HHS Ombudsman Managed Care Assistance Team 2nd Quarter FY 2023

As Required by
Section 531.0213 of the
Government code

Office of the Ombudsman
May 2023

TEXAS
Health and Human Services

Revised May 2023

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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 second quarter of fiscal year 2023 (FY23), OMCAT received 6,107 contacts; of which, 2,192 were complaints and 3,915 were inquiries.

Complaints made up 36 percent of total contacts. Of the 2,192 complaints received, 2,178 complaints were resolved during the quarter with the remaining 14 pending resolution. Of those resolved complaints:

- 10.0 percent (or 218) were substantiated;
- 26.3 percent (or 572) were unable to substantiate;
- 51.5 percent (or 1,122) were referred and;
- 12.2 percent (or 266) were unsubstantiated.

Figure 1 below shows the number of inquiries and complaints received for this quarter.

Figure 1: Second Quarter Total Contacts Received

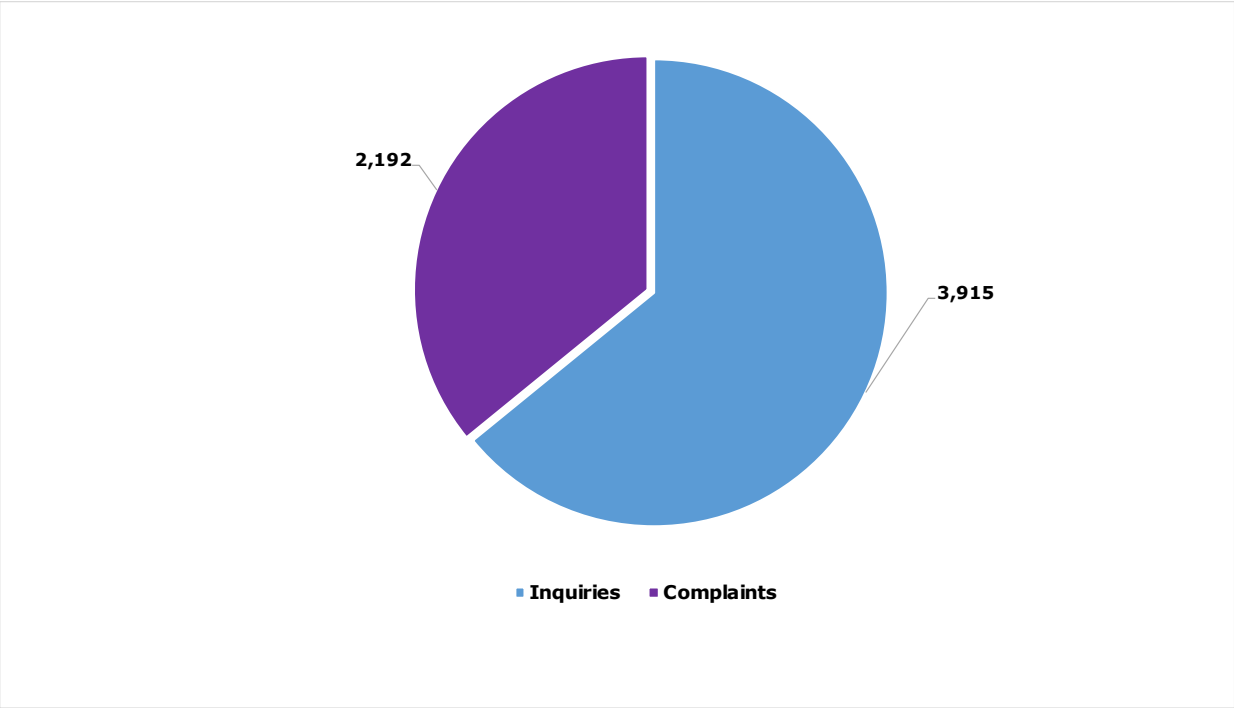
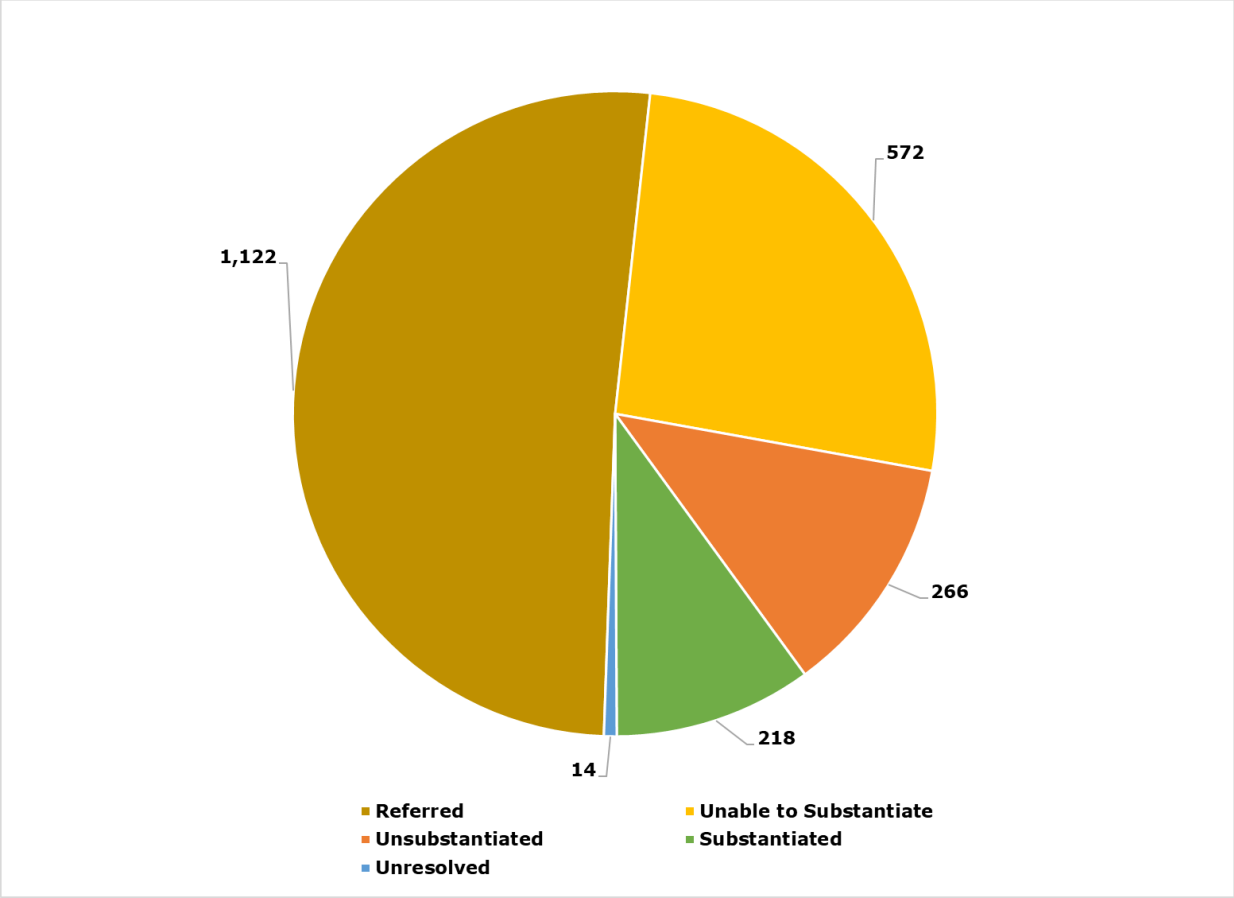


