

HHS Ombudsman Managed Care Assistance Team 4th Quarter FY 2021

**As Required by
Section 531.0213 of the
Government code**

**Texas Health and Human Services
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TEXAS
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Executive Summary

In accordance with [Government Code Chapter 531, Section 531.0213\(d\)\(5\)](#), the Health and Human Services Commission (HHSC) is required to collect and maintain statistical information 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, access problems, and recurring barriers in the Medicaid system; and,
- indicate other problems identified with Medicaid managed care.

OMCAT categorizes contacts received from consumers as a complaint or an inquiry. A complaint is a contact in which a consumer expresses any dissatisfaction. An inquiry is a contact in which a consumer requests information about HHS programs or services.

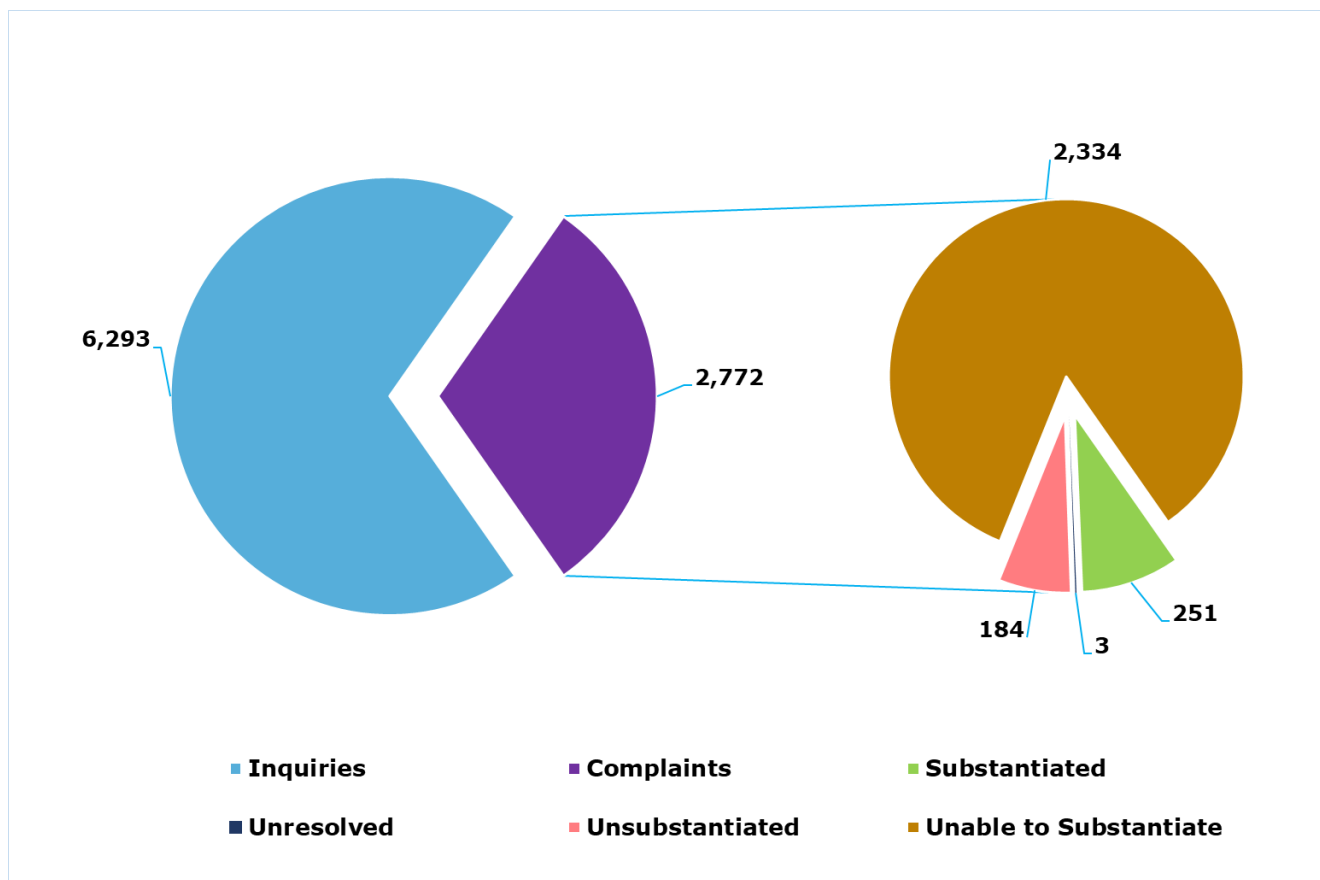
During the fourth quarter of fiscal year 2021 (FY21), OMCAT received 9,065 contacts; of which, 2,772 were complaints and 6,293 were inquiries.

Complaints made up 31 percent of total contacts. Of the 2,772 complaints received, 2,769 complaints were resolved with the remaining 3 pending investigation. Of those resolved complaints:

- nine percent (or 251) were substantiated;
- 84 percent (or 2,334) were unable to substantiate; and,
- seven percent (or 184) were unsubstantiated.

Figure 1 compares the number of contacts received (the larger pie graph) with their determination of the resolution of complaints (the smaller pie graph) as substantiated, unable to substantiate, or unsubstantiated for the quarter.

Figure 1: Fourth Quarter Total Contacts Received



Introduction

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

The data contained in the report are exclusive to contacts received by OMCAT, and do not include contacts received by other areas within HHS. Therefore, the report does not include all Medicaid managed care complaints received by the agency, vendors, or Managed Care Organizations (MCOs).

The report includes consumer contacts on fee-for-service Medicaid, Medicaid managed care, and those who do not have full Medicaid benefits or are in the process of applying for Medicaid.

OMCAT In Action

The following is a case received during the quarter that spotlights the impact that OMCAT can have on the Medicaid managed care system.

As of June 1, 2021, the service of non-emergency medical transportation (NEMT) was transferred from HHSC's Medical Transportation Program to Managed Care Organizations (MCO) for Medicaid consumers on managed care. NEMT provides Medicaid recipients with transportation to medical appointments.

OMCAT was contacted by an elderly person who was scheduled to receive kidney dialysis treatments three days a week at the same time and location every week. The consumer contacted OMCAT after they had missed five consecutive dialysis appointments. The consumer's next scheduled dialysis appointment was on a Saturday when the MCO offices and HHSC were closed. OMCAT contacted the MCO and requested the member be placed on a list that tracks the members pickup and drop off times and has backup transportation on standby. OMCAT also requested the MCO provide contact information for the scheduled driver, backup options for transport and contact information for the transportation provider's supervisor who would ensure transport. The OMCAT supervisor tracked the member's ride and contacted the member to verify the member was successfully transported. OMCAT continued to track the member's rides for the next three months to ensure that the member did not continue to have difficulty receiving rides at the scheduled pickup and drop-off times.

Background

Consumers can contact OMCAT through either the toll-free Medicaid Managed Care Helpline (the helpline), which has been in operation since 2001 (pursuant to Senate Bill 601, 74th Texas Legislature, Regular Session), and online submission forms which can be found on the [OMCAT website](#).

Consumer contacts are captured in the Ombudsman's primary record keeping system: the HHS Enterprise Administrative Report and Tracking System (HEART). Data contained within HEART include consumer specific information, a summary of the issue/complaint, and the findings and resolutions of the OMCAT investigation.

There are three important data distinctions:

- *Contact* is defined as any instance of communication where a client, stakeholder, legislative liaison, or advocate communicates with the Ombudsman. A contact may either be an inquiry or complaint.
- *Contact reason* is a specific description of the nature of the inquiry or complaint received. For example, if a client has a complaint about their inability to access a prescription due to needing a prior authorization, the contact reason would be "access to prescriptions - prior authorization."
- *Category* is a description of the types of complaints that are related to one another because of a similar issue. Using the same example above, the category would be "access to prescriptions."

There may be instances where a consumer may report multiple complaints in a single contact; as such, the number of complaint types presented in the analyses that follow may be more than the number of total contacts received.

Finally, an important note related to unresolved cases:

- When data are extracted for report production, some investigations are not yet completed. The complaints presented in this report only analyze those investigations where the outcome has been resolved.

