

HHS Ombudsman Managed Care Assistance Team 3rd Quarter FY 2022

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

**Office of the Ombudsman
2022**



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 (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.

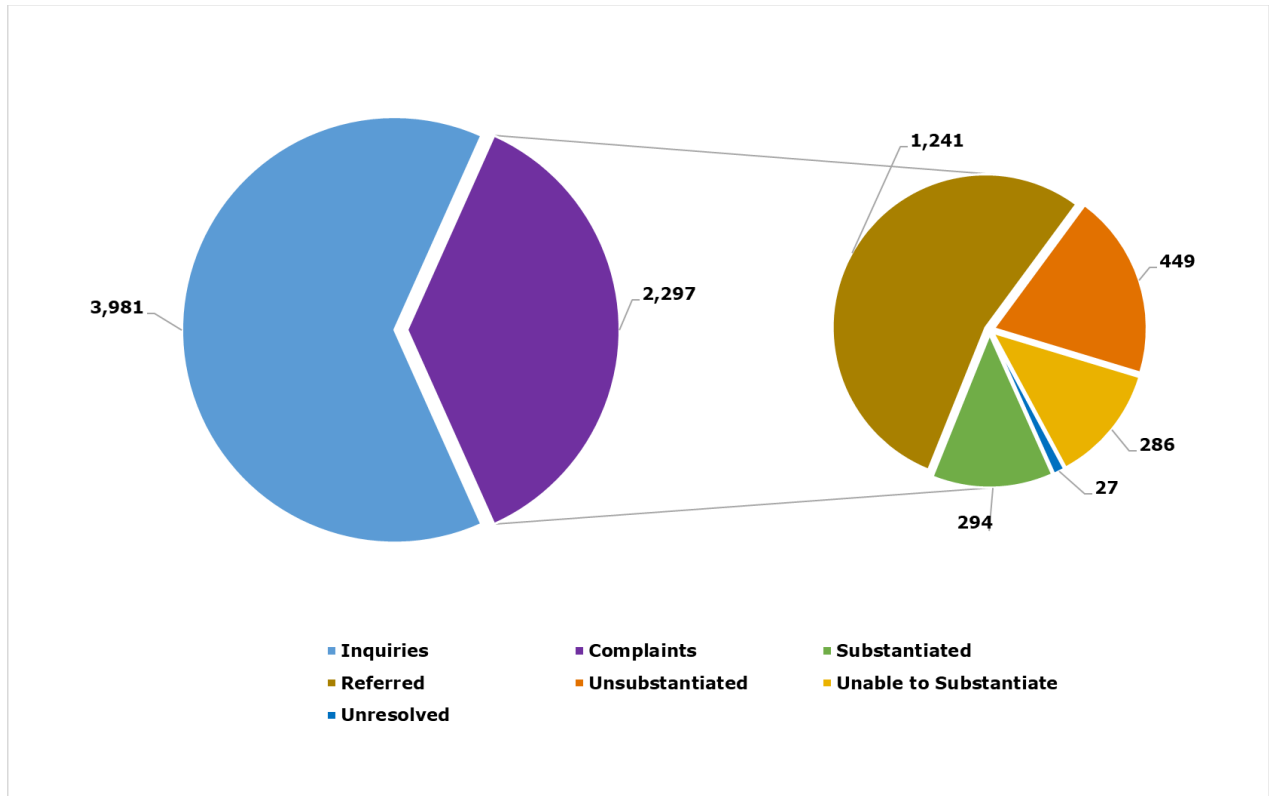
During the third quarter of fiscal year 2022 (FY22), OMCAT received 6,278 contacts; of which, 2,297 were complaints and 3,981 were inquiries.

Complaints made up 37 percent of total contacts. Of the 2,297 complaints received, 2,270 complaints were resolved with the remaining 27 pending resolution. Of those resolved complaints:

- 12.95 percent (or 294) were substantiated;
- 12.60 percent (or 286) were unable to substantiate;
- 54.67 percent (or 1,241) were referred and;
- 19.78 percent (or 449) 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 unsubstantiated for the quarter, or referred.

Figure 1: Third 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.

OMCAT was contacted within this quarter by a parent on behalf of their child who was diagnosed with cancer. The child's cancer was threatening to spread throughout their body. The doctor scheduled to perform the surgery was not in-network with the member's current health plan because the family had recently moved counties and had not yet updated their address or selected a new health plan. Therefore, the surgery was not approved by the member's health plan.

OMCAT advised the parent to report their address change to HHSC immediately. After the address was updated in the HHSC system, OMCAT was able to have the current health plan release the member one month early and work with the new health plan to accept the member one month earlier than current policy requires. The member was able to receive the scheduled surgery.

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 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.

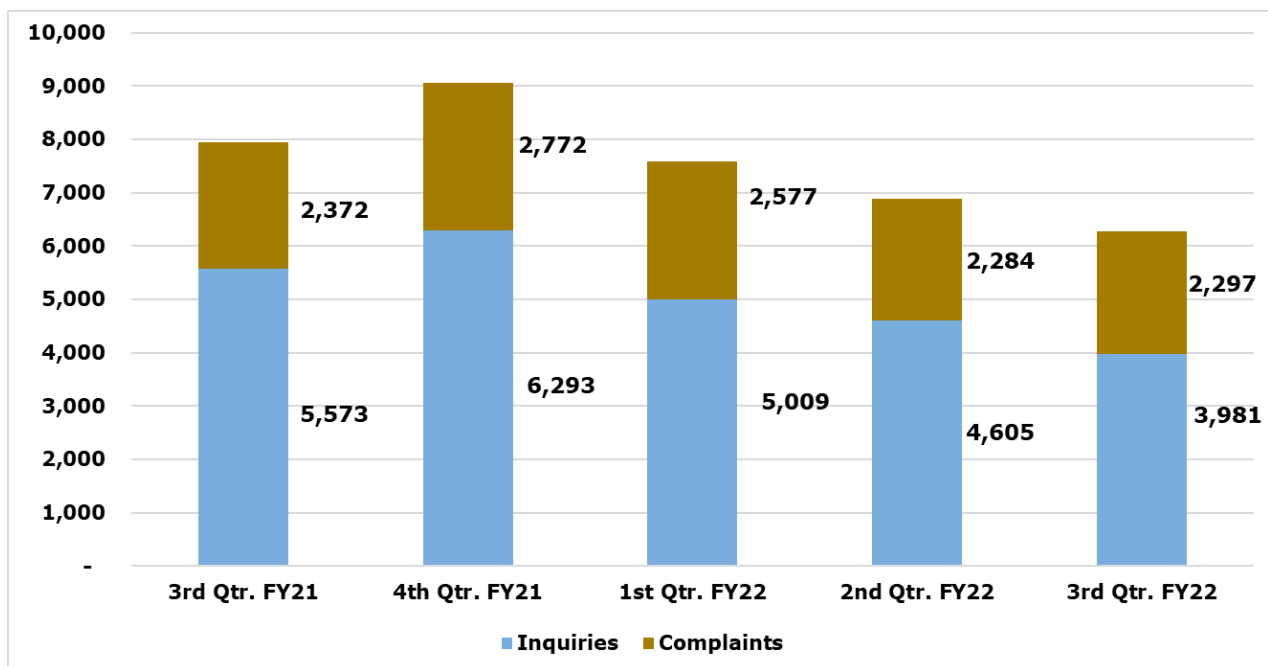
Consumer Contacts

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, over the previous four quarters.

