HHS Ombudsman Managed Care Assistance Team 1st Quarter FY 2023

As Required by
Section 531.0213 of the
Government code

Office of the Ombudsman
2023

Revised: March 2023

Table of Contents

Executive Summary **3**

Introduction **6**
OMCAT In Action 6

Background **8**
Methodology 9

Consumer Contacts **10**
All Contacts Received 10

Inquiries **11**
Inquiries Process 11
Inquiries Received 11

Resolved Complaints **13**
Why We Include More than Substantiated Complaints 14
Complaints Received 15
Resolved Complaints by Determination 15
Substantiated Complaints 16

Complaints by Managed Care Program **18**
STAR 18
STAR+PLUS 20
STAR Kids 21
Fee for Service/Traditional Medicaid 23

Conclusion **25**

Appendix A: Managed Care Program Tables **26**

Appendix B: Complaints by Service Area **29**

Glossary **31**

List of Acronyms **32**

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 first quarter of fiscal year 2023 (FY23), OMCAT received 6,584 contacts; of which, 2,339 were complaints and 4,245 were inquiries.

Complaints made up 36 percent of total contacts. Of the 2,339 complaints received, 2,319 complaints were resolved during the quarter with the remaining 20 pending resolution. Of those resolved complaints:

- 10.82 percent (or 251) were substantiated;
- 27.86 percent (or 646) were unable to substantiate;
- 46.57 percent (or 1,080) were referred and;
- 14.75 percent (or 342) were unsubstantiated.

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

Figure 1: First Quarter Total Contacts Received

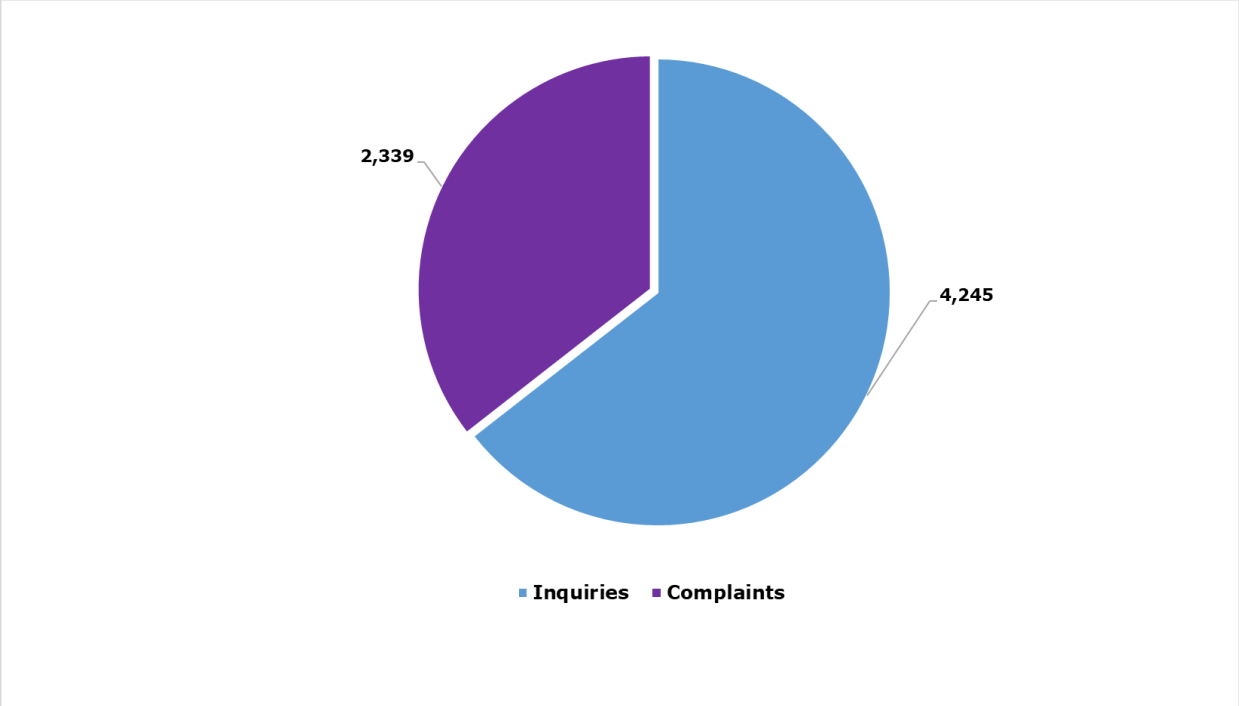
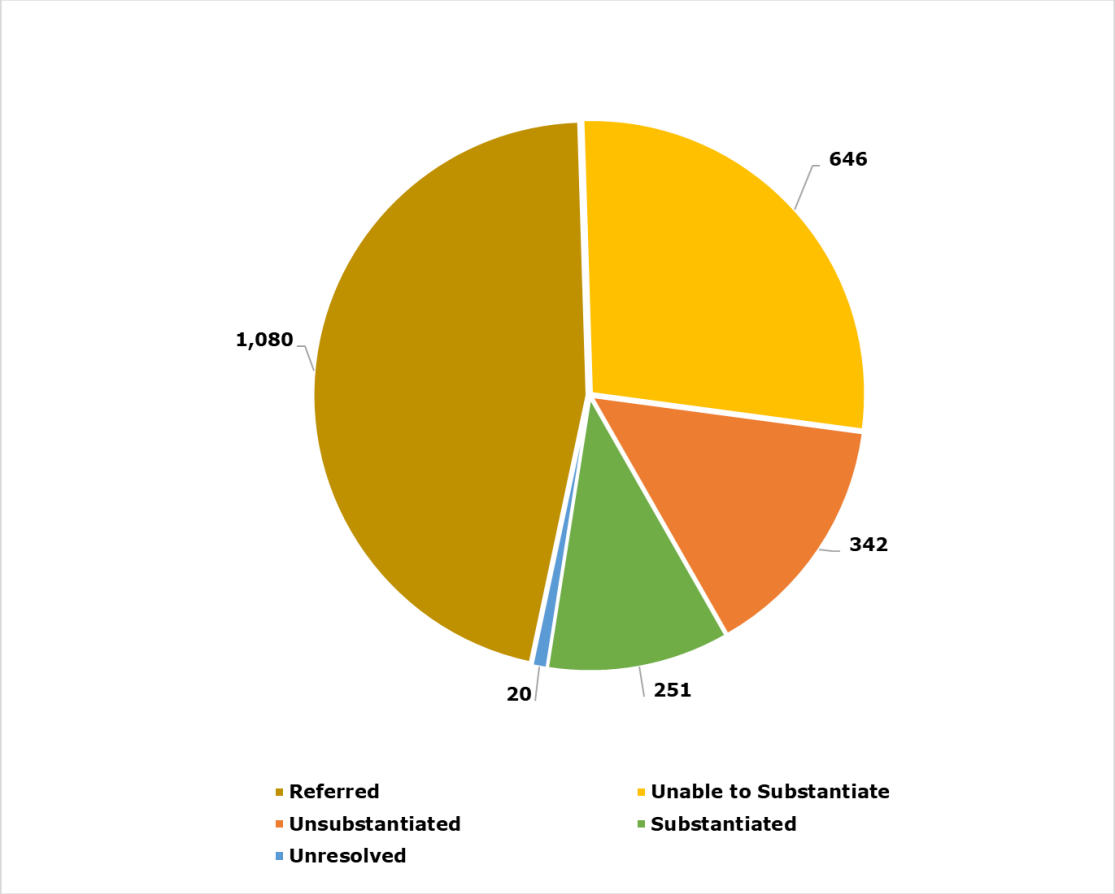