Methodology

Data and contact summary narratives are thoroughly reviewed to help identify trends and potential issues. Examples of this analysis include:

- Total number of inquiries and complaints received;

- Types of inquiries and complaints received;
- Number and types of complaints by service delivery area and managed care program; and
- Number of complaints resolved that were substantiated, unable to be substantiated, and unsubstantiated.

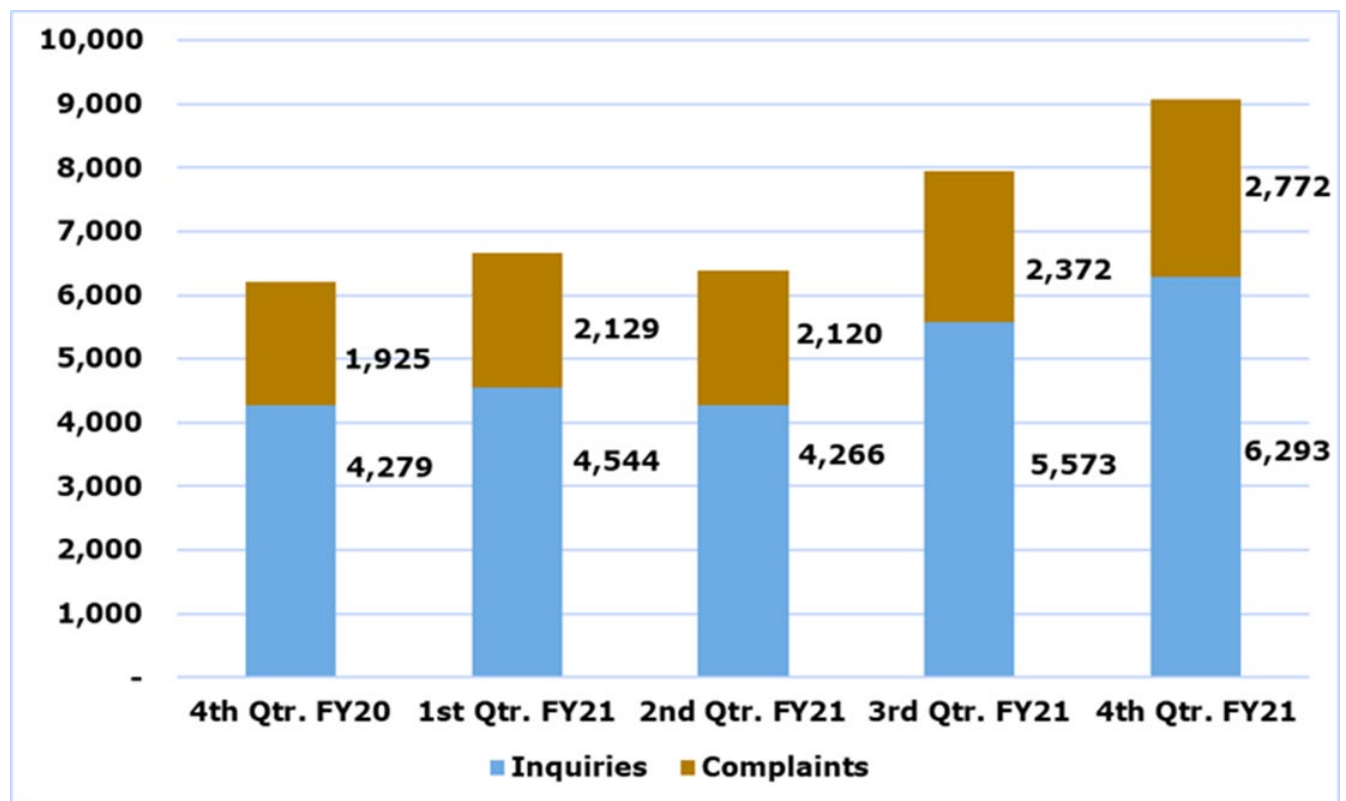
Consumer Contacts

Consumer contacts include inquiries and complaints from consumers, legislative staff on behalf of consumers, and other stakeholders. Contact methods include phone, online submission form, postal mail, and faxes. All consumer contacts received are logged in HEART.

All Contacts Received

Figure 2 shows the volume of all contacts received, including inquiries and complaints for the fourth quarter of FY21 and previous four quarters.

Figure 2: All Contacts Received FY20 & FY21



In the fourth quarter of FY21, OMCAT received a total of 9,065 contacts. This is a 14 percent increase from the third quarter in FY21. The data show that total contacts for the fourth quarter of FY21 have increased by 46 percent compared to the fourth quarter of FY20.

Inquiries Process

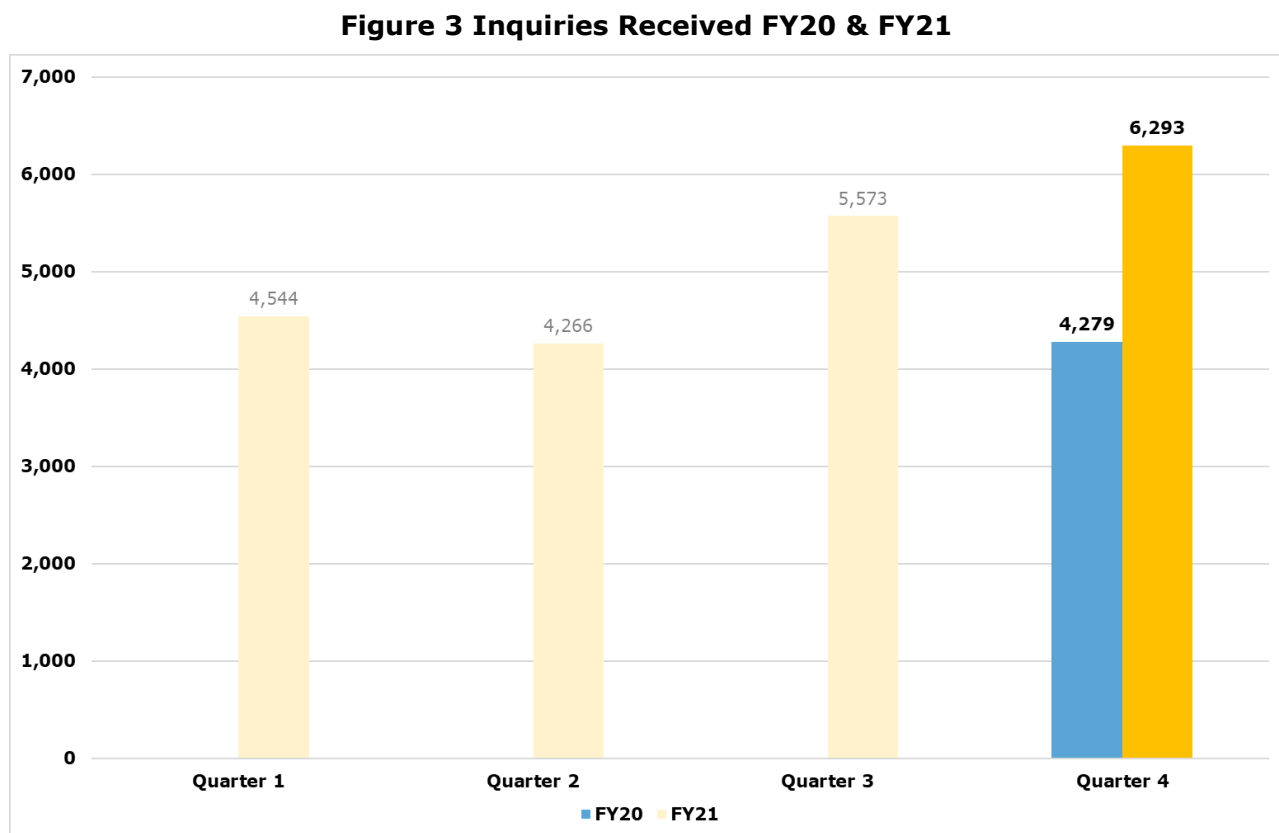
Inquiries are an important indicator of consumers' need for information. While complaints offer valuable insight regarding what issues are preventing the successful

delivery of Medicaid services, inquiries inform the agency of potential gaps in information that consumers need to better understand the Medicaid managed care system.