Figure 2 below shows the number of complaints with their determination of resolution as substantiated, unable to substantiate, unsubstantiated, or referred for the quarter.

Figure 2: Second Quarter Complaint Determination



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 (Managed Care Organizations) 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.

OMCAT was contacted by the mother of a minor who required emergency medical transportation. During a doctor's visit, the doctor discovered an infection constituting a medical emergency that required immediate hospitalization and surgery.

The doctor ordered a helicopter transport for the youth to the nearest hospital available to treat the infection. The member’s mother declined the helicopter transport because she was concerned, she would have no way to return home after the surgery. The mother asked the doctor if her child could be stabilized for the mother to transport the child with her personal vehicle. The doctor was able to stabilize the youth and approve transport with the mother’s personal vehicle.

The mother proceeded to drive several hours to the nearest hospital available to perform the surgery. After returning home from the hospital stay, the mother submitted an Individual Transportation Participant (ITP) request for gas reimbursement and meal reimbursement for the mother. The mother provided an

explanation to the MCO that due to the medical emergency she did not have time to get the trip pre-authorized by the MCO.

The MCO denied the reimbursement request because travel outside of county of residence requires 5 business days' notice in accordance with the Non-Emergency Medical Transportation (NEMT) Handbook. OMCAT requested that the MCO make an exception to the NEMT Handbook, as it was not possible that the mother could have provided advanced notice due to the urgency of the recommended surgery. The MCO reconsidered their initial determination and reversed their decision. The MCO provided full reimbursement for gas and meals for the mother.

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 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 area and managed care program; and,
- Number of complaints resolved that were substantiated, unable to be substantiated, and unsubstantiated.

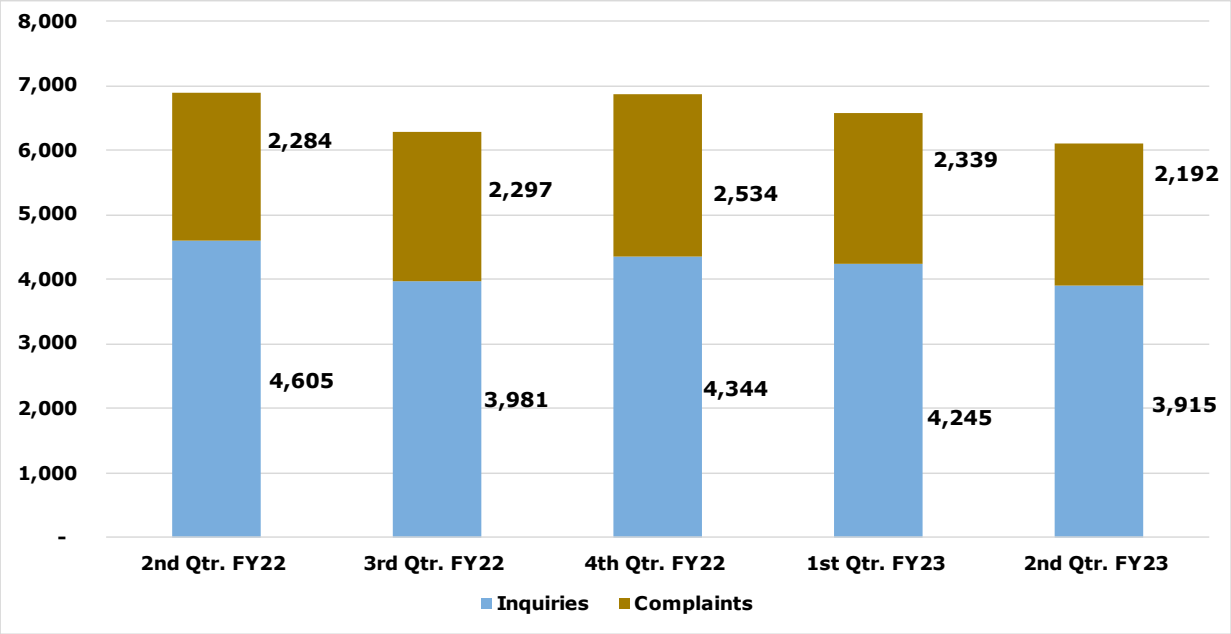
Consumer Contacts

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 3 shows the volume of all contacts received, including inquiries and complaints, over the previous four quarters.

Figure 3: Contacts Received FY22 & FY23



In the second quarter of FY23, OMCAT received a total of 6,107 contacts. This is a seven percent decrease from the first quarter in FY23. The data show that total contacts for the second quarter of FY23 decreased by 11 percent compared to the second quarter of FY22.

Inquiries

Inquiries are an important indicator of a member's 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.

