsed.

One explanation of the large number of cases OMCAT is not able to substantiate is that many consumers have not attempted to resolve their complaint with the MCO or appropriate HHS program area first before contacting OMCAT. In accordance with the statute that created OMCAT (Sec. 531.0213), OMCAT team members are required to educate consumers so they can advocate for themselves. When consumers are educated on how to file their complaint with the appropriate area, this results in an initial referral to health plan or appropriate HHS program. In these cases, OMCAT will not have the final resolution to the complaints and therefore cannot determine if the complaints were substantiated or not.



Four complaints are still pending from the first quarter of fiscal year 2019 which is why they are not represented in the chart.

Substantiated: a complaint where research clearly indicates agency policy was violated or agency expectations were not met. (Example: Consumer complains that their home health attendant did not show up for duty. Research shows that the home health agency confirmed that the attendant was not able to work that day.)
Unable to Substantiate: a complaint where research does not clearly indicate if agency policy was violated or agency expectations were met. (Example: Consumer has a complaint about accessing medical services and is referred to their MCO to address the complaint since they have not yet tried to work with their MCO.)
Unsubstantiated: a complaint where research clearly indicates agency policy was not violated or agency expectations were met. (Example: Consumer complains that that their prescription was rejected at the pharmacy. Research shows that the consumer is not yet due to refill that prescription.)

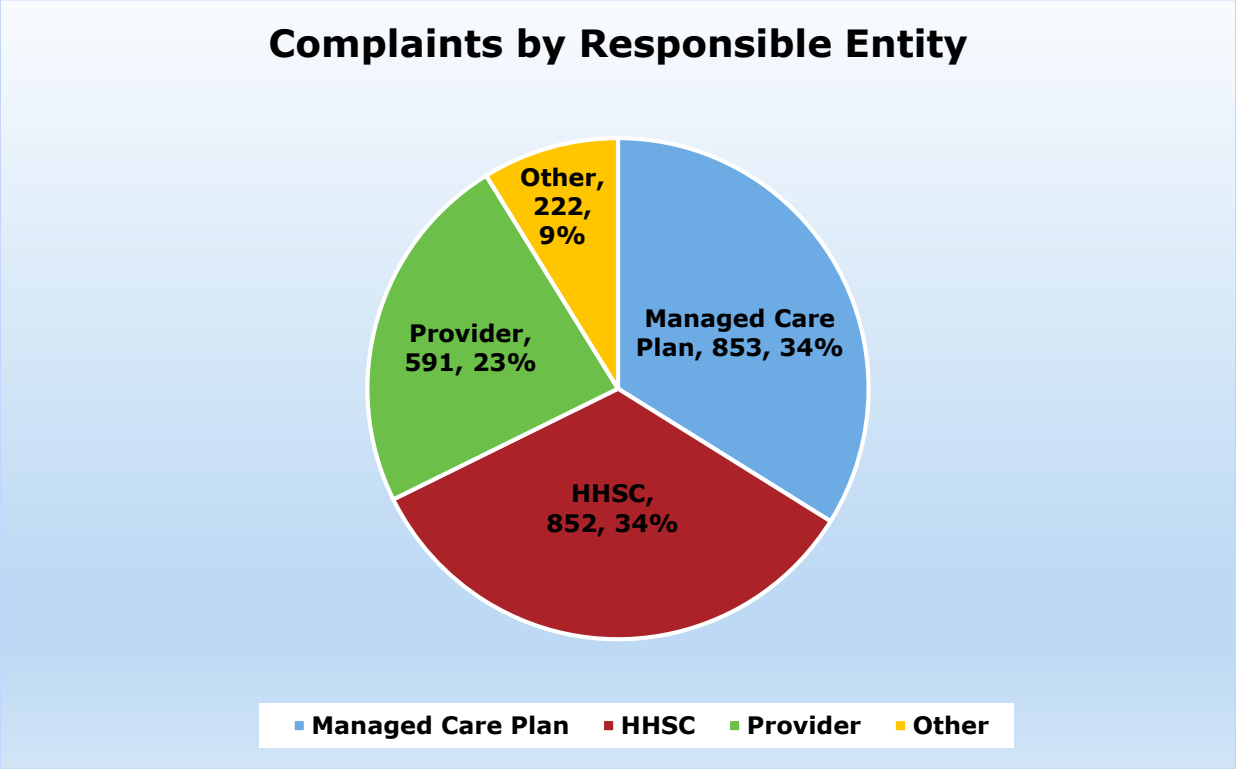
The top 10 substantiated complaints were related to:

