Quarterly Report from the HHS Ombudsman Managed Care Assistance Team 3rd Quarter FY 2019

As Required by

Section 531.0213 of the

Government Code

TEXAS
Health and Human Services

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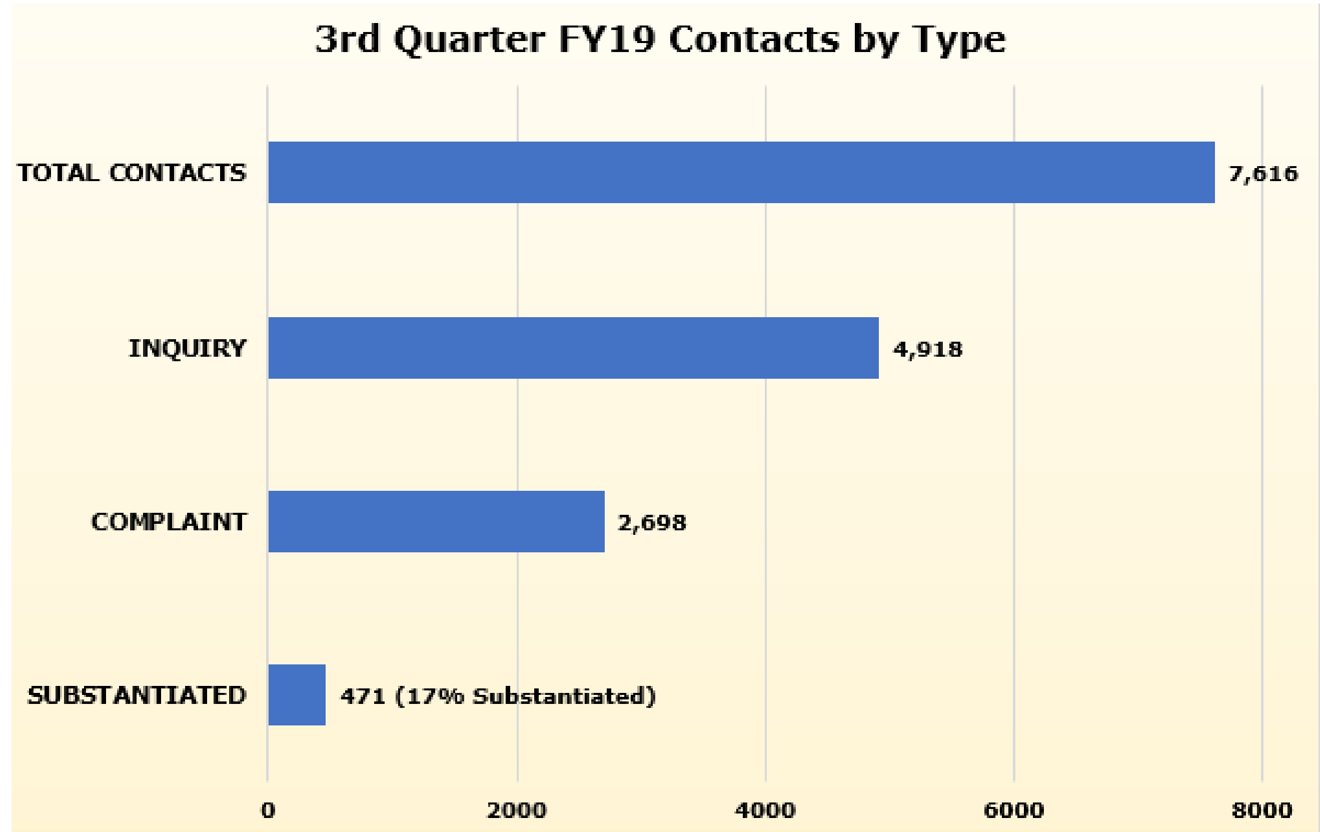
Executive Summary

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 7,616 contacts during the third quarter of fiscal year 2019; of these contacts, 2,698 were complaints and 4,918 were inquiries. Of the complaints that were received, 471 were substantiated, 389 were unsubstantiated, and 1,838 were unable to be substantiated (e.g. there was not enough evidence to determine whether agency policy or expectations were violated).

Figure 1 3rd Quarter FY19 Contacts by Type



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

- Medicaid Eligibility/Recertification
- Billing Issues
- Access to Long Term Services and Supports
- Prescription Services – Other Insurance
- Case Information Error

This report contains recommendations to mitigate issues related to consumer access to prescriptions that is hindered by erroneous insurance information on Medicaid cases. These continue to be 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 through HHS programs and their vendors.

The report provides high-level information regarding consumer inquiries and complaints reported to OMCAT during the third 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 third 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 Managed Care Organizations (MCO) 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 third quarter of fiscal year 2019, a complaint was received regarding an MCO that was utilizing its own guideline to determine medical necessity for Private Duty Nursing (PDN) services. The complainant believed this was the reason numerous consumers were being denied PDN services. OMCAT reviewed Texas Administrative Code (TAC) and the MCO’s policy related to eligibility for PDN services and found that the MCO’s policy requiring the consumer to have a complex medical condition, which was then further defined by the MCO, did not align with the requirements for PDN in TAC. OMCAT provided a recommendation to HHSC to have the MCO’s policy amended by removing the requirement of having a complex medical condition in order to receive PDN services. HHSC responded that a Corrective Action Plan (CAP) was in place for the MCO and continues to monitor the CAP.

4. Contacts and Complaints

Contact Data Analysis - Total Contacts

OMCAT received 7,616 contacts in the third quarter of fiscal year 2019. Compared to the second quarter of fiscal year 2019, the third quarter saw an increase of ten percent (669) 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 4,918 inquiries, which is an increase of six percent (279), in the third quarter compared to the second 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 61.4% (3,018) of the total number of inquiries received during the third quarter. Nine of the top inquiry reasons remained the same compared to the second quarter except for Other/NA. The overall increase as well as the increase in contacts coded as Other/NA was due to the Managed Care Compliance Operations (MCO) program transferring consumer contacts by letter and fax to OMCAT. Many of those contacts did not provide enough detail to identify the issue or consumers had faxed forms to Managed Care Compliance Operations (MCCO) that were supposed to be faxed to the MCO, thus causing the increase in inquiries labeled as Other/NA.

