Quarterly Report from the HHS Ombudsman Managed Care Assistance Team 4th Quarter FY 2019

As Required by

Section 531.0213 of the

Government Code

Office of the Ombudsman

May 2020

TEXAS
Health and Human Services

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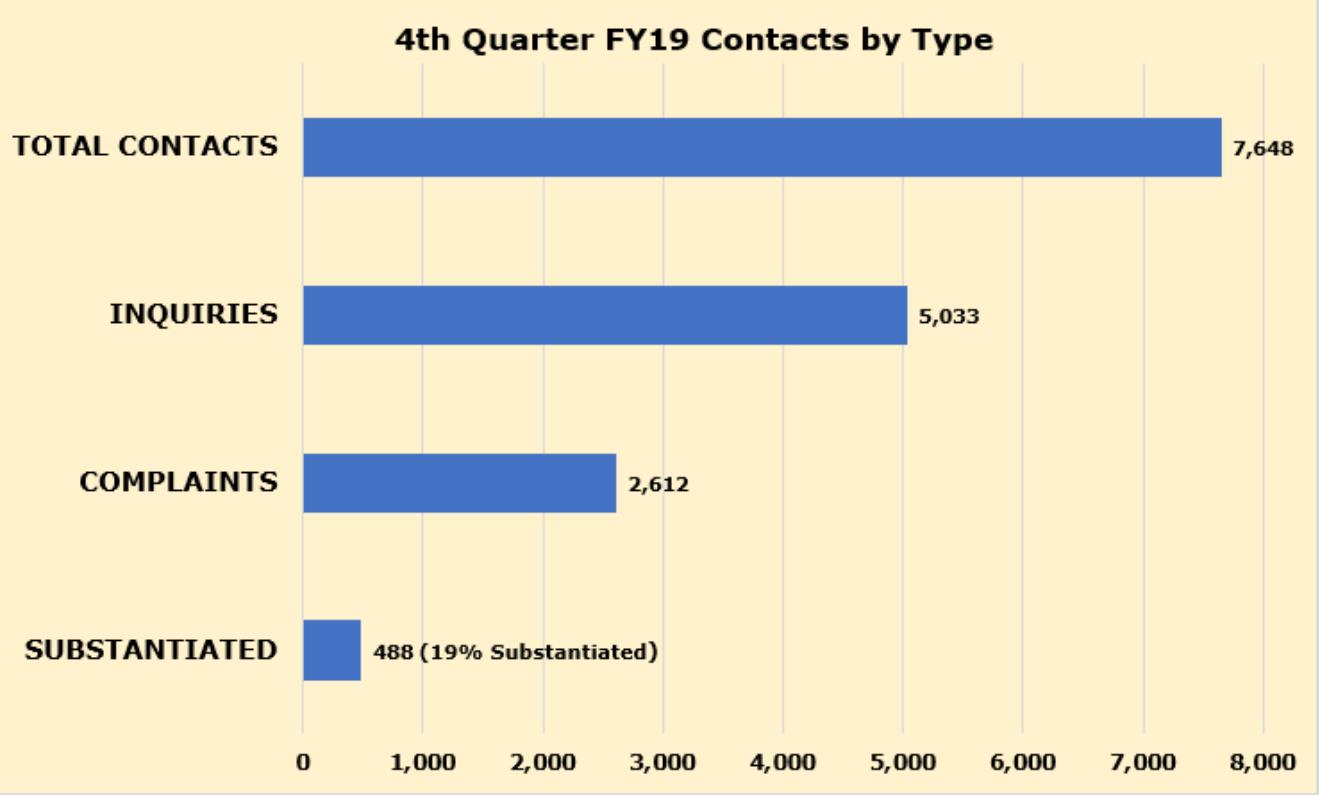
Executive Summary

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 7,648 contacts during the fourth quarter of fiscal year 2019; of these contacts, 2,615 were complaints and 5,033 were inquiries. Of the complaints that were received, 488 were substantiated, 226 were unsubstantiated, and 1,898 were unable to be substantiated (e.g. there was not enough evidence to determine whether agency policy or expectations were violated).

Figure 1 4th Quarter FY19 Contacts by Type



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

- Access to Prescriptions – Member Not Showing as Active in HHSC or MCO systems
- Access to Prescriptions – Erroneous Other Insurance on File
- Access to Long Term Services and Supports
- Access to Prescriptions – Pharmacy Billed Incorrect Health Plan
- Access to Prescriptions – Other

This report contains recommendations to mitigate issues related to consumer access to prescriptions. These issues continue to be the most frequent and ongoing barriers to care that drive Medicaid managed care consumers to contact OMCAT.

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 provided through HHS programs and their vendors.

The report provides high-level information regarding consumer inquiries and complaints reported to OMCAT during the fourth 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

2. 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 Ombudsman 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 several HHS programs. HEART tracks consumer specific information, consumer issues, regional and program data, as well as the findings and resolutions of OMCAT investigations.

3. Message from the Managed Care Ombudsman

This is the fourth of an ongoing series of publicly available quarterly reports that OMCAT will be publishing on its website at HHS Ombudsman Managed Care Help as well as on the HHS Reports and Presentations website at HHS Reports and Presentations.

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 investigates consumer complaints, works with Medicaid and CHIP Services to determine compliance with state and agency rules and policies, determines if agency expectations were met, and provides recommendations for resolution with the goal of preventing future occurrences.

OMCAT welcomes feedback from stakeholders to improve this report in its ability to reflect the experience of Medicaid consumers who have contacted OMCAT.

OMCAT In Action

During the fourth quarter of fiscal year 2019, OMCAT assisted a STAR+PLUS consumer with accessing dental services through the STAR+PLUS Waiver. The consumer had already received some of the dental services needed but was informed that not all dental procedures needed would be covered by Medicaid. OMCAT confirmed with Texas Medicaid Health Partnership (TMHP) that one of the services was not a Medicaid benefit. Not receiving all needed dental work could have seriously affected the consumer's other medical conditions. Because the covered Medicaid dental work could not be performed without first performing the non-covered dental procedure, OMCAT asked the consumer's MCO and its dental vendor to consider providing all services needed. The MCO provided an exception to cover the remaining service.

4. Contacts and Complaints

Contact Data Analysis - Total Contacts

OMCAT received 7,648 contacts in the fourth quarter of fiscal year 2019. Compared to the third quarter of fiscal year 2019, the fourth quarter saw an increase of less than one percent (32) in total contacts. 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 5,033 inquiries, which is an increase of two percent (115), in the fourth quarter compared to the third quarter of fiscal year 2019. Inquiries remain an important indicator of member's educational needs and requests for information.

Top 10 Inquiries

The top ten inquiries listed below represent 62.63% (3,152) of the total number of inquiries received during the fourth quarter.

