HHS Ombudsman
Managed Care Assistance Team
2nd Quarter FY 2021

As Required by
Section 531.0213 of the
Government code

Office of the Ombudsman
2021

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.

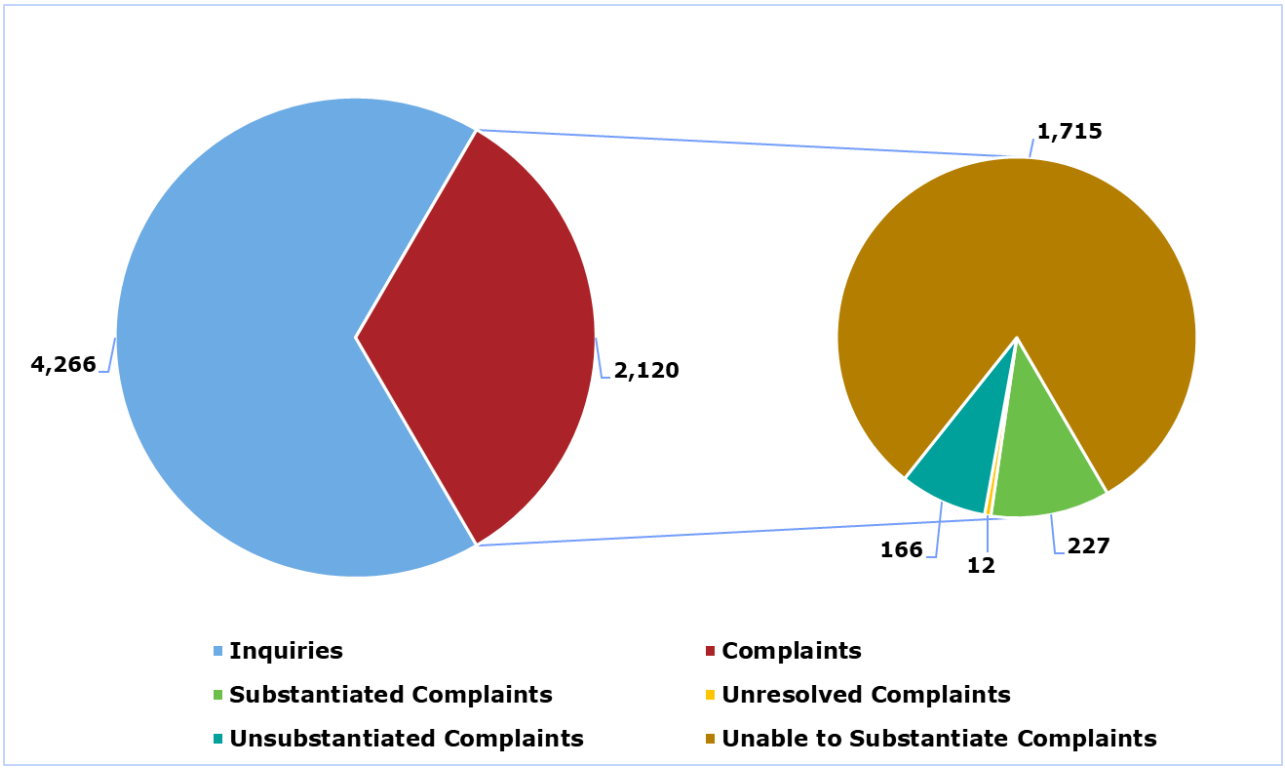
During the second quarter of fiscal year 2021 (FY21), OMCAT received 6,386 contacts; of which, 2,120 were complaints and 4,266 were inquiries.

Complaints made up 33 percent of total contacts. Of the 2,120 complaints received, 2,108 complaints were resolved with the remaining 12 pending investigation. Of those resolved complaints:

- 11 percent (or 227) were substantiated;
- 81 percent (or 1,715) were unable to substantiate; and,
- 8 percent (or 166) were unsubstantiated.

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

Figure 1: Second 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 case received during the second quarter of FY21 spotlights the impact OMCAT can have on the Medicaid managed care system.

In December 2020, a consumer was identified as requiring a double lung transplant due to complications of COVID-19. The consumer remained in the hospital, waiting for placement on a lung transplant list and to transfer to a hospital that specializes in lung transplant surgery.