- Inability to access prescriptions due to the consumer not showing as active with the MCO's pharmacy benefits manager (PBM) or with traditional Medicaid (64);
  - Consumers who are active with an MCO but not showing as active in the MCO's PBM is due to clients that were retroactively enrolled in the MCO effective the first of the month, but their enrollment file has not yet been uploaded into the MCO's PBM's system at the time the consumer is trying to obtain prescriptions.
  - Consumer being active with traditional Medicaid but not showing as having coverage in pharmacy systems is due to the fact that it takes three to five business days for a consumer's Medicaid coverage to show in pharmacy systems after the consumer is determined eligible for Medicaid. Although there is not a policy in place that prohibits the delay in accessing Medicaid services after determination of eligibility, it does create an actual barrier to accessing care.
- Accessing long term services and supports (LTSS) such as in-home provider services (43);
- Errors on the Medicaid case such as incorrect date of birth (DOB), incorrect due date on Pregnancy Women's Medicaid, eligibility for managed care program does not trigger timely, incorrect spelling of consumer's name, or incorrect residential status on case are some of the errors noted on consumer cases during the quarter (40);
- Inability to access prescriptions due to erroneous insurance showing on the consumer's file with the MCO (40);
- Medicaid cases incorrectly denied, or coverage terminated in error (29);
- Errors in HHS or MCO related systems such as MCO shows the wrong managed care program type for client in their system, wrong type of Medicaid showing for client in one of the HHSC systems, client is not showing as an active member in the MCO's system, and client showing incorrectly as having Medicare in some HHS systems (24);
- Inability to access durable medical equipment (DME) (21);
- Inability to access prescriptions for other reasons (20); and
  - There are many reasons that a consumer may encounter problems with accessing prescriptions, not all reasons can be captured with a specific complaint category that OMCAT can report on.

- Incorrect information or guidance provided to consumer (15).

All Complaints by Responsible Entity

The Responsible Entity refers to the area found responsible for the consumer's issue. Complaints received in the first quarter were found to be associated to three main responsible entities: managed care plans, HHSC, and providers. **Managed care plans** were responsible for 34 percent of complaints (853), **HHSC** was responsible for 34 percent of complaints (852), and **providers** were responsible for 23 percent of complaints (591). The remainder of complaints were against various entities not already mentioned, and made up 9 percent (222) of all complaints received for the quarter.



Top 5 Complaints by Responsible Entity

The tables below show the top 5 complaints by responsible entity**. Complaints include those that are substantiated, unsubstantiated and unable to substantiate.**

HHSC

Complaint	Count	Substantiated	% Substantiated
Medicaid Eligibility/Recertification	289	20	7%
Case Information Error	112	33	29%
Access to Prescriptions - Not showing active in systems	66	19	29%
Access to Prescriptions – Other Insurance on File	64	17	27%
Billing Issues	57	2	4%

- There were 852 complaints received where the entity responsible for the complaint was HHSC. Out of those complaints, 129 (15%) were substantiated.
- Complaints of incorrect information on client cases are related to incorrect date of birth (DOB), incorrect due date on Pregnancy Women's Medicaid, consumer not enrolled timely into managed care program, incorrect spelling of consumer's name, or incorrect residential status.
- Complaints of inability to access prescriptions where consumers are not showing as having active Medicaid in pharmacy systems are due to consumers having to wait three to five business days after being deemed eligible for Medicaid before their coverage will show in pharmacy payment systems.
- Complaints of inability to access prescriptions due to erroneous insurance on Medicaid cases are related to consumers' Medicaid cases showing private insurance that the consumer either no longer has or never had.
- Complaints of billing issues where the entity responsible was noted as HHSC were regarding consumers having to pay for Medicare premiums or agency was not paying the residual 20% of covered services although consumers were active with a Medicare savings program.

Managed Care Plans

Complaint	Count	Substantiated	% Substantiated
Access to LTSS	116	24	21%
Access to Prescriptions - Other Insurance on File	92	20	22%
Access to Prescriptions - Not showing active in MCOs' systems	75	33	44%

Complaint	Count	Substantiated	% Substantiated
Access to Durable Medical Equipment (DME)	63	14	22%
Access to Prescriptions - Other	61	6	10%

- There were 853 complaints received where the entity responsible for the complaint was an MCO. Out of those complaints, 145 (17%) were substantiated.
- Complaints of accessing long term services and supports (LTSS) include: issues with obtaining an assessment for home health services; decreases in home health provider hours where the decision to decrease was overturned; and not receiving a response from the MCO after the assessment for home health services was completed.
- Complaints of inability to access prescriptions due to erroneous insurance on Medicaid cases are related to MCO consumer files showing private insurance or even Medicare coverage that the consumer either no longer has or never had.
- Complaints of inability to access prescriptions due to consumer not showing as having active coverage in the MCO's pharmacy system are usually due to the consumer's enrollment information being sent to the MCO on a daily file; however, the MCO doesn't upload the file daily into their systems.
- Complaints of DME include: access to mobility devices (such as wheelchairs, scooters, walkers and lifts), incontinent supplies, shower chairs, hospital beds, and portable oxygen devices. Problems with accessing medical equipment and supplies are due to equipment needing repairs, delays in receiving supplies, being denied equipment or supplies, and consumers who have left a nursing facility and returned to the community but did not have transition plan in place to ensure the equipment and/or supplies were authorized before returning to the community.
- Complaints of inability to access prescriptions for other reasons capture problems with obtaining medications for reasons that are not common such as: consumer is not sure why the prescription is not going through but also has not yet contacted the MCO so is referred to the MCO for assistance first; MCO's pharmacy system was down at the time the pharmacy tried to run the prescription; and uncommon error occurred with the MCO's pharmacy system.