Questions or requests for information from consumers are tracked in the same database that complaints are captured. Ombudsmen assist with answering questions, providing information about accessing Medicaid services and educating and empowering consumers on how to advocate for themselves in the Medicaid managed care system.

Inquiries Received

Figure 3 focuses on the comparison of the volume of inquiries received for the fourth quarter of FY21 with the same quarter of the previous year.

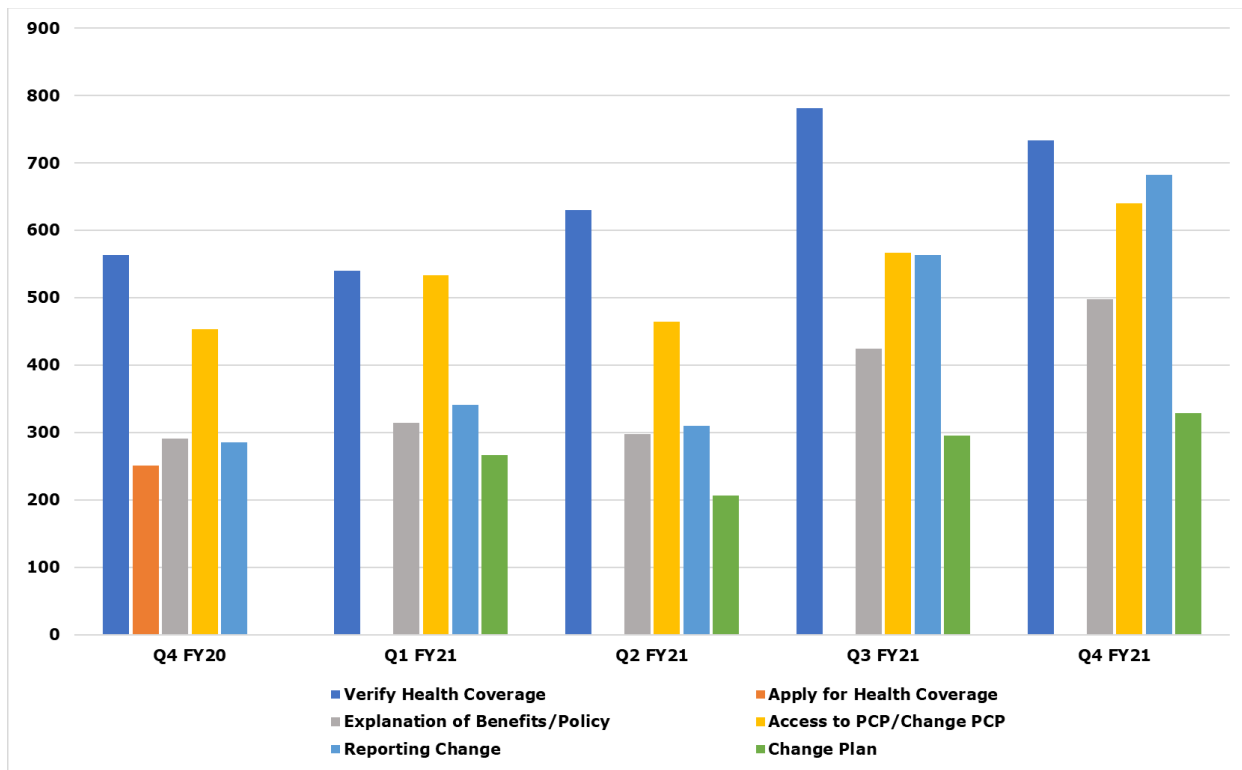


The data indicate that the volume of inquiries received for the fourth quarter of FY21 increased by 47 percent (or 2,014 more) as compared to the fourth quarter of FY20. Additionally, when compared with the third quarter of FY21, the data show that the volume of inquiries received during the fourth quarter of FY21 increased by 13 percent.

Top Inquiries

Figure 4 presents a comparison of the top reasons for inquiries for the fourth quarter of FY21 and previous four quarters.

Figure 4: Top Inquiries Received FY20 & FY21



The data shows that inquiries related to verifying health coverage, reporting changes and access to a PCP/changing PCP are among the top reasons for inquiries throughout FY20 and into FY21.

Figure 4 shows that in the fourth quarter of FY21 questions related to verifying health coverage were the top inquiry but decreased by 6 percent from the third quarter to the fourth quarter of FY21. The decrease in inquiries can be attributed to fewer inquiries regarding consumers requesting verification that their child's health plan was active. A review of case narratives indicates that consumers needed to verify if their child's health plan was active, how to obtain Medicaid IDs and information about current health plan enrollment.

Figure 4 also shows that in the fourth quarter of FY21 questions related to reporting changes were also among the top inquiries and increased by 17 percent from the third quarter to the fourth quarter of FY21. A review of case narratives indicates consumers were calling to add a newborn child to the Medicaid case, report an address change or terminate Texas Medicaid benefits because the member had moved out of state.

The data show that accessing a PCP or changing the PCP were among the top inquiries in the fourth quarter of FY21 and increased by 11 percent from the third quarter of to the fourth quarter of FY21. A review of case narratives indicates that consumers inquired about changing their child's PCP, finding a PCP who accepted their health plan and finding a PCP out of the health plan's network because the consumer had moved to a different service delivery area.

Resolved Complaints

Resolved complaints are categorized in HEART as: substantiated, unsubstantiated, and unable to substantiate.

Sometimes OMCAT involves other parties, such as providers, HHS program areas, or MCOs when resolving a complaint. In these situations, OMCAT contacts all parties involved to gather more information.

OMCAT requests the review and interpretation of Medicaid policy and managed care rules and regulations with the appropriate HHS program area or MCO. After the review is complete, OMCAT reviews the findings for compliance with HHS policy and Medicaid and managed care rules and regulations. A complaint is considered resolved when a determination is made as to whether a complaint is substantiated or not and no further action is necessary. OMCAT may make recommendations on Medicaid policy and managed care rules and regulations to HHS programs.

Table 1 below provides an overview of the definitions for each complaint resolution determination.

Table 1: Complaint Resolution Determination

	DEFINITION	EXAMPLE	FINDINGS	RESOLUTION
Substantiated	Research clearly indicates that agency policies or expectations were violated.	Consumer complaint that home health attendant did not show up for duty.	Investigation confirms that home health agency attendant did not appear for work that day.	OMCAT worked with MCO to ensure that home health agency will send a replacement when the attendant is not available.
Unable to Substantiate	Research cannot indicate whether agency policies or expectations were or were not violated.	Consumer complaint about accessing medical services.	Investigation confirms that consumer has not discussed complaint with MCO.	OMCAT referred the consumer to MCO per complaint resolution process.

	DEFINITION	EXAMPLE	FINDINGS	RESOLUTION
Unsubstantiated	Research indicated that agency policies or expectations were not violated.	Consumer complaint that their prescription was rejected at the pharmacy.	Investigation confirms that the consumer is not yet due to refill that prescription.	OMCAT advised consumer of when the prescription will be ready for refill.

The Ombudsman provides consumers an independent and neutral resolution of HHS-related complaints. Consumers typically contact the ombudsman after they have tried unsuccessfully to find resolutions elsewhere.

Why “Unable to Substantiate” Matters

OMCAT educates consumers so that they can advocate for themselves, which includes advising consumers on how to make their complaint initially with the appropriate HHSC program area or MCO. In these cases, OMCAT will not have the final resolution and the team is unable to determine if the complaint was substantiated. Additionally, with many complaints there may not be enough information or there may be discrepancies to determine a complaint as substantiated or not. Examples are below.

- Incomplete investigation – ombudsman may need more information from the consumer during the investigation but if the ombudsman is not able to reach the consumer after several attempts, the investigation is closed.
- Discrepant information - consumer complains that the MCO has not authorized a referral for an MRI. The MCO states the request for authorization was never received and the referring physician claims the request was sent to the MCO.