OMCAT worked with the consumer's medical care team to identify a hospital in Texas that specialized in lung transplants and that would accept the consumer's health plan. OMCAT also worked with the Chief Medical Director of Medicaid Chip Services who coordinated with the Medical Directors of the hospital and consumer's MCO to obtain authorization for the consumer to be placed on the transplant list and be transferred to a hospital that could perform the surgery. As a result, the consumer was able to obtain the transplant 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 which can be found on the OMCAT website.

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

There are three important data distinctions:

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

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

Finally, an important note related to unresolved cases. When data are extracted for report production, some investigations are not yet completed. The complaints presented in this report only analyze those investigations where the outcome has been resolved.

Methodology

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

- Total number of inquiries and complaints received;
- Types of inquiries and complaints received;

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

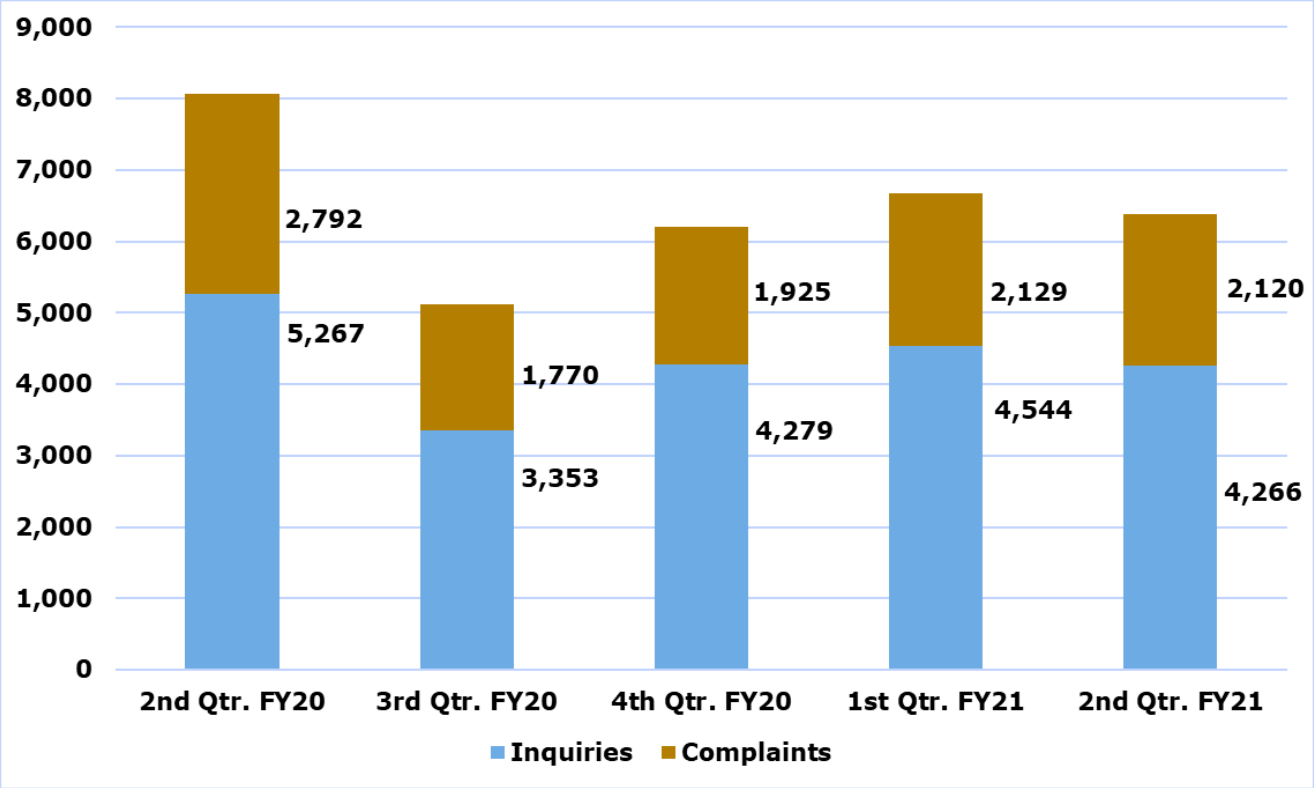
Consumer Contacts

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

All Contacts Received

Figure 2 shows the volume of all contacts received including inquiries and complaints over the previous fiscal year.