Figure 2 below shows the number of complaints with their determination of resolution as substantiated, unable to substantiate, unsubstantiated, or referred for the quarter.

Figure 2: First 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 parent of a child who was assessed to receive an allotted number of hours per week of private duty nursing due to the child's complex medical needs. The parent reported that their child was receiving less than half of the allotted hours resulting in three 10-hour shifts but leaving Friday to Sunday unstaffed. The parent was informed by the home health agency that they had requested an enhanced nursing rate from the MCO. The parent stated that the MCO declined to offer the enhanced nursing rate because the child did not meet the requirements.

OMCAT contacted the health plan to inquire about the nursing rate for the child and asked that the health plan provide an alternative plan for staffing the unmet need of Friday to Sunday if they could not offer the enhanced rate for nursing. The MCO contacted multiple home health agencies over several months and was unable to obtain consistent staffing. After two months of unsuccessful attempts to staff the child through multiple home health agencies the MCO agreed to the enhanced rate with the original home health provider. The MCO entered into a single case

agreement with the original home health agency and moved forward with the full 84 hours of weekly nursing.

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

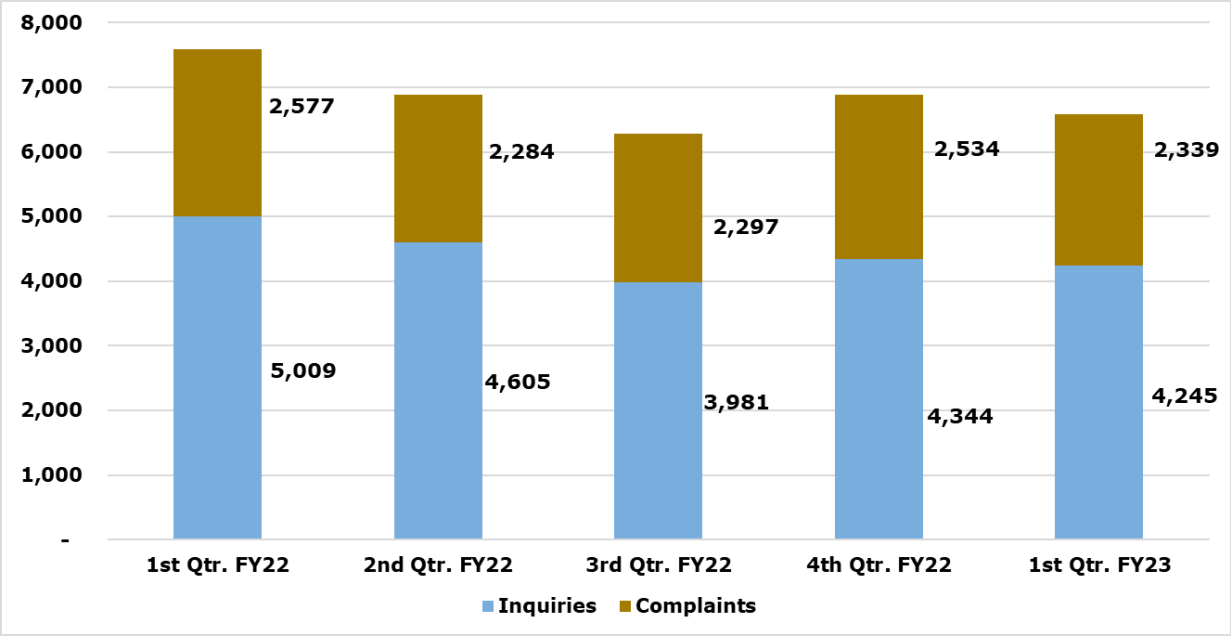
Consumer Contacts

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 first quarter of FY23, OMCAT received a total of 6,584 contacts. This is a four percent decrease from the fourth quarter in FY22. The data show that total contacts for the first quarter of FY23 decreased by 13 percent compared to the first 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.

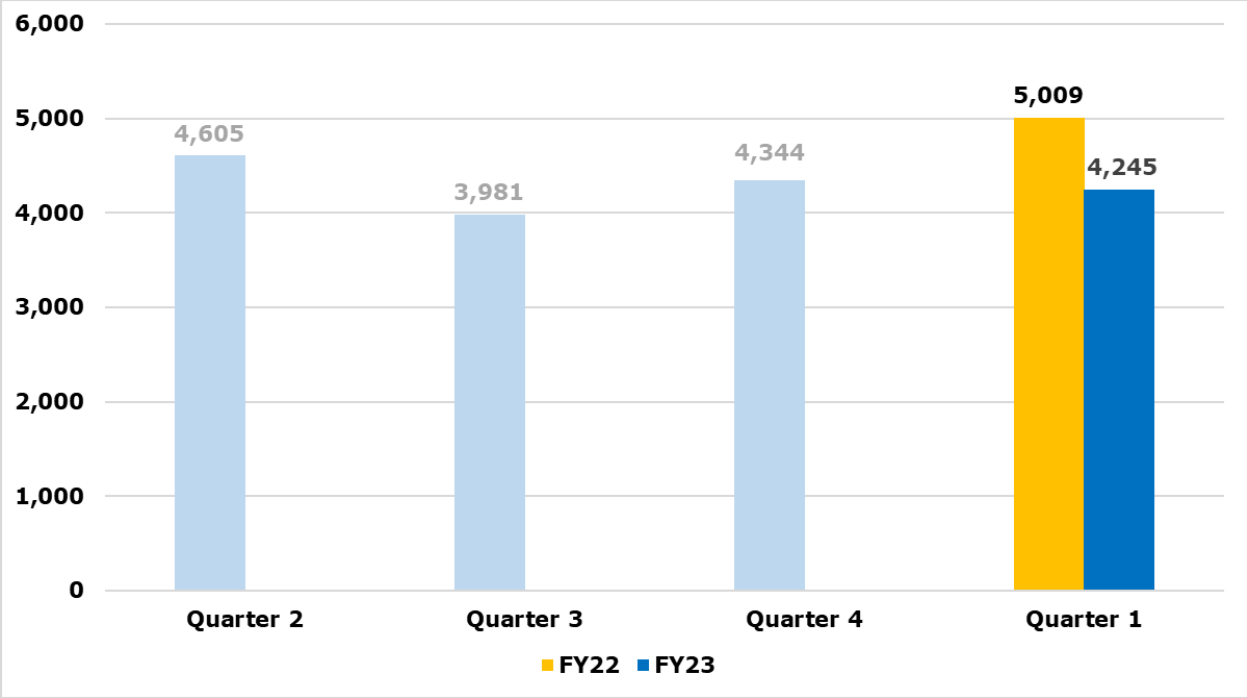
Inquiries Process

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 first 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 first quarter of FY23 decreased by two percent (or 99 fewer) as compared to the fourth quarter of FY22. Additionally, when compared with the first quarter of FY22, the data show that the volume of inquiries received during the first 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.