Table 1 Top 10 Inquiries

Inquiry Reason	Count	Percent of Total
Verify Health Coverage	839	17%
Explanation of Benefits/Policy	382	8%
Access to PCP/Change PCP	292	6%
Apply for Health Coverage	280	6%
Access to LTSS	263	5%
Caller Disconnected/Didn't respond	263	5%
Reporting Change	232	5%
Change Plan	229	5%
Billing Inquiry	187	4%

Inquiry Reason	Count	Percent of Total
Other/NA	186	4%

*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.

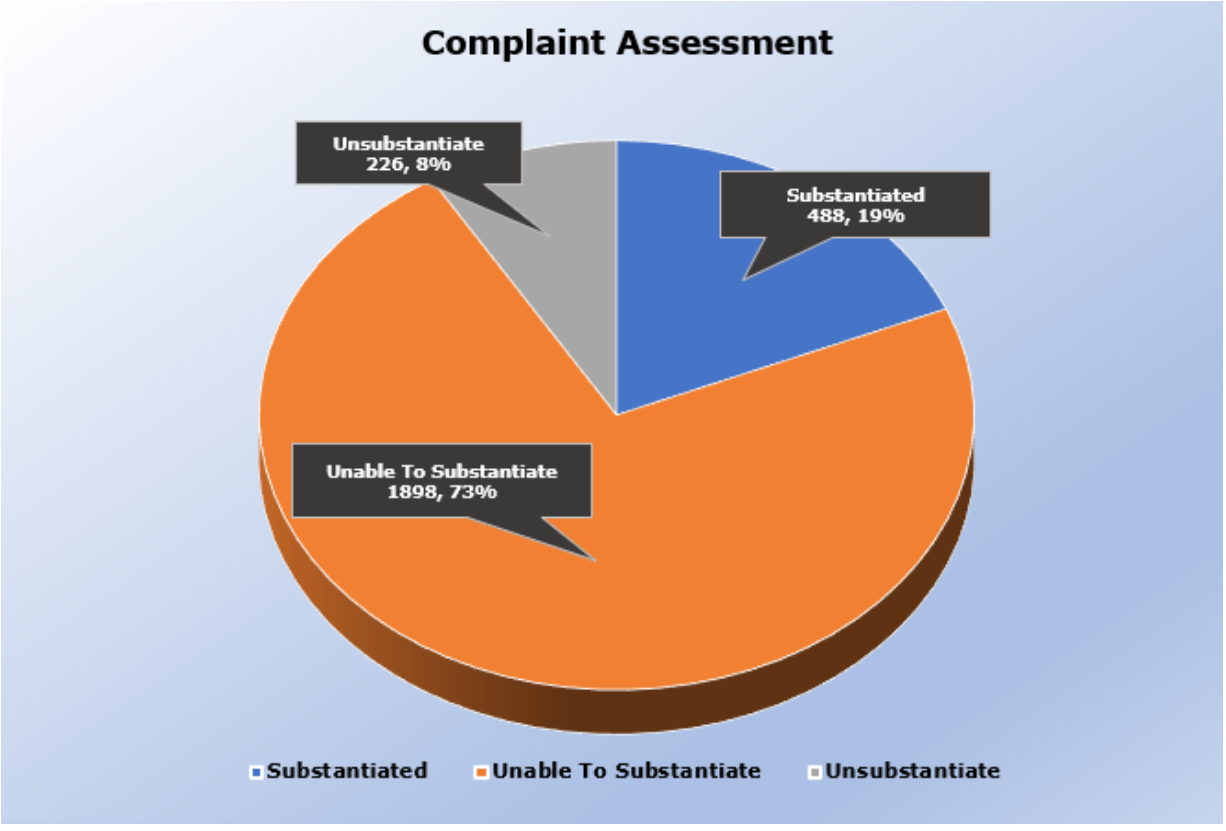
Complaint Data Analysis

OMCAT received 2,615 complaints, which is a decrease of three percent (-83), in the fourth quarter of fiscal year 2019 compared to the third quarter.

Substantiated Complaints (488)

OMCAT substantiated 19 percent of complaints received, which is an increase of less than two percent compared to the third quarter. Complaints include those received by consumers on Fee for Service Medicaid, Medicaid managed care, and by consumers applying for or whose Medicaid has lapsed.

Figure 2 Complaints Assessment



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 the 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.

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.)

Top Ten Substantiated Complaints

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 (68);

- Consumers who are active with an MCO but not showing as active in the MCO's PBM is due to consumers who 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
- Consumers who were recently certified for Medicaid, but the coverage is not yet reflected in all HHS related systems and therefore not showing as active in pharmacies' systems

Inability to access prescriptions due to erroneous insurance showing on the consumer's file with the MCO's or HHSC's systems (57);

Accessing long term services and supports (LTSS) such as in-home provider services (51);

Pharmacies running prescriptions through/billing the incorrect health plan (40);

Access to Prescriptions – Other (26);

Medicaid cases incorrectly denied, or coverage terminated in error (26);

Consumers being billed by Medicaid providers (24);

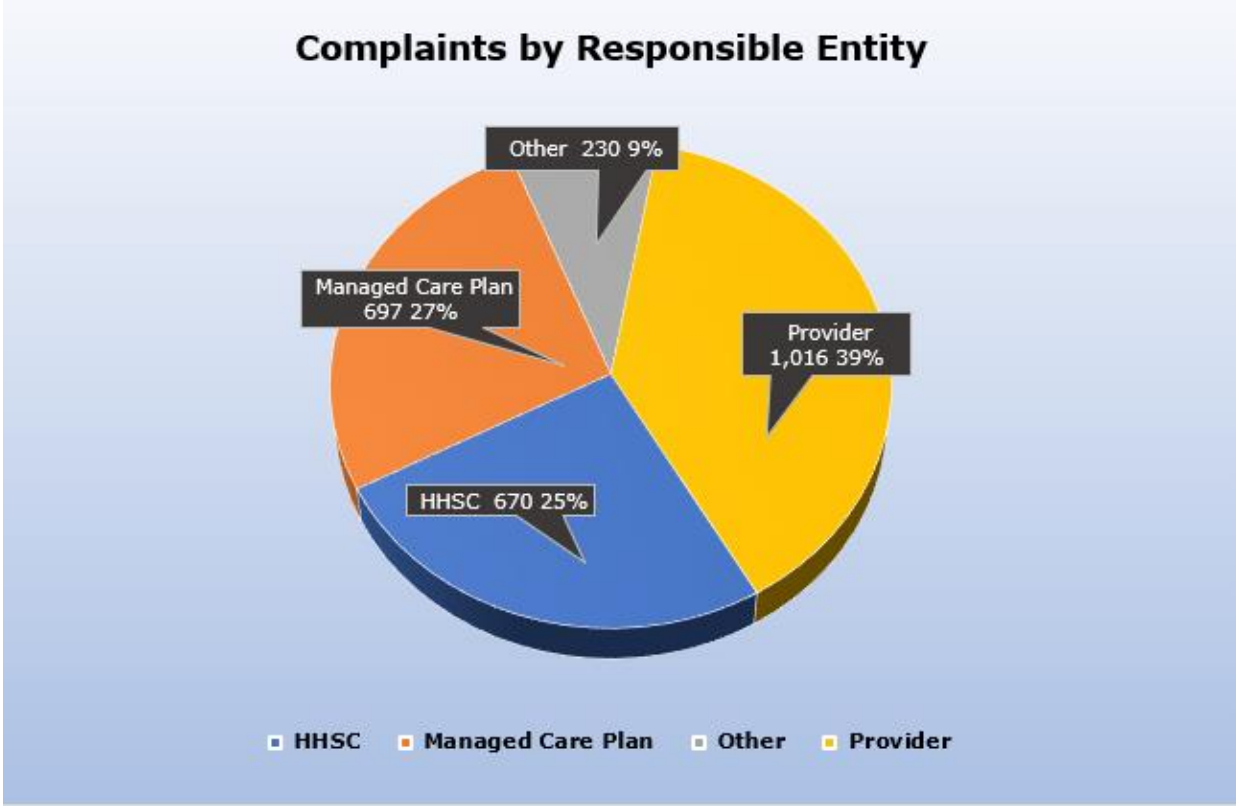
Access to Primary Care Provider (PCP) (22);