Provider

Complaint	Count	Substantiated	% Substantiated
Access to Prescriptions - Other	110	7	6%
Billing Issues	100	8	8%
Access to Prescriptions – Other Insurance on File	46	3	7%
Access to LTSS	34	3	9%

Complaint	Count	Substantiated	% Substantiated
Access to Prescriptions - Not showing active in Pharmacy Systems	30	8	27%

- There were 591 complaints received where the entity responsible for the complaint was a provider. Out of those complaints, 58 (10%) were substantiated.
- Complaints of inability to access prescriptions for other reasons include: prescription is not on the Medicaid formulary and prescribing physician is not willing to write another prescription for a different medication; pharmacy did not run the prescription correctly causing a rejection; consumer is unhappy that the pharmacy is not able to fill compound medications; and pharmacy does not know the correct claim codes to use to process the claim for the medication.
- Complaints related to consumers being billed by the provider include: providers billing consumers because the provider missed the claim filing deadline; consumers with a Medicare savings program being billed for the remaining 20% that Medicare does not pay; providers or collection agencies billing consumers after having received a denial on a claim; and consumers being billed by out of state providers when the consumer sought medical care outside of Texas.
- Complaints of inability to access prescriptions due to erroneous insurance on the consumer's file are due to the pharmacies showing other insurance, but HHSC systems do not show any other insurance for the consumer.
- Complaints of accessing long term services and supports (LTSS) with the provider as the entity responsible include: consumers who have complaints that the home health agency has not been able to provide a home health provider for all hours that consumer is authorized for; and consumers who are discharged from nursing facilities without the facility informing their health plan so that a transition plan could be established prior to discharge.
- Complaints of inability to access prescriptions due to provider not showing the consumer as having active coverage are related to pharmacies whose systems do not show consumer has having active Medicaid coverage, but the consumer is currently receiving Medicaid.

Complaints by Medicaid Managed Care Program

The following tables show the top five reasons for complaints for each managed care program. Complaints include those that are substantiated, unsubstantiated and unable to substantiate.

OMCAT receives many different types of complaints; therefore, the top five complaints may not always comprise a majority of total complaints for each service area.

STAR+PLUS (526,684*) - Top 5 Complaints (1,043)

Complaint Reasons	Count	Substantiated	% Substantiated
Access to LTSS	136	28	21%
Billing Issues	93	5	5%
Access to DME	75	15	20%
Access to Prescriptions - Medicare	56	6	11%
Access to Prescriptions - Other	54	3	6%

**Average Monthly Enrollment*

OMCAT received 1,043 complaints from consumers in the STAR+PLUS program in the first quarter of fiscal year 2019, and of those 132 (13%) were substantiated. The top five complaints noted in the table above make up 40 percent of the total complaints received by consumers on STAR+PLUS.

- Complaints of accessing long term services and supports (LTSS) include: issues with obtaining an assessment for home health services; decreases in home health provider hours; and not receiving a response from the MCO after the assessment for home health services was completed.
- Complaints of billing issues include: providers billing consumers after claims are denied by the MCO, and dual-eligible consumers (those with Medicaid and Medicare) being billed by Medicare providers who did not attempt to bill HHSC for the 20% that Medicare does not pay.
- Complaints of accessing durable medical equipment (DME) include: access to mobility devices (such as wheelchairs, scooters, walkers and lifts), incontinent supplies, shower chairs, hospital beds, and portable oxygen devices. Problems with accessing medical equipment and supplies are due to equipment needing repairs, delays in receiving supplies, being denied equipment or supplies, and consumers who have left a nursing facility and returned to the community but did not have transition plan in place to ensure the equipment and/or supplies were authorized before returning to the community.
- Complaints of accessing prescriptions from consumers in the STAR+PLUS program include: consumers who recently became eligible for Medicare and did not know prescriptions would now be covered by Medicare instead of Medicaid; dual-eligible consumers' inability to afford co-payments; and Medicaid only consumers that showed incorrectly as having Medicare in the Medicaid eligibility system.

STAR (2,881,642*) - Top 5 Complaints (637)

Complaint Reasons	Count	Substantiated	% Substantiated
Access to Prescriptions - Other Insurance on File	107	17	16%

Complaint Reasons	Count	Substantiated	% Substantiated
Access to Prescriptions - Not showing active	76	32	42%
Access to Prescriptions - Other	74	7	9%
Billing Issues	58	6	10%
Third Party Resources (Other Insurance)	32	3	9%

**Average Monthly Enrollment*

OMCAT received 637 complaints from consumers in the STAR program in the first quarter of fiscal year 2019, and of those 98 (15%) were substantiated. The top five complaints noted in the table above make up 54 percent of the total complaints received by consumers on STAR.