Figure 2: All Contacts Received FY20 & FY21



In the second quarter of FY21, OMCAT received a total of 6,386 contacts. This is a four percent decrease from the first quarter in FY21. The data show that total contacts for the second quarter of FY21 has decreased by 21 percent compared to the second quarter of FY20.

Note: The U.S. Health and Human Services Secretary Alex Azar declared a public health emergency (PHE) late in the second quarter of FY20. Due to this unprecedented event, restrictions were put into place and healthcare coverages were extended which may

have caused the volume of contacts to temporarily decrease. As restrictions are slowly lifted, the total volume of contacts has steadily increased.

Inquiries

Inquiries are an important indicator of member's educational needs and requests 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.

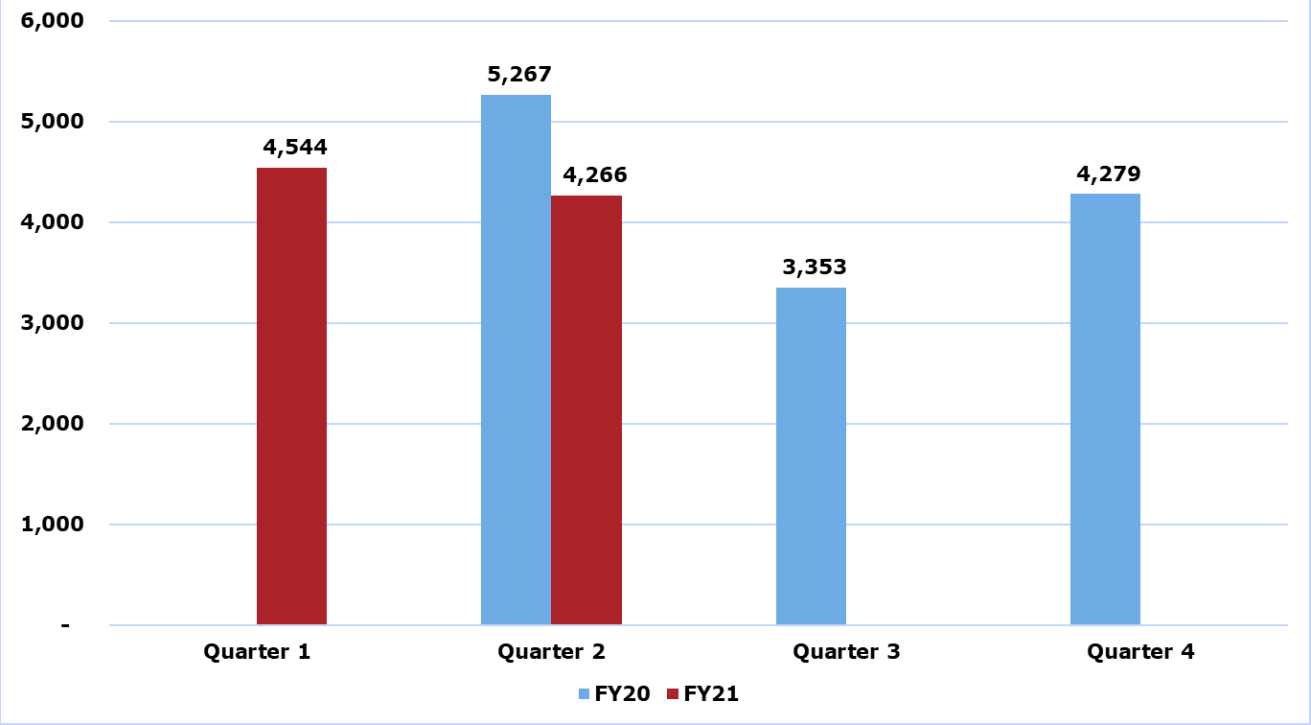
Inquiries Process

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 shows the volume of inquiries received for the current quarter in comparison with the previous fiscal year. The data indicate that the volume of inquiries received for second quarter of FY21 decreased by 19 percent (or 1,001 fewer) as compared to the second quarter of FY20. When compared with the first quarter of FY21, the data show that the volume of inquiries received during the second quarter of FY21 decreased by 6 percent. As discussed earlier, the change between the second quarters of FY20 and FY21 can be explained by the impact the PHE had on contact volume.