Inability to access durable medical equipment (DME) (21); and

Errors on Medicaid cases 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 (21).

All Complaints by Responsible Entity

Figure 3 Complaints by Responsible Entity



The Responsible Entity refers to the area found or presumed responsible for the program or service about which the consumer is contacting OMCAT. Complaints in this section of the report include those that were substantiated, unsubstantiated and those that OMCAT was unable to substantiate. Complaints received in the fourth quarter were found to be associated to three main responsible entities: managed care plans, HHSC, and providers. **HHSC** and **providers** were the Responsible Entity in 64 percent of complaints (1,686), **Managed care plans** were the Responsible Entity in 27 percent of complaints (697), The remainder of complaints were against various entities not already mentioned and made up nine percent (230) of all complaints received in the fourth 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

Table 2 HHSC Top 5 Complaints

HHSC Top 5 Complaints	Count	Substantiated	% Substantiated*
Medicaid Eligibility/Recertification	287	21	29%
Case Information Error	132	15	21%
Access to LTSS	40	8	11%
Balance Billing	28	1	1%
Access to Prescriptions - Over the Limit (3)	25	1	1%

Table 3 HHSC Top 5 Substantiated Complaints

HHSC Top 5 Substantiated Complaints	Count	Substantiated	% Substantiated*
Medicaid Eligibility/Recertification	287	21	29%
Case Information Error	132	15	21%
Access to LTSS	40	8	11%
Access to Prescriptions - Medicare	8	5	7%
Access to Prescriptions - Other Insurance	21	5	7%

*represents percent of total substantiated complaints

There were 783 complaints received where the entity responsible for the complaint was HHSC. Of those complaints, 73 (9%) were substantiated. The fourth quarter had an increase of seventeen percent (162) in complaints compared to the third quarter (945). The fourth quarter had a percentage decrease of four percent in substantiated complaints compared to the third quarter.

Complaints related to Medicaid eligibility errors include: applications not processed within required timeframes; cases denied for failure to provide additional information, but the information requested was provided timely; consumer certified for the incorrect type of Medicaid; and a file interface from SSA that was not processed correctly by HHS systems resulting in the early termination of an SSI Medicaid case.

Complaints of incorrect information on consumer cases are related to incorrect DOB, name, or residential information; incorrect type of Medicaid; authorized representative information missing on case; or consumer erroneously showing as deceased on case.

Complaints of accessing long term services and supports (LTSS) include: issues with obtaining home health services due to a change in the type of Medicaid that consumer was not aware of; issues with obtaining an assessment to continue waiver services; and interruption in home health services due to provider not being paid.

Managed Care Plans

Table 4 Managed Care Plans Top 5 Complaints

MCO Top 5 Complaints	Count	Substantiated	% of Substantiated*
Access to LTSS	112	38	17%
Access to Prescriptions - Other Insurance	56	35	16%
Balance Billing	53	10	4%
Access to DME	52	15	7%
Access to In-Network Provider (non-PCP)	49	13	6%

Table 5 Managed Care Plans Top 5 Substantiated Complaints

MCO Top 5 Substantiated Complaints	Count	Substantiated	% of Substantiated*
Access to LTSS	112	38	17%
Access to - Member Not Showing Active	46	35	16%

MCO Top 5 Substantiated Complaints	Count	Substantiated	% of Substantiated*
Access to Prescriptions - Other Insurance	56	35	16%
Access to DME	52	15	7%
Access to In-Network Provider (non-PCP)	49	13	6%

*represents percent of total substantiated complaints

There were 873 complaints received where the entity responsible for the complaint was an MCO. Of those complaints, 223 (26%) were substantiated. The fourth quarter had a decrease of six percent (-52) in complaints compared to the third quarter (925). The fourth quarter had a percentage increase of four percent in substantiated complaints compared to the third quarter.

Complaints of accessing long term services and supports (LTSS) include: issues with obtaining home health services; issues with obtaining respite services; obtaining assessment for home health service; transitioning from a facility back into the community; interruptions in home health services; not all scheduled hours of home health are being covered by the agency; and decreases in home health provider hours.

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 inability to access prescriptions due to erroneous insurance on Medicaid cases are related to MCO consumer files showing private insurance that the consumer either no longer has or never had.

Complaints of inability to access DME are related to: being referred by MCO to a DME supply company that is no longer in-network; not receiving supplies timely or at all; or denied DME that was overturned at the Fair Hearing process.

Complaints if inability to access an in-network provider include: issues with obtaining pain management, ophthalmologist, dialysis center, and pulmonary specialist.

Provider

Table 6 Provider Top 5 Complaints

Provider Top 5 Complaints	Count	Substantiated	% of Substantiated*
Balance Billing	160	13	8%
Access to Prescriptions - Other	107	20	13%
Access to Prescriptions - Other Insurance	81	15	10%
Access to Prescriptions - Billed Incorrect Health Plan	71	34	22%
Access to Prescriptions - Member Not Showing Active	67	25	16%

Table 7 Provider Top 5 Substantiated Complaints

Provider Top 5 Substantiated Complaints	Count	Substantiated	% of Substantiated*
Access to Prescriptions - Billed Incorrect Health Plan	71	34	22%
Access to Prescriptions - Member Not Showing Active	67	25	16%
Access to Prescriptions - Other	107	20	13%
Access to Prescriptions - Other Insurance	81	15	10%
Balance Billing	65	13	8%

*represents percent of total substantiated complaints

There were 1,156 complaints received where the entity that the complaint was against was a provider. Of those complaints, 157 (14%) were substantiated. The fourth quarter had an increase of 25 percent (228) in complaints compared to the third quarter (928). The fourth quarter had a percentage increase of two percent in substantiated complaints compared to the third quarter. Four of the top five MCO

complaints were the same except for Access to Prescriptions - Billed incorrect health plan.