Figure 2: All Contacts Received FY21 & FY22



In the third quarter of FY22, OMCAT received a total of 6,278 contacts. This is a nine percent decrease from the second quarter in FY22. The data show that total contacts for the third quarter of FY22 decreased by 21 percent compared to the third quarter of FY21.

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.

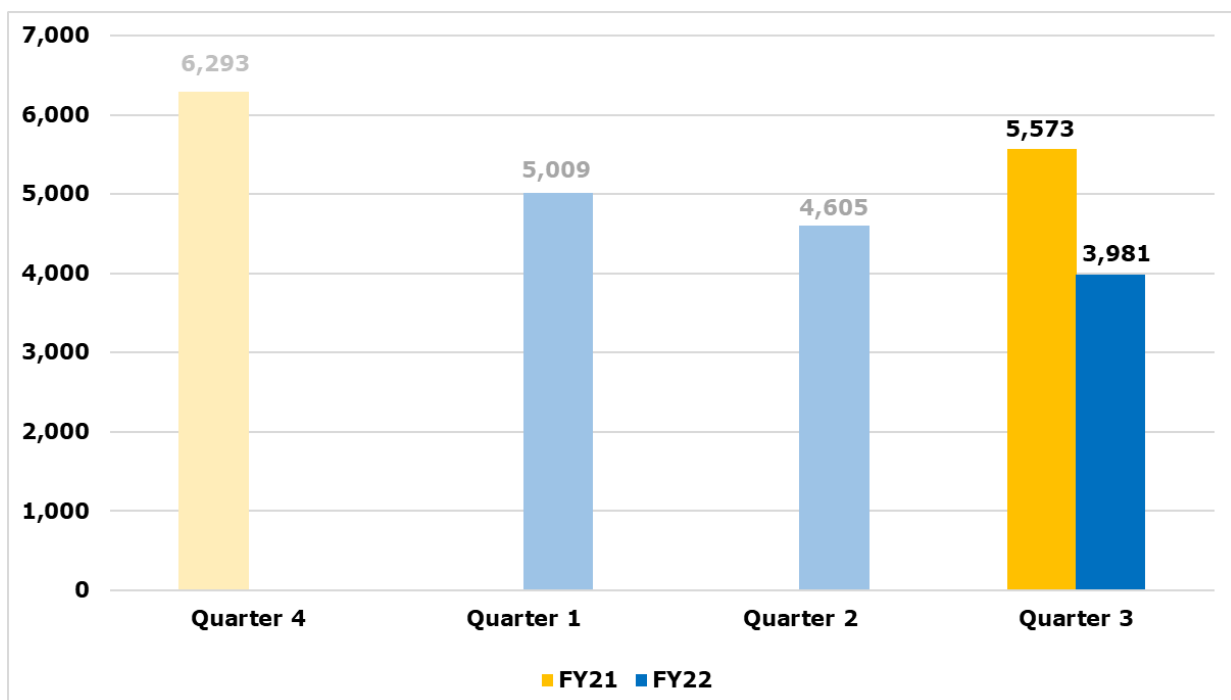
Inquiries Process

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 3 focuses on the comparison of the volume of inquiries received for the third quarter of FY22 with the same quarter of the previous year.

Figure 3: Inquiries Received FY21 & FY22

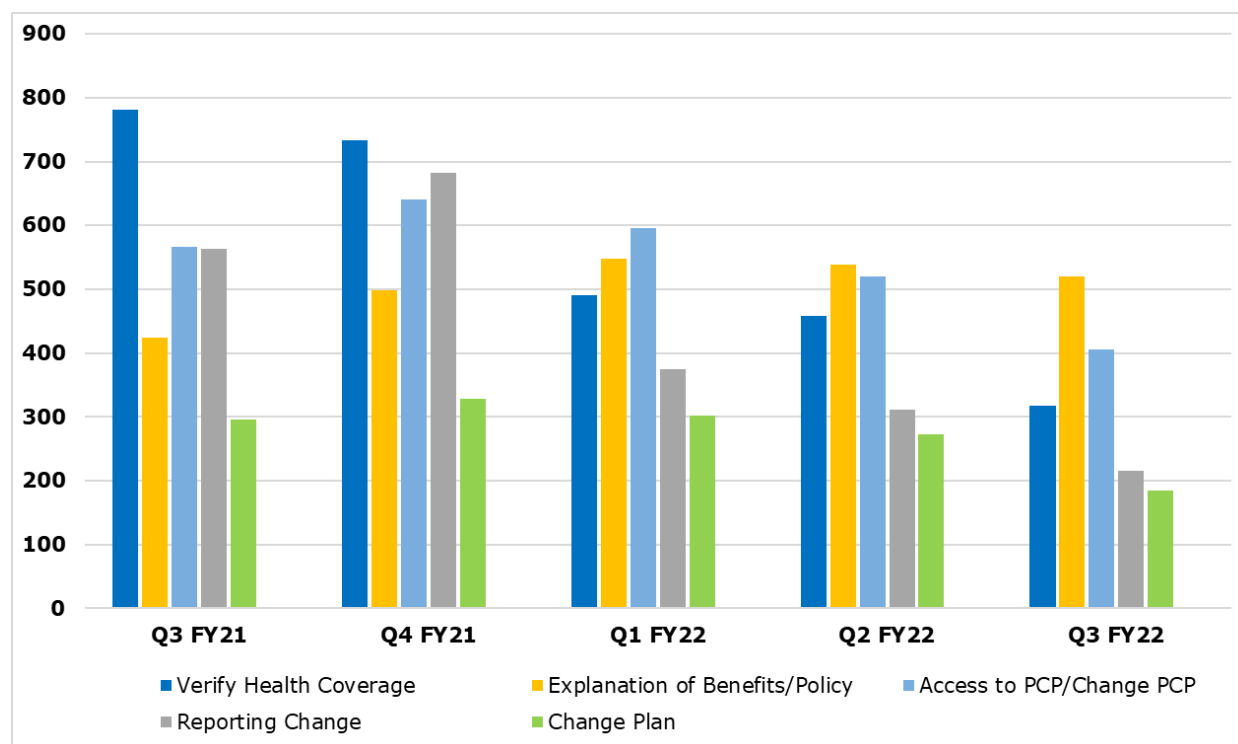


The data indicate that the volume of inquiries received for the third quarter of FY22 decreased by fourteen percent (or 624 fewer) as compared to the second quarter of FY22. However, when compared with the third quarter of FY21, the data show that the volume of inquiries received during the third quarter of FY22 decreased by 29 percent.