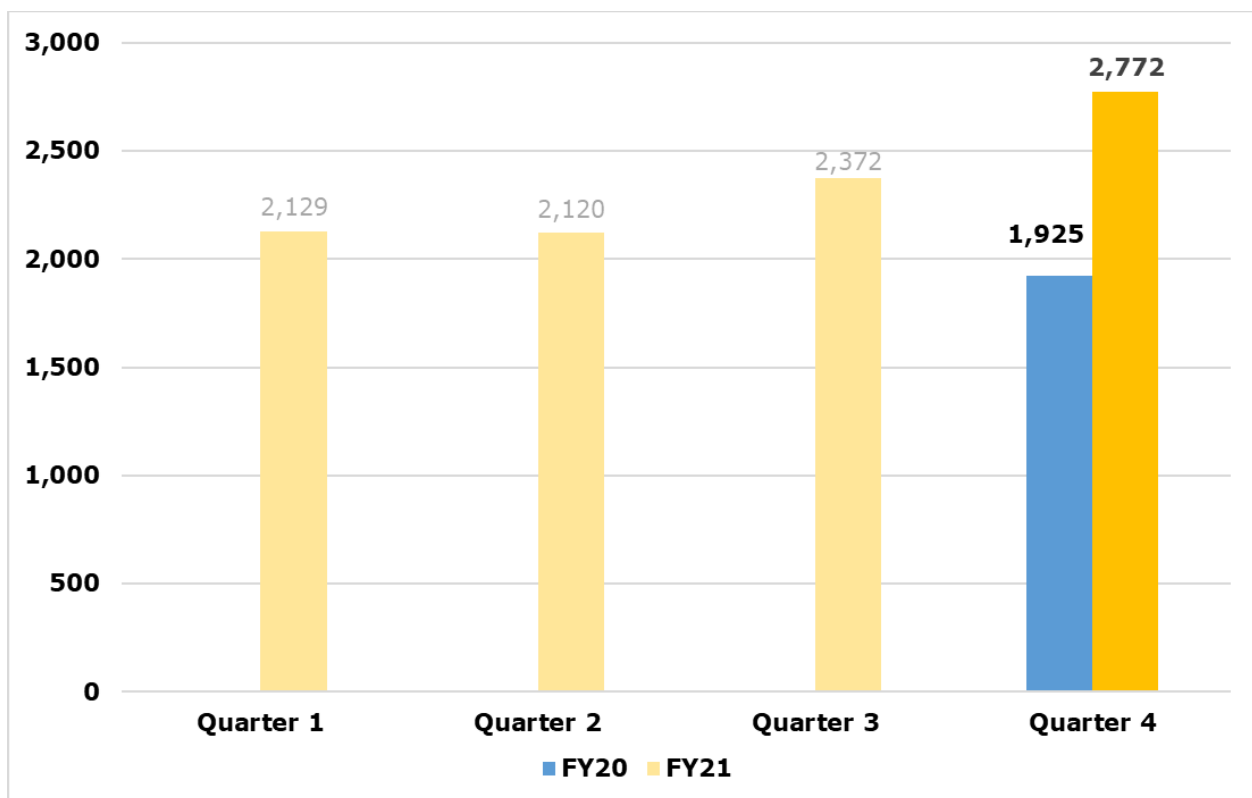
It is important to capture, analyze and report on all complaints reported to OMCAT, including those deemed as “unable to substantiate,” to facilitate a better understanding of trends in barriers that prevent consumers from accessing needed care.

Complaints Received

Figure 5 focuses on the comparison of the total complaints received for the fourth quarter with the same quarter of the previous fiscal year. In the fourth quarter of FY21, OMCAT received 2,772 complaints, which is an increase of 44 percent (or 847 more)

compared to the fourth quarter of FY20 and is an increase of 17 percent (or 400 more) compared to the third quarter of FY21.

Figure 5: Complaints Received FY20 & FY21

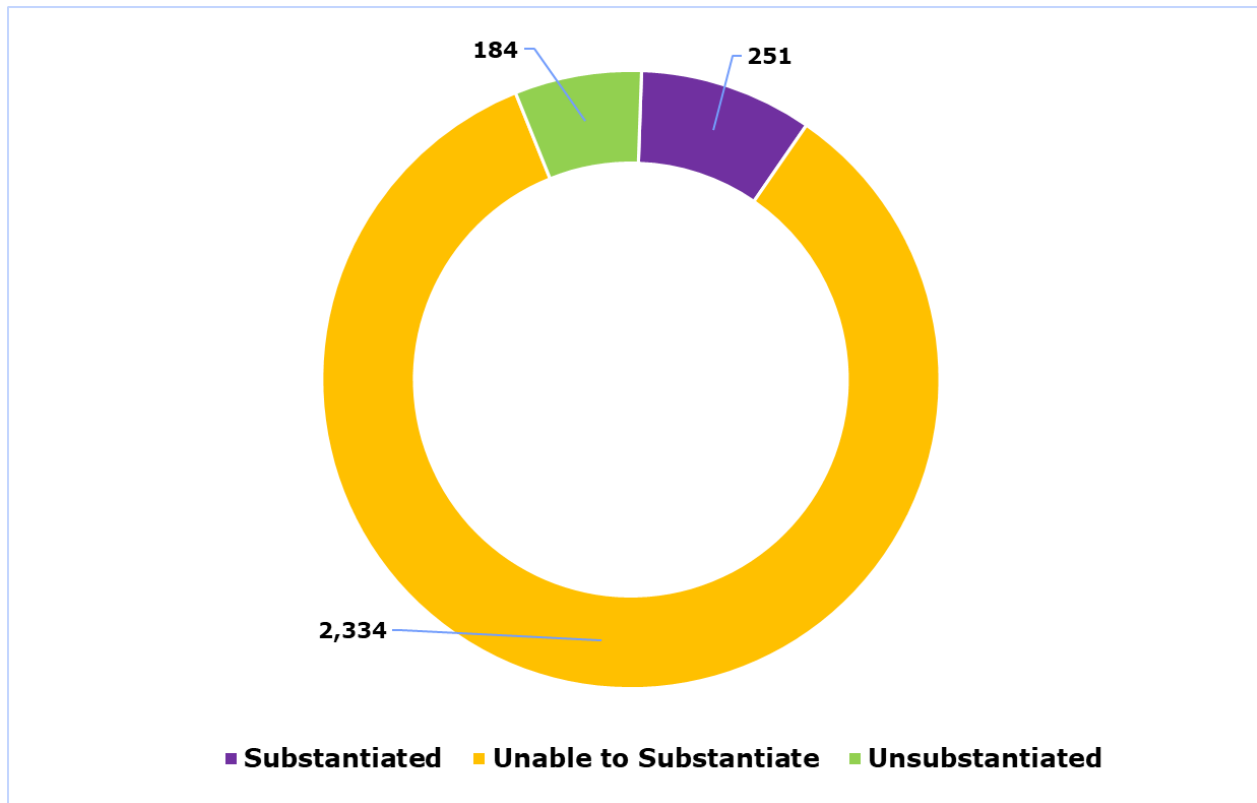


In comparison to the fourth quarter of FY20, complaints regarding access to care, prescription services and member enrollment increased in the fourth quarter of FY21.

Resolved Complaints by Determination

Figure 6 below shows the total resolved complaints by determination received in the fourth quarter of FY21. OMCAT resolved 2,769 complaints out of 2,772 received. Three complaints were still being investigated at the end of the fourth quarter of FY21.

Figure 6: Complaints by Resolution Determination



Substantiated Complaints

In the fourth quarter of FY21, OMCAT substantiated 251, or nine percent of resolved complaints. There is no change in percentage points compared to the previous quarter (where OMCAT substantiated 9 percent of the complaints).

The top substantiated complaint for the quarter was related to consumers who had difficulty accessing out-of-network providers. Consumers reported difficulty accessing OBGYN and PCP providers after moving to a new service area.

The second highest substantiated complaint for the quarter was related to consumers who were not able to access prescriptions due to erroneous secondary insurance information showing in HHSC, pharmacy or MCO systems. Consumers were unable to access needed prescriptions until the erroneous insurance was removed, because unlike other medical services where the service is received before the provider is reimbursed, prescriptions must be paid for before being dispensed.