Complaints of inability to access prescriptions due to claims submitted to incorrect health plan include: pharmacies submitting claims to a consumer's previous MCO instead of to traditional Medicaid; and pharmacies submitting claims to prior MCO instead of to consumers' MCO at the time of service.

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 was eligible for Medicaid at the time of service.

Complaints of inability to access prescriptions for other reasons include: pharmacy submitting claim incorrectly; prescribing provider prescribing a non-Medicaid covered medication; and doctor prescribing an amount that is not covered by Medicaid.

Complaints of inability to access prescriptions are due to pharmacy systems showing other insurance aside from Medicaid; however, consumer did not have any other insurance at the time of service.

Complaints of consumer being billed are due to providers billing consumers for all or part of services provided although consumers were active with Medicaid at the time of service; or Medicare providers billing the dual-eligible consumer (a consumer that has both Medicaid and Medicare) for the balance of acute care services provided when the provider should have billed traditional Medicaid for the balance that Medicare does not cover.

Top 5 Complaints by Medicaid Managed Care Program

In the previous section of this report, complaints were analyzed by the entity responsible. In this section, complaints are analyzed by the Medicaid program that consumers had at the time of the complaint.

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 (526,827*)
Complaints -- (962 total/149 substantiated)

Table 8 STAR+PLUS Top 5 Complaints

Top 5 Complaint Reasons	Count	Substantiated	% of Substantiated**
Access to LTSS	142	40	4%
Balance Billing	69	12	1%
Access to DME	59	8	1%
Medicaid Eligibility/Recertification	44	2	0%
Access to Prescription - Other	42	4	0%

*average monthly enrollment **represents percent of total substantiated complaints

OMCAT received 962 complaints from consumers in the STAR+PLUS program in the fourth quarter, and of those 149 (15%) complaints were substantiated. Complaints decreased by seven percent (-70) and the percentage of substantiated complaints decreased by two percent compared to the third quarter. The top five complaints noted in the table above make up 37 percent of the total complaints received by consumers on STAR+PLUS.

Substantiated complaints of accessing long term services and supports (LTSS) include: starting home health services after being authorized; interruptions in receiving home health services due to break in Medicaid eligibility, incorrect information on the Medicaid case, or due to health plan change; obtaining home health services through the Consumer Direct Services option; obtaining an assessment for home health services; not all approved hours covered by the home health agency; transitioning from a facility to the community or from the community to a facility; obtaining respite services; decreases in home health provider hours; and home health provider not being paid.

Substantiated complaints of billing issues include: provider billing dual eligible consumers instead of billing traditional Medicaid for the balance that Medicare does not cover; and providers billing consumers when claims are denied by the MCO.

Substantiated complaints of accessing DME include: access to mobility devices (such as wheelchairs, scooters, walkers and lifts), hearing aids, pain management supplies, and diabetic supplies. Problems with accessing medical equipment and supplies are due to equipment needing repairs, delays in receiving supplies, and not receiving all supplies authorized.

STAR (2,867,873*)
Complaints -- (719 total/141 substantiated)

Table 9 STAR Top 5 Complaints

Top 5 Complaint Reasons	Count	Substantiated	% of Substantiated**
Access to Prescriptions - Other Insurance	93	30	21%
Balance Billing	80	8	6%
Access to Prescriptions - Member Not Showing Active	62	33	23%
Case Information Error	44	7	5%
Access to Prescriptions - Other	39	9	6%

*average monthly enrollment **represents percent of total substantiated complaints

OMCAT received 719 complaints from consumers in the STAR program in the fourth quarter, and of those 141 (20%) complaints were substantiated. Complaints decreased by six percent (-48) and the percentage of substantiated complaints increased by one percent compared to the third quarter. The top five complaints noted in the table above make up 44 percent of the total complaints received by consumers on STAR.

Substantiated complaints of inability to access prescriptions due to other insurance showing in pharmacy systems are due to outdated insurance showing on the consumers' Medicaid cases in HHSC systems or on the MCO's pharmacy system.

Substantiated complaints of consumers receiving bills are due to providers billing consumers after receiving denial for payment by consumer's MCO. In these cases, the provider submitted the claims incorrectly causing the denial of payment.

Substantiated complaints of inability to access prescriptions due to consumer not showing as having active coverage in the MCO's pharmacy system are due to: MCOs not having updated eligibility files for the consumers in their system; or pharmacy systems that do not show active coverage for the consumer although the consumer is active with Medicaid.

Substantiated complaints related to errors on consumers' Medicaid cases include: misspelling of name; DOB incorrect; incorrect residential information; and incorrect SSN on case.

Substantiated complaints of inability to access prescriptions for other reasons include: pharmacies submitting claims incorrectly; and pharmacies with incorrect consumer information in their systems.

STAR Kids (158,872*)
Complaints -- (237 total/53 substantiated)

Table 10 STAR Kids Top 5 Complaints

Top 5 Complaint Reasons	Count	Substantiated	% of Substantiated**
Medicaid Eligibility/Recertification	19	0	0%
Access to DME	18	8	15%
Access to LTSS	18	5	9%
Service Coordination/Service Management	15	3	6%
Denial of Services	14	2	4%

*average monthly enrollment **represents percent of total substantiated complaints

OMCAT received 237 complaints from consumers in the STAR Kids program in the fourth quarter, and of those 53 (22%) were substantiated. Complaints increased by three percent (7) and the percentage of substantiated complaints decreased by five percent compared to the third quarter. The top five complaints noted in the table above make up 35 percent of the total complaints received by consumers on STAR Kids.

Substantiated complaints of accessing DME include: access to mobility devices (such as wheelchairs, scooters, walkers and lifts), incontinent supplies, backup ventilator, specialized car seat, hospital bed, and feeding tube supplies. Problems with accessing medical equipment and supplies are due to DME providers not knowing where to submit claims when consumers are in hospice, delays in delivery due to contract negotiations between DME provider and MCO, MCOs denying DME, or delays due to interruptions in Medicaid eligibility.

Substantiated complaints of accessing long term services and supports (LTSS) include: authorization issues for home health services; interruptions in home health services; and issues with the way the assessment for waiver services was performed.