Top Inquiries

Figure 4 presents a comparison of the top reasons for inquiries for the third quarter of FY22 and the previous four quarters.

Figure 4: Top Inquiries Received FY21 & FY22



The data shows that inquiries related to explanation of benefits/policy, access to a primary care provider (PCP)/changing PCP and verifying health coverage were among the top reasons for inquiries in FY22.

Figure 4 shows that questions related to explanation of benefits and policy remain the top inquiry for the second and third quarter of FY22. Members enrolled in STAR+PLUS had the most inquiries regarding explanations of benefits and policy followed by individuals with no Medicaid and members enrolled in the STAR Program. A review of case summaries showed consumers inquired about which dental services were covered by Medicaid. Medicaid covers medically necessary

dental services for consumers under the age of 21 years of age. Medicaid recipients 21 years of age and older are excluded from receiving dental services unless the dental service is considered a medical procedure. Consumers 21 years and older enrolled in the STAR+PLUS HCBS waiver are eligible to receive dental benefits. Consumers also had questions regarding how to request a new health plan identification card and requested updates on their Medicaid application status.

The data show that accessing a PCP or changing a PCP was the second highest inquiry in the third quarter of FY22. Members enrolled in STAR had the most inquiries regarding accessing a PCP or changing a PCP. A review of case summaries indicates that callers had questions regarding changing their child's PCP and locating a PCP in their service area for their child and for themselves.

Figure 4 also shows that consumer questions related to verifying health coverage was the third highest inquiry in the third quarter of FY22. Members enrolled in STAR and individuals with no Medicaid had the most inquiries regarding verifying health coverage followed by STAR+PLUS members. A review of case narratives shows that consumers called to verify if their Medicaid coverage was still active. Consumers also called to obtain Medicaid case information such as which health plan the member is enrolled in and their Medicaid ID number.

Resolved Complaints

Resolved complaints are categorized in HEART as: substantiated, unsubstantiated, unable to substantiate, and referred. Referred is a new category of resolved complaints. A referred complaint is one that is either outside the scope of OMCAT's work or is one 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 complaint that 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 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 submits complaint online about accessing medical services.	Consumer does not respond to Ombudsman contacts to request information from consumer.	OMCAT closes complaint because information was needed from the consumer to process the complaint.
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.
Referred	The complaint is neither fully researched nor fully investigated because it needs to be addressed by another area.	Consumer complaint that they 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 neutral resolution of HHS-related complaints. Consumers typically contact the ombudsman after they have tried unsuccessfully to find resolutions elsewhere.

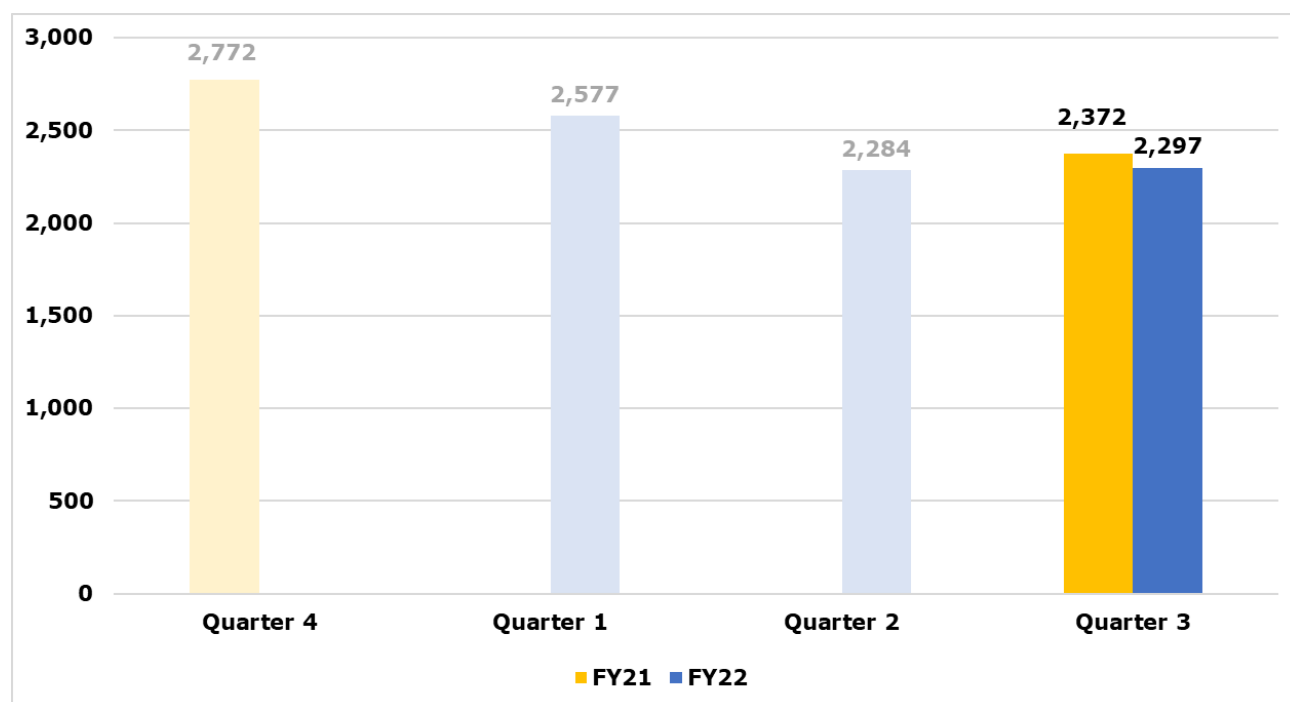
Why We Include More than Substantiated Complaints

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 third quarter with the same quarter of the previous fiscal year. In the third quarter of FY22, OMCAT received 2,297 complaints, which is a decrease of three percent (or 75 fewer) compared to the third quarter of FY21 and is an increase of one percent (or 13 more) compared to the second quarter of FY22.