- Complaints of inability to access prescriptions are due to outdated insurance showing on the consumers' Medicaid cases in HHSC systems or on the MCO's pharmacy system. HHSC was responsible for 30% (31) of all complaints from STAR consumers where there was outdated private insurance showing on consumers' Medicaid cases in HHSC systems.
- Complaints of inability to access prescriptions due to consumer not showing as having active coverage in the MCO's pharmacy system are usually due to the consumer's enrollment information being sent to the MCO on a daily file; however, the MCO doesn't upload the file into their system daily. One MCO made up 34% (26) of all complaints from consumers on STAR who were not able to access prescriptions due to the MCO not showing the consumers as active in their pharmacy system despite consumers being active consumers with the MCO. As a comparison, the MCO with the next highest number of complaints related to not showing the consumer in the MCO pharmacy system received 9 complaints for the quarter.
- Complaints of inability to access prescriptions for other reasons include: pharmacy did not carry the needed medication; errors in the pharmacy's system; medications were prescribed by a non-Medicaid physician; physician is not willing to assist the consumer with obtaining medication (either will not write a prescription for the consumer's preferred medication or fails to call the MCO to get a prior authorization); pharmacy does not have the codes needed to process the claim; and consumer was informed a medication was denied but has not yet contacted their MCO for assistance. The pharmacy or physician was the entity responsible for the problem in more than half of the complaints in this category.
- Complaints of consumers being billed include: consumers who received bills prior to being active with Medicaid or during a lapse in Medicaid; parents receiving a bill for their newborn whose Medicaid was still being processed at the time the child was seen for services; consumer received bill because there was outdated insurance showing on the consumer's case and claim was denied due to provider not filing with

other insurance; and consumer did not provide proof of Medicaid at the time of service and received a bill for services. There was no trend regarding a specific provider who was billing Medicaid consumers.
- Complaints related to having erroneous other insurance are related to consumers who are not able to access various Medicaid services due to their Medicaid case showing outdated private insurance.

STAR Kids (159,033*) - Top 5 Complaints (193)

Complaint Reasons	Count	Substantiated	% of Substantiated
Access to LTSS	18	5	28%
Access to Prescriptions - Other	16	4	25%
Access to Prescriptions - Not showing active in Systems	16	9	56%
Access to In-Network Provider	13	3	23%
Billing Issues	11	0	0%

**Average Monthly Enrollment*

OMCAT received 193 complaints from consumers in the STAR Kids program in the first quarter of fiscal year 2019, and of those 32 (17%) were substantiated. The top five complaints noted in the table above make up 38 percent of the total complaints received by consumers on STAR Kids.

- Complaints of access to LTSS include: reductions in attendant or nursing hours; attendants not showing up for duty; home health agency not able to provide attendants or nurses for all hours consumer was approved for; and consumers not receiving scheduled assessments.
- Complaints of inability to access prescriptions for other reasons include: manufacturer of the medication is not approved by Medicaid; the dosage prescribed is higher than what Medicaid allows; the form in which the medication was prescribed (compound, tablet, capsule) is not approved by Medicaid; and consumer shows active with current MCO and former MCO's pharmacy system at the same time.
- Complaints of access to an in-network provider include: consumers not able to access a physician due to MCO not showing consumers as active in their system; and difficulty finding specialists that accept the MCO.
- Complaints related to billing issues include: consumers not being on Medicaid at the time they received the service and were therefore billed for services rendered; consumers being billed by Medicaid providers even though they were active with Medicaid at the time services were rendered; and consumer billed due to receiving medical services outside Texas (out of state provider was not contracted with Texas Medicaid.)

STAR+PLUS Dual Demo (40,247*) – Top 5 Complaints (30)

Complaint Reasons	Count	Substantiated	% Substantiated
Access to LTSS	4	0	0%
Access to Prescriptions - Other	3	0	0%
Access to In-Network Provider	3	0	0%
Billing Issues	2	0	0%
Systems Issues	2	1	50%

**Average Monthly Enrollment*

OMCAT received 30 complaints from consumers in the STAR+PLUS Dual Demo program in the first quarter of fiscal year 2019, and of those 1 (3%) was substantiated. The top five complaints noted in the table above make up 47 percent of the total complaints received by consumers on STAR+PLUS Dual Demo.

- There were no trends to report regarding complaints from STAR+PLUS Dual Demonstration consumers.

STAR Health (34,446*) - Top 5 Complaints (27)

Complaint Reasons	Count	Substantiated	% Substantiated
Billing Issues	5	0	0%
Access to Prescriptions - Other	3	0	0%
Access to LTSS	3	1	33%
Access to DME	2	0	0%
Other/NA	2	0	0%

**Average Monthly Enrollment*

OMCAT received 27 complaints from consumers in the STAR Health program in the first quarter of fiscal year 2019, and of those 4 (15%) were substantiated. The top five complaints noted in the table above make up 56 percent of the total complaints received from consumers on STAR Health.

- There were no trends to report regarding complaints received from STAR Health families.

Dental Managed Care (3,217,371*) - Top 5 Complaints (22)

Complaint Reasons	Count	Substantiated	% Substantiated
Access to Dental Services	7	2	29%
Incorrect Information or Guidance	3	0	0%
Case Information Error	3	2	67%
Access to Care Coordination	2	0	0%
Access to Prescriptions – Other Insurance on File	1	1	100%

**Average Monthly Enrollment*

OMCAT received 22 complaints from consumers in the Dental Managed Care program in the first quarter of fiscal year 2019, and of those 5 (23%) were substantiated. The top five complaints noted in the table above make up 73 percent of the total complaints received by consumers on Dental Managed Care.

- Complaints of access to dental services include consumers who did not show active in the dental managed organization (DMO) and consumers who were denied services because the DMO showed the consumers already received the same services.