The third most common substantiated complaint for the quarter was related to non-emergency medical transportation. Consumers reported that they were not transported after scheduling transportation services, scheduling errors when attempting to schedule transportation and problems getting reimbursed for individual transportation participant

claims (ITP). ITP is a benefit that allows the consumer to choose a driver authorized by the health plan to transport the consumer to medical appointments and receive reimbursement for gas mileage used for transport.

Top Complaint Categories

The complaints analyzed in this section are those that were resolved and determined to either be substantiated or unable to substantiate. Resolved complaints determined to be unsubstantiated are not included in the analysis of complaints in this report since the investigation determined that policy was correctly followed in those cases. Although the analysis of complaints determined to be unsubstantiated are not included in this report, OMCAT does review unsubstantiated complaints to determine if there is policy that may need to be reviewed for the way it is applied and has an impact on the delivery of services.

As previously mentioned, contact reasons (or the nature of the complaint) are grouped into larger complaint categories for complaints that share a commonality.

Figure 7 shows a comparison of the top complaint categories for the current quarter and previous four quarters.

Figure 7: Top Complaint Categories Received FY20 & FY21

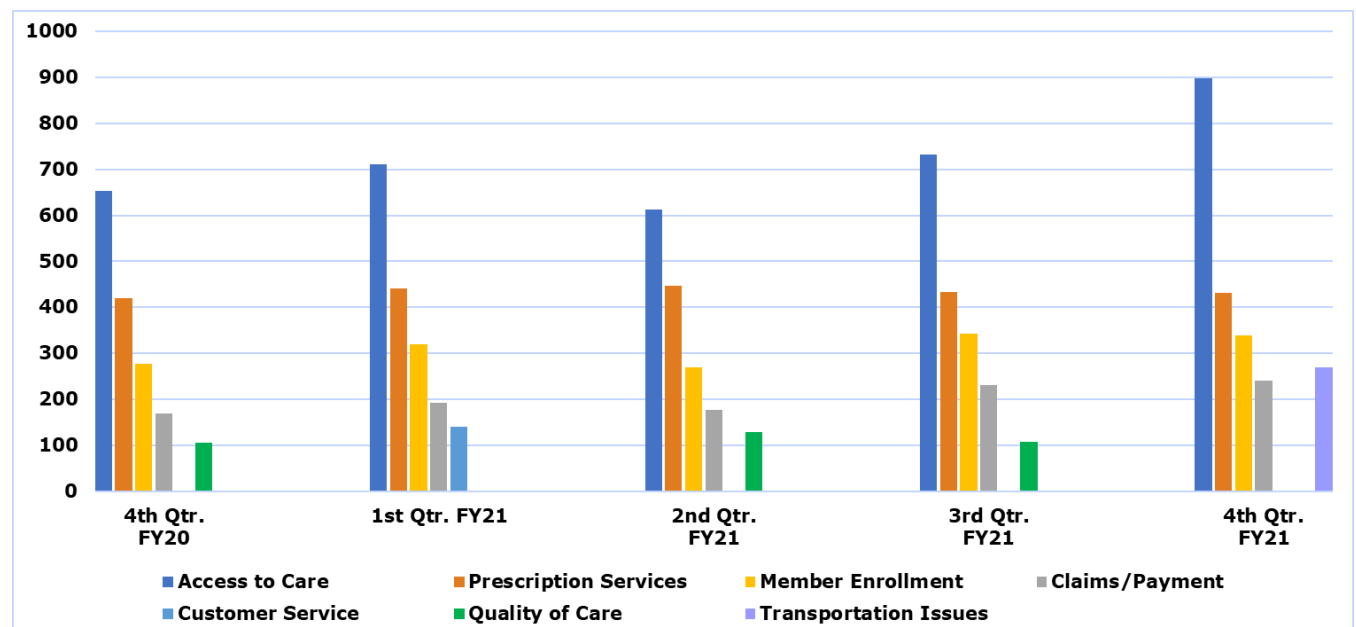


Figure 7 shows that Transportation Issues was added as a complaint category in the fourth quarter due to changes effective June 1, 2021, at which time the MCOs began providing medical transportation as a benefit for managed care consumers.

Data show that complaints related to access to care increased from the third to the fourth quarter of FY21 and remained the top complaint category in the fourth quarter of FY21. After reviewing the contact reasons, the top contact reason was consumers who report having difficulty accessing home health services. A thorough review of case narratives revealed consumers had difficulty receiving home health services because attendants were not available to work authorized hours. Data also show that complaints regarding issues with accessing out-of-network providers and PCPs increased from the third to the fourth quarter of FY21. A review of case narratives showed problems accessing out-of-network OBGYNs after consumers had moved to a different service area and had not yet been enrolled with the MCO in their new service area.

The data also show that complaints related to accessing prescription services remained the second highest complaint throughout all quarters and into the fourth quarter of FY21. A review of contact reasons shows that complaints of consumer issues related to having other insurance aside from Medicaid and consumers not showing active in pharmacy and MCO systems remained the top complaint reasons for the fourth quarter of FY21.

Figure 7 also shows that complaints related to member enrollment remained the third highest complaint throughout all quarters and into the fourth quarter of FY21. A review of contact reasons shows complaints related to problems regarding Medicaid eligibility and case information errors in HHSC systems were the top complaint reasons for member enrollment.

Complaints by Managed Care Program

Managed care programs deliver Medicaid healthcare benefits and services to Medicaid recipients. Managed care programs differ by the population served for each program. Presenting complaints by managed care program provides information on the unique needs and challenges of each population receiving Medicaid services.

The complaints analyzed in this section are those that were resolved and determined to either be substantiated or unable to substantiate. This section highlights managed care programs where OMCAT's analysis identified potential trends or anomalies. Complaint data for the managed care programs not included in this section are included in Appendix A. The average monthly number of Medicaid consumers enrolled by managed care program is also provided in Appendix A.

Please note that the top complaint categories represented in the charts in this section below are a subset of the total complaints received for each managed care program. The top complaint categories may fluctuate from quarter to quarter for each managed care program as new or different consumer issues and priorities can change over time.

STAR

The STAR program serves healthy children, pregnant women, and some parents of children on Medicaid¹. In the fourth quarter of FY21, OMCAT received 944 complaints of which 111 (or 12 percent) were substantiated.

Figure 8 shows a comparison of the top complaint categories for the current quarter and previous four quarters.

¹ The average monthly enrollment for the STAR program in the fourth quarter of FY21 is 3,976,831.