Figure 5: Complaints Received FY21 & FY22

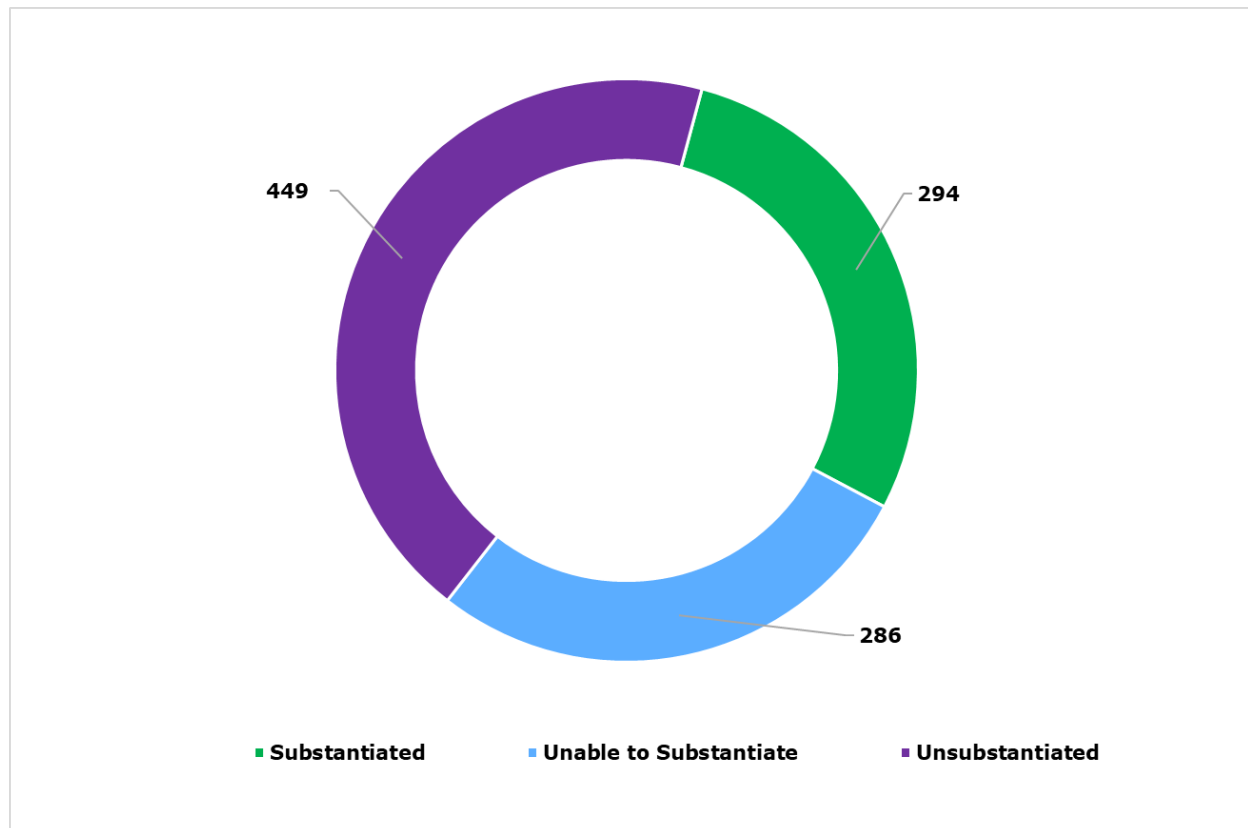


Resolved Complaints by Determination

Figure 6 below shows the total resolved complaints by determination received in the third quarter of FY22. OMCAT resolved 2,270 complaints out of 2,297 received.

Twenty-seven complaints were still being investigated at the end of the third quarter of FY22. (Note: Referred complaints are not included in figure 6 to focus on complaints the office fully investigated)

Figure 6: Complaints by Resolution Determination



Substantiated Complaints

In the third quarter of FY22, of the 1,029 complaints investigated, OMCAAT substantiated 294, or 29 percent of total investigated complaints.

The top substantiated complaint reason for the quarter was related to consumers who had difficulty receiving prescription medications 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. When consumers have incorrect insurance on file the pharmacy is not able to process the medication payment through Medicaid.

Two complaint reasons ranked as the second highest substantiated complaint for the quarter, consumers who had difficulty accessing a PCP and members who had difficulty accessing home health services.

Consumers who are enrolled in a health plan are required to have a PCP chosen by the consumer. The PCP directs the consumer's health care needs including referrals to health care specialists. Consumers reported difficulty finding a dentist for their children and in network OBGYNs that accepted the consumer's health plan. Children are required by their Dental Managed Care Organization to select a dental PCP to coordinate their dental services and pregnant women often choose to use an OBGYN as their PCP.

Consumers reported difficulty receiving home health assessments and difficulty receiving continuation of home health services.

The third most substantiated complaint for the quarter was related to consumers who were incorrectly billed for Medicaid covered services. Providers enrolled in Medicaid may not bill consumers for Medicaid covered services. A review of case summaries shows that Medicaid providers mistakenly billed the consumer instead of the health plan for medical services.

Top Complaint Categories

The complaints analyzed in this section are those that were resolved and determined to either be substantiated, referred 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 FY21 & FY22

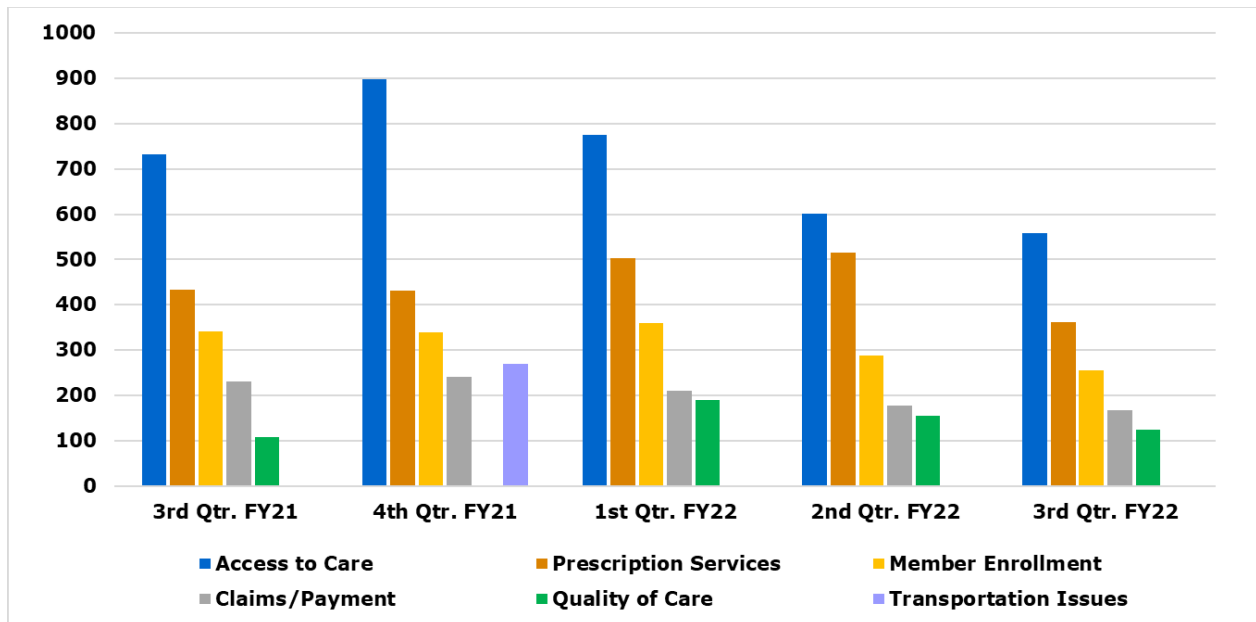


Figure 7 shows that complaints related to access to care remain the top complaint category in the third quarter of FY22. The top complaint reasons relating to access to care include consumers who reported difficulty receiving home health services, consumers who reported problems accessing in-network specialist and facilities, and consumers with complaints related to denial of services.