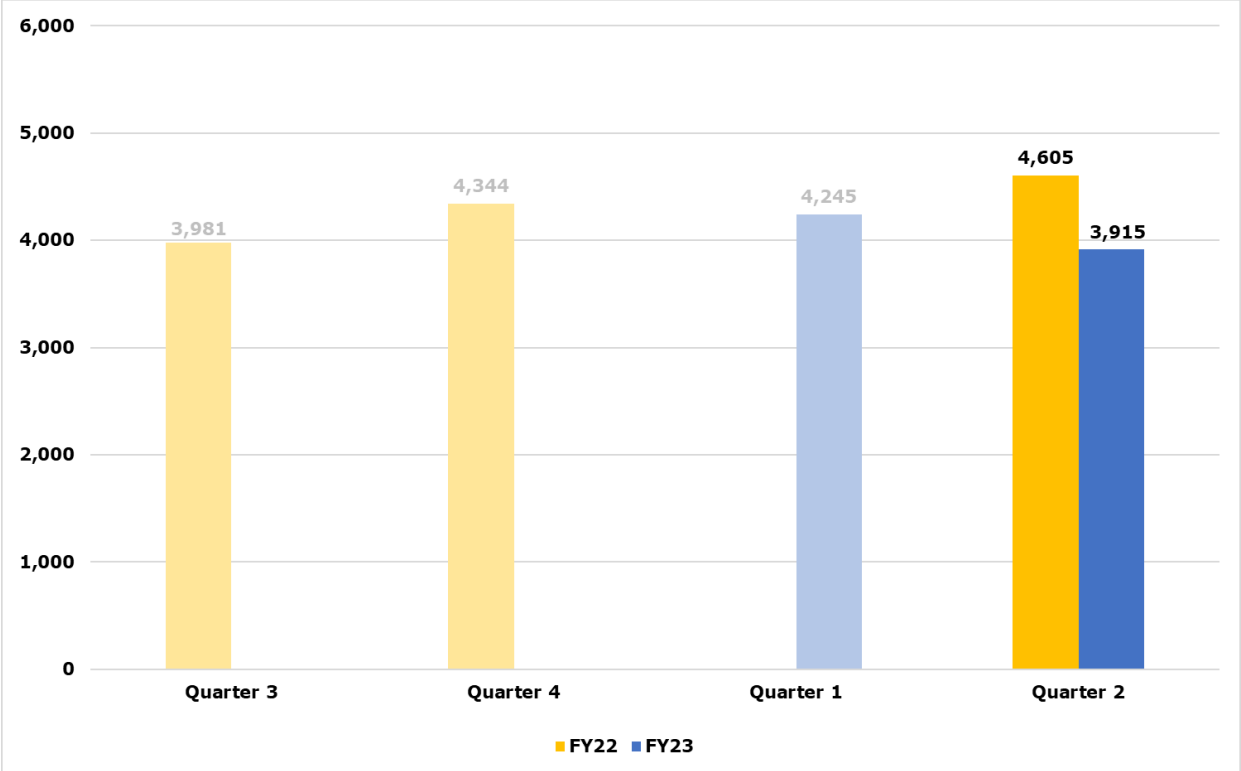
Inquiries Process

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 4 focuses on the comparison of the volume of inquiries received for the second quarter of FY23 with the same quarter of the previous year.

Figure 4: Inquiries Received FY22 & FY23



The data indicate that the volume of inquiries received for the second quarter of FY23 decreased by eight percent (or 330 fewer) as compared to the first quarter of FY23. Additionally, when compared with the second quarter of FY22, the data show that the volume of inquiries received during the second quarter of FY23 decreased by 15 percent.

Resolved Complaints

Resolved complaints are categorized in HEART as: substantiated, unsubstantiated, unable to substantiate, and referred. A referred complaint is one that is either outside the scope of OMCAT's work or where the client has not yet attempted to resolve their issue with the HHS program area.

In some instances, 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 states the 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 home health agency will send a replacement when the attendant is not available.

	DEFINITION	EXAMPLE	FINDINGS	RESOLUTION
Unable to Substantiate	Research cannot indicate whether agency policies or expectations were or were not violated.	Consumer cannot access medical services.	Consumer does not respond to Ombudsman contacts to request information.	OMCAT closes complaint because information was needed from the consumer to process the complaint.
Unsubstantiated	Research indicates that agency policies or expectations were not violated.	Consumer's prescription was rejected at the pharmacy.	Investigation confirms that refill is not yet due.	OMCAT advised consumer of when the prescription will be ready for refill.
Referred	Research indicates the complaint must be addressed by another area.	Consumer cannot find a doctor in their area.	Consumer has not yet contacted their health plan for assistance in finding a provider.	Consumer is referred to their health plan for assistance in finding an in-network doctor.

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

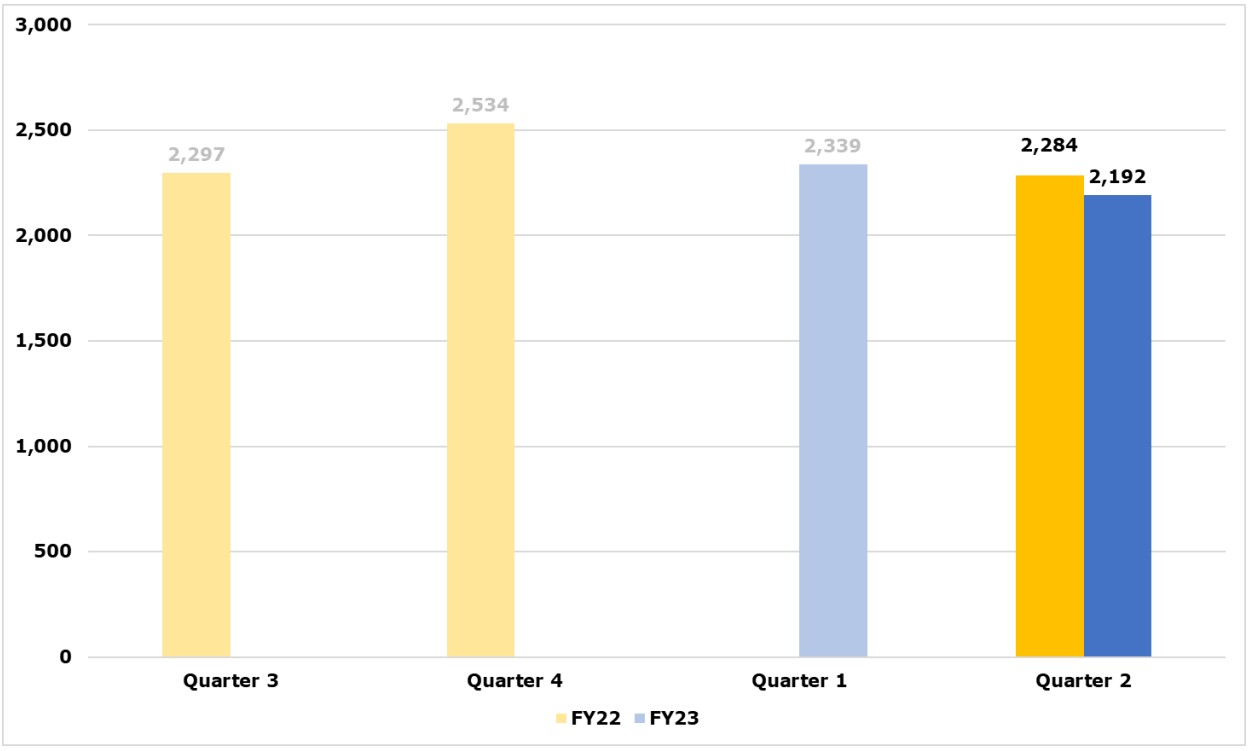
Why We Include More than Substantiated Complaints