Figure 8: Top STAR Complaint Categories FY20 & FY21

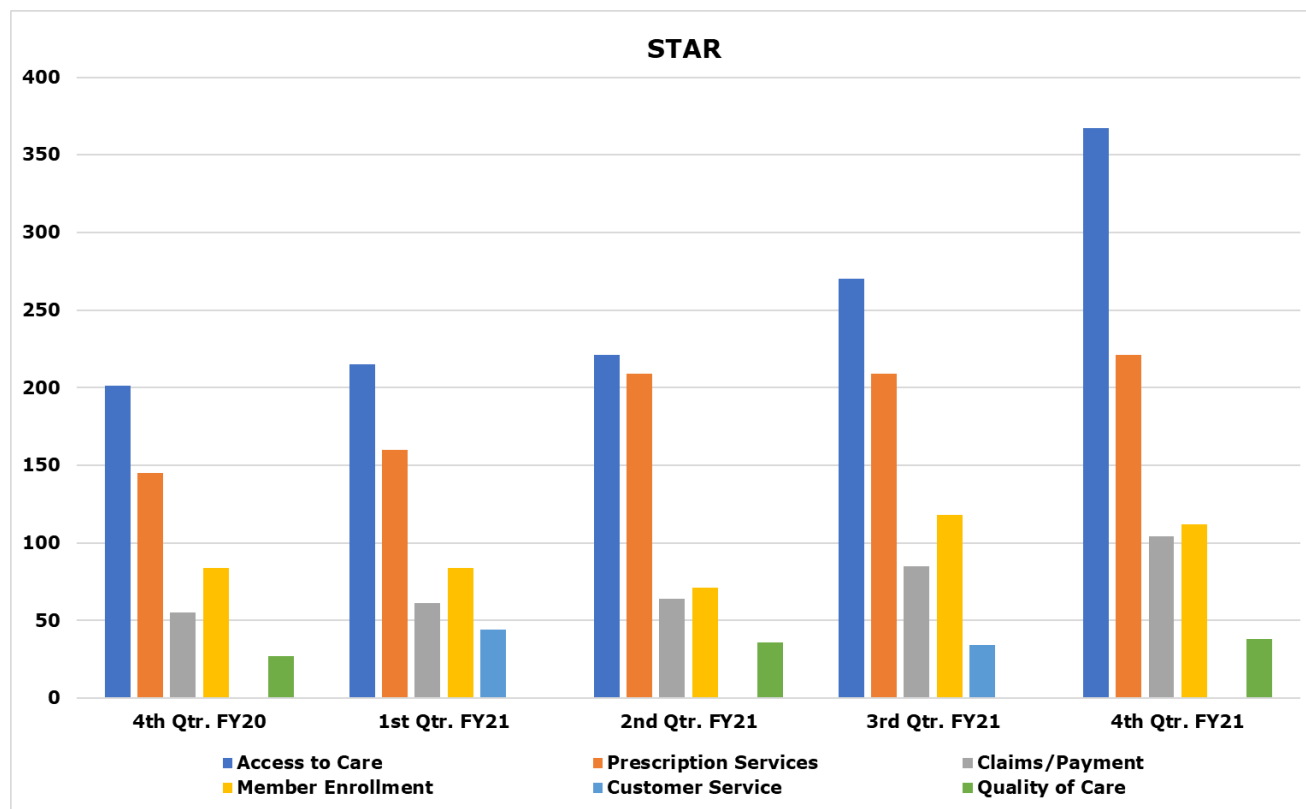


Figure 8 shows that access to care, access to prescription services and member enrollment continue to remain among the top three complaint categories from the fourth quarter of FY20 through the fourth quarter of FY21.

Access to care is the top complaint category in the fourth quarter of FY21. Complaints related to access to care also increased from the third quarter of FY21 to the fourth quarter of FY21. The increase in complaints from the third quarter to the fourth quarter can be attributed to an increase in the following complaint reasons: issues related to having other insurance aside from Medicaid; consumers having difficulty accessing PCPs increased; consumers accessing in-network specialists and facilities; and consumers accessing out-of-network providers. The top complaint reasons which attributed to the increase in complaints from the third to fourth quarter of FY21 were also the top complaint reasons for the fourth quarter of FY21.

Complaints related to prescription services is the second highest complaint category beginning in the fourth quarter of FY20 and into the fourth quarter of FY21. Top complaint contact reasons relating to access to prescription services included consumers having difficulty accessing prescription services due to other insurance on their Medicaid profile in HHSC, MCO or pharmacy systems and consumers not showing as active with coverage in MCO or pharmacy systems.

Complaints related to member enrollment is the third highest complaint category beginning in the fourth quarter of FY20 and into the fourth quarter of FY21. Data show the top complaint reasons for the fourth quarter of FY21 were complaints of case information errors in HHSC and MCO data systems and problems regarding Medicaid eligibility and recertification.

STAR+PLUS

The STAR+PLUS program serves adults who have disabilities or are age 65 or older². In the fourth quarter of FY21, OMCAT received 888 complaints of which 94 (or 11 percent) were substantiated. Figure 9 shows a comparison of the top complaint categories for the current quarter and previous four quarters.

Figure 9: Top STAR+PLUS Health Complaint Categories FY20 & FY21

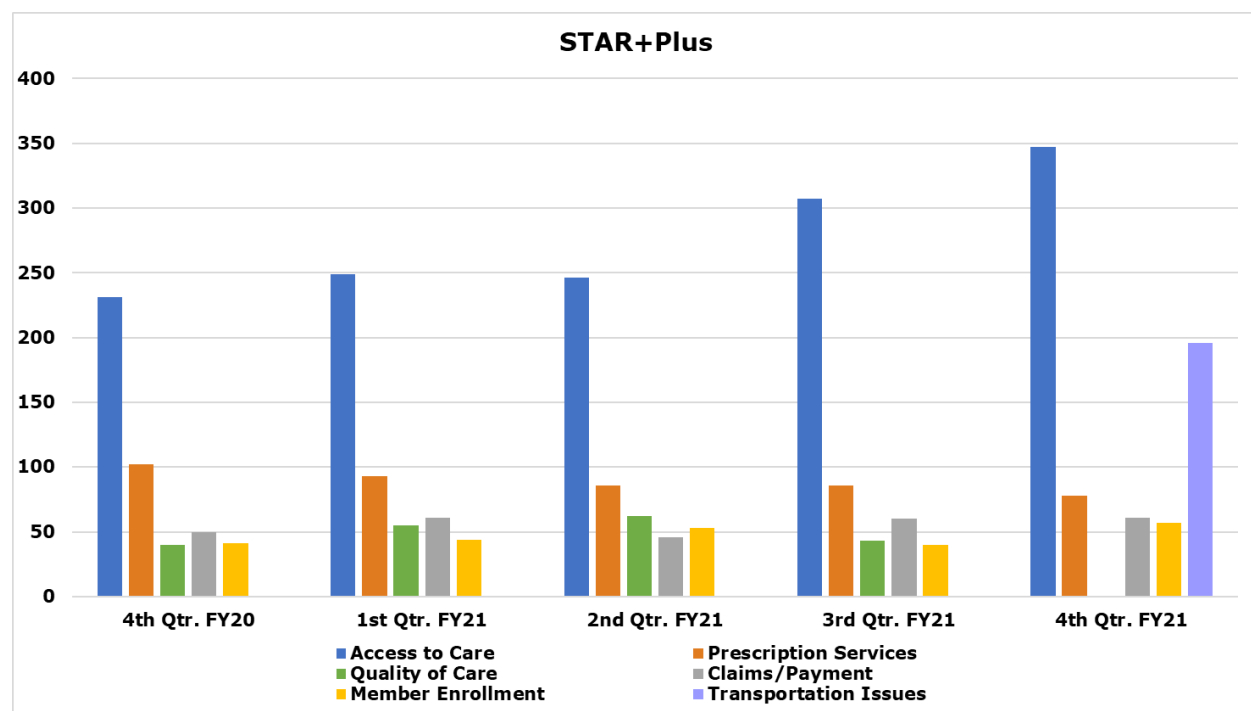


Figure 9 shows that access to care is the top complaint category for five consecutive quarters beginning in the fourth quarter of FY20 and into the fourth quarter of FY21. Complaints related to access to care increased from the third to fourth quarter of FY21. The increase in complaints from the third to fourth quarter of FY21 can be attributed to an increase in complaints related to accessing out-of-network providers and PCPs. Top contact reasons in the fourth quarter of FY21 were complaints related to consumers having difficulty accessing home health services, durable medical equipment and in-network specialists and facilities. Case summaries indicate that the most common

² The average monthly enrollment for the STAR+Plus program in the third quarter of FY21 is 540,483.

consumer complaints were regarding home health attendants not being available to work authorized hours, difficulty receiving incontinence supplies and problems accessing a pain management doctor.

The data show that complaints related to transportation issues is the second highest complaint category in the fourth quarter of FY21. As previously mentioned, transportation complaints can be attributed to the service of medical transportation being transferred to the MCOs effective June 1, 2021. The top complaint reasons were complaints of consumers with not being transported, consumers having difficulty scheduling rides and consumers having difficulty receiving ITP claims.

Access to prescription services is the third highest complaint category in the fourth quarter of FY21. After review of the contact reasons, data show the top complaint reasons for the fourth quarter of FY21 were consumers having other insurance aside from Medicaid and consumers not showing active in pharmacy and MCO systems.

STAR Kids

The STAR Kids program serves children and adults 20 and younger who have disabilities³. In the third quarter of FY21, OMCAT received 176 complaints of which 19 (or 11 percent) were substantiated. Figure 10 shows a comparison of the top complaint categories for the current quarter as well as the previous four quarters.

³ The average monthly enrollment for the STAR Kids program in the fourth quarter of FY21 is 168,065.