A review of home health complaint case summaries shows that consumers had difficulty receiving authorized hours for personal attendant services and private duty nursing. Consumers also reported that their personal attendants had difficulty being paid for services rendered.

Case summaries for consumers who reported difficulty accessing in-network specialists and facilities revealed that consumers had problems locating in-network mental health services such as psychiatry services, autism services and inpatient psychiatric services. Consumers reported that there was a lack of mental health service providers in their service delivery area. Further analysis shows there was no trend found in any region or health plan. OMCAT will continue to monitor complaints regarding lack of mental health service providers.

Consumers reported difficulty accessing in-network OBGYNs because the health plans' provider directories were not up to date as the providers listed were no longer accepting the health plans. Consumers also reported issues with accessing OBGYNs when moving out of their service delivery area. When consumers move to

a new service area in which their current health plan is not available, OBGYNs in their new area are considered out-of-network providers and requires authorization from the health plan. Further analysis shows there was no trend found relating to specific regions or health plans regarding difficulties in accessing OBGYN providers. OMCAT will continue to monitor these complaints for any trends.

Complaints of accessing dental providers due to a lack of dental providers in the consumer's area that also accepted the consumer's health plan.

Consumer complaints related to denial of services show that consumers reported being denied enrollment in the STAR+PLUS Home and Community Based (HCBS) Waiver. The STAR+PLUS HCBS Waiver is a waiver program for consumers who qualify for Nursing Facility level of care and provides long term services and supports in the community. In addition, consumers reported receiving denial for dental and medical procedures such as orthognathic surgery, dental fillings, and braces for children.

Complaints related to accessing prescription medication continue to be the second highest complaint category in the third quarter of FY22. The top complaint reasons related to prescriptions services were consumers complaints of erroneous additional insurance showing on their Medicaid profile in HHSC, MCO or pharmacy data systems, consumers reporting not showing active with Medicaid in HHSC data systems and consumers who had difficulty accessing medication that was not listed in the Medicaid Formulary. Prescription medication must be listed on the Medicaid Prescription drug formulary list to be authorized for payment by Medicaid.

Complaints related to member enrollment remains the third highest complaint category in the third quarter of FY22. The top complaint reasons relating to member enrollment include consumer complaints of Medicaid eligibility and recertification and consumers reporting case information errors on their Medicaid profile in HHSC systems. Review of case summaries showed complaints of incorrect name or address in HHSC systems, the length of time to process Medicaid applications and difficulty adding a newborn to the Medicaid case.

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 Medicaid¹. In the third quarter of FY22, OMCAT received 611 complaints of which 104 (or 17 percent) were substantiated.

Figure 8 shows a comparison of the top complaint categories for the current quarter and previous four quarters. Please note that the top complaint categories represented in the chart below are a subset of the total complaints received for the STAR program.

¹ The average monthly enrollment for the STAR program in the third quarter of FY22 is 4,379,280.

Figure 8: Top STAR Complaint Categories FY21 & FY22

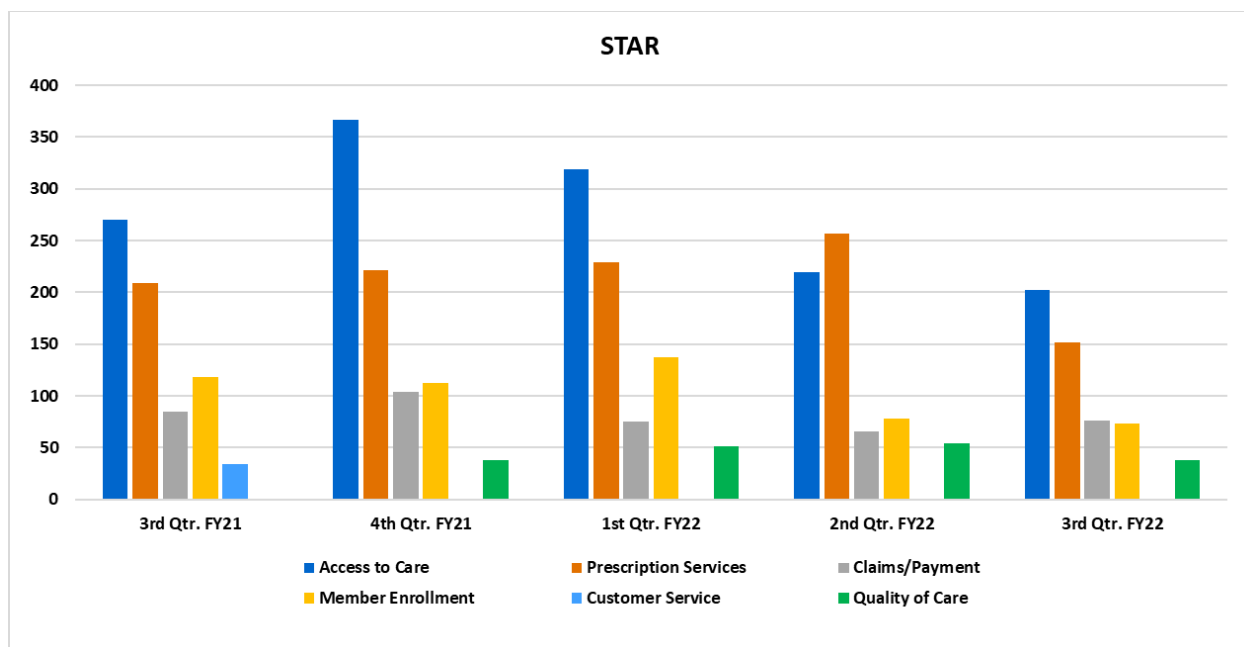


Figure 8 shows that the top three complaint categories for STAR members in the third quarter of FY21 into the third quarter of FY22 were complaints related to: accessing care, accessing prescription services, and consumers who had problems with claims/payment.

Access to care is the highest complaint category in the third quarter of FY22. The top complaint reasons include members who reported difficulty accessing in-network specialists and facilities, out-of-network providers, and primary care physicians. Review of case summaries show that members had difficulty accessing OBGYNs after moving to another service area. Members reported problems with accessing in-network mental health services such as behavioral health facilities and outpatient psychiatrist services. Members also reported difficulty accessing PCPs due to receiving an out-of-date list of PCPs from their health plan.