The OMCAT report includes complaints determined to be "substantiated," "unable to substantiate," and "referred" in its analysis to better understand the totality of consumer experiences. Having a holistic view of complaints allows the Office of the Ombudsman to better identify trends and provide recommendations to address potential barriers to accessing care.

Complaints Received

Figure 5 focuses on the comparison of the total complaints received for the second quarter with the same quarter of the previous fiscal year. In the second quarter of FY23, OMCAT received 2,192 complaints, which is a decrease of six percent (or 147 fewer) compared to the first quarter of FY23 and a decrease of four percent (or 92 fewer) compared to the second quarter of FY22.

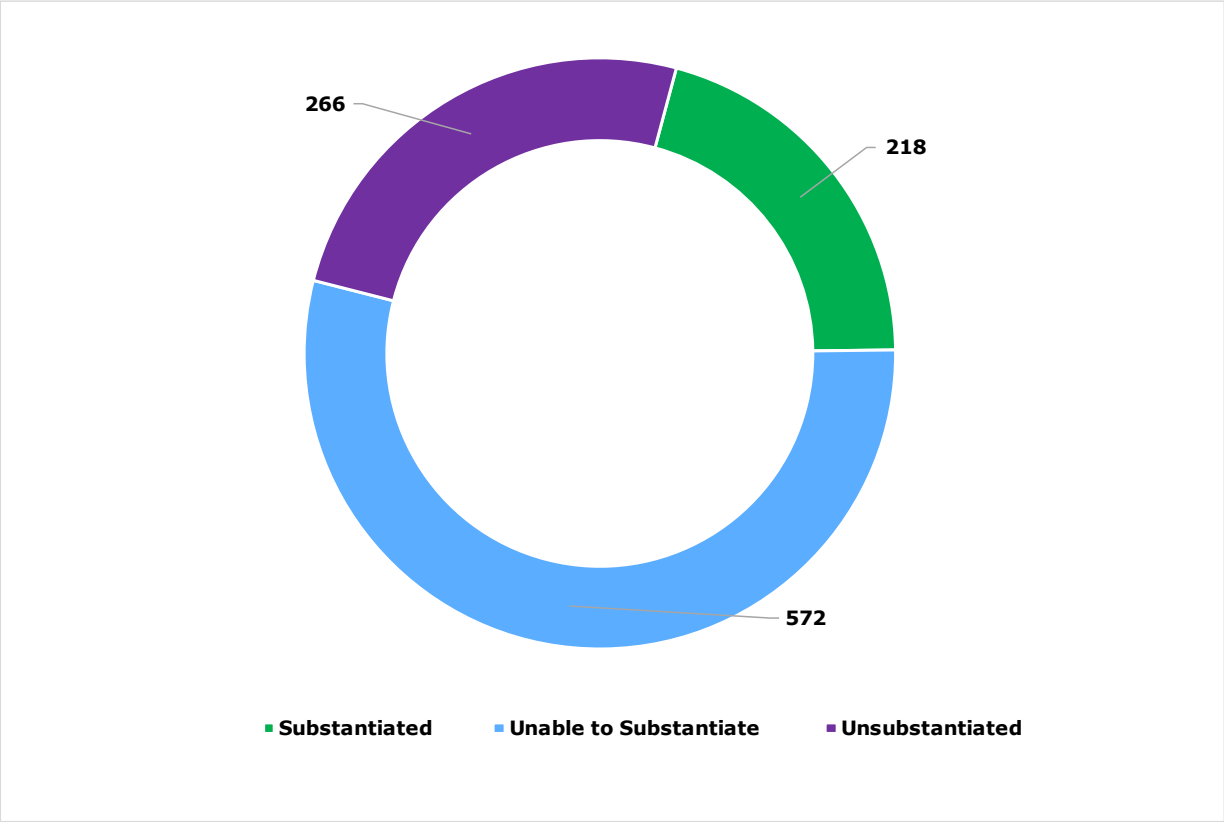
Figure 5: Complaints Received FY22 & FY23



Resolved Complaints by Determination

Figure 6 below shows total resolved complaints by determination received in the second quarter of FY23. Figure 6 does not include referred complaints as these must be investigated by a different area. OMCAT investigated and resolved 1,056 complaints out of 2,192 received. Fourteen complaints were still being investigated at the end of the second quarter of FY23. (Note: Referred complaints are not included in Figure 6.)

Figure 6: Complaints by Resolution Determination



Substantiated Complaints

Of the 1,056 complaints investigated in the second quarter of FY23, OMCAT substantiated 218, or 21 percent of total investigated complaints.

The top substantiated complaint reason for the second quarter of FY23 was related to consumers who had difficulty accessing in-network specialists and facilities, which accounted for 15 percent of all substantiated complaints. Review of case summaries show that consumers had trouble obtaining OBGYN services after they moved out of their service delivery area. MCOs are required to assist members with continuity of care when they move service delivery areas until their address is updated in HHSC data systems and select a new MCO in their new service area.

The data show that the second highest substantiated complaint reason was consumers who reported difficulty accessing home health services. Review of case summaries showed that members had difficulty receiving assessments to determine

the amount of home health hours and receiving authorization for home health services from the MCO after assessments were performed.