Table 1 Top 10 Inquiries

Inquiry Reason	Count	Percent of Total
Verify Health Coverage	626	13%
Explanation of Benefits/Policy	421	9%
Access to PCP/Change PCP	328	7%
Caller Disconnected/Didn't respond*	317	6%
Apply for Health Coverage	310	6%
Access to Long Term Care	228	5%
Reporting Change	221	4%

Inquiry Reason	Count	Percent of Total
Billing Inquiry	199	4%
Other/NA	195	4%
Change Plan – Provider (PCP, Facility, DME)	173	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.

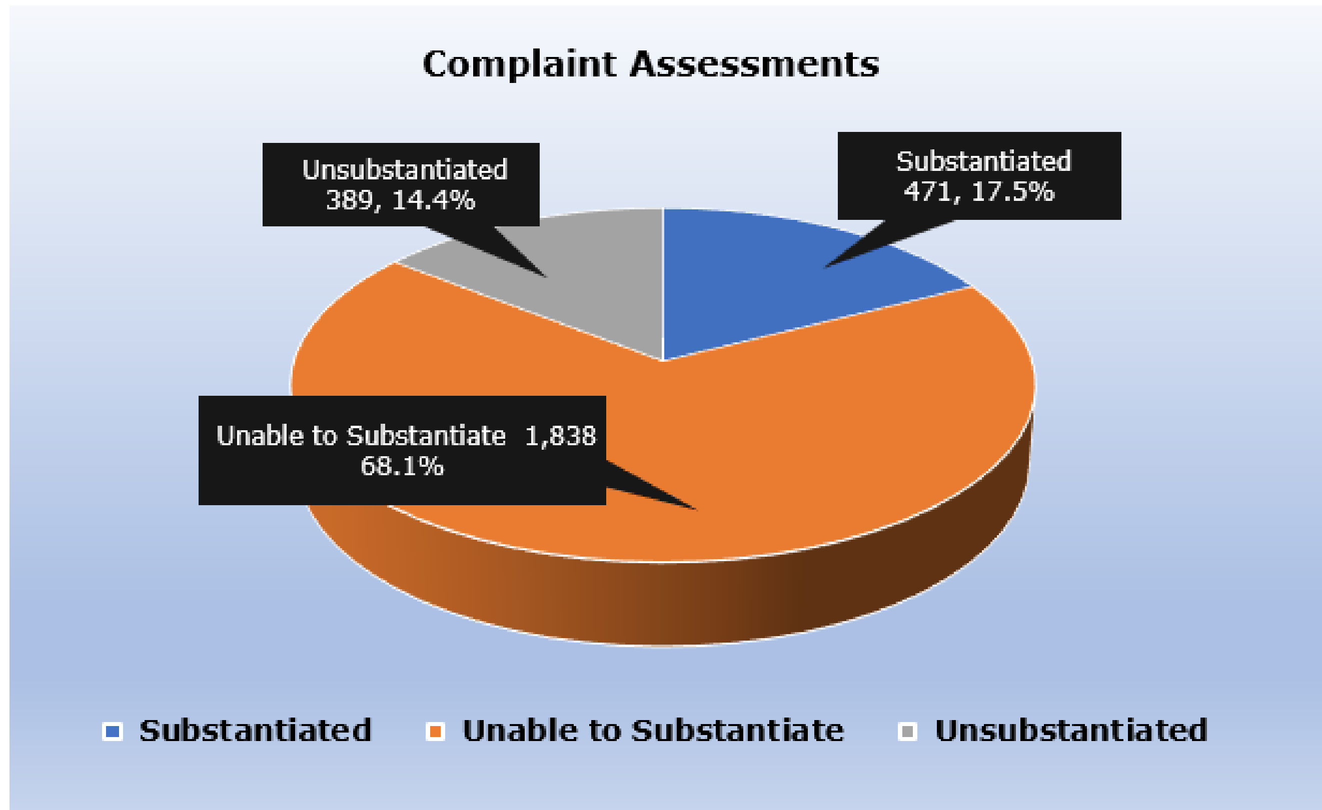
Complaint Data Analysis

OMCAT received 2,698 complaints, which is an increase of 17 percent (390), in the third quarter of fiscal year 2019 compared to the second quarter. OMCAT experienced an increase overall in different types of complaints which is common in the third quarter as compared to the second quarter during which the volume of contacts decreases due the holiday season. Complaints related to consumers receiving bills for Medicaid covered services increased the most during the third quarter of FY 2019 with an increase of 52% (+106). There was no trend identified among these complaints.

Substantiated Complaints (471)

OMCAT substantiated 17 percent of complaints received, which is a percentage increase of three percentage points (14%) compared to the second 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 Assessments



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 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 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 the pharmacy's system. (76);

Inability to access prescriptions due to erroneous insurance showing on the consumer's file with the MCO's or HHSC's systems (46);

Accessing long term services and supports (LTSS) such as in-home provider services (43);

Medicaid cases incorrectly denied, or coverage terminated in error (36);

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 cases (31);

Pharmacies running prescriptions through/billing the incorrect health plan (26);

Prescription services – Other (25);