Prescription Services dropped from the highest complaint category in the second quarter of FY22 to the second highest complaint category in the third quarter of FY22. The top complaint reasons were members who reported difficulty receiving medications due to erroneous information showing in HHSC, MCO or pharmacy data systems. Members also reported difficulty receiving medications due to not showing active in HHSC data system. Review of case narratives show that members had difficulty obtaining medications for their children due to other insurance showing on their Medicaid profile. Case narratives also showed that consumers with traditional Medicaid had difficulty obtaining medications over the three-prescription limit.

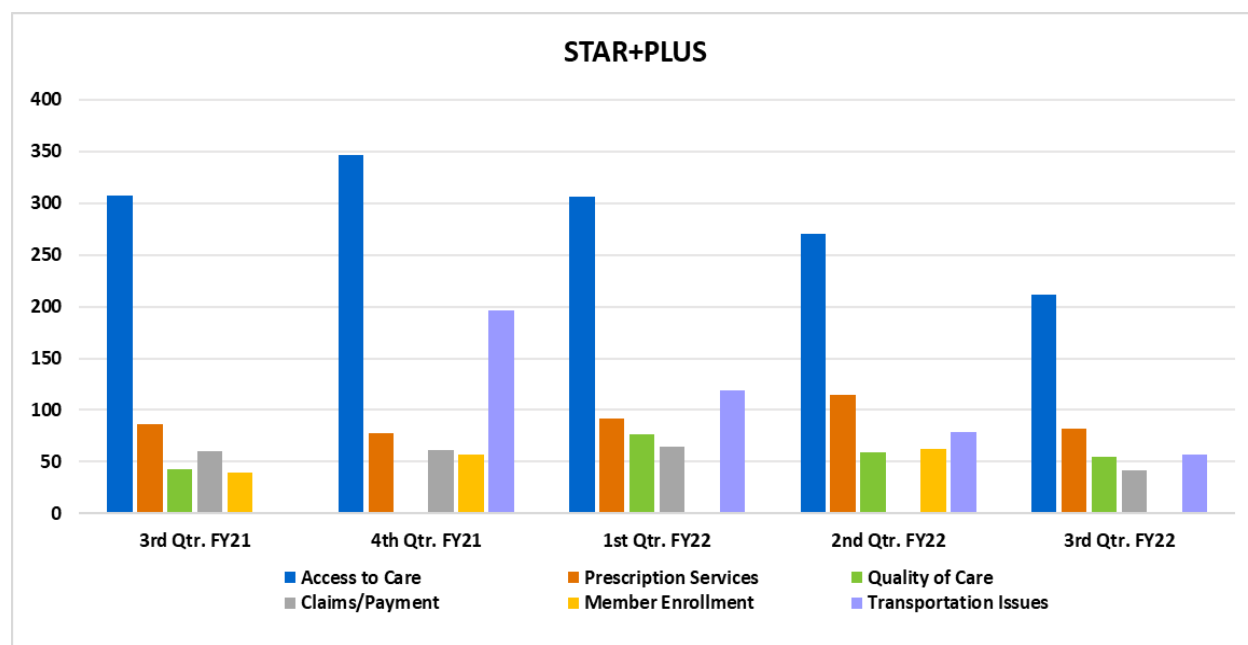
Traditional Medicaid covers three prescriptions per month. Case narratives revealed that consumers had difficulty obtaining medication because they presented the wrong health plan ID card to the pharmacy.

Claims payment was the third highest complaint category in the third quarter of FY22. The third quarter of FY22 marks the first time that claims payment is in the top three complaint categories for STAR members. Claims payment emergence in the top three complaint categories can mostly be attributed to a decrease in complaints related to member enrollment. Member enrollment was previously the third highest complaint category for STAR members for the past four quarters. The top complaint reason included members who reported receiving a bill for Medicaid services. Providers enrolled in Medicaid cannot bill consumers for Medicaid covered services. Members reported receiving bills related to childbirth, emergency room services and medical imaging services.

STAR+PLUS

The STAR+PLUS program serves adults who have disabilities or are age 65 or older². In the third quarter of FY22, OMCAT received 569 complaints of which 100 (or 18 percent) were substantiated. Figure 9 shows a comparison of the top complaint categories for the current quarter and the previous four quarters.

Figure 9: Top STAR+PLUS Complaint Categories FY21 & FY22



² The average monthly enrollment for the STAR+PLUS program in the third quarter of FY22 is 551,581.

Figure 9 shows that complaints related to consumers who reported experiencing barriers to accessing care is the top complaint category for the last five consecutive quarters.

The top complaint reasons related to accessing care for the third quarter of FY22 include members who reported difficulty receiving home health services, members who had problems accessing durable medical equipment and members who were denied services. A review of case summaries indicates that members reported having difficulty receiving all authorized home health hours, problems initiating a home health assessment to determine the number of hours needed and issues with their home health attendant being paid through the consumer directed services option or the home health agency.

Members reported delays in receiving power wheelchairs and incontinence supplies. In addition, members filed complaints regarding denial of the STAR+PLUS Home and Community Based Services (HCBS) Waiver. When members file a complaint regarding denial of services or programs, OMCAT informs members of their right to appeal including the option to file an External Medical Review and State Fair Hearing if their appeal is denied by their health plan.

Complaints related to prescription services continue to be the second highest complaint category for STAR+PLUS members. The top complaint reasons are related to member complaints related to difficulty receiving medication due to erroneous secondary insurance showing in HHSC, MCO or Pharmacy data systems and member complaints involving problems receiving medication because a clinical authorization from the member's doctor is required to fill their medication script. A review of case summaries shows that complaints were related to members who were unaware that inactive private insurance coverage was listed on their Medicaid profile and members who experienced delays in receiving pain medication because submission of a clinical authorization was required from their doctor.

Transportation complaints remained the third highest complaint category in the third quarter of FY22. The top complaint reasons related to transportation include members who reported not being transported to scheduled medical appointments and members who had difficulty receiving reimbursement for individual transportation claims. Members are eligible to receive reimbursement for gas when driving themselves or having another individual drive them to medical appointments under individual transportation claims. No trend was noted regarding complaints related to individual transportation claims. A review of case narratives shows that transportation providers failed to provide alternative transportation

when primary transportation could not meet scheduled pickup times and failed to communicate with members when scheduled transportation was unable to arrive at least one hour prior to their scheduled appointment.

STAR Kids

The STAR Kids program serves children and adults 20 and younger who have disabilities³. In the third quarter of FY22, OMCAT received 87 complaints of which 20 (or 23 percent) were substantiated. Figure 10 shows a comparison of the top complaint categories for the current quarter as well as the previous four quarters.