The third highest substantiated complaint reasons were consumers who reported difficulty accessing prescriptions due to erroneous insurance showing active in HHSC, MCO or pharmacy data systems and consumers who reported difficulty accessing a primary care physician. A review of case summaries show consumers were provided an outdated list of primary care physicians from their MCO. No trend was found regarding complaints regarding erroneous insurance showing active on the consumers Medicaid profile.

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, unable to substantiate or referred. 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 children, pregnant women, and some parents of children on Medicaid[1]. In the second quarter of FY23, OMCAT received 639 complaints of which 86 (or 13 percent) were substantiated.

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

[1] The average monthly enrollment for the STAR program in the second quarter of FY23 is 4,811,608.

Figure 7: Top STAR Complaint Categories FY22 & FY23

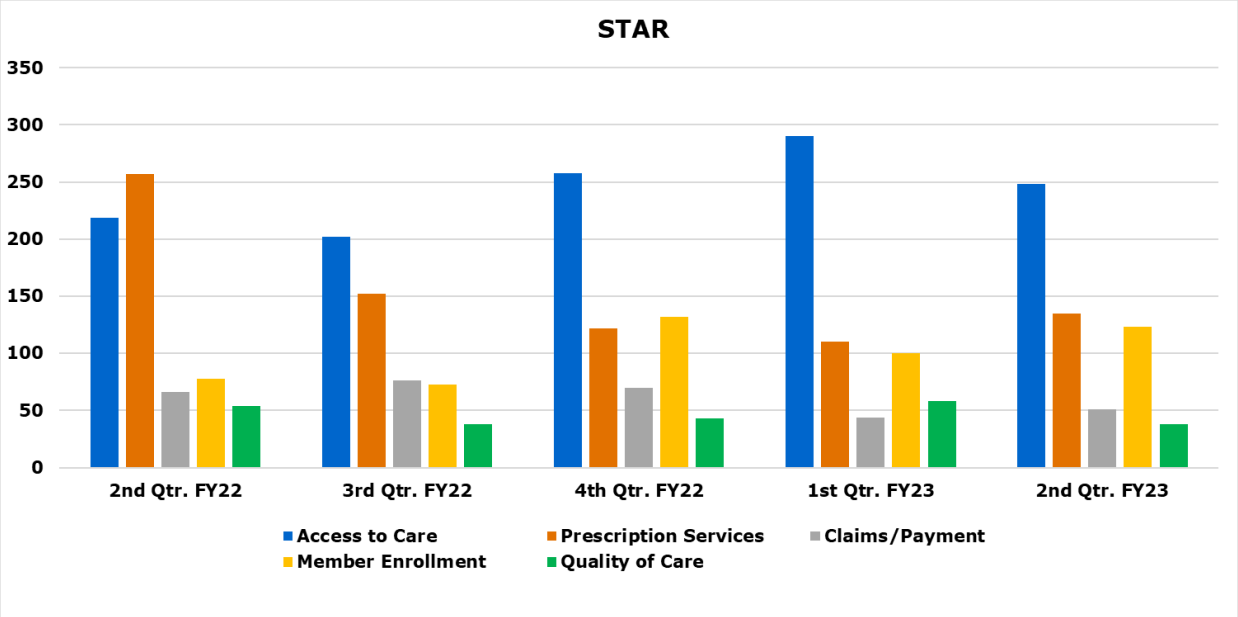


Figure 7 shows that the top three complaint categories for STAR consumers in the second quarter of FY23 and in three of the previous four quarters were complaints related to: accessing care, difficulty accessing prescription services and problems with member enrollment.

Access to care is the top complaint category in the second quarter of FY23. STAR consumer complaints regarding access to care decreased by 36 percent from the first quarter to the second quarter of FY23. During the second quarter of FY23 the top three complaint reasons include consumers who reported difficulty accessing in-network specialists and facilities, out-of-network providers, and PCPs. Complaints regarding consumers reporting difficulty accessing in-network specialist decreased 40 percent from the first quarter to the second quarter of FY23. Complaints regarding consumers reporting difficulty accessing out-of-network providers decreased by 65 percent from the first quarter to the second quarter of FY23. Complaints regarding difficulty accessing PCP remained the same from the first quarter to the second quarter of FY23.

A review of case summaries shows STAR consumers statewide had difficulty obtaining in-network (22) and out-of-network (19) OBGYN services. Consumers also reported issues locating in-network neurologists (5) and out-of-network pediatricians (4). Consumers reported difficulty locating specialists due to moving service areas, which caused the provider to be out-of-network, and issues locating specialists who accepted their MCO. Consumers also reported receiving outdated

lists of PCPs from their MCO and problems finding a PCP that was accepting new patients.

Consumers residing in Harris County reported the most complaints regarding problems accessing in-network and out-of-network specialists and facilities. Consumers residing in El Paso County recorded the second most complaints (7) regarding accessing out-of-network providers. Consumers residing in Dallas County had the most complaints related to accessing a PCP.

A review of case summaries revealed that consumers in Harris County had difficulty accessing in-network and out-of-network OBGYN services (15). No trend was noted regarding consumers in El Paso County problems accessing out-of-network providers. Consumers in Dallas County reported issues accessing a PCP that would accept their MCO.

Complaints of prescription services is the second highest complaint category in the second quarter of FY23. The top complaint reasons included: consumers who reported difficulty receiving prescription medication due to erroneous insurance showing on HHSC, MCO or pharmacy data systems; consumers whose Medicaid profile was not active in HHSC, MCO or pharmacy data systems; and consumers whose medication required clinical prior authorization or medication that was not listed on the Medicaid formulary. No trend was found regarding consumers who reported difficulty obtaining medication due to insurance other than Medicaid showing active on their Medicaid profile, consumers who reported barriers to accessing medication that required clinical authorization or consumers who had difficulty receiving medications not listed on the Medicaid formulary.

Complaints of member enrollment is the third highest complaint category in the second quarter of FY23. The top complaint reasons related to member enrollment are consumer reports of case information errors on the Medicaid profile and complaints related to Medicaid eligibility and recertification. Consumers reported that their information such as address, name or date of birth was not updated on their Medicaid profile after being reported to HHSC. OMCAT does not investigate case information errors, case information complaints are transferred to the Specialized Ombudsman Services for review and determination.