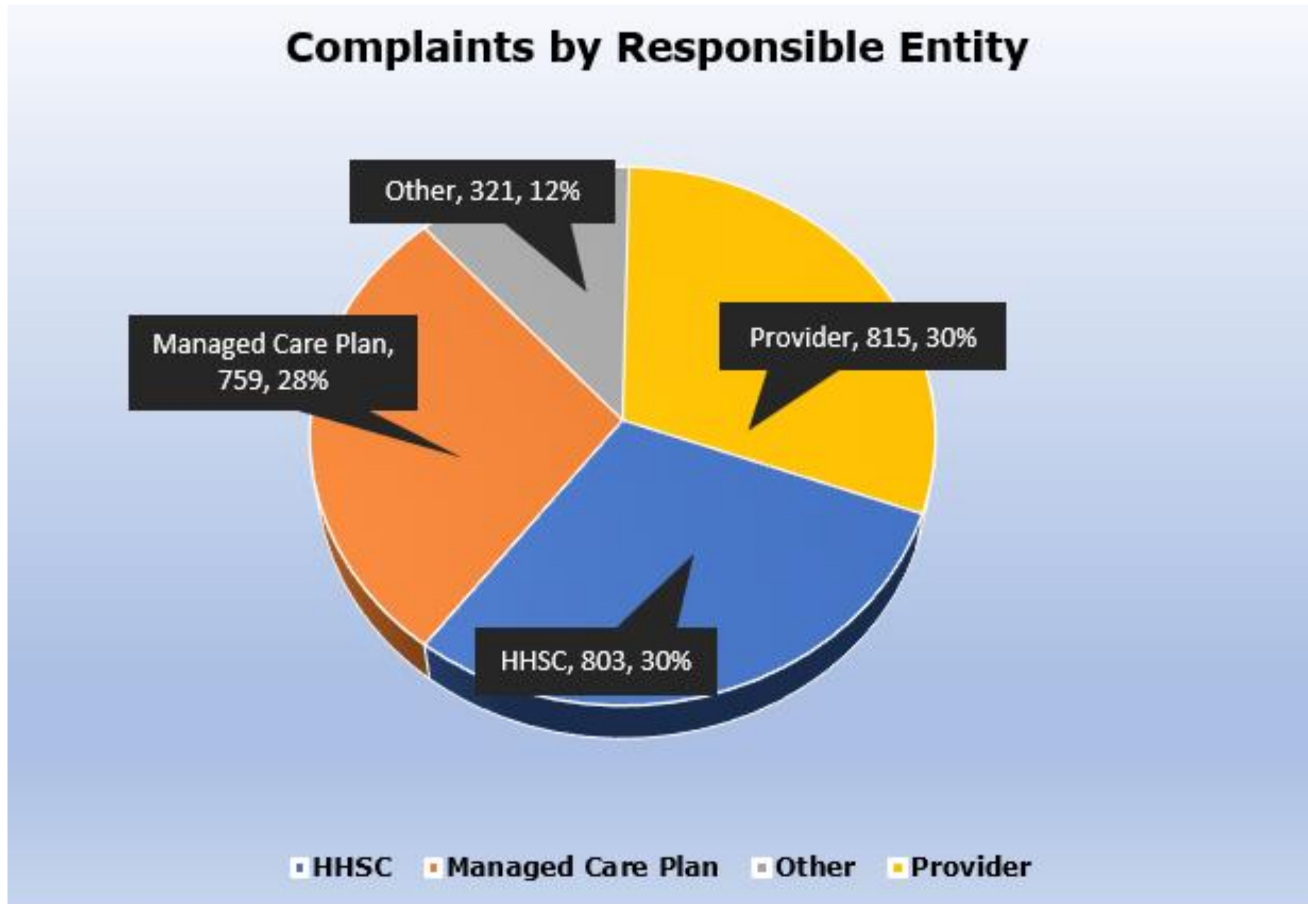
Inability to access durable medical equipment (DME) (24);

Consumers being billed by Medicaid providers (22); and

Prescriptions being delayed due to a prior authorization needed (19)

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 in 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 third qurter were found to be associated to three main responsible entities: managed care plans, HHSC, and providers. **HHSC** and **providers** were the Responsible Entity in 60 percent of complaints (1,618, 30 percent each), **Managed care plans** were the Responsible Entity in 28 percent of complaints (759), The remainder of complaints were against various entities not already mentioned and made up twelve percent (321) of all complaints received in the third 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	296	26	21%
Case Information Error	111	27	22%
Balance Billing	66	6	5%
Systems Issues	46	11	9%
Access to Prescriptions - Other Insurance on File	39	9	7%

Table 3 HHSC Top 5 Substantiated Complaints

HHSC Top 5 Substantiated Complaints	Count	Substantiated	% Substantiated*
Case Information Error	111	27	22%
Medicaid Eligibility/Recertification	296	26	21%
Access to Prescriptions - Not showing active in systems	35	12	10%
Systems Issues	46	11	9%
Access to Prescriptions - Other Insurance on File	39	9	7%

*represents percent of total substantiated complaints

There were 945 complaints received where the entity responsible for the complaint was HHSC. Of those complaints, 124 (13%) were substantiated. The third quarter had an increase of ten percent (88) in complaints compared to the second quarter (857). The third quarter had a percentage increase of one percent in substantiated complaints compared to the second quarter.

Substantiated complaints of incorrect information on consumer cases were related to incorrect DOB, incorrect spelling of consumer’s name, incorrect residential information, or incorrect employment information.

Substantiated complaints related to Medicaid eligibility include: not all HHSC systems were showing consumers as active with Medicaid due to consumers having recently recertified for Medicaid (it can take 3-5 days for all HHSC systems to show a consumer’s Medicaid coverage after recertification is complete); cases denied in error; and consumers who were unaware the Medicaid had terminated.

Substantiated complaints of inability to access prescriptions where consumers were not showing as having active Medicaid in pharmacy systems were due to consumers having to wait three to five business days after being deemed eligible for Medicaid before their coverage would show in pharmacy payment systems.

Substantiated complaints related to systems issues were due to consumers trying to access medical services other than prescriptions and not all HHSC, vendor or MCO systems showed the consumers as having active coverage.

Substantiated complaints of inability to access prescriptions due to erroneous insurance on Medicaid cases were related to consumers’ Medicaid cases showing private insurance that the consumer either no longer has or never had.

Managed Care Plans

Table 4 Managed Care Plans Top 5 Complaints

MCO Top 5 Complaints	Count	Substantiated	% Substantiated*
Access to LTSS	121	26	13%
Access to Prescriptions - Other Insurance on File	74	30	15%
Billing Issues	73	5	2%
Access to DME	65	14	7%
Access to Prescriptions - Not showing active in systems	56	39	19%

Table 5 Managed Care Plans Top 5 Substantiated Complaints

MCO Top 5 Substantiated Complaints	Count	Substantiated	% Substantiated*
Access to Prescriptions - Not showing active in systems	56	39	19%
Access to Prescriptions - Other Insurance on File	74	30	15%
Access to LTSS	121	26	13%
Access to DME	65	14	7%
Access to In-Network Provider (non-PCP)	50	10	5%

*represents percent of total substantiated complaints

There were 925 complaints received where the entity responsible for the complaint was an MCO. Of those complaints, 201 (22%) were substantiated. The third quarter had an increase of ten percent (87) in complaints compared to the second quarter (838). The third quarter had a percentage increase of three percent in substantiated complaints compared to the second quarter. The top five MCO complaints remained the same as compared to last quarter.

Substantiated complaints of inability to access prescriptions due to consumer not showing as having active coverage in the MCO's pharmacy system were due to the consumer's enrollment information being sent to the MCO on a daily file; however, the MCO didn't upload the file daily into their systems.

Substantiated complaints of inability to access prescriptions due to erroneous insurance on Medicaid cases were related to MCO consumer files showing private insurance or even Medicare coverage that the consumer either no longer or never had.