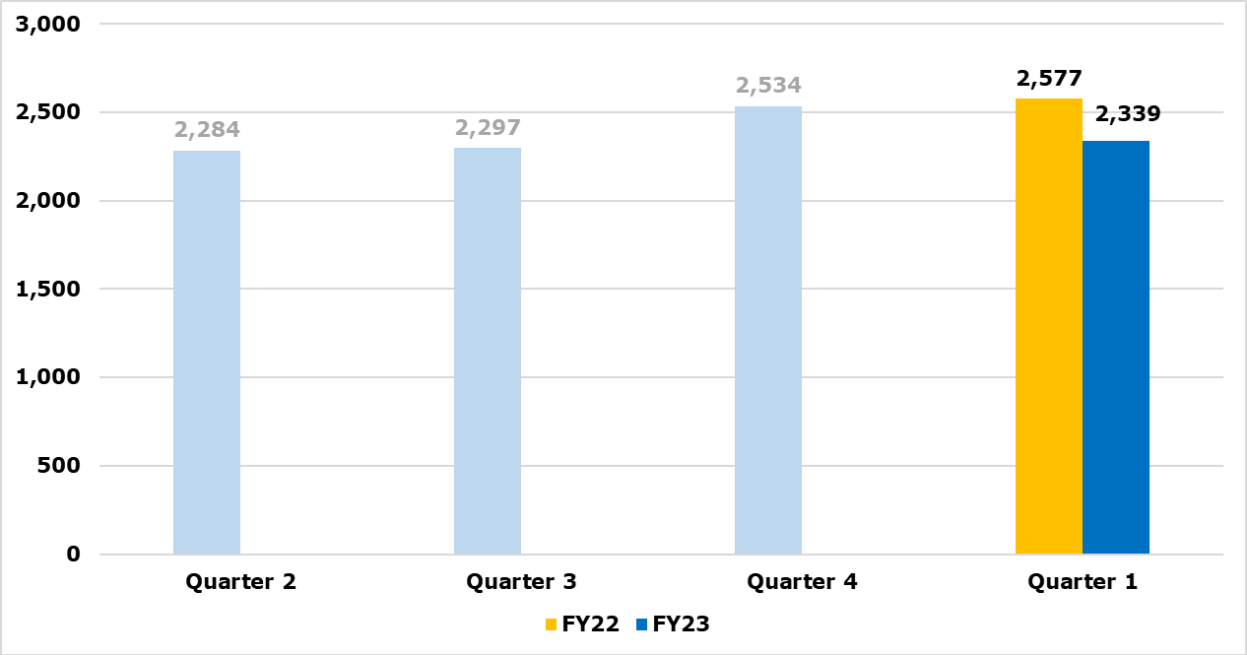
Why We Include More than Substantiated Complaints

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 first quarter with the same quarter of the previous fiscal year. In the first quarter of FY23, OMCAT received 2,339 complaints, which is a decrease of eight percent (or 195 fewer) compared to the fourth quarter of FY22 and is a decrease of nine percent (or 238 fewer) compared to the first quarter of FY22.

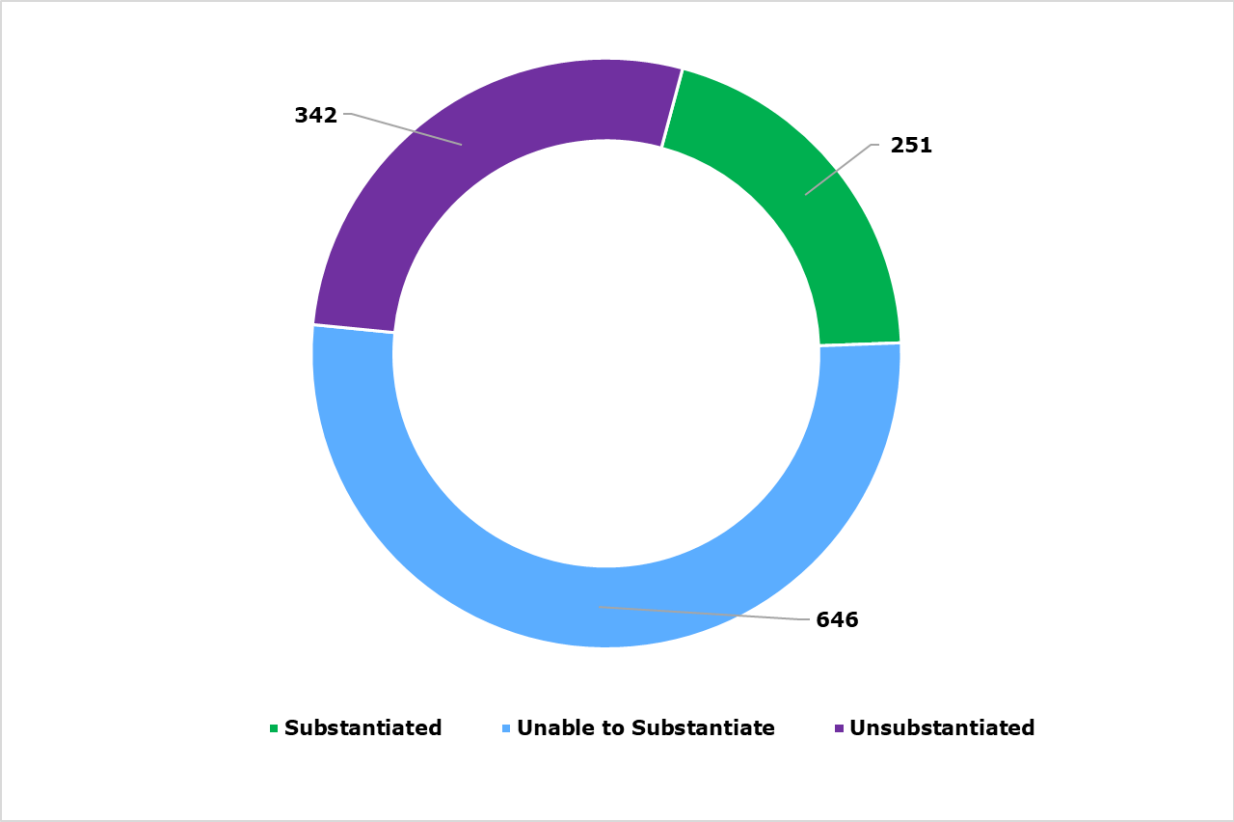
Figure 5: Complaints Received FY22 & FY23