STAR+PLUS

The STAR+PLUS program serves adults who have disabilities or are age 65 or older[2]. In the second quarter of FY23, OMCAT received 579 complaints of which 87 (or 15 percent) were substantiated. Figure 8 shows a comparison of the top complaint categories for the current quarter and the previous four quarters.

Figure 8: Top STAR+PLUS Complaint Categories FY22 & FY23

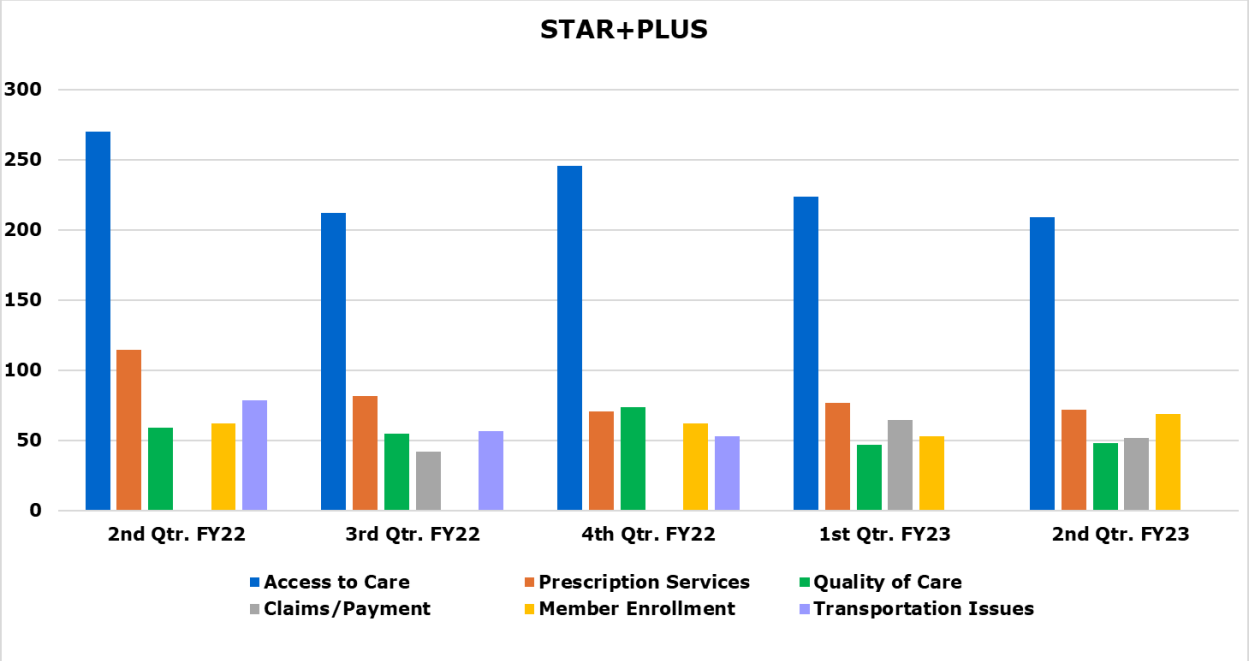


Figure 8 shows that complaints related to consumers who reported experiencing barriers to accessing care is the top complaint category for five consecutive quarters.

The top complaint reasons related to accessing care for the second quarter of FY23 include consumers who reported problems receiving home health services, had issues receiving durable medical equipment (DME) and consumers who reported disagreement with denial of Medicaid services. Consumers residing in Harris County had the highest number of complaints regarding home health services.

A review of case summaries related to accessing home health services revealed that consumers reported problems receiving assessments to determine the consumer's need for personal attendant services (PAS) and disagreement with

[2] The average monthly enrollment for the STAR+PLUS program in the second quarter of FY23 is 572,162.

denial or reduction of PAS services. Consumers reported problems utilizing the Consumer Directed Services (CDS) options, such as CDS employees not being paid timely by the Financial Management Services Agency (FMSA) and MCO authorization of all CDS hours as determined by the member's CDS assessment. The CDS option gives consumers and the authorized representatives the opportunity to recruit, hire and manage employees who deliver PAS services. The CDS option includes the requirement that consumers select an FMSA to assist with management of employees including paying taxes and employee payroll.

Another review of case summaries showed that consumers reported difficulty receiving authorization for wheelchairs and problems receiving wheelchair repairs. Consumers also had complaints related to denial of dental services and medical imaging such as PET scans, MRIs and x-rays. General dental services are not a covered Medicaid service for adults unless the dental treatment is classified as a medical procedure. However, consumers enrolled in the STAR+PLUS HCBS waiver are eligible to receive dental services up to 5,000 dollars per plan year.

Complaints related to prescription services is the second highest complaint category for STAR+PLUS consumers. The top complaint reasons related to prescription services include consumer complaints of insurance other than Medicaid erroneously showing in HHSC, MCO or pharmacy data systems, consumers who had difficulty obtaining medication that require a clinical authorization, and consumers who had problems obtaining medication not listed in the Medicaid drug formulary. A review of case summaries show that incorrect private insurance listed on the Medicaid profile prevented consumers from processing their medication at the pharmacy and consumers complained that their PCP did not submit clinical prior authorization to the pharmacy. Consumers also filed complaints that their medication was not listed on the Medicaid formulary forcing their PCP to prescribe generic medication instead of brand name medication.

Member enrollment is the third highest complaint category in the second quarter of FY23. The top complaint reasons related to member enrollment include consumers who had problems with their Medicaid eligibility and recertification and case information errors showing on the consumer's Medicaid profile.

A review of case summaries revealed consumers had complaints regarding notices sent from the Social Security Administration (SSA) informing them that SSA would no longer pay their Medicare Part B premiums and complaints from consumers living in nursing facilities and assisted living facilities who required a redetermination of their Medicaid type because they were ready to move into the

community. Callers also reported incorrect information on their Medicaid profile such as wrong address, name, and date of birth.

STAR Kids

The STAR Kids program serves children and adults 20 years of age and younger who have disabilities[3]. In the second quarter of FY23, OMCAT received 84 complaints of which 15 (or 18 percent) were substantiated. Figure 9 shows a comparison of the top complaint categories for the current quarter as well as the previous four quarters.