Substantiated complaints of accessing long term services and supports (LTSS) include: interruption in home health services, termination of home health services, issues with obtaining home health services; LTSS providers not being paid, issues with obtaining an assessment for home health services; issues with transitioning from a facility back into the community; and decreases in home health provider hours.

Substantiated complaints of in ability to access durable medical equipment (DME) include: access to mobility devices (such as wheelchairs, walkers and lifts), diabetic supplies, hospital beds, and hearing aids. Problems with accessing medical equipment and supplies were due to: not receiving assistance from the MCO in finding a DME provider; prescribing providers were not following through with all paperwork needed to obtain the DME; DME company no longer contracted with consumers' MCO; or DME

companies no longer providing supplies/equipment to consumers due to not being paid by MCOs.

Substantiated complaints of accessing an in-network provider were related to: MCO provider directories being outdated, MCO did not contract with the type of surgeon that consumer's condition required, or the closest in-network specialist was located much farther out than what is contractually required. Specialists that consumers had difficulty accessing included: behavioral health specialists, gastroenterologists, a maxillofacial surgeon, a pain management provider, and specialized surgeons.

Provider

Table 6 Provider Top 5 Complaints

Provider Top 5 Complaints	Count	Substantiated	% Substantiated*
Billing Issues	143	10	9%
Access to Prescriptions – Billed Incorrect Health Plan	88	25	23%
Access to Prescriptions – Other	81	13	12%
Access to Prescriptions - Prior Authorization	77	12	11%
Access to Prescriptions - Other Insurance on File	54	3	3%

Table 7 Provider Top 5 Substantiated Complaints

Provider Top 5 Substantiated Complaints	Count	Substantiated	% Substantiated*
Access to Prescriptions - Billed incorrect health plan	88	25	23%
Access to Prescriptions - Not showing active in systems	47	15	14%
Access to Prescriptions - Other	81	13	12%
Access to Prescriptions - Prior Authorization	77	12	11%

Provider Top 5 Substantiated Complaints	Count	Substantiated	% Substantiated*
Billing Issues	143	10	9%

*represents percent of total substantiated complaints

There were 928 complaints received where the entity, that the complaint was against, was a provider. Of those complaints, 109 (12%) were substantiated. The third quarter had an increase of 41 percent (270) in complaints compared to the second quarter. The third quarter had a percentage increase of four percent in substantiated complaints compared to the second 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 were due to pharmacies submitting claims to a consumer's previous MCO although the consumer had traditional Medicaid at the time of service.

Complaints of inability to access prescriptions due to provider not showing the consumer as having active coverage were related to pharmacies whose systems did not show consumer as 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; pharmacy's system erroneously rejected the prescription, pharmacy did not have an adequate supply of the medication, prescribing provider submitted the prescription to the wrong pharmacy, and the medication was denied because the prescription was written by a nurse practitioner instead of by a doctor.

Complaints of inability to access prescriptions due to authorizations required include: prescribing provider refused to request the authorization for the prescription; prescribing provider called in the authorization but the MCO still had not approved it after several days; consumer was waiting on their provider to request the authorization; and MCO denied prescription even though a prior authorization was called in by the prescribing provider.

Complaints of being billed for services include: consumers with Medicare and Medicaid who were billed for the portion that Medicaid would have covered; home health agency not paying consumer's attendant; consumer billed for a not showing up for a visit; consumer billed for services obtained out of state; and consumers billed by Medicaid providers although the consumers were active with Medicaid at time of service.

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 (525,964+)
Complaints -- (1,032 total/141 substantiated)

Table 8 STAR+PLUS Top 5 Complaints

Top 5 Complaint Reasons	Count	Substantiated	% of Substantiated*
Access to LTSS	147	34	24%
Billing Issues	103	9	6%
Access to DME	72	17	12%
Medicaid Eligibility/Recertification	54	2	1%
Authorization Issue	39	3	2%

+average monthly enrollment *represents percent of total substantiated complaints

OMCAT received 1,032 complaints from consumers in the STAR+PLUS program in the third quarter, and of those 141 (14%) complaints were substantiated. Complaints increased by 16 percent (145) and the percentage of substantiated complaints increased by two percent compared to the second quarter. The top five complaints noted in the table above make up 40 percent of the total complaints received by consumers on STAR+PLUS.

Substantiated complaints of accessing long term services and supports (LTSS) include: home health providers not being paid and therefore ceasing to provide services; home health agencies not able to cover all required attendant/nursing hours; issues with obtaining or the quality of minor home modifications; issues with obtaining an assessment for home health services; delay in authorized home health services starting; decreases in home health provider hours; MCO not showing consumer as an active member in their system; issues with Medicaid eligibility that interrupted home health services; issues with how the MCO conducted the assessment; and issues with obtaining assistance in transitioning from a facility back into the community.

Substantiated complaints of accessing DME include: access to wheelchairs, incontinent supplies, shower aids, hospital beds, hearing aids and diabetic supplies. Problems with

accessing medical equipment and supplies are due to equipment needing repairs, delays in authorization, billing issues with the DME provider, and interruption in Medicaid eligibility.

STAR (2,891,719+)
Complaints -- (767 total/159 substantiated)

Table 9 STAR Top 5 Complaints

Top 5 Complaint Reasons	Count	Substantiated	% of Substantiated*
Access to Prescriptions - Other Insurance on File	106	26	16%
Billing Issues	82	9	6%
Access to Prescriptions - Not showing active in systems	78	48	30%
Case Information Error	58	16	10%
Medicaid Eligibility/Recertification	55	11	7%

+average monthly enrollment *represents percent of total substantiated complaints

OMCAT received 767 complaints from consumers in the STAR program in the third quarter, and of those 159 (21%) complaints were substantiated. Complaints increased by 18 percent (115) and the percentage of substantiated complaints increased by three percent compared to the second quarter. The top five complaints noted in the table above make up 49 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.

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 the updated file for the consumer in their system; newborns and pregnant women whose eligibility file has not been uploaded by the MCO timely; or pharmacy systems that do not show active coverage for the consumer although the consumer is active with Medicaid.