Figure 10: Top STAR Kids Complaint Categories FY20 & FY21

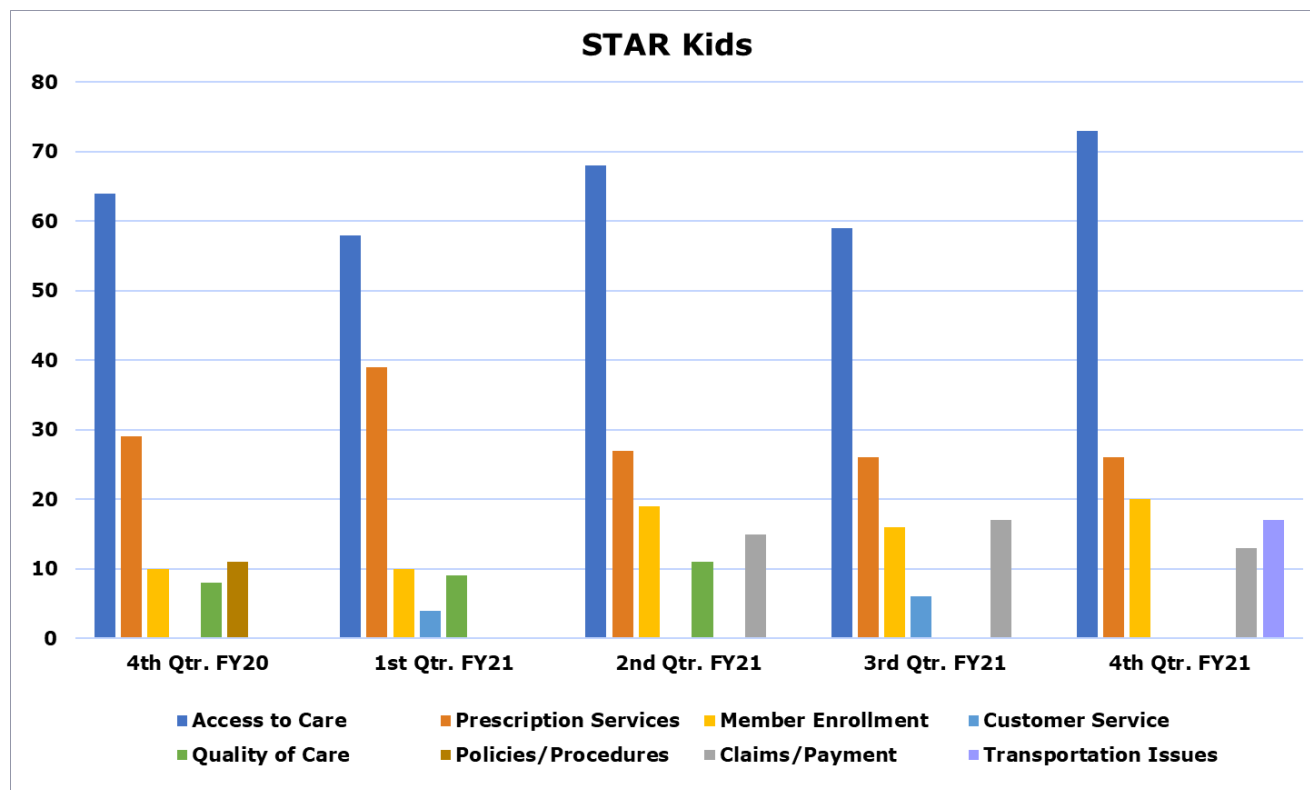


Figure 10 shows access to care is the top complaint category beginning in the fourth quarter of FY20 and into the fourth quarter of FY21. The data show the top complaint reasons for the fourth quarter of FY21 were related to consumers having issues accessing home health services, access to in-network specialists and facilities and consumers having difficulty accessing durable medical equipment.

Data show access to prescription services is the second highest complaint category beginning in the fourth quarter of FY20 and into the fourth quarter of FY21 for STAR Kids. After a review of the contact reasons, data show the top complaint reasons were related to consumers having other insurance aside from Medicaid and prior authorizations related to drugs listed on the preferred drug list.

Complaints related to member enrollment is the third highest complaint category in the fourth quarter of FY21. The data show the complaint reasons for the fourth quarter of FY21 were complaints related to problems regarding Medicaid eligibility and case information errors in HHSC and MCO data systems.

Fee for Service/Traditional Medicaid

Fee for service, also known as traditional Medicaid, is the population of Medicaid recipients that are not enrolled in any managed care program⁴. OMCAT assists all consumers on Medicaid, as such, it is important to capture complaints for all populations of Medicaid consumers.

In the fourth quarter of FY21, OMCAT received 166 complaints, of which 23 (or 14 percent) were substantiated. Figure 11 shows a comparison of the top complaint categories for the current quarter as well as the previous four quarters.

Figure 11: Top Fee for Service/Traditional Medicaid Complaint Categories FY20 & FY21

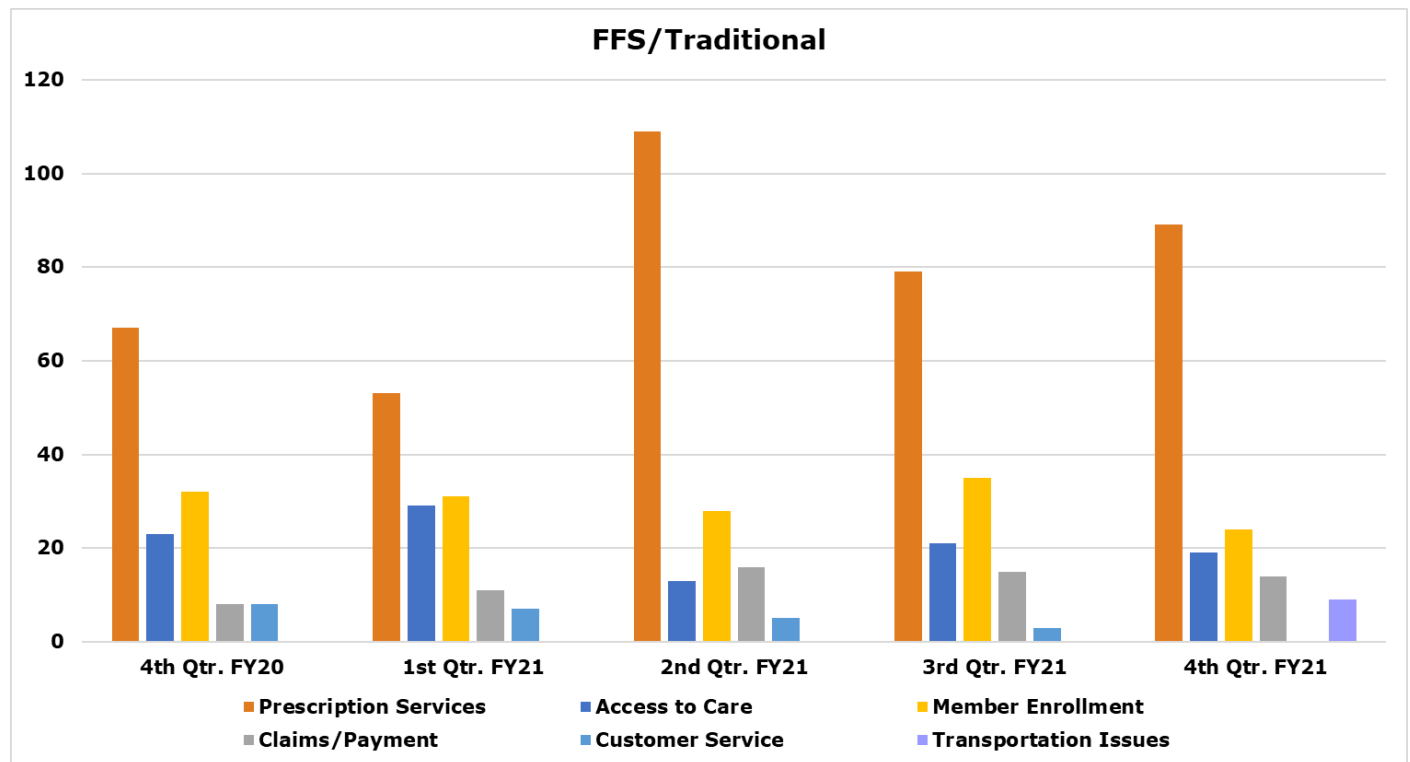


Figure 11 shows access to prescription services is the top complaint category beginning in the fourth quarter of FY20 and into the fourth quarter of FY21. A review of contact reasons shows the top complaint reasons were issues related to consumers showing as having other insurance aside from Medicaid in HHS and pharmacy systems, not showing active with Medicaid in pharmacy systems and complaints related to consumers prescribing physician not being enrolled as a Medicaid provider. Medicaid consumers can only be prescribed services through a Medicaid enrolled provider.