Figure 3: Inquiries Received FY20 & FY21

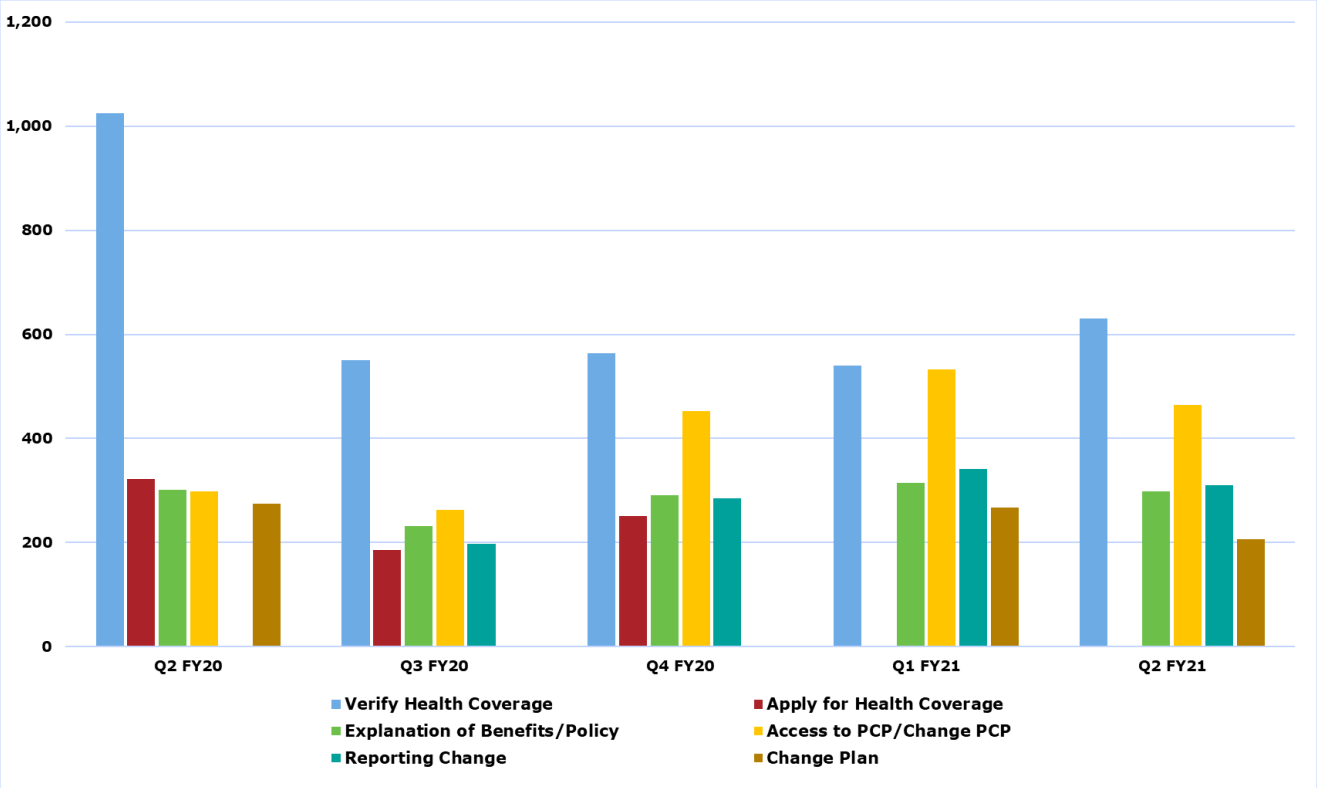


Top Inquiries

Figure 4[1] presents a comparison of the top reasons for inquiries for the second quarter of FY21 and previous fiscal year.

[1] The contact reason of "Change Plan – Provider (PCP, Facility, DME)" only appears in the first quarter of FY20. This contact reason was retired from the HEART system in the second quarter of FY20 and was replaced by the simpler name of "Change Plan."

Figure 4: Top Inquiries Received FY20 & FY21



The data show that inquiries related to verifying health coverage, access to PCP/changing PCP and reporting change explanation of benefits/policy are among the top reason for inquiries throughout FY20 and into FY21.