STAR Kids (158,884+)
Complaints -- (230 total/40 substantiated)

Table 10 STAR Kids Top 5 Complaints

Top 5 Complaint Reasons	Count	Substantiated	% of Substantiated*
Billing Issues	19	2	5%
Access to Prescriptions - Other Insurance on File	19	5	13%
Access to LTSS	18	1	3%
Medicaid Eligibility / Recertification	18	5	13%
Access to DME	12	1	3%

+average monthly enrollment *represents percent of total substantiated complaints

OMCAT received 230 complaints from consumers in the STAR Kids program in the third quarter, and of those 40 (17%) were substantiated. Complaints increased by 43 percent (69) and the percentage of substantiated complaints decreased by five percent compared to the second quarter. The top five complaints noted in the table above make up 37 percent of the total complaints received by consumers on STAR Kids.

Substantiated complaints of inability to access prescriptions due to other insurance appearing 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 related to Medicaid eligibility and recertification are due to renewal for MDCP being delayed, and consumers not being able to access services due to being recently renewed for Medicaid but the MCO's system is not yet showing the consumers as active members.

STAR+PLUS Dual Demo (39,826+)
Complaints -- (46 total/8 substantiated)

Table 11 STAR Plus Dual Demo Top 5 Complaints

Top 5 Complaint Reasons	Count	Substantiated	% of Substantiated*
Access to LTSS	10	4	50%

Top 5 Complaint Reasons	Count	Substantiated	% of Substantiated*
Billing Issues	4	0	0%
Authorization Issue	3	1	13%
Medicaid Eligibility / Recertification	3	1	13%
Denial of Services	3	0	0%

+average monthly enrollment *represents percent of total substantiated complaints

OMCAT received 46 complaints from consumers in the STAR+PLUS Dual Demo program in the third quarter, and of those 8 (17%) complaints were substantiated. Complaints increased by 10 percent (4) and the percentage of substantiated complaints remained the same compared to the second 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 50 percent of the total complaints received by consumers on STAR+PLUS Dual Demo.

Substantiated complaints of access to long term services and supports include: access to respite services, home health agency not covering all attendant hours; interruption in home health services due to Enrollment Broker not updating the consumer's disenrollment from the Dual Demonstration; and interruption in home health services due to consumer being enrolled into the Dual Demonstration although the home health agency did not accept the Dual Demonstration health plan.

STAR Health (32,974+)
Complaints -- (16 total/0 substantiated)

Table 12 STAR Health Top 5 Complaints

Top 5 Complaint Reasons	Count	Substantiated	% of Substantiated*
Case Information Error	3	0	0%
Access to Prescriptions - Other	2	0	0%
Medicaid Eligibility / Recertification	2	0	0%

Top 5 Complaint Reasons	Count	Substantiated	% of Substantiated*
Billing Issues	2	0	0%
Access to Prescriptions – Other Insurance	1	0	0%

+average monthly enrollment *represents percent of total substantiated complaints

OMCAT received 16 complaints from consumers in the STAR Health program in the third quarter, and of those zero complaints were substantiated. Complaints decreased by 16 percent (-3) compared to the second quarter. The top five complaints noted in the table above make up 63 percent of the total complaints received by consumers on STAR Health.

Dental Managed Care (2,809,667+) Complaints -- (45 total/10 substantiated)

Table 13 Dental Managed Care Top 5 Complaints

Top 5 Complaint Reasons	Count	Substantiated	% of Substantiated*
Billing Issues	7	0	0%
Authorization Issue	6	1	10%
Access to In-Network Provider (non-PCP)	5	2	20%
Access to PCP	5	3	30%
Case Information Error	5	1	10%

+average monthly enrollment *represents percent of total substantiated complaints

OMCAT received 45 complaints from consumers in the Dental Managed Care program in the third quarter, and of those 10 (22%) complaints were substantiated. Complaints increased by 73 percent (19) and the percentage of substantiated complaints increased by seven percent compared to the second quarter. The top five complaints noted in the table above make up 62 percent of the total complaints received by consumers on Dental Managed Care.

Substantiated complaints of access to a dental PCP include: Dental Managed Care Organization (DMO) does not show the consumers' authorized representatives (AR) in their system preventing the ARs from being able to change the PCP; and a consumer was denied the right to change the PCP due to not having an AR over the age of 18 despite the fact that the consumer was of age and showed as head of household. All substantiated complaints were made against the same DMO.

Fee for Service/Traditional Medicaid (234,173+) Complaints -- (569 total/91 substantiated)

Table 14 Fee For Service Top 5 Complaints

Top 5 Complaint Reasons	Count	Substantiated	% of Substantiated*
Access to Prescriptions - Billed incorrect health plan	59	17	19%
Medicaid Eligibility/Recertification	54	4	4%
Access to Prescriptions - Other	47	9	10%
Access to Prescriptions – Prior Authorization	45	4	4%
Access to Prescriptions - Not showing active in systems	42	13	14%

+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 569 complaints from consumers in the Fee for Service/Traditional Medicaid program in the third quarter, and of those 91 (16%) were substantiated. Complaints increased by 46 percent (180) and the percentage of substantiated complaints increased by two percent compared to the second quarter. The top five complaints noted in the table above make up 43 percent of the total complaints received by consumers on Fee for Service/Traditional Medicaid.

Complaints of inability to access prescriptions due to pharmacy billing the wrong health plan are due to claims being submitted to consumers' previous MCO instead of to traditional 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 an issue with a consumer's coverage crossing over from HHSC systems to pharmacy systems.

No Medicaid
Complaints -- (474 total/22 substantiated)

Table 15 No Medicaid Top 5 Complaints

Top 5 Complaint Reasons	Count	Substantiated	% of Substantiated*
Medicaid Eligibility/Recertification	196	13	59%
Billing Issues	61	1	5%
Case Information Error	27	2	9%
Access to Prescriptions – Medicare	20	0	0%
Access to LTSS	18	1	5%

*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 consumers applying or reapplying for Medicaid. Below are the top five complaints from these consumers.

OMCAT received 474 complaints from consumers who were not on Medicaid in the third quarter, and of those 22 (5%) were substantiated. Complaints increased by 12 percent (50) and the percentage of substantiated complaints remained the same compared to the second quarter. The top five complaints noted in the table above make up 68 percent of the total complaints received of No Medicaid.