STAR+PLUS Dual Demo (38,878*)
Complaints -- (48 total/5 substantiated)

Table 11 STAR Plus Dual Demo Top 5 Complaints

Top 5 Complaint Reasons	Count	Substantiated	% of Substantiated**
Balance Billing	7	0	0%
Denial of Services	4	0	0%
Disenrollment Request	3	0	0%
Rx - Medicare	3	0	0%
Access to LTSS	3	1	20%

*average monthly enrollment **represents percent of total substantiated complaints

OMCAT received 48 complaints from consumers in the STAR+PLUS Dual Demo program in the fourth quarter, and of those 5 (10%) complaints were substantiated. Complaints increased by four percent (2) and the percentage of substantiated complaints increased seven percent as compared to the third quarter. There was no trend identified in the entity related or types of complaints that were substantiated. The top five complaints noted in the table above make up 42 percent of the total complaints received by consumers on STAR+PLUS Dual Demo.

Complaints related to consumers being billed include: consumer receiving bills from out of network providers; consumer's part B Medicare premium not being paid although enrolled in a Medicare Savings Plan; consumer's home health provider not being paid by the home health agency; and consumers billed for various services received although active with Medicare and Medicaid at the time of service.

STAR Health (32,702*)
Complaints -- (15 total/1 substantiated)

Table 12 STAR Health Top 5 Complaints

Top 5 Complaint Reasons	Count	Substantiated	% of Substantiated**
Access to Prescriptions - Other	3	1	100%
Denial of Services	2	0	0%

Top 5 Complaint Reasons	Count	Substantiated	% of Substantiated**
Access to Prescriptions - Member Not Showing Active	2	0	0%
Balance Billing	2	0	0%
Access to Prescriptions - Billed Incorrect Health Plan	1	0	0%

*average monthly enrollment **represents percent of total substantiated complaints

OMCAT received 15 complaints from consumers in the STAR Health program in the fourth quarter, and of that one complaint was substantiated. Complaints decreased by six percent (-1) and the percentage of substantiated complaints increased seven percent as compared to the third quarter. The top five complaints noted in the table above make up 67 percent of the total complaints received by consumers on STAR Health.

Dental Managed Care (2,767,643*) Complaints -- (54 total/7 substantiated)

Table 13 Dental Managed Care Top 5 Complaints

Top 5 Complaint Reasons	Count	Substantiated	% of Substantiated**
Provider Treatment Inappropriate/Ineffective	10	0	0%
Fair Hearing/Appeals	5	1	14%
Authorization Issue	5	1	14%
Access to In-Network Provider (non-PCP)	4	2	29%
Fraud	3	0	0%

*average monthly enrollment **represents percent of total substantiated complaints

OMCAT received 54 complaints from consumers in the Dental Managed Care program in the fourth quarter, and of those 7 (13%) complaints were

substantiated. Complaints increased by 20 percent (9) and the percentage of substantiated complaints increased by nine percent compared to the fourth quarter. The top five complaints noted in the table above make up 50 percent of the total complaints received by consumers on Dental Managed Care.

Complaints related to provider treatment being inappropriate or ineffective that OMCAT was not able to substantiate include: a dental provider who provided a local anesthetic to remove wisdom teeth for a consumer with a developmental disability; a consumer who had to wait seven months for the dental provider to get authorization to repair a broken tooth and refused to provide further services to the consumer; dental services to treat one cavity were delayed a year while the dental provider researched how best to treat the consumer who had a heart problem and by the time treatment was provided, one cavity turned into seven cavities; a dental provider who did not attend to a consumer whose fillings had fallen out but ordered x-rays and a cleaning instead; a dental provider who cancelled an appointment without prior notice to the consumer; and a consumer who was reported by a dental provider as has having missed an appointment the consumer had never scheduled.

Fee for Service/Traditional Medicaid (242,167*) Complaints -- (512 total/110 substantiated)

Table 14 Fee For Service Top 5 Complaints

Top 5 Complaint Reasons	Count	Substantiated	% of Substantiated**
Access to Prescriptions - Other	46	8	7%
Access to Prescriptions - Other Insurance	42	11	10%
Medicaid Eligibility/Recertification	42	6	5%
Access to Prescriptions - Billed Incorrect Health Plan	38	24	22%
Access to Prescriptions - Non-Medicaid Provider	35	5	5%

*average monthly enrollment **represents percent of total substantiated complaints

OMCAT receives contacts from all consumers on Medicaid. This includes those that are on traditional Medicaid which means they are not enrolled with an MCO.

OMCAT received 512 complaints from consumers in the Fee for Service/Traditional Medicaid program in the fourth quarter, and of those 110

(21%) were substantiated. Complaints decreased by ten percent (-57) and the percentage of substantiated complaints decreased by five percent compared to the third quarter. The top five complaints noted in the table above make up 40 percent of the total complaints received by consumers on Fee for Service/Traditional Medicaid.

Substantiated complaints of inability to access prescriptions due to claims submitted to incorrect health plan include: pharmacies submitting claims to a consumer's previous Medicaid or CHIP MCO instead of to traditional Medicaid.

Substantiated complaints of inability to access prescriptions due to other insurance showing in pharmacy systems are due to outdated insurance showing on the consumers' Medicaid cases in HHSC systems or in the pharmacy's system.

Substantiated complaints of inability to access prescriptions for other reasons include: pharmacy billed under incorrect Medicaid ID number; doctors prescribed 12 refills for birth control for consumers on Texas Healthy Women's program, however only 11 refills are covered; pharmacies incorrectly processing claims; and consumers being told by pharmacies that their prescription was denied but when ombudsmen contacted the pharmacy, the prescriptions had already been filled.

No Medicaid Complaints -- (524 total/22 substantiated)

Table 15 No Medicaid Top 5 Complaints

Top 5 Complaint Reasons	Count	Substantiated	% of Substantiated*
Medicaid Eligibility/Recertification	230	12	55%
Balance Billing	62	3	14%
Case Information Error	42	1	5%
Access to LTSS	16	1	5%
Other/NA	14	0	0%

*represents percent of total substantiated complaints

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. Many of these contacts are related to clients applying or reapplying for Medicaid. Below are the top five complaints from these consumers.

OMCAT received 524 complaints from consumers who were not on Medicaid in the fourth quarter, and of those 22 (4%) were substantiated. Complaints increased by 11 percent (50) and the percentage of substantiated complaints increased by one percent as compared to the third quarter. The top five complaints noted in the table above make up 69 percent of the total complaints received of No Medicaid.