Fee for Service/Traditional Medicaid - Top 5 Complaints (490)

Complaint Reasons	Count	Substantiated	% Substantiated
Access to Prescriptions - Other	68	6	9%
Medicaid Eligibility/Recertification	56	5	9%
Access to Prescriptions - Not showing active in Systems	51	7	14%
Access to Prescriptions - Other Insurance on File	44	7	16%
Case Information Error	31	4	13%

OMCAT received 490 complaints from consumers on FFS Medicaid in the first quarter of fiscal year 2019, and of those 54 (11%) were substantiated. The top five complaints noted in the table above make up 51 percent of the total complaints received by consumers on Fee for Service Medicaid.

- Complaints of inability to access prescriptions for other reasons include: prescribing physician is not a Medicaid provider; prescription is not covered under the Women's Health Program; pharmacy did not have the correct codes to process the claim under FFS Medicaid.
- Complaints of inability to access prescriptions due to not showing active in systems include; pharmacy systems not updated with consumers' coverage due to consumers being approved for Medicaid just prior to trying to obtain prescriptions; and pharmacies running the prescription claims under consumers' previous MCO, but the consumer is on traditional Medicaid at the time of service.

- Complaints of errors on the Medicaid case include: incorrect DOB; incorrect spelling of consumers' names; incorrect type of Medicaid showing on case; Medicare showing on case but consumers do not have Medicare; and incorrect gender.
- Complaints of inability to access prescriptions due to erroneous insurance on file include; consumers not realizing there is other insurance on file or other insurance was reported to HHSC as having ended but continues to show in the HHSC systems, or consumer never had other insurance, but another type of insurance is erroneously showing in either the pharmacy's system or HHSC systems.

No Medicaid - Top 5 Complaints (415)

OMCAT receives inquiries and complaints from consumers that may not be on any type of Medicaid or may have a type of Medicaid that only pays for their Medicare premium, copays and deductibles for Medicare services. Below are the top five complaints from these consumers.

Complaint Reasons	Count	Substantiated	% Substantiated
Medicaid Eligibility/Recertification	195	18	9%
Billing Issues	41	1	2%
Case Information Error	31	8	26%
Other/NA	18	0	0%
Access to LTSS	15	2	13%

OMCAT received 415 complaints from consumers who were not on Medicaid in the first quarter of fiscal year 2019, and of those 32 (8%) were substantiated. The top five complaints noted in the table above make up 72 percent of the total complaints received of No Medicaid.

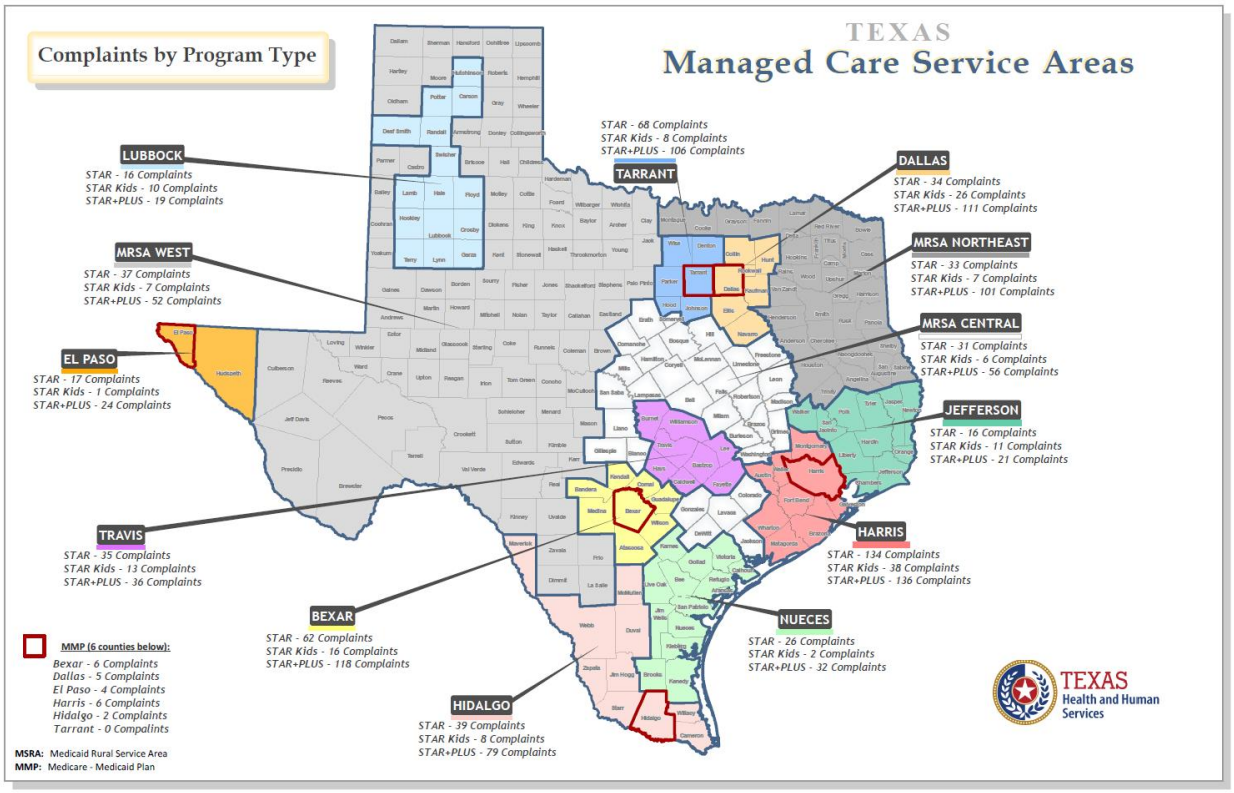
- Substantiated complaints related to Medicaid eligibility and recertification include: Medicaid terminated in HHSC systems erroneously such as Pregnancy Medicaid ending before the consumer's due date, application was mislabeled when uploaded case as a document other than an application, consumer was erroneously excluded as part of the household when the Medicaid case was processed; and HHSC systems terminated consumers' Supplemental Security Income Medicaid (SSI) even though the interface with Social Security Administration shows the SSI coverage as ongoing.
- Complaints of consumers receiving bills include: consumers only on a Medicare Savings Program receiving bills from Medicare providers for the portion that Medicaid would pay; consumers who lost Medicaid coverage but have bills for services they received while on Medicaid including those whose accounts were sent to collection agencies; and consumers who are on the Medicare Savings Program (MSP) but Medicaid is not paying for the Medicare Part B premium.
- Substantiated complaints of incorrect information on the Medicaid case include: incorrect Social Security Number (SSN) on consumer's MSP case; consumer not tested for Health Texas Women's Program after being erroneously removed from the household on the case; SSI consumer trying to establish Medicaid in Texas after having moved from another state but the DOB on the case is incorrect.