Figure 9: Top STAR Kids Complaint Categories FY22 & FY23

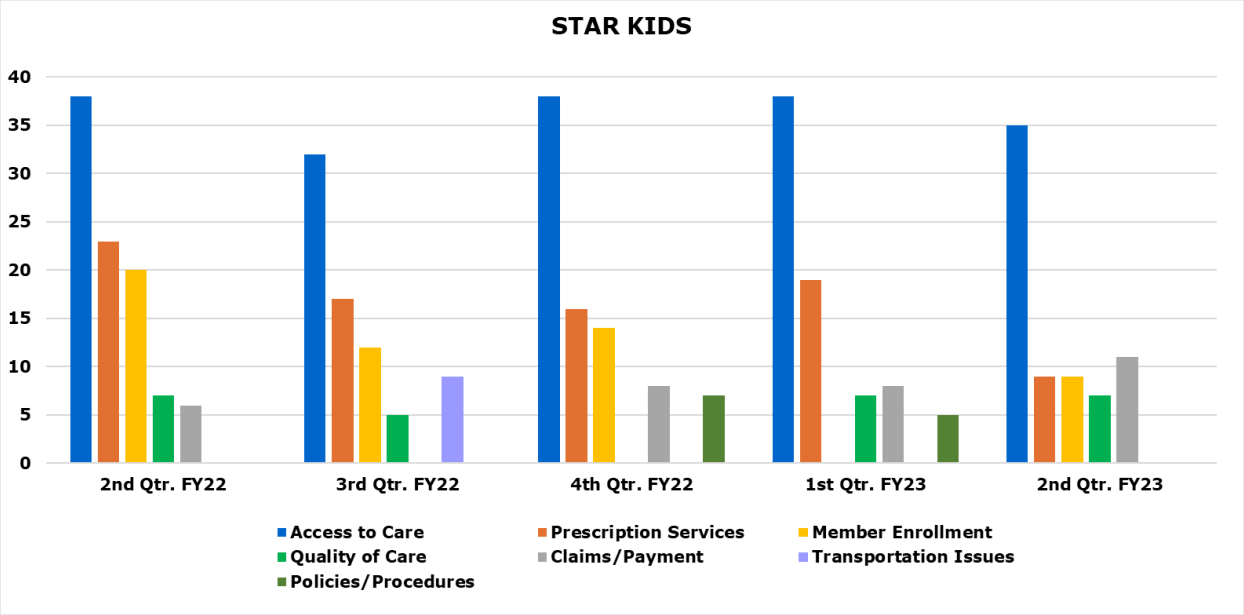


Figure 9 shows that complaints related to access to care continue to be the top complaint category for STAR Kids consumers in the second quarter of FY23. The top complaint reasons of access to care were consumer complaints related to problems accessing out-of-network providers, consumers who reported difficulty accessing in-network specialists and facilities and consumers who had issues accessing home health services. A review of case summaries showed consumers had complaints regarding locating a PCP after moving to a new service area. Authorized representatives also reported difficulty accessing residential and substance abuse facilities for their children. No trends were found regarding complaints related to

[3] The average monthly enrollment for the STAR Kids program in the second quarter of FY23 is 169,903.

problems accessing in-network specialists and facilities and difficulty accessing home health services.

Complaints related to claims payment is the second highest complaint category in the second quarter of FY23. A review of case summaries revealed consumers reported that their home health agency had not paid their employees.

Access to member enrollment is the third highest complaint category in the second quarter of FY23. The top complaint reasons related to member enrollment include consumers who reported case information errors on their Medicaid profile and problems with their Medicaid eligibility. No trends were found regarding case information error or Medicaid eligibility related complaints.

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 program[4]. OMCAT assists all consumers on Medicaid, as such, it is important to capture complaints for all populations of Medicaid consumers.

In the second quarter of FY23, OMCAT received 153 complaints, of which 19 (or 12 percent) were substantiated. Figure 10 shows a comparison of the top complaint categories for the current quarter as well as the previous four quarters.

[4] The average monthly enrollment for the Fee for Service/Traditional Medicaid program in the second quarter of FY23 is 169,664.

Figure 10: Top Fee for Service/Traditional Medicaid Complaint Categories FY22 & FY23

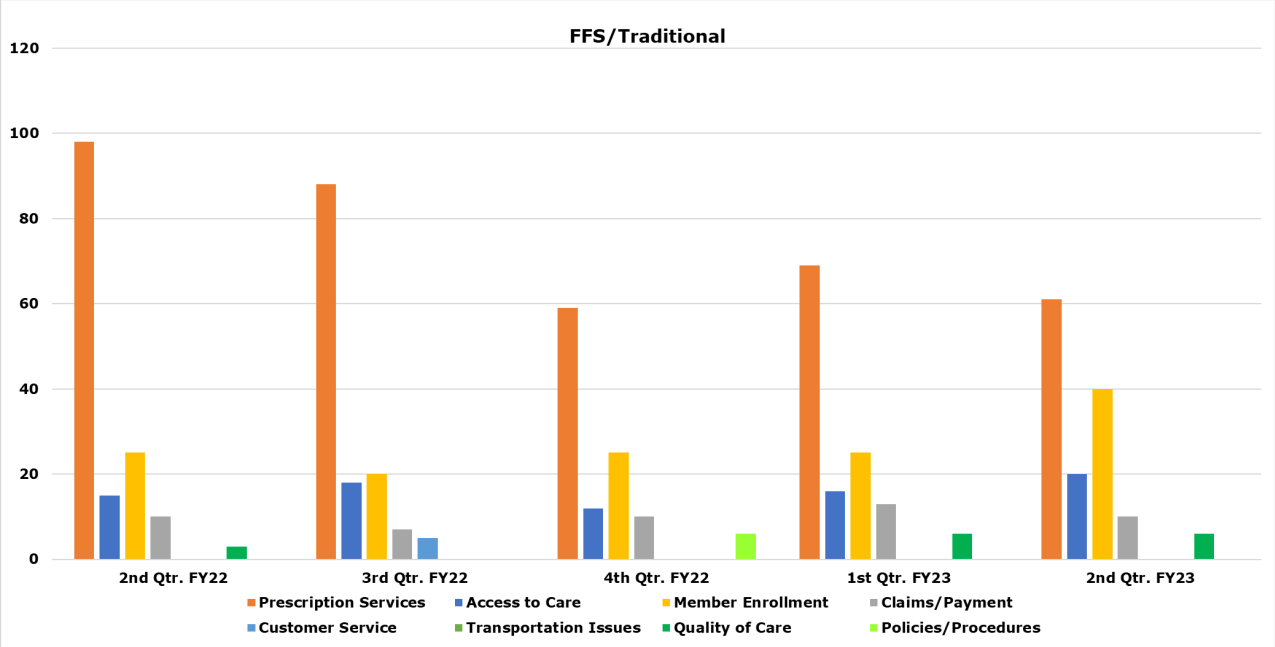


Figure 10 shows complaints related to accessing prescription services, member enrollment and access to care continue to be the top complaint categories in the second quarter of FY23.