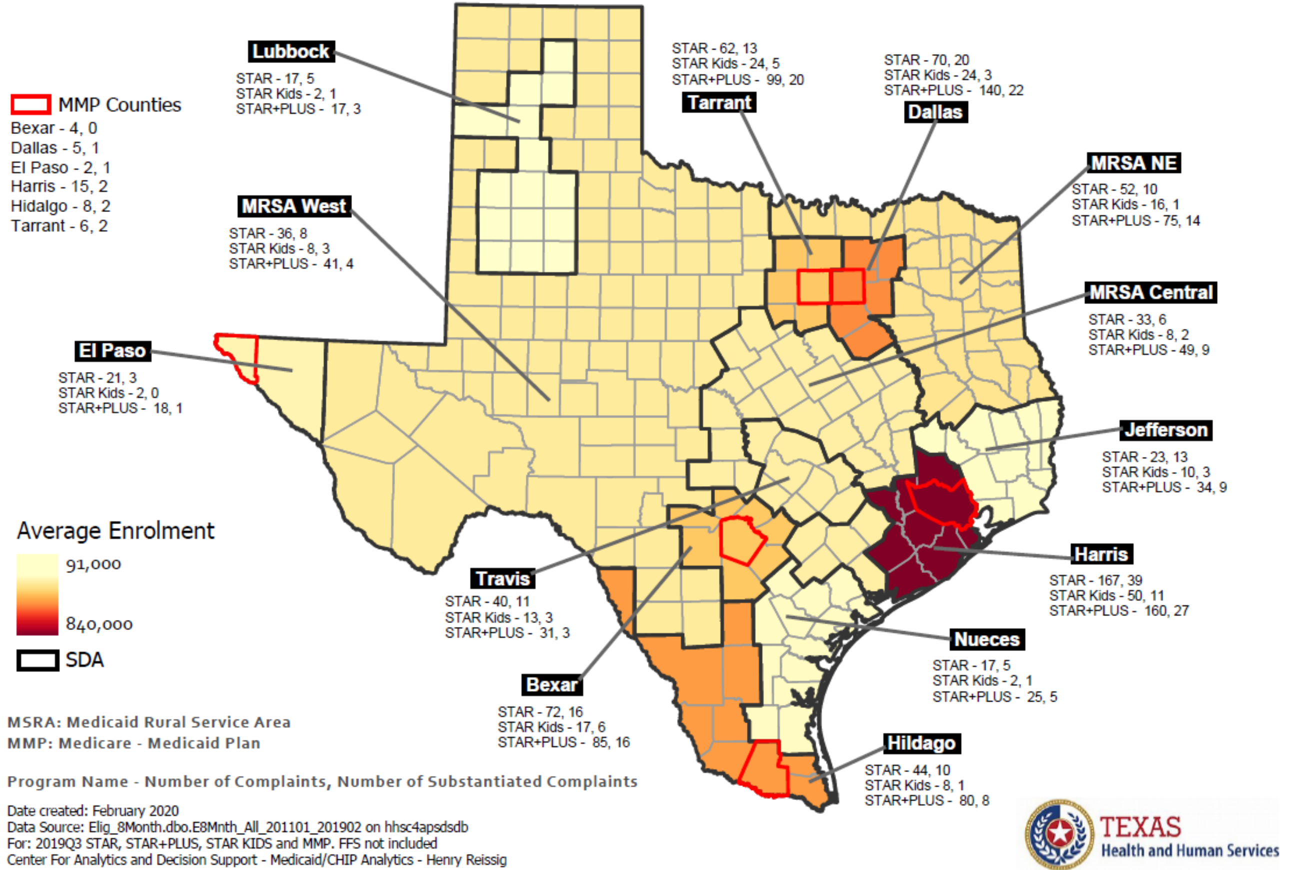
Substantiated complaints related to Medicaid eligibility and recertification include: consumers applications denied for failure to provide required documents however the documents were received timely by HHSC; consumers' cases terminated early in error; HHSC did not show consumers' Supplemental Security Income Medicaid (SSI) as active however, Social Security Administration (SSA) showed consumers as having active coverage; newborn not added to the case although mother reported the birth two months prior; consumer's child's coverage was erroneously denied when the consumer requested to withdraw the adult Medicaid; and no notice of denial was generated for a consumer when the Medicaid was denied.

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 (321,472+)
Complaints -- (212 total/38 substantiated)

Table 16 Bexar Top 5 Complaints

Bexar – Top 5 Complaints	Count	Substantiated	% of Substantiated*
Access to Prescriptions - Other Insurance on File	26	9	24%
Billing Issues	19	2	5%
Access to DME	17	5	13%
Access to LTSS	17	2	5%
Access to Prescriptions – Other	10	2	5%

Table 17 Bexar Top 5 Inquiries

Bexar – Top 5 Inquiries	Count
Access to PCP/Change PCP	38
Verify Health Coverage	28
Reporting Change	20
Explanation of Benefits/Policy	17
Access to Specialist	14

+average monthly enrollment *represents percent of total substantiated complaints

OMCAT received 212 complaints from consumers in the Bexar Service Area in the third quarter, and of those 38 (18%) were substantiated. Complaints increased by 7 percent (14) and the percentage of substantiated complaints increased by three percent compared to the second quarter. The top five complaints noted in the table above make up 42 percent of the total complaints received of Bexar Service Area.

Dallas (469,303+)
Complaints -- (287 total/46 substantiated)

Table 18 Dallas Top 5 Complaints

Dallas – Top 5 Complaints	Count	Substantiated	% of Substantiated*
Billing Issues	42	3	7%
Access to LTSS	30	7	15%
Medicaid Eligibility/Recertification	19	2	4%
Case Information Error	18	4	9%
Access to DME	14	3	7%

Table 19 Dallas Top 5 Inquiries

Dallas – Top 5 Inquiries	Count
Verify Health Coverage	28
Explanation of Benefits/Policy	28
Access to PCP/Change PCP	24
Access to Long Term Care	22
Change Plan-Provider (PCP, Facility, DME)	16

+average monthly enrollment *represents percent of total substantiated complaints

OMCAT received 287 complaints from consumers in the Dallas Service Area in the third quarter, and of those 46 (16%) were substantiated. Complaints increased by 13 percent (32) and the percentage of substantiated complaints remained the same compared to the second quarter. The top five complaints noted in the table above make up 43 percent of the total complaints received of Dallas Service Area.