- Complaints of access to LTSS include: consumer losing attendant after losing Medicaid due to failing to return paperwork to recertify coverage; consumers lost Medicaid after leaving the nursing facility (NF) when NF failed to contact the consumers' MCO to coordinate transition services into the community; and consumers not on Medicaid and/or only on Medicare trying to obtain LTSS.

Complaints received by consumers enrolled in Medicaid managed care totaled 853 complaints of which 145 (17%) were substantiated. Complaints received by consumers in Fee for Service Medicaid (FFS) totaled 435 complaints of which 54 (12%) were substantiated.

Service Area Complaints and Inquiries

Map of Managed Care Service Areas and Related Complaints and Inquiries



The map includes all complaints whether substantiated, unsubstantiated or where it was not possible to determine whether the complaint could be substantiated. A map of the Texas Managed Care Service Areas can be accessed at

https://hhs.texas.gov/sites/default/files/documents/services/health/medicaid-chip/programs/managed-care-service-areas-map.pdf

Top 5 Reasons for Complaints and Inquiries by Service Area

Complaints include those that are substantiated, unsubstantiated and unable to substantiate.

Bexar (352,649*)

Bexar - Top 5 Complaints	235	Substantiated	% Substantiated
Access to LTSS	30	2	7%
Billing Issues	22	2	9%
Access to Prescriptions - Private Ins	20	2	10%
Access to DME	18	3	17%
Access to Prescriptions - Other	14	2	14%
Bexar - Top 5 Inquiries	**303**		
Access to PCP/Change PCP	39		
Verify Health Coverage	30		
Explanation of Benefits/Policy	19		
Reporting Change	17		
Access to LTSS	15		

Dallas (536,026*)

Dallas - Top 5 Complaints	244	Substantiated	% Substantiated
Access to LTSS	31	6	19%
Billing Issues	19	2	11%
Access to Prescriptions - Not showing active in Systems	18	8	44%
Access to Prescriptions - Other	18	3	17%
Access to In-Network Provider	15	5	33%
Dallas - Top 5 Inquiries	**321**		
Access to PCP/Change PCP	44		
Verify Health Coverage	35		
Access to LTSS	27		
Explanation of Benefits/Policy	25		
Reporting Change	24		

El Paso (163,412*)

El Paso - Top 5 Complaints	54	Substantiated	% Substantiated
Access to Prescriptions - Other Insurance on File	7	1	14%
Access to Prescriptions - Other	4	0	0%
Access to Prescriptions - Medicare	4	0	0%
Medicaid Eligibility/Recertification	3	0	0%
Access to In-Network Provider	3	0	0%
El Paso - Top 5 Inquiries	**84**		
Verify Health Coverage	14		
Access to PCP/Change PCP	7		
Explanation of Benefits/Policy	6		
Access to LTSS	6		
Obtain Medicaid ID card	5		

Harris (951,892*)

Harris - Top 5 Complaints	360	Substantiated	% Substantiated
Access to Prescriptions - Other Insurance on File	31	2	6%
Access to Prescriptions - Not showing active in Systems	28	16	57%
Billing Issues	28	1	4%
Access to LTSS	24	6	25%
Access to Prescriptions - Other	20	2	10%
Harris - Top 5 Inquiries	**521**		
Access to PCP/Change PCP	72		
Verify Health Coverage	63		
Adult Dental	35		
Reporting Change	35		
Change Plan - Other	32		

**Average Monthly Enrollment*

Hidalgo (431,288*)