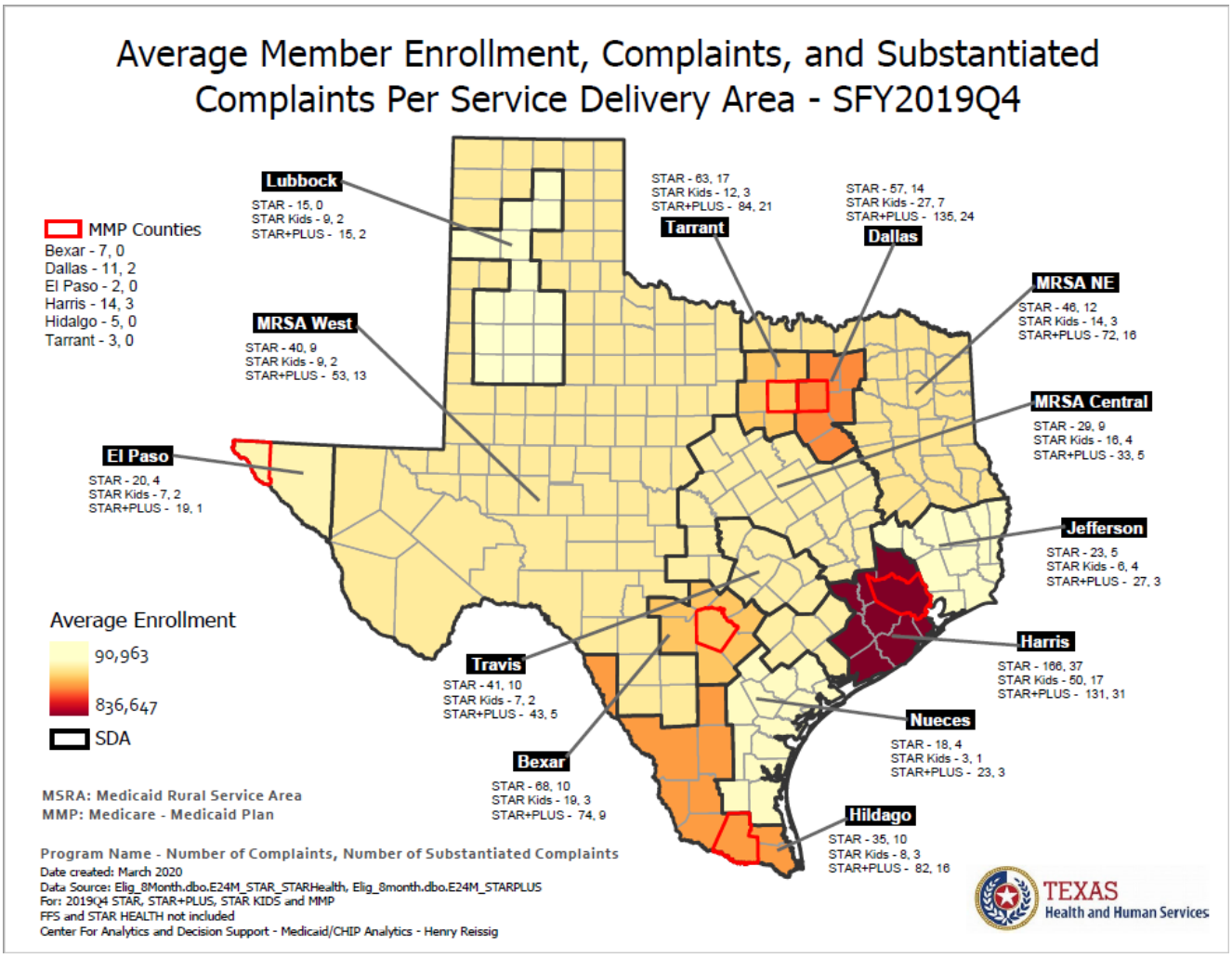
Substantiated complaints related to Medicaid eligibility and recertification include: applications not processed within required timeframes; cases denied for failure to provide additional information, but the information requested was provided timely; consumer certified for the incorrect type of Medicaid; and a file interface from SSA that was not processed correctly by HHS systems resulting in the early termination of an SSI Medicaid case.

Service Area Complaints and Inquiries

Map of Managed Care Service Areas and Related Complaints

The map includes all complaints and substantiated complaints by program type for each service area. Here's a map of the Texas Managed Care Service Areas.

Figure 4 Managed Care Service Areas and Related Complaints Map



Top 5 Reasons for Complaints and Inquiries by Service Area

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

Bexar (320,583*)
Complaints -- (203 total/22 substantiated)

Table 16 Bexar Top 5 Complaints

Bexar – Top 5 Complaints	Count	Substantiated	% of Substantiated**
Access to LTSS	21	3	14%

Bexar – Top 5 Complaints	Count	Substantiated	% of Substantiated**
Access to Prescriptions - Other Insurance	16	5	23%
Balance Billing	16	1	5%
Access to In-Network Provider (non-PCP)	13	1	5%
Access to DME	10	2	9%

Table 17 Bexar Top 5 Inquiries

Bexar – Top 5 Inquiries	Count
Verify Health Coverage	47
Access to PCP/Change PCP	34
Change Plan	23
Access to LTSS	19
Reporting Change	19

*average monthly enrollment **represents percent of total substantiated complaints

OMCAT received 203 complaints from consumers in the Bexar Service Area in the fourth quarter, and of those 22 (11%) were substantiated. Complaints decreased by four percent (-9) and the percentage of substantiated complaints increased by seven percent compared to the third quarter. The top five complaints noted in the table above make up 37 percent of the total complaints received of Bexar Service Area.

Dallas (467,532*)
Complaints -- (276 total/47 substantiated)

Table 18 Dallas Top 5 Complaints

Dallas – Top 5 Complaints	Count	Substantiated	% of Substantiated**
Access to LTSS	29	7	15%
Balance Billing	23	2	4%
Access to Prescriptions - Other	17	2	4%
Access to In-Network Provider (non-PCP)	15	0	0%
Case Information Error	12	3	6%

Table 19 Dallas Top 5 Inquiries

Dallas – Top 5 Inquiries	Count
Verify Health Coverage	47
Access to PCP/Change PCP	27
Change Plan	25
Explanation of Benefits/Policy	23
Reporting Change	20

*average monthly enrollment **represents percent of total substantiated complaints

OMCAT received 276 complaints from consumers in the Dallas Service Area in the fourth quarter, and of those 47 (17%) were substantiated. Complaints decreased by four percent (-11) and the percentage of substantiated complaints decreased by one percent as compared to the third quarter. The top five complaints noted in the table above make up 35 percent of the total complaints received of Dallas Service Area.

El Paso (149,952*)
Complaints -- (56 total/7 substantiated)

Table 20 El Paso Top 5 Complaints

El Paso – Top 5 Complaints	Count	Substantiated	% of Substantiated**
Balance Billing	6	1	14%
Access to Prescriptions - Other	4	0	0%
Authorization Issue	4	0	0%
Access to Prescriptions - Member Not Showing Active	3	1	14%
Case Information Error	3	1	14%

Table 21 El Paso Top 5 Inquiries

El Paso – Top 5 Inquiries	Count
Verify Health Coverage	9
Billing Inquiry	7
Explanation of Benefits/Policy	5
Access to PCP/Change PCP	2
Referral/Authorization	2

*average monthly enrollment **represents percent of total substantiated complaints

OMCAT received 56 complaints from consumers in the El Paso Service Area in the fourth quarter, and of those 7 (13%) were substantiated. Complaints increased by twelve percent (6) and the percentage of substantiated complaints decreased by three percent compared to the third quarter. The top five complaints noted in the table above make up to 36 percent of the total complaints received of El Paso Service Area.