Resolved Complaints by Determination

Figure 6 below shows total resolved complaints by determination received in the first quarter of FY23. OMCAT investigated and resolved 1,239 complaints out of 2,339 received. Twenty complaints were still being investigated at the end of the first quarter of FY23. (Note: Referred complaints are not included in figure 6 to focus on fully investigated complaints)

Figure 6: Complaints by Resolution Determination



Substantiated Complaints

Of the 1,239 complaints investigated in the first quarter of FY23, OMCAT substantiated 251, or 20 percent of total investigated complaints.

The top substantiated complaint reason for the first quarter of FY23 was related to consumers who had difficulty accessing in-network specialists and facilities. A review of case summaries showed that five consumers were referred to neurologists by their health plan who were not willing to accept the consumer's MCO.

The data show that the second highest substantiated complaint reason was consumers who reported difficulty accessing home health providers. A review of case summaries revealed that consumers reported difficulty receiving personal assistance services due to delays in being assessed for services.

The third highest substantiated complaint reason was consumers who reported difficulty accessing prescription medication due to not showing active with Medicaid in pharmacy systems. A review of case narratives shows that pharmacy data

systems reported a delay in updating consumers' case information needed to obtain prescription medication. There was no trend noted regarding any specific pharmacy chain that had a delay in updating the consumer's case information.

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 first quarter of FY23, OMCAT received 704 complaints of which 102 (or 14 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 first quarter of FY23 is 4,656,369.

Figure 7: Top STAR Complaint Categories FY22 & FY23

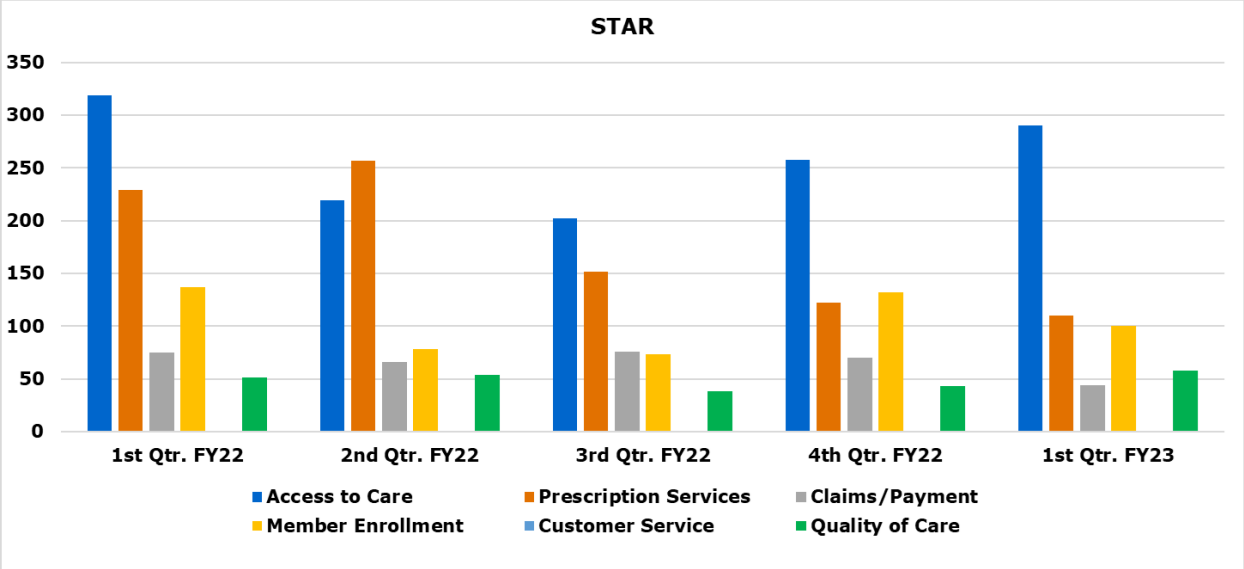


Figure 7 shows that the top three complaint categories for STAR consumers in the first quarter of FY23 were complaints related to: accessing care, difficulty accessing prescription services and problems with member enrollment.

Access to care is the top complaint category in the first quarter of FY23. A review of case summaries shows that 27 consumers reported difficulty locating OBGYNs that accepted their health plan. Most complaints related to accessing out-of-network specialists were due to consumers who had moved service areas but had not yet enrolled with an MCO serving their new service area. Consumers also reported difficulty receiving Medicaid services when they discovered erroneous third-party insurance on their Medicaid profile while at a doctor's appointment.

Complaints of access to prescriptions is the second highest complaint category in the first quarter of FY23. Consumers reported difficulty receiving prescription medication due to erroneous insurance showing on HHSC, MCO or pharmacy data systems. No trend was found regarding erroneous insurance showing on consumers Medicaid profile.