Hidalgo - Top 5 Complaints	146	Substantiated	% Substantiated
Access to Prescriptions - Other Insurance on File	16	5	31%
Access to LTSS	11	3	27%
Access to DME	10	2	20%
Billing Issues	9	1	11%
Access to Prescriptions - Not showing active in Systems	8	4	50%
Hidalgo - Top 5 Inquiries	**187**		
Access to PCP/Change PCP	24		
Change Plan - Other	23		
Verify Health Coverage	16		
Access to LTSS	14		
Change Plan- for Preferred Provider (PCP, Facility, DME)	11		

Jefferson (110,977*)

Jefferson - Top 5 Complaints	57	Substantiated	% Substantiated
Access to Prescriptions - Other	8	0	0%
Access to DME	5	2	40%
Billing Issues	4	0	0%
Access to LTSS	4	1	25%
Fair Hearing/Appeals	4	0	0%
Jefferson - Top 5 Inquiries	**95**		
Verify Health Coverage	11		
Access to PCP/Change PCP	10		
Access to Long Term Care	9		
Explanation of Benefits/Policy	7		
Reporting Change	7		

**Average Monthly Enrollment*

Lubbock (100,617*)

Lubbock - Top 5 Complaints	51	Substantiated	% Substantiated
Access to Prescriptions - Other	6	1	17%
Medicaid Eligibility/Recertification	5	0	0%
Access to LTSS	4	0	0%
Access to In-Network Provider	4	0	0%
Access to Prescriptions - Other Insurance on File	4	0	0%
Lubbock - Top 5 Inquiries	**55**		
Access to LTSS	7		
Reporting Change	5		
Access to PCP/Change PCP	5		
Adult Dental	5		
Explanation of Benefits/Policy	4		

MRSA Central (175,295*)

MRSA Central - Top 5 Complaints	112	Substantiated	% Substantiated
Billing Issues	14	1	7%
Access to LTSS	11	3	27%
Access to Prescriptions - Other	10	1	10%
Medicaid Eligibility/Recertification	8	1	13%
Access to Prescriptions - Other Insurance on File	6	4	67%
MRSA Central - Top 5 Inquiries	**117**		
Access to PCP/Change PCP	16		
Explanation of Benefits/Policy	12		
Reporting Change	9		
Verify Health Coverage	9		
Change Plan - Other	7		

**Average Monthly Enrollment*

MRSA Northeast (224,068*)

MRSA Northeast - Top 5 Complaints	159	Substantiated	% Substantiated
Access to Prescriptions - Other Insurance on File	19	3	16%
Access to LTSS	14	5	36%
Access to Prescriptions - Other	13	1	8%
Medicaid Eligibility/Recertification	12	1	8%
Billing Issues	12	0	0%
MRSA Northeast - Top 5 Inquiries	**188**		
Access to PCP/Change PCP	21		
Verify Health Coverage	20		
Reporting Change	15		
Adult Dental	13		
Explanation of Benefits/Policy	12		

MRSA West (195,330*)

MRSA West - Top 5 Complaints	109	Substantiated	% Substantiated
Billing Issues	11	0	0%
Access to Prescriptions - Other Insurance on File	10	2	20%
Access to DME	8	2	25%
Access to LTSS	8	2	25%
Access to Prescriptions - Other	8	2	25%
MRSA West - Top 5 Inquiries	**169**		
Access to PCP/Change PCP	22		
Reporting Change	15		
Explanation of Benefits/Policy	11		
Verify Health Coverage	11		
Adult Dental	11		

**Average Monthly Enrollment*

Nueces (121,767*)

Nueces - Top 5 Complaints	64	Substantiated	% Substantiated
Access to LTSS	8	2	25%
Access to Prescriptions - Other Insurance on File	7	4	57%
Access to Prescriptions - Other	7	0	0%
Billing Issues	7	0	0%
Access to Prescriptions - Prior Authorization	4	1	25%
Nueces - Top 5 Inquiries	**72**		
Access to PCP/Change PCP	13		
Access to Long Term Care	10		
Verify Health Coverage	6		
Reporting Change	5		
Change Plan- for Preferred Provider (PCP, Facility, DME)	5		

Tarrant (365,397*)

Tarrant - Top 5 Complaints	214	Substantiated	% Substantiated
Access to Prescriptions - Other	26	2	8%
Access to Prescriptions - Other Insurance on File	21	6	29%
Billing Issues	20	2	10%
Access to LTSS	14	2	14%
Medicaid Eligibility/Recertification	13	2	15%
Tarrant - Top 5 Inquiries	**255**		
Access to PCP/Change PCP	35		
Verify Health Coverage	22		
Adult Dental	21		
Reporting Change	19		
Explanation of Benefits/Policy	17		

**Average Monthly Enrollment*

Travis (202,826*)

Travis - Top 5 Complaints	98	Substantiated	% Substantiated
Billing Issues	14	2	14%
Access to Prescriptions - Not showing active in Systems	9	4	44%
Access to In-Network Provider	8	3	38%
Medicaid Eligibility/Recertification	7	0	0%
Access to Prescriptions - Other Insurance on File	5	0	0%
Travis - Top 5 Inquiries	**158**		
Access to PCP/Change PCP	17		
Reporting Change	15		
Access to Long Term Care	13		
Verify Health Coverage	12		
Explanation of Benefits/Policy	11		

**Average Monthly Enrollment*

Barriers and Recommendations to Address Them

Access to prescriptions

Access to prescriptions was the top reason for complaints received by OMCAT for this quarter. Problems of accessing prescriptions due to consumers having erroneous insurance on their cases or not showing as active consumers in MCO systems, together made up 43 percent of all prescription related complaints during the quarter.