Figure 10: Top STAR Kids Complaint Categories FY21 & FY22

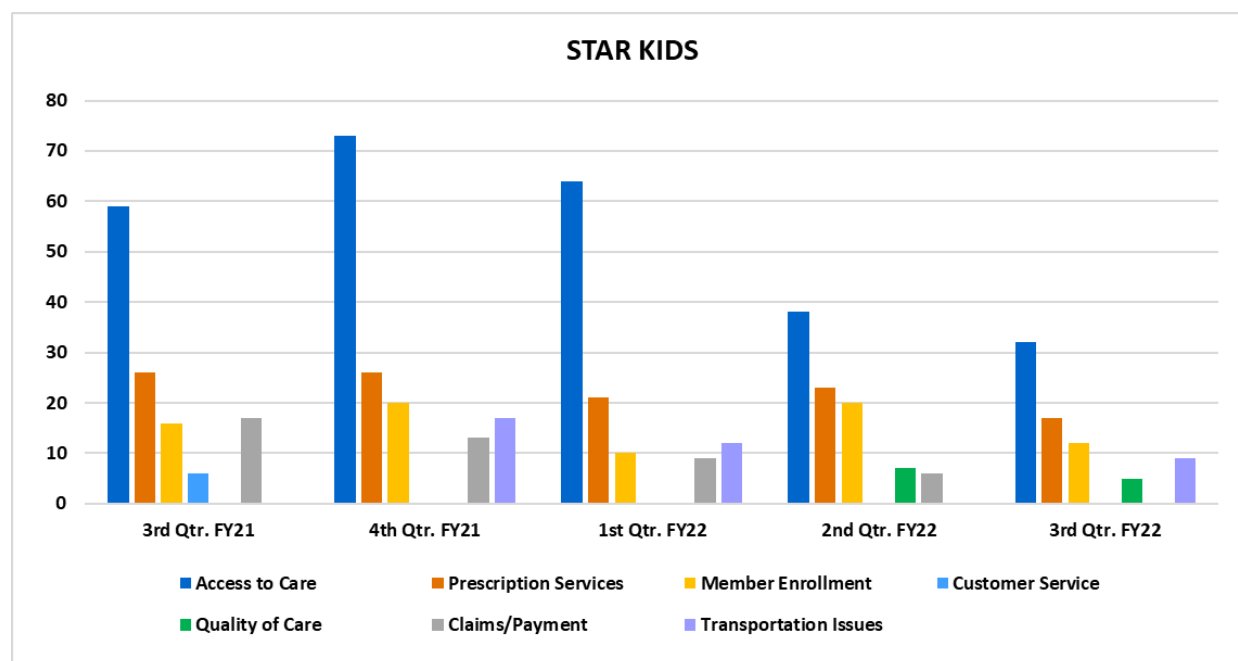


Figure 10 shows that complaints related to access to care continue to be the top complaint category for STAR Kids members in the third quarter of FY22. The top complaint reason related to access to care was access to home health services. Review of case narratives show no trend regarding complaints related to accessing home health services.

Access to prescription services is the second highest complaint category in the third quarter of FY22. The top complaint reason is difficulty obtaining medication because of erroneous secondary insurance showing in HHSC, MCO or pharmacy data systems. Review of case narratives indicate that members were unaware of

³ The average monthly enrollment for the STAR Kids program in the third quarter of FY22 is 169,394.

erroneous secondary insurance showing on their Medicaid profile in one or more of these systems.

Complaints related to member enrollment is the third highest complaint category in the third quarter of FY22. The top complaint reason for member enrollment includes members who had trouble receiving Medicaid services due to case information errors on their Medicaid profile in HHSC data systems. A review of case narratives did not indicate a trend regarding member enrollment 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 program⁴. OMCAT assists all consumers on Medicaid, as such, it is important to capture complaints for all populations of Medicaid consumers.

In the third quarter of FY22, OMCAT received 154 complaints, of which 31 (or 20 percent) were substantiated. Figure 11 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 third quarter of FY22 is 167,833.

Figure 11: Top Fee for Service/Traditional Medicaid Complaint Categories FY21 & FY22

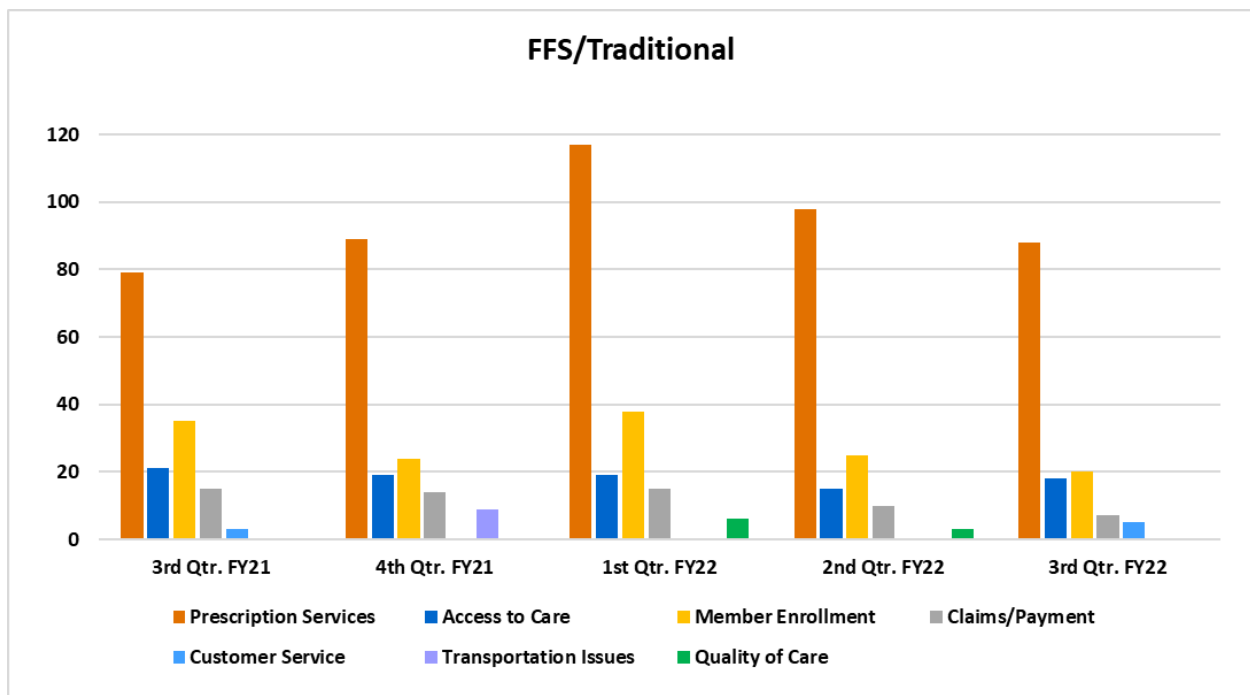


Figure 11 shows complaints for prescription services continue to be the top complaint category in the third quarter of FY22. The top complaint reasons related to accessing prescription services were due to erroneous secondary insurance showing in HHSC, MCO or pharmacy data systems, consumers unable to access medication because the consumer showed as not active in HHSC data systems and consumers whose prescribed medication was not listed in the Medication drug formulary.