El Paso (148,229+)
Complaints -- (50 total/5 substantiated)

Table 20 El Paso Top 5 Complaints

El Paso – Top 5 Complaints	Count	Substantiated	% of Substantiated*
Billing Issues	7	2	40%
Access to LTSS	6	1	20%
Access to DME	3	0	0%
Access to Prescriptions – Other	3	0	0%
Access to Prescriptions - Prior Authorization	3	2	40%

Table 21 El Paso Top 5 Inquiries

El Paso – Top 5 Inquiries	Count
Access to PCP/Change PCP	11
Reporting Change	8
Verify Health Coverage	7
Adult Dental	6
Change Plan-Provider (PCP, Facility, DME)	6

+average monthly enrollment *represents percent of total substantiated complaints

OMCAT received 50 complaints from consumers in the El Paso Service Area in the third quarter, and of those 5 (10%) were substantiated. Complaints decreased by seven percent (-4) and the percentage of substantiated complaints decreased by one percent compared to the second quarter. The top five complaints noted in the table above make up 44 percent of the total complaints received of El Paso Service Area.

Harris (844,860+)
Complaints -- (475 total/91 substantiated)

Table 22 Harris Top 5 Complaints

Harris – Top 5 Complaints	Count	Substantiated	% of Substantiated*
Billing Issues	46	4	11%
Access to LTSS	32	7	18%
Access to Prescriptions – Not showing active in systems	32	17	45%
Access to Prescriptions - Other Insurance on File	31	6	16%
Medicaid Eligibility/Recertification	28	5	13%

Table 23 Harris Top 5 Inquiries

Harris – Top 5 Inquiries	Count
Verify Health Coverage	56
Access to PCP/Change PCP	41
Explanation of Benefits/Policy	40
Change Plan-Provider (PCP, Facility, DME)	34
Reporting Change	30

+average monthly enrollment *represents percent of total substantiated complaints

OMCAT received 475 complaints from consumers in the Harris Service Area in the third quarter, and of those 91 (19%) were substantiated. Complaints increased by 39 percent (133) and the percentage of substantiated complaints increased by four percent compared to the second quarter. The top five complaints noted in the table above make up 36 percent of the total complaints received of Harris Service Area.

Five of the 17 substantiated complaints related to inability to access prescriptions due to consumer not showing active in systems were due to one STAR MCO that did not show consumers as active members in their system although their coverage with the health plan was active in all HHSC systems.

Hidalgo (431,555+)
Complaints -- (174 total/21 substantiated)

Table 24 Hidalgo Top 5 Complaints

Hidalgo – Top 5 Complaints	Count	Substantiated	% of Substantiated*
Access to LTSS	24	2	5%
Billing Issues	19	2	5%
Medicaid Eligibility/Recertification	12	2	5%
Staff Behavior	11	0	0%
System Issues	10	0	0%

Table 25 Hidalgo Top 5 Inquiries

Hidalgo – Top 5 Inquiries	Count
Access to PCP/Change PCP	20
Change Plan-Provider (PCP, Facility, DME)	16
Access to LTSS	14
Verify Health Coverage	12
Reporting Change	11

+average monthly enrollment *represents percent of total substantiated complaints

OMCAT received 174 complaints from consumers in the Hidalgo Service Area in the third quarter, and of those 21 (12%) were substantiated. Complaints increased by 39 percent (49) and the percentage of substantiated complaints decreased by four percent compared to the second quarter. The top five complaints noted in the table above make up 44 percent of the total complaints received of Hidalgo Service Area.

Jefferson (103,859+)
Complaints -- (76 total/25 substantiated)

Table 26 Jefferson Top 5 Complaints

Jefferson – Top 5 Complaints	Count	Substantiated	% of Substantiated*
Billing Issues	8	0	0%
Access to Prescriptions - Not showing active in systems	8	8	32%
Access to Prescriptions - Medicare	8	1	4%
Access to LTSS	7	2	8%
Access to In-Network Provider (non-PCP)	5	3	12%

Table 27 Jefferson Top 5 Inquiries

Jefferson - Top 5 Inquiries	Count
Access to PCP/Change PCP	10
Verify Health Coverage	9
Reporting Change	6
Obtain Medicaid ID card	5
Explanation of Benefits/Policy	5

+average monthly enrollment *represents percent of total substantiated complaints

OMCAT received 76 complaints from consumers in the Jefferson Service Area in the third quarter, and of those 25 (33%) were substantiated. Complaints increased by 52 percent (26) and the percentage of substantiated complaints increased by 21 percent compared to the second quarter. The top five complaints noted in the table above make up 47 percent of the total complaints received of Jefferson Service Area. Substantiated 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' MCO but MCO is not showing consumer as an active member.

Lubbock (91,387+)
Complaints -- (46 total/9 substantiated)

Table 28 Lubbock Top 5 Complaints

Lubbock – Top 5 Complaints	Count	Substantiated	% of Substantiated*
Authorization Issue	4	2	22%
Billing Issues	4	0	0%
Medicaid Eligibility/Recertification	4	1	11%
Access to LTSS	3	1	11%
Access to Prescriptions – Prior Authorization	3	0	0%

Table 29 Lubbock Top 5 Inquiries

Lubbock – Top 5 Inquiries	Count
Reporting Change	8
Change Plan-Provider (PCP, Facility, DME)	8
Access to PCP/Change PCP	7
Verify Health Coverage	6

Lubbock – Top 5 Inquiries	Count
Apply for Health Coverage	5

+average monthly enrollment *represents percent of total substantiated complaints

OMCAT received 46 complaints from consumers in the Lubbock Service Area in the third quarter, and of those 9 (20%) were substantiated. Complaints increased by 48 percent (15) and the percentage of substantiated complaints decreased by six percent compared to the second quarter. The top five complaints noted in the table above make up 39 percent of the total complaints received of Lubbock Service Area.

MRSA Central (177,276+)
Complaints -- (111 total/17 substantiated)

Table 30 MRSA Central Top 5 Complaints

MRSA Central – Top 5 Complaints	Count	Substantiated	% of Substantiated*
Access to Prescriptions - Other Insurance on File	12	2	12%
Case Information Error	10	2	12%
Medicaid Eligibility/Recertification	10	0	0%
Billing Issues	8	0	0%
Access to LTSS	6	3	18%

Table 31 MRSA Central Top 5 Inquiries

MRSA Central – Top 5 Inquiries	Count
Explanation of Benefits/Policy	11
Access to Long Term Care	11
Verify Health Coverage	10
Access to PCP/Change PCP	9

MRSA Central – Top 5 Inquiries	Count
Other/NA	8

+average monthly enrollment *represents percent of total substantiated complaints

OMCAT received 111 complaints from consumers in the MRSA Central Service Area in the third quarter, and of those 17 (15%) were substantiated. Complaints increased by 22 percent (20) and the percentage of substantiated complaints decreased by six percent compared to the second quarter. The top five complaints noted in the table above make up 41 percent of the total complaints received of MRSA Central Service Area.