Complaints of member enrollment is the third highest complaint category in the first quarter of FY23. The top complaint reason related to member enrollment is consumer reports of case information errors on their Medicaid profile. Consumers reported that they needed their information such as address, name and date of birth updated on their Medicaid profile.

STAR+PLUS

The STAR+PLUS program serves adults who have disabilities or are age 65 or older[2]. In the first quarter of FY23, OMCAT received 577 complaints of which 86 (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

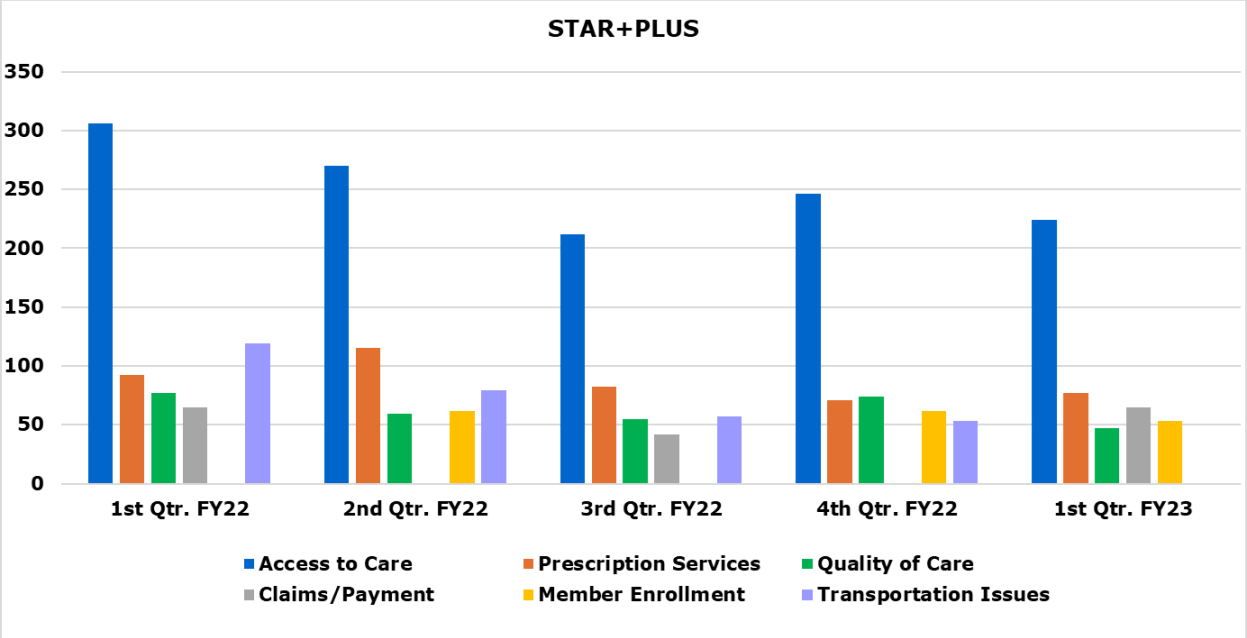


Figure 8 shows that complaints related to consumers who reported experiencing barriers to accessing care is the top complaint category for five consecutive quarters.

The top complaint reasons related to accessing care for the first quarter of FY23 include consumers who reported problems receiving home health services, consumers who had problems accessing durable medical equipment (DME) and consumers who reported denial of Medicaid services. A review of case summaries revealed that consumers reported difficulty receiving their authorized hours of Personal Assistance Services (PAS), problems receiving assessments to determine the consumer's need for PAS and assistance switching home health agencies. Several consumers reported problems receiving wheelchairs, incontinence supplies and shower chairs due to coordination issues between their PCP and the DME

[2] The average monthly enrollment for the STAR+PLUS program in the first quarter of FY23 is 565,600.

supplier. Consumers also reported being denied eligibility for the STAR+PLUS Home and Community Based Services (HCBS) Waiver[3].

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 difficulty obtaining medication not listed in the Medicaid drug formulary. A review of case narratives did not reveal a trend regarding prescription services related complaints.

Claims payment is the third highest complaint category in the first quarter of FY23. The first quarter of FY23 marks the first time in the past four quarters that claims payment was in the top three complaint categories for STAR+PLUS. The top complaint reason related to claims payment was complaints related to consumers who reported being charged 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.[4]

STAR Kids

The STAR Kids program serves children and adults 20 years of age and younger who have disabilities[5]. In the first quarter of FY23, OMCAT received 92 complaints of which 19 (or 21 percent) were substantiated. Figure 9 shows a comparison of the top complaint categories for the current quarter as well as the previous four quarters.

[3] Consumers must be assessed to show the need for nursing facility level of care to qualify for the STAR+PLUS HCBS Waiver.
4 Providers enrolled in Medicaid may not bill consumers for Medicaid covered services.
[5] The average monthly enrollment for the STAR Kids program in the first quarter of FY23 is 169,657.