Harris (836,647*)
Complaints -- (436 total/88 substantiated)

Table 22 Harris Top 5 Complaints

Harris – Top 5 Complaints	Count	Substantiated	% of Substantiated**
Balance Billing	36	6	7%
Access to LTSS	29	9	10%
Access to Prescriptions – Not showing active in systems	28	19	22%
Access to Prescriptions - Other Insurance on File	28	10	11%
Access to Prescriptions - Other	21	5	6%

Table 23 Harris Top 5 Inquiries

Harris – Top 5 Inquiries	Count
Verify Health Coverage	74
Access to PCP/Change PCP	39
Explanation of Benefits/Policy	38
Reporting Change	34
Change Plan	31

*average monthly enrollment **represents percent of total substantiated complaints

OMCAT received 436 complaints from consumers in the Harris Service Area in the fourth quarter, and of those 88 (20%) were substantiated. Complaints decreased by eight percent (39) and the percentage of substantiated complaints decreased by one percent compared to the third quarter. The top five complaints noted in the table above make up 33 percent of the total complaints received of Harris Service Area.

Hidalgo (428,299*)
Complaints -- (163 total/29 substantiated)

Table 24 Hidalgo Top 5 Complaints

Hidalgo – Top 5 Complaints	Count	Substantiated	% of Substantiated**
Access to LTSS	21	8	28%
Balance Billing	16	1	3%
Case Information Error	13	2	7%
Provider Treatment Inappropriate/Ineffective	10	1	3%
Access to DME	10	3	10%

Table 25 Hidalgo Top 5 Inquiries

Hidalgo – Top 5 Inquiries	Count
Verify Health Coverage	29
Access to LTSS	25
Access to PCP/Change PCP	19
Reporting Change	17
Explanation of Benefits/Policy	16

*average monthly enrollment **represents percent of total substantiated complaints

OMCAT received 163 complaints from consumers in the Hidalgo Service Area in the fourth quarter, and of those 29 (18%) were substantiated. Complaints decreased by six percent (-11) and the percentage of substantiated complaints decreased by six percent compared to the third quarter. The top five complaints noted in the table above make up 43 percent of the total complaints received of Hidalgo Service Area.

Jefferson (103,070*)
Complaints -- (64 total/12 substantiated)

Table 26 Jefferson Top 5 Complaints

Jefferson – Top 5 Complaints	Count	Substantiated	% of Substantiated**
Access to Prescriptions - Other Insurance	11	2	17%
Access to Prescriptions - Member Not Showing Active	5	4	33%
Access to Prescriptions - Other	5	0	0%
Access to In-Network Provider (non-PCP)	5	0	0%
Access to Prescriptions - Prior Authorization	5	1	8%

Table 27 Jefferson Top 5 Inquiries

Jefferson - Top 5 Inquiries	Count
Billing Inquiry	6
Access to LTSS	5
Reporting Change	5
Obtain Health Plan ID card	4
Access to PCP/Change PCP	4

*average monthly enrollment **represents percent of total substantiated complaints

OMCAT received 64 complaints from consumers in the Jefferson Service Area in the fourth quarter, and of those 12 (19%) were substantiated. Complaints decreased by 16 percent (-12) and the percentage of substantiated complaints increased by 14 percent compared to the third quarter.

Lubbock (90,963*)
Complaints -- (42 total/4 substantiated)

Table 28 Lubbock Top 5 Complaints

Lubbock – Top 5 Complaints	Count	Substantiated	% of Substantiated**
Access to Prescriptions - Prior Authorization	5	1	25%
Access to Prescriptions - Other Insurance	4	1	25%
Access to Prescriptions - Other	3	0	0%
Access to LTSS	3	0	0%
Balance Billing	3	0	0%

Table 29 Lubbock Top 5 Inquiries

Lubbock – Top 5 Inquiries	Count
Access to PCP/Change PCP	7
Verify Health Coverage	6
Reporting Change	5
Explanation of Benefits/Policy	4
Access to LTSS	4

*average monthly enrollment **represents percent of total substantiated complaints

OMCAT received 42 complaints from consumers in the Lubbock Service Area in the fourth quarter, and of those 4 (10%) were substantiated. Complaints decreased by 9 percent (-4) and the percentage of substantiated complaints increased by 10 percent compared to the third quarter.

MRSA Central (177,011*)
Complaints -- (95 total/18 substantiated)

Table 30 MRSA Central Top 5 Complaints

MRSA Central – Top 5 Complaints	Count	Substantiated	% of Substantiated**
Access to LTSS	11	2	11%
Case Information Error	8	1	6%
Access to DME	8	1	6%
Medicaid Eligibility/Recertification	8	1	6%
Access to Prescriptions - Member Not Showing Active	7	4	22%

Table 31 MRSA Central Top 5 Inquiries

MRSA Central – Top 5 Inquiries	Count
Verify Health Coverage	18
Change Plan	18
Access to PCP/Change PCP	15
Access to LTSS	9
Billing Inquiry	9

*average monthly enrollment **represents percent of total substantiated complaints

OMCAT received 95 complaints from consumers in the MRSA Central Service Area in the fourth quarter, and of those 18 (19%) were substantiated. Complaints decreased by 14 percent (-16) and the percentage of substantiated complaints decreased by four percent compared to the third quarter. The top five complaints noted in the table above make up 44 percent of the total complaints received of MRSA Central Service Area.

MRSA Northeast (223,363*)
Complaints -- (159 total/31 substantiated)

Table 32 MRSA Northeast Top 5 Complaints

MRSA Northeast – Top 5 Complaints	Count	Substantiated	% of Substantiated**
Access to Prescriptions - Other Insurance	16	7	23%
Access to LTSS	12	5	16%
Balance Billing	11	2	6%
Case Information Error	10	3	10%
Medicaid Eligibility/Recertification	9	0	0%

Table 33 MRSA Northeast Top 5 Inquiries

MRSA Northeast – Top 5 Inquiries	Count
Verify Health Coverage	25
Access to PCP/Change PCP	19
Obtain Health Plan ID card	12
Change Plan	12
Explanation of Benefits/Policy	10

*average monthly enrollment **represents percent of total substantiated complaints

OMCAT received 159 complaints from consumers in the MRSA Northeast Service Area in the fourth quarter, and of those 31 (19%) were substantiated. Complaints decreased by five percent (-9) and the percentage of substantiated complaints decreased by five percent compared to the third quarter.