Figure 4 shows that in the second quarter of FY21 questions related to verifying health coverage was the top inquiry. A review of case narratives indicates that consumers needed to verify if their Medicaid was still active or if they were still active with their preferred health plan. Consumers also inquired about termination of Medicaid, Medicaid coverage ending after the PHE, or needing information regarding status on the waiting list for the STAR+PLUS waiver.

The data show that accessing a PCP or changing a PCP were among the top inquiries. A review of the case narratives indicates that some consumers seeking this information were on traditional Medicaid and did not know how to find or change their PCP.

Figure 4 also shows that in the second quarter of FY21 questions related to reporting change were among the top inquires. A review of case narratives indicates that consumers were calling to report an address change, add a newborn child to the Medicaid case or terminate Medicaid benefits because they had moved out of state.

Resolved Complaints

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

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

OMCAT facilitates 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 determines if the party's response and/or approach to the consumer's complaint was appropriate and complies with HHS policy and Medicaid and managed care rules and regulations.

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

Table 1: Complaint Resolution Determination

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

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

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

Why "Unable to Substantiate" Matters

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

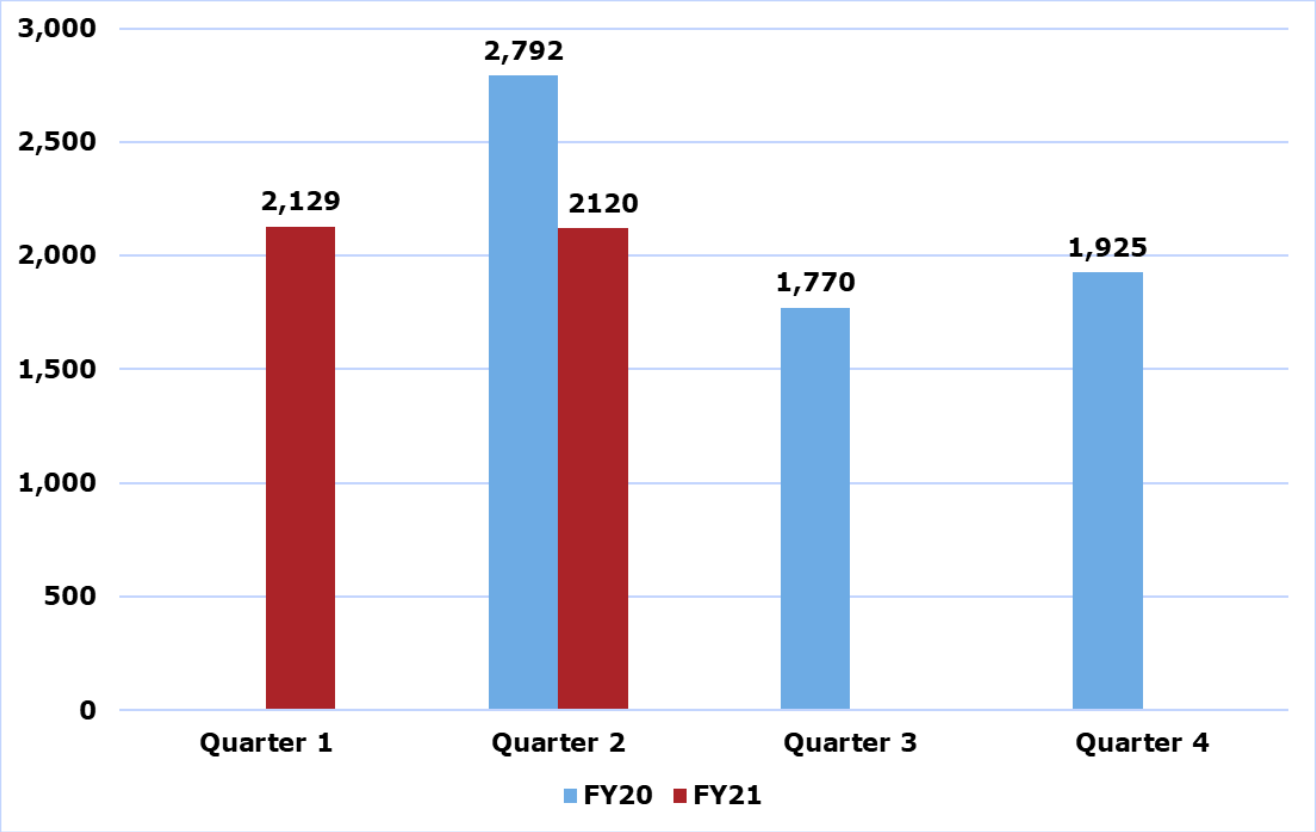
- Incomplete investigation – ombudsman may need more information from the consumer during the investigation but if the ombudsman is not able to reach the consumer after several attempts, the investigation is closed.
- Discrepant information - consumer complains that the MCO has not authorized a referral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