Figure 9: Top STAR Kids Complaint Categories FY22 & FY23

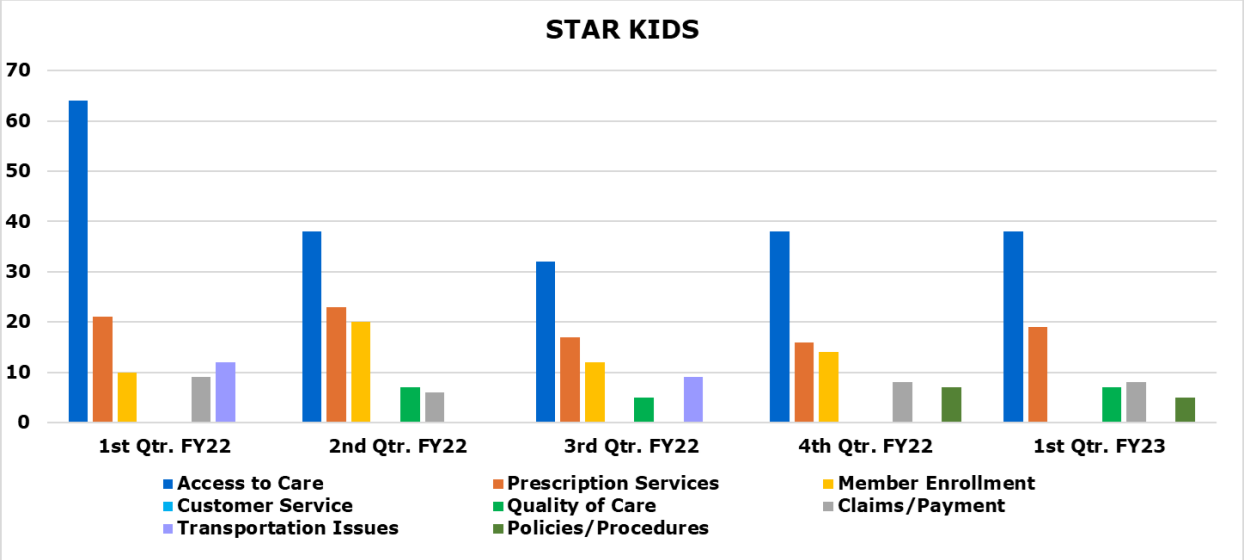


Figure 9 shows that complaints related to access to care continue to be the top complaint category for STAR Kids consumers in the first quarter of FY23. The top complaint reasons of access to care were complaints related to denial of services, access to out-of-network providers, and consumers who reported difficulty accessing in-network specialists and facilities. A review of case summaries shows that consumers had complaints related to denial of eligibility for the Medically Dependent Children's Program. Consumers reported moving service areas which created a need for accessing out-of-network providers. There was no trend identified regarding consumer complaints of difficulty locating in-network specialists and facilities.

Access to prescription services is the second highest complaint category in the first quarter of FY23. Consumers reported erroneous secondary insurance showing in HHSC, MCO or pharmacy data systems and not showing with active Medicaid in HHS data systems. A review of case summaries did not reveal any trends.

Complaints related to claims payment is the third highest complaint category in the first quarter of FY23. Consumers complained of being billed for Medicaid services and problems with authorization of claims for Medicaid services. A review of case summaries did not reveal a trend for complaints related to claims payment.

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

In the first quarter of FY23, OMCAT received 149 complaints, of which 25 (or 17 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 50: Top Fee for Service/Traditional Medicaid Complaint Categories FY22 & FY23