MRSA West (191,872*)
Complaints -- (119 total/24 substantiated)

Table 34 MRSA West Top 5 Complaints

MRSA West – Top 5 Complaints	Count	Substantiated	% of Substantiated**
Access to LTSS	11	6	25%
Medicaid Eligibility/Recertification	9	0	0%
Balance Billing	8	0	0%
Access to Prescriptions - Other Insurance	7	2	8%
Access to DME	7	1	4%

Table 35 MRSA West Top 5 Inquiries

MRSA West – Top 5 Inquiries	Count
Explanation of Benefits/Policy	15
Adult Dental	13
Verify Health Coverage	13
Other/NA	11
Reporting Change	10

*average monthly enrollment **represents percent of total substantiated complaints

OMCAT received 119 complaints from consumers in the MRSA West Service Area in the fourth quarter, and of those 24 (20%) were substantiated. Complaints increased by 23 percent (22) and the percentage of substantiated complaints decreased by five percent compared to the third quarter. The top five complaints noted in the table above make up 35 percent of the total complaints received of MRSA West Service Area.

Nueces (112,235*)
Complaints -- (51 total/8 substantiated)

Table 36 Nueces Top 5 Complaints

Nueces – Top 5 Complaints	Count	Substantiated	% of Substantiated**
Access to Prescriptions - Other Insurance	6	1	13%
Access to Prescriptions - Prior Authorization	4	0	0%
Access to Prescriptions - Member Not Showing Active	3	2	25%
Authorization Issue	3	0	0%
Access to Prescriptions - Other	3	1	13%

Table 37 Nueces Top 5 Inquiries

Nueces – Top 5 Inquiries	Count
Verify Health Coverage	10
Access to PCP/Change PCP	9
Access to LTSS	9
Change Plan	8
Access to Specialist	7

*average monthly enrollment **represents percent of total substantiated complaints

OMCAT received 51 complaints from consumers in the Nueces Service Area in the fourth quarter, and of those 8 (16%) were substantiated. Complaints decreased by four percent (-2) and the percentage of substantiated complaints increased by five percent compared to the third quarter. The top five complaints noted in the table above make up 37 percent of the total complaints received of Nueces Area.

Tarrant (318,422*)
Complaints -- (193 total/41 substantiated)

Table 38 Tarrant Top 5 Complaints

Tarrant – Top 5 Complaints	Count	Substantiated	% of Substantiated**
Balance Billing	20	4	10%
Access to LTSS	15	4	10%
Access to Prescriptions - Other Insurance	13	5	12%
Access to Prescriptions - Other	12	2	5%
Access to Prescriptions - Member Not Showing Active	11	7	17%

Table 39 Tarrant Top 5 Inquiries

Tarrant – Top 5 Inquiries	Count
Verify Health Coverage	47
Reporting Change	22
Explanation of Benefits/Policy	19
Access to PCP/Change PCP	19
Access to LTSS	18

*average monthly enrollment **represents percent of total substantiated complaints

OMCAT received 193 complaints from consumers in the Tarrant Service Area in the fourth quarter, and of those 41 (21%) were substantiated. Complaints decreased by 14 percent (-31) and the percentage of substantiated complaints decreased by four percent compared to the third quarter. The top five complaints noted in the table above make up 37 percent of the total complaints received of Tarrant Area.

Travis (175,500*)
Complaints -- (109 total/17 substantiated)

Table 40 Travis Top 5 Complaints

Travis – Top 5 Complaints	Count	Substantiated	% of Substantiated**
Balance Billing	16	3	18%
Access to LTSS	12	1	6%
Medicaid Eligibility/Recertification	9	1	6%
Case Information Error	7	1	6%
Access to In-Network Provider (non-PCP)	6	2	12%

Table 41 Travis Top 5 Inquiries

Travis – Top 5 Inquiries	Count
Verify Health Coverage	18
Explanation of Benefits/Policy	14
Access to PCP/Change PCP	11
Billing Inquiry	11
Obtain Health Plan ID card	10

*average monthly enrollment **represents percent of total substantiated complaints

OMCAT received 109 complaints from consumers in the Travis Service Area in the fourth quarter, and of those 17 (16%) were substantiated. Complaints increased by eight percent (8) and the percentage of substantiated complaints increased by one percent compared to the third quarter. The top five complaints noted in the table above make up 46 percent of the total complaints received of Travis Area.

5. Barriers and Recommendations to Address Them

Access to prescriptions

Access to prescriptions made up 47% of all substantiated 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 continue to be the top two reasons for complaints related to accessing prescriptions.

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--remained the top substantiated complaint this fiscal year. This occurs when consumers are retroactively enrolled with an MCO after the first of the month due to their re-certification with Medicaid occurring after the first of the month. Their eligibility with the MCO is sent to the MCO on a daily file; however, if that daily file is not uploaded by the MCO soon after receiving it, the MCO will not show that consumer as their member in their system.

OMCAT recommends that HHSC require the MCOs to upload daily files to their systems within one business day of receiving the files.

6. Ombudsman Collaboration and Initiatives

OMCAT collaborates with HHS programs and MCOs in identifying and resolving barriers to accessing Medicaid services. During the fourth quarter of fiscal year 2019, OMCAT worked with Medicaid and CHIP Services' Managed Care Compliance and Operations (MCCO), the organization within HHSC that has oversight of the MCO contracts, to resolve a consumer's issue.

The consumer had a minor home modification (MHM) installed over a year prior to receipt of the complaint and since that installation the MHM had caused damage to the consumer's manufactured home. OMCAT worked with MCCO and the consumer's MCO to have the MHM and repairs needed to the home assessed. Through ongoing collaboration between parties, the MCO agreed to replace the manufactured home with a new model that was ADA compliant to accommodate the consumer's mobility issues. This consumer issue was extraordinary in that it was unprecedented and required extensive collaboration among HHS program areas as well as the MCO to resolve.

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 continues to work 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.

7. Conclusion

OMCAT is the HHS's public facing contact for consumers who need to make complaints and inquiries regarding Medicaid services. 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.

In the fourth quarter of FY 2019, Access to Prescriptions was the top reason for complaints and OMCAT will seek opportunities to work with HHSC Medicaid CHIP Services in finding ways to address and prevent these issues.

8. Glossary

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

Complaint – A contact regarding any expression of dissatisfaction.

Dual Eligible – A consumer that has both Medicaid and Medicare.

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.

Lock-In Program – The program restricts consumers whose use of medical services is documented as being excessive. Consumers are "Locked-In" to a specific pharmacy to prevent consumers from obtaining excessive quantities of prescribed drugs through multiple visits to physicians and pharmacies.

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.

Medicare Savings Program – the use of Medicaid funds to help eligible consumers pay for all or some of their out-of-pocket Medicare expenses, such as premiums, deductibles or co-insurance.

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