A review of case narratives indicates that pharmacy data systems incorrectly showed consumers as inactive with Medicaid although HHSC data systems showed that the consumers' Medicaid was active. No trends were identified for consumer complaints regarding other insurance showing incorrectly in HHSC, MCO or pharmacy data systems or for consumer complaints related to denial of prescribed medication not listed in the Medicaid drug formulary.

Member enrollment is the second highest complaint category for the third quarter of FY22. The top complaint reasons for member enrollment includes complaints related to consumers who experienced problems with their Medicaid eligibility and recertification and consumers who reported case information errors on their Medicaid profile in HHSC data systems. A review of case narratives shows that consumers reported incorrect name, address, and date of birth on their Medicaid

profile. No trend was found regarding complaints related to Medicaid eligibility and recertification.

Access to care is the third highest complaint category for the third quarter of FY22. The top complaint reasons for access to care issues include consumers who reported errors on their Medicaid profile in HHSC data systems causing difficulty accessing in-network specialists.

Conclusion

The third quarter of FY22 continued to show a steady decrease in contact volume for the OMCAT team. This quarter marks the lowest contact volume experienced by OMCAT since the fourth quarter of FY20.

Review of complaint categories show the largest decrease occurred in the complaint category access to care, with complaints in this category decreasing by 38 percent from the fourth quarter of FY21 to third quarter of FY22.

Review of inquiries revealed that the largest decrease was inquiries related to consumers who had questions about reporting changes to their Medicaid profile, which decreased by 68 percent from the fourth quarter of FY21 to the third quarter of FY22. Inquiries related to consumers contacting OMCAT to verify their health coverage also decreased by 59 percent from the third quarter of FY21 to the third quarter of FY22.

The third quarter marks the first full quarter in which a segment of complaints are designated as “referred” upon closure of the complaint. Complaints are designated as “referred” when the consumer’s issue is outside of the scope of OMCAT’s work or when the consumer has not yet attempted to resolve their complaint initially with the appropriate area and therefore the issue must be referred elsewhere for resolution. OMCAT’s goal is to make a determination of substantiated or unsubstantiated on all investigated complaints. The OMCAT team was able to substantiate or unsubstantiate 71 percent of all investigated cases in the third quarter of FY22.

Beginning in the third quarter of FY22, members enrolled in STAR, STAR+PLUS/STAR+PLUS HCBS, STAR Kids/MDCP and STAR Health have the option to file an External Medical Review (EMR) for services denied based on medical necessity. If a member receives a service denial from their MCO, the member has the right to file an internal appeal with their MCO. If the MCO has reviewed the member’s appeal and upholds the decision to deny services, the member is then offered the option to request an EMR in conjunction with a State Fair Hearing. When members file a complaint regarding denial of services, OMCAT informs members of their full appeal rights and the steps necessary to initiate appeal, which now includes informing members of their right to request an EMR for service denials based on medical necessity.

Recommendations

There are no new recommendations for this quarter.

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 Q3 FY22

	STAR+PLUS	STAR	STAR Kids	STAR+PLUS Dual-Demo	STAR Health	Dental	FFS	No Medicaid
Access to Care	212	202	32	11	3	37	18	41
Prescription Services	82	152	17	2	2	0	88	14
Member Enrollment	42	73	12	1	1	0	20	107
Claims/ Payment	42	76	4	0	0	11	7	24
Quality of Care	55	38	5	3	4	9	3	6
Transportation Issues	57	17	9	2	1	0	5	0
Customer Service	32	25	3	1	2	8	5	20
Non-Medicaid /CHIP Services	17	7	0	1	0	0	3	50
Policies/ Procedures	14	8	1	0	1	3	4	11
Therapy	10	11	4	0	1	0	0	1
Fraud	2	0	0	0	0	0	0	6
Member Health and Safety	2	1	0	0	0	0	1	2
Value-Added Services	2	1	0	0	0	1	0	0

Table 3 includes the monthly average of Medicaid consumers enrolled for managed care program for the third quarter of FY22.

Table 3: Average Monthly Enrollment by Managed Care Program Q3 FY22

Managed Care Program	Average Monthly Enrollment
STAR	4,379,280
Dental	3,939,230
STAR+PLUS	551,581
STAR Kids	169,394
FFS	167,833
STAR HEALTH	45,477
STAR+PLUS Dual-Demo	35,321

Appendix B: Average Enrollment by Service Area

Table 4 includes the monthly average of Medicaid consumers enrolled for each service area for the third quarter of FY22.

Table 4: Average Enrollment by Service Area

Service Area	Average Enrollment
Bexar	454,543
Dallas	675,546
El Paso	194,346
Harris	1,237,489
Hidalgo	554,444
Jefferson	149,770
Lubbock	129,381
MRSA Central	248,986
MRSA Northeast	312,301
MRSA West	280,287
Nueces	151,925
Tarrant	485,737
Travis	260,821

Appendix C: 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 5 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 5 are a subset of the total complaints received for the service areas.

Table 5. Complaints by Service Area Q3 FY22

	Bexar	Dallas	El Paso	Harris	Hidalgo	Jefferson	Lubbock	MRSA Central	MRSA Northeast	MRSA West	Nueces	Tarrant	Travis
Access to Care	29	66	10	115	36	20	10	17	37	20	11	59	27
Prescription Services	31	23	7	60	17	7	8	14	13	13	7	30	23
Member Enrollment	18	10	6	33	5	3	1	9	9	6	3	13	12
Claims /Payment	11	19	5	29	3	5	3	6	13	7	1	14	7
Quality of Care	8	16	1	27	16	4	0	3	5	2	2	16	5
Transportation Issues	5	13	3	22	2	0	2	4	10	8	0	10	2
Customer Service	3	4	5	18	10	0	2	2	6	3	0	5	3
Policies /Procedures	3	3	2	3	2	2	0	4	0	0	2	2	0
Therapy	2	3	1	11	1	0	0	0	1	1	2	3	0
Non-Medicaid /CHIP	3	0	0	6	3	0	0	1	5	0	2	3	2
Member Health and Safety	1	0	0	1	0	0	0	0	0	0	1	0	0
Fraud	0	1	0	0	0	0	0	0	0	0	0	1	0
Value-Added Services	0	1	0	1	0	0	0	0	0	0	0	0	1

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

Fiscal Year 2022 – The 12-month period from September 1, 2021 through August 31, 2022, 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