The top complaint reasons for prescription services include consumers who had difficulty obtaining prescription medication due to not showing active in HHSC or pharmacy data systems, consumers who experienced barriers to accessing medication due to their prescription not being listed in the Medicaid formulary and consumers who reported problems receiving medication due to insurance other than Medicaid showing active on their Medicaid profile. A review of case summaries revealed that pharmacies had incorrect information such as Bank Identification Number (BIN), Processor Control Number (PCN) or Group Number causing the member to show inactive in pharmacy data systems.

Member enrollment is the second highest complaint category for the second quarter of FY23. The top complaint reason for member enrollment is complaints related to consumers having difficulty with Medicaid eligibility and recertification. A review of case summaries showed that consumers had complaints regarding Medicaid application processing errors, wait times and denials. Consumers also reported complaints regarding notices sent from the Social Security Administration (SSA) informing them that SSA would no longer pay their Medicare Part B premiums.

Callers also reported incorrect information on their Medicaid profile such as wrong address, name or date of birth.

Complaints of access to care is the third highest complaint category for the second quarter of FY23. The top contact reasons relating to access to care include consumer complaints of difficulty accessing in-network specialists and facilities, consumers who had problems receiving home health services and consumers who reported denial of Medicaid services.

A review of case summaries revealed consumers had difficulty with:

- Locating in-network OBGYNs,
- Receiving assessments for home health services,
- Locating an attendant that could provide the authorized number of home health hours, and
- Denials of dental care, medical imaging, and personal attendant services.

Conclusion

Total contacts decreased 14 percent in the first two quarters of FY23 in comparison to the same time in FY22. Total contacts also decreased by 11 percent from the first to the second quarter of FY23. Although total contacts decreased slightly from the first to second quarter of FY23, complaints related to Medicaid eligibility and recertification increased by 33 percent from the first to second quarter of FY23.

A review of case summaries of Medicaid eligibility and recertification related complaints showed an increase in complaints related to notices sent from the Social Security Administration (SSA) informing consumers that SSA would no longer pay their Medicare Part B premiums. The Office of the Ombudsman received notice from Access Eligibility Services that a system error incorrectly provided notice that the state would no longer pay their Medicare Part B premiums. HHSC was able to correct this error and reinstate consumer's Medicare Part B coverage to affected consumers.

Appendix A: Managed Care Program Tables

Table 2 includes the top resolved complaints determined to either be substantiated, unable to be substantiated or referred 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 2: Complaint Categories by Managed Care Program Q2 FY23

	STAR+PLUS	STAR	STAR Kids	STAR+PLUS Dual-Demo	STAR Health	Dental	FFS	No Medicaid
Access to Care	168	135	21	6	2	10	16	21
Prescription Services	64	103	9	0	1	0	53	19
Member Enrollment	66	102	8	2	2	7	39	105
Non-Medicaid /CHIP	29	52	3	0	2	0	10	109
Claims/ Payment	37	34	7	4	0	6	10	19
Quality of Care	37	28	5	1	1	12	4	19
Customer Service	33	25	0	0	4	3	3	25
Policies/ Procedures	17	5	4	0	0	3	0	10
Transportation Issues	29	11	3	1	0	0	1	1
Therapy	1	3	3	0	0	0	0	0
Fraud	5	3	0	1	0	0	0	5
Member Health and Safety	4	2	0	0	0	0	0	1
Value-Added Services	3	0	0	0	0	1	0	0

Table 3 includes the monthly average of Medicaid consumers enrolled for managed care program for the second quarter of FY23.

Table 3: Average Monthly Enrollment by Managed Care Program Q2 FY23

Managed Care Program	Average Monthly Enrollment
STAR	4,811,608
Dental	4,199,625
STAR+PLUS	572,162
STAR Kids	169,903
FFS	169,664
STAR HEALTH	46,586
STAR+PLUS Dual-Demo	33,810

Appendix B: 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 4 includes the top complaints that were resolved and determined to either be substantiated or unable to substantiate by service area. The complaints represented in Table 4 are a subset of the total complaints received for the service areas.

Table 4. Complaints by Service Area Q1 FY23

	Bexar	Dallas	El Paso	Harris	Hidalgo	Jefferson	Lubbock	MRSA Central	MRSA Northeast	MRSA West	Nueces	Tarrant	Travis
Access to Care	24	49	13	86	20	16	6	16	18	14	8	35	25
Prescription Services	14	19	4	35	5	8	8	15	20	19	3	19	7
Member Enrollment	14	30	9	42	3	4	4	11	13	12	1	23	12
Claims /Payment	7	10	2	22	7	3	6	3	3	4	2	9	4
Quality of Care	9	15	3	15	3	1	0	4	6	6	1	8	0
Customer Service	12	7	1	14	8	0	0	4	4	3	2	3	0
Transportation Issues	1	6	1	12	2	2	1	7	4	3	0	2	3
Non-Medicaid /CHIP	5	18	1	15	2	2	4	5	10	2	5	9	6
Policies /Procedures	3	2	0	7	2	0	1	1	4	0	1	1	4
Therapy	0	0	1	3	0	0	0	0	2	0	0	1	0
Fraud	1	1	3	1	0	2	0	0	0	0	0	1	0
Member Health and Safety	0	2	1	1	0	0	0	0	0	0	0	1	1
Value-Added Services	0	1	0	0	1	0	0	0	0	0	0	1	0

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 2022 – The 12-month period from September 1, 2021, through August 31, 2022, covered by this report.

Fiscal Year 2023 - The 12-month period from September 1, 2022, through August 31, 2023, 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

MCO – Managed Care Organization

MDCP – Medically Dependent Children's Program

MRSA – Medicaid Rural Service Area

PCP – Primary Care Provider

PHE – Public Health Emergency

PDL – Preferred Drug List

SA – Service Area