⁴ The average monthly enrollment for the Fee for Service/Traditional Medicaid program in the fourth quarter of FY21 is 158,815.

Complaints related to member enrollment is the second highest complaint category beginning in the fourth quarter of FY20 and into the fourth quarter of FY21. A review of contact reasons shows the top complaint reasons were problems regarding Medicaid eligibility and case information errors in HHSC systems.

Figure 11 also shows that access to care is the third highest complaint category in the fourth quarter of FY21. A review of contact reasons shows the top complaint reasons were consumers having issues with accessing home health services, access to PCPs and access to in-network specialists and facilities.

Complaints by Service Area

Service areas (SA) represent the geographical locations of Medicaid consumers. There are 13 service areas across Texas. Except for vast rural areas, service areas are comprised of a highly populated county and its surrounding counties. Most service areas are named by their most populous county. Rural service areas are named by their general position within the state such as west, central and northeast.

OMCAT collects and reports contacts received by SA to identify complaint trends unique to an area of Texas.

Table 2 includes the top categories of complaints that were resolved and determined to either be substantiated or unable to substantiate by service area. The complaints represented in Table 2 are only those where 10 or more complaints were received in the service area and are a subset of the total complaints received for the service areas. The number of enrolled Medicaid consumers by service area is provided in Appendix B.

Table 2: Top Complaints by Service Area Q4 FY21

	Bexar	Dallas	El Paso	Harris	Hidalgo	Jefferson	Lubbock	MRSA Central	MRSA Northeast	MRSA West	Nueces	Tarrant	Travis
Access to Care	54	197	25	153	47	15	16	33	60	45	36	73	49
Prescription Services	40	57	10	77	10	12	9	10	30	17	8	34	11
Transportation	23	45	5	50	6	8	2	19	23	25	7	29	12
Member Enrollment	21	50	6	29	8	5	7	10	17	11	6	13	8
Claims/Payment	12	32	4	34	10	7	3	17	9	18	6	21	10

	Bexar	Dallas	El Paso	Harris	Hidalgo	Jefferson	Lubbock	MRSA Central	MRSA Northeast	MRSA West	Nueces	Tarrant	Travis
Quality of Care	13	25	4	20	7	6	3	2	3	2	1	8	4
Customer Service	4	17	3	21	1	0	0	4	4	4	1	9	4
Policies/ Procedures	5	11	1	9	2	1	1	2	3	3	3	4	3

Conclusion

In the 86th Legislature, Regular Session, 2019, House Bill 1576 transferred operation of medical transportation services from HHS Medical Transportation Program to MCOs for consumers in Medicaid managed care. Due to the effect of this bill, OMCAT saw a significant increase in complaints related to transportation.

OMCAT believes the increase in complaints is due to standard challenges that come with a major transfer of services from an HHS program to MCOs. OMCAT will continue to monitor transportation complaints and will continue to note any trends related to access to transportation as well as consider recommendations if needed.

Recommendations

There are no new recommendations for this quarter.

Recommendations from previous reports and updates to those recommendations are included in Appendix C.

Appendix A: Managed Care Program Tables

Table 3 includes the top resolved complaints determined to either be substantiated or unable to be substantiated for all managed care programs. Please note that the top complaint categories represented in the table below are a subset of the total complaints received for the managed care programs.

Table 3: Complaint Categories by Managed Care Program Q4 FY21

	STAR+PLUS	STAR	STAR Kids	STAR+PLUS Dual-Demo	STAR Health	Dental	FFS	No Medicaid
Access to Care	385	386	81	16	10	33	22	40
Prescription/Services	89	244	30	0	7	0	105	14
Member Enrollment	57	119	22	2	8	9	28	107
Transportation Issues	201	38	20	5	0	0	10	6
Claims/Payment	63	111	13	5	4	10	17	28
Quality of Care	54	38	7	0	1	16	2	15
Customer Service	29	39	4	1	1	6	5	14
Policies/Procedures	36	10	6	1	0	3	2	15
Non-Medicaid/CHIP Services	14	3	2	1	0	0	1	30

Table 4 includes the monthly average of Medicaid consumers enrolled in managed care programs for the fourth quarter of FY21.

Table 4: Average Monthly Enrollment by Managed Care Program Q4 FY21

Managed Care Program	Average Monthly Enrollment
Dental	3,652,934
FFS	158,815
STAR+PLUS Dual-Demo	37,996
STAR	3,976,831
STAR HEALTH	44,977
STAR Kids	168,065
STAR+PLUS	540,483

Appendix B: Average Enrollment by Service Area

Table 5 includes the monthly average of Medicaid consumers enrolled for each service area for the fourth quarter of FY21.

Table 5: Average Enrollment by Service Area

Service Area	Average Enrollment
Bexar	418,034
Dallas	617,630
El Paso	180,550
Harris	1,131,808
Hidalgo	522,219
Jefferson	137,556
Lubbock	119,318
MRSA Central	229,740
MRSA Northeast	288,741
MRSA West	257,978
Nueces	142,486
Tarrant	439,453
Travis	237,862

Appendix C: Recommendations and Updates from Previous Reports

Expedited Enrollment for Consumers Who Have Moved Out of the Service Area

In prior quarterly reports (first and second quarter of FY21), OMCAT observed that Medicaid consumers who move out of their service area experience challenges in accessing care when the new service area is not serviced by their MCO. OMCAT recommended that MCS review the feasibility of expediting enrollment retroactively during the month the new MCO is chosen, as soon as the consumer has updated the address for the new service area.

OMCAT has shared case examples regarding consumers who have moved out of a service delivery area to determine the length of time before the member's case information was updated in the HHSC and MCO systems after the move was reported to HHSC. OMCAT is using this information to better inform the Medicaid CHIP Services program regarding the feasibility of expediting retroactive enrollment when a member moves to a different service delivery area and chooses a new MCO.

Erroneous Secondary Insurance on Consumer Medicaid Cases

In previous quarterly reports, OMCAT provided recommendations to mitigate incorrect secondary insurance information on consumer cases in HHSC systems. HHSC took several actions to reduce occurrences of incorrect secondary insurance on consumers' cases. These actions include TMHP transitioning to a new pharmacy data match subcontractor effective October, 1 2021, and collaboration between HHSC and the health plans to identify process improvements for situations when pharmacies incorrectly identify consumers' other insurance and correction of over 80,000 pharmacy records that were incorrect or duplicate records.

Glossary

Category – A description of the types of complaints that are related to one another because of a similar issue.

Contact – Any instance of communication wherein a client, stakeholder, legislative liaison or advocate communicates with the Ombudsman.

Contact reason – A specific description of the nature of the inquiry or complaint received.

Complaint – A contact regarding an expression of dissatisfaction.

Fiscal Year 2020 – The 12-month period from September 1, 2019 through August 31, 2020, covered by this report.

Fiscal Year 2021 – The 12-month period from September 1, 2020 through August 31, 2021, covered by this report.

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

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

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

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.

Unresolved Complaints – Complaints that were still being investigated at the time the data in this report was presented.

List of Acronyms

CHIP – Children’s Health Insurance Program

ITP - Individual Transportation Participant

MCO – Managed Care Organization

MDCP – Medically Dependent Children’s Program

MRSA – Medicaid Rural Service Area

NEMT - Non-emergency medical transportation

PCP – Primary Care Provider

PHE – Public Health Emergency

PDL – Preferred Drug List

SA – Service Area