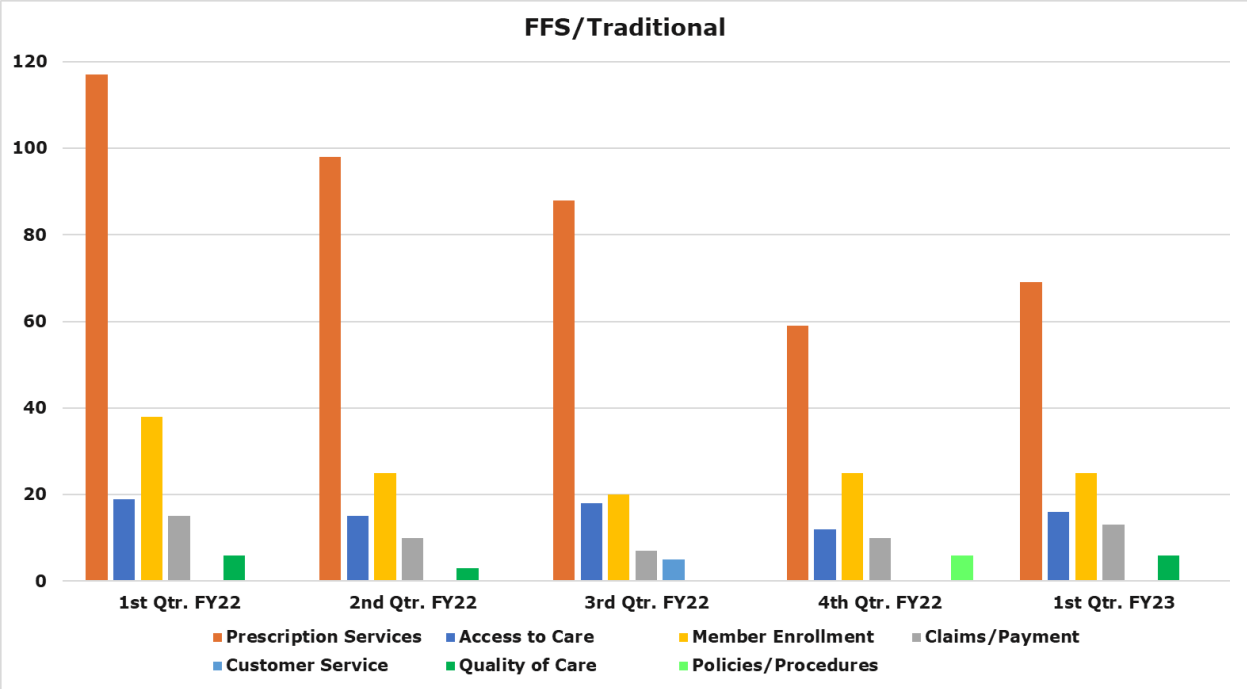


Figure 10 shows complaints related to accessing prescription services continue to be the top complaint category in the first quarter of FY23.

The top complaint reasons for prescription services include consumers showing as inactive with Medicaid in HHSC data systems, consumers who reported difficulty obtaining more than three prescriptions in one month and consumers who reported difficulty receiving medication because the prescription was written by a non-Medicaid doctor. A review of case narratives shows that consumers did not show as

[6] The average monthly enrollment for the Fee for Service/Traditional Medicaid program in the first quarter of FY23 is 204,913.

having active Medicaid in HHSC or pharmacy data systems when they were enrolled in Medicaid managed care, and issues with pharmacies processing medications under the incorrect health care coverage.[7]

Member enrollment is the second highest complaint category for the first 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 narratives did not reveal any trends.

Complaints of access to care is the third highest complaint category for the first quarter of FY23. The top contact reason was related to consumers who reported denial of services. No trend was found regarding the types of services being denied.

[7] Consumers who are enrolled in FFS Medicaid are limited to three prescriptions per month--conversely, consumers enrolled in Managed Care receive unlimited prescriptions.

Conclusion

The largest decrease in complaint categories from the fourth quarter of FY22 to the first quarter of FY23 was a 19 percent decrease in complaints related to member enrollment. A review of case summaries reveals that consumers had fewer complaints regarding the length of time taken to process their Medicaid application and regarding Medicaid application denials.

The decrease in Medicaid eligibility related contacts is not expected to continue into the second quarter of FY23. In the second quarter of FY23, Congress released the Omnibus Appropriations Bill. A portion of the Omnibus Appropriations Bill authorizes states to end continuous Medicaid coverage which was a response to the Public Health Emergency. HHSC and OMCAT expect contact volumes to increase as consumers receive notices from HHSC about the end of continuous Medicaid coverage. All stakeholders can access information regarding end of continuous coverage at End of Continuous Medicaid Coverage Ambassador Toolkit | Texas Health and Human Services.

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 Q1 FY23

	STAR+PLUS	STAR	STAR Kids	STAR+PLUS Dual-Demo	STAR Health	Dental	FFS	No Medicaid
Access to Care	170	200	28	10	4	12	13	36
Prescription Services	79	106	16	2	1	0	75	9
Member Enrollment	39	91	2	2	3	6	20	101
Non-Medicaid /CHIP	19	24	0	1	1	1	9	100
Claims/ Payment	51	40	9	2	0	7	10	19
Quality of Care	39	39	3	1	1	12	6	22
Customer Service	16	28	3	2	1	3	3	23
Policies/ Procedures	20	9	3	2	0	5	4	12
Transportation Issues	32	13	2	1	0	0	2	1
Therapy	6	8	1	0	0	0	0	0
Fraud	4	3	1	0	0	0	0	7
Member Health and Safety	2	1	3	0	0	0	0	1
Value-Added Services	2	2	0	0	0	0	0	0

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

Table 3: Average Monthly Enrollment by Managed Care Program Q1 FY23

Managed Care Program	Average Monthly Enrollment
STAR	4,656,369
Dental	4,107,195
STAR+PLUS	565,600
STAR Kids	169,657
FFS	204,913
STAR HEALTH	46,349
STAR+PLUS Dual-Demo	33,866

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	38	61	8	86	32	9	8	19	31	14	11	56	35
Prescription Services	20	19	7	51	14	14	4	12	14	15	9	19	5
Member Enrollment	9	15	5	33	6	8	0	7	10	6	6	14	15
Claims /Payment	10	19	1	20	8	4	0	6	8	6	3	7	10
Quality of Care	10	17	5	14	6	3	3	4	6	1	1	10	2
Customer Service	4	7	1	13	5	2	2	0	3	4	0	4	4
Transportation Issues	4	10	1	10	1	3	0	4	9	1	0	3	2
Non-Medicaid /CHIP	3	4	2	10	4	0	1	2	5	2	2	6	3
Policies /Procedures	2	1	0	9	5	1	1	6	2	2	2	3	0
Therapy	0	4	0	4	1	1	1	2	1	1	0	0	0
Fraud	1	3	0	1	1	0	1	0	0	1	0	0	0
Member Health and Safety	1	1	0	0	1	1	0	0	1	0	0	0	1
Value-Added Services	0	1	0	1	1	0	0	0	0	0	1	0	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