Complaints related to consumers who are not able to access prescriptions from the pharmacy due to MCOs not showing them as having active coverage, although the consumer is enrolled with the MCO, could be prevented.

OMCAT recommends that our office work with Medicaid CHIP Services to determine the scope and resolution(s) of the issue.

Erroneous Insurance Information on Consumer Cases

Consumers showing in HHS or MCO systems as having other insurance when the consumer is no longer active with that coverage or the other insurance was erroneously added to the consumer's case continues to be another major barrier to consumers receiving Medicaid services. In the first quarter of fiscal year 2019, all complaints related to consumers experiencing problems with accessing services due to outdated/erroneous insurance information showing on their cases, whether in HHS systems or in the MCOs' systems, is the third highest reason for complaints.

Various sources can report the existence of third party resource information (other insurance) on a consumer's case. These can include the consumer, a provider, a consumer's caseworker, the consumer's MCO, the enrollment broker, or data match files from other systems.

OMCAT recommends that our office work with Medicaid CHIP Services to determine the scope and resolution(s) of the issue.

Ombudsman Collaboration and Initiatives

OMCAT collaborates with HHS programs and MCOs in identifying and resolving barriers to accessing Medicaid services. During the first quarter of fiscal year 2019, OMCAT identified two problems and notified Managed Care Compliance Operations (MCCO), the organization within HHSC that has oversight of the MCO contracts, of these issues.

The first issue was with an MCO where consumers had erroneous Medicare information showing in the MCO's system. This error was preventing consumers from accessing prescriptions due to the MCO's pharmacy system rejecting the claim. OMCAT worked with the MCO to identify the cause and develop a fix to the system.

The second issue identified involved a DME provider which mailed letters to its consumers stating their MCO would reduce consumers' Medicaid managed care and CHIP benefits by 50 percent as of November 21, 2018. In this letter, the DME provider also encouraged its consumers to change health plans to avoid this reduction in services. OMCAT notified MCCO of the letter. MCCO contacted the MCO, which then sent a cease and desist order to the DME provider.

OMCAT coordinates a network of HHS program areas that have a direct or indirect impact on the delivery of Medicaid services to HHS consumers. The network meets quarterly to share information regarding barriers to care that Medicaid consumers experience, discusses how to mitigate or resolve barriers to care, and provides training to ensure all HHS areas participating in the network are aware of the work and functions of their counterparts.

OMCAT is involved in a project to route Medicaid consumer complaints received through MCCO and other HHS offices to OMCAT for handling. The project will include updating Medicaid MCO consumer handbooks to direct consumers to OMCAT to register complaints with the agency. The goal of this project is an effort to streamline the Medicaid complaints process for consumers and to enhance and standardize the reporting process.

OMCAT is working with MCCO to align complaint reason codes to be used by OMCAT, MCCO and the MCOs. This alignment will allow HHS to better track and trend issues that Medicaid consumers experience.

Conclusion

OMCAT is the HHS's public facing contact for consumers who need to make complaints and inquiries regarding Medicaid managed care. As such, the HHS Office of the Ombudsman's goal in this report is to spotlight issues that Medicaid consumers face and provide recommendations to remove barriers where possible, thereby improving the experience of Texas Medicaid consumers.

Glossary

Contact – An attempt by HHS consumers to inquire or complain about HHS programs or services.

Complaint – A contact regarding any expression of dissatisfaction.

Fiscal Year 2018 - The 12-month period from September 1, 2017 through August 31, 2018, covered by this report.

Fiscal Year 2019 - The 12-month period from September 1, 2018 through August 31, 2019, covered by this report.

HHS Enterprise Administrative Report and Tracking System (HEART) – A web-based system that tracks all inquiries and complaints OMCAT receives.

Inquiry – A contact regarding a request for information about HHS programs or services.

Managed Care Organization - A health plan that is a network of contracted health care providers, specialists, and hospitals.

Managed Care Compliance Operations - the area within HHSC that provides oversight of the managed care contracts.

Provider - An individual such as a physician or nurse, or group of physicians and nurses such as a clinic or hospital, that delivers health care directly to patients.

Resolution – The point at which a determination is made as to whether a complaint is substantiated and no further action is necessary by the OMCAT.

Substantiated – A complaint determination where research clearly indicates agency policy was violated or agency expectations were not met.

Unable to Substantiate – A complaint determination where research does not clearly indicate if agency policy was violated or agency expectations were met.

Unsubstantiated – A complaint determination where research clearly indicates agency policy was not violated or agency expectations were met.

List of Acronyms

Acronym	Full Name

CHIP - Children’s Health Insurance Program

DME - Durable Medical Equipment

LTSS - Long Term Services and Supports

MCO - Managed Care Organization

MCCO - Managed Care Compliance Operations

MDCP - Medically Dependent Children’s Program

MRSA - Medicaid Rural Service Area

PAS - Personal Attendant Services

PCP - Primary Care Provider

PDL - Preferred Drug List

PDN - Private Duty Nursing

TDD - Telephonic Device for the Deaf