MRSA Northeast (225,006+)
Complaints -- (168 total/25 substantiated)

Table 32 MRSA Northeast Top 5 Complaints

MRSA Northeast – Top 5 Complaints	Count	Substantiated	% of Substantiated*
Access to Prescriptions - Other Insurance on File	21	4	16%
Access to LTSS	15	3	12%
Medicaid Eligibility/Recertification	14	2	8%
Billing Issues	10	1	4%
Access to Prescriptions - Other	10	1	4%

Table 33 MRSA Northeast Top 5 Inquiries

MRSA Northeast – Top 5 Inquiries	Count
Explanation of Benefits/Policy	17
Verify Health Coverage	17
Access to Specialist	11
Other/NA	10
Access to LTSS	10

+average monthly enrollment *represents percent of total substantiated complaints

OMCAT received 168 complaints from consumers in the MRSA Northeast Service Area in the third quarter, and of those 25 (15%) were substantiated. Complaints increased by 14 percent (20) and the percentage of substantiated complaints remained the same compared to the second quarter. The top five complaints noted in the table above make up 42 percent of the total complaints received of MRSA Northeast Service Area.

MRSA West (194,067+)
Complaints -- (97 total/15 substantiated)

Table 34 MRSA West Top 5 Complaints

MRSA West – Top 5 Complaints	Count	Substantiated	% of Substantiated*
Billing Issues	12	1	7%
Access to Prescriptions - Other Insurance on File	12	5	33%
Access to LTSS	9	1	7%
Case Information Error	8	4	27%
Medicaid Eligibility/Recertification	7	0	0%

Table 35 MRSA West Top 5 Inquiries

MRSA West – Top 5 Inquiries	Count
Access to PCP/Change PCP	16
Billing Issues	10
Reporting Change	10
Adult Dental	9
Explanation of Benefits/Policy	9

+average monthly enrollment *represents percent of total substantiated complaints

OMCAT received 97 complaints from consumers in the MRSA West Service Area in the third quarter, and of those 15 (15%) were substantiated. Complaints decreased by seven percent (-7) and the percentage of substantiated complaints increased by one percent compared to the second quarter. The top five complaints noted in the table above make up 57 percent of the total complaints received of MRSA West Service Area.

Nueces (113,225+)
Complaints -- (53 total/11 substantiated)

Table 36 Nueces Top 5 Complaints

Nueces – Top 5 Complaints	Count	Substantiated	% of Substantiated*
Access to LTSS	6	2	18%
Billing Issues	4	0	0%
Access to Prescriptions - Not showing active in systems	4	4	36%
Access to Prescriptions - Prior Authorization	4	0	0%
Service Coordination/Service Management	4	1	9%

Table 37 Nueces Top 5 Inquiries

Nueces – Top 5 Inquiries	Count
Access to PCP/Change PCP	15
Explanation of Benefits/Policy	8
Reporting Change	6
Access to LTSS	6
Obtain Health Plan ID card	4

+average monthly enrollment *represents percent of total substantiated complaints

OMCAT received 53 complaints from consumers in the Nueces Service Area in the third quarter, and of those 11 (21%) were substantiated. Complaints decreased by two percent (-1) and the percentage of substantiated complaints increased by eight percent compared to the second quarter. The top five complaints noted in the table above make up 42 percent of the total complaints received of Nueces Service Area.

Tarrant (319,513+)
Complaints -- (224 total/40 substantiated)

Table 38 Tarrant Top 5 Complaints

Tarrant – Top 5 Complaints	Count	Substantiated	% of Substantiated*
Access to LTSS	22	7	18%
Billing Issues	19	4	10%
Access to Prescriptions - Other	13	4	10%
Access to DME	12	3	8%
Access to Prescriptions - Not showing active in systems	12	7	18%

Table 39 Tarrant Top 5 Inquiries

Tarrant – Top 5 Inquiries	Count
Access to PCP/Change PCP	31
Verify Health Coverage	30
Reporting Change	26
Explanation of Benefits/Policy	26
Billing Inquiry	15

+average monthly enrollment *represents percent of total substantiated complaints

OMCAT received 224 complaints from consumers in the Tarrant Service Area in the third quarter, and of those 40 (18%) were substantiated. Complaints increased by 17 percent (32) and the percentage of substantiated complaints increased by eight percent compared to the second quarter. The top five complaints noted in the table above make up 35 percent of the total complaints received of Tarrant Area.

Travis (176,641+)
Complaints -- (101 total/17 substantiated)

Table 40 Travis Top 5 Complaints

Travis – Top 5 Complaints	Count	Substantiated	% of Substantiated*
Medicaid Eligibility/Recertification	11	1	6%
Billing Issues	10	1	6%
Other Insurance	7	0	0%
Access to Prescriptions - Other Insurance on File	7	3	18%
Access to LTSS	5	1	6%

Table 41 Travis Top 5 Inquiries

Travis – Top 5 Inquiries	Count
Verify Health Coverage	17
Explanation of Benefits/Policy	14
Adult Dental	11
Billing Inquiry	11
Access to Specialist	10

+average monthly enrollment *represents percent of total substantiated complaints

OMCAT received 101 complaints from consumers in the Travis Service Area in the third quarter, and of those 17 (17%) were substantiated. Complaints increased by five percent (5) and the percentage of substantiated complaints increased by four percent compared to the second quarter. The top five complaints noted in the table above make up 40 percent of the total complaints received of Travis Service Area.

5. Barriers and Recommendations to Address Them

Access to prescriptions

Access to prescriptions made up 43% 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, was the top substantiated complaint for the quarter. 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 with one business day of receiving the files.

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. This issue was the second most common substantiated complaint for the quarter. When a consumer shows to have other insurance in addition to Medicaid, that other insurance must be billed first before Medicaid can be billed. This causes access to care issues when a consumer cannot access a service due to erroneous insurance showing on a consumer’s case which prevents the provider from being paid and therefore may not be willing to provide the service. In most cases this occurs with accessing prescriptions since it is point of sale service. Consumers may also be denied access to their Medicaid provider since most providers verify consumers’ coverage before providing services. If that provider doesn’t accept the type of insurance that is erroneously showing on the consumer’s case, then the provider will refuse to see the consumer.

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.

6. Ombudsman Collaboration and Initiatives

OMCAT collaborates with HHS programs and MCOs in identifying and resolving barriers to accessing Medicaid services.

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 and 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.

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.

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.

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