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

Complaints Received

Figure 5 compares the total complaints received for the second quarter with the previous fiscal year. In the second quarter of FY21, OMCAT received 2,120 complaints, which is a decrease of 24 percent (or 672 fewer) compared to the second quarter of FY20 and is a decrease of less than one percent (or 9 fewer complaints) compared to the first quarter of FY21.

Figure 5: Complaints Received FY20 & FY21

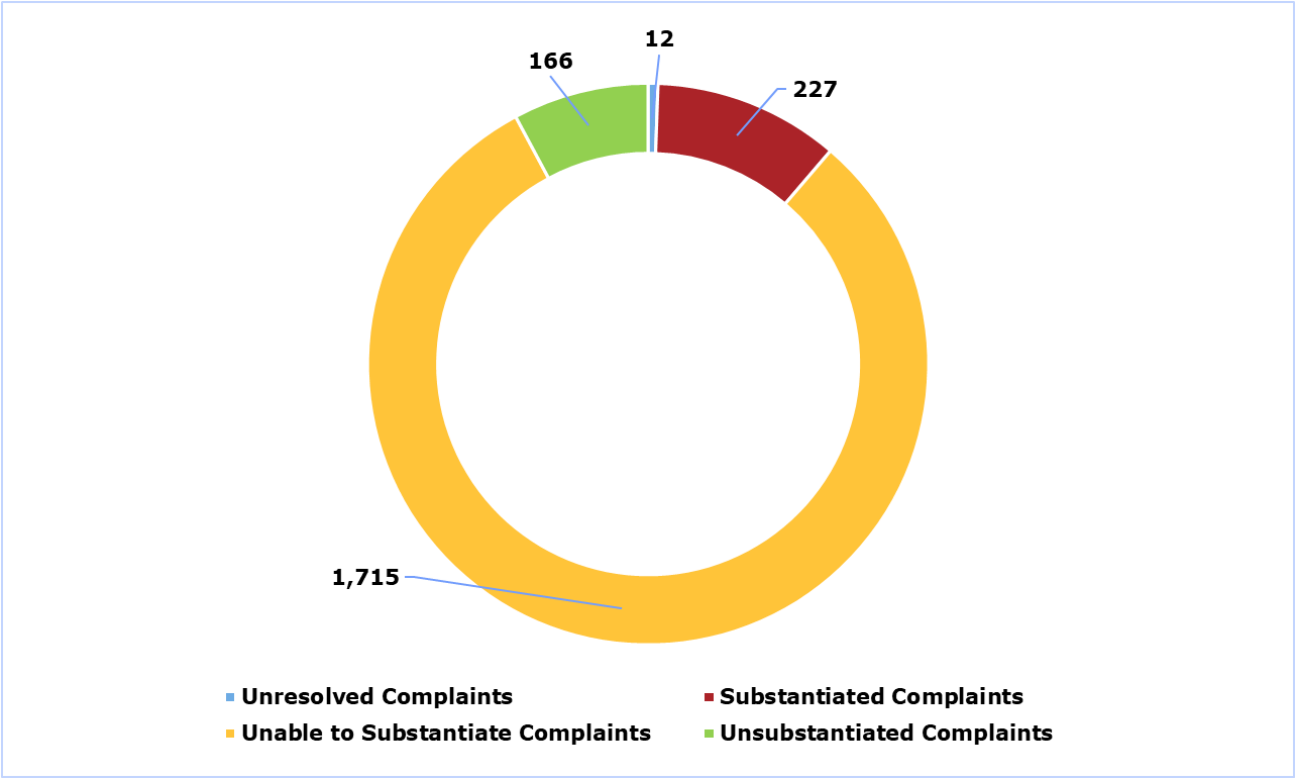


The decrease in complaints volume seen in quarter three is due to the impact that the PHE had on contact volume. As activities have begun to normalize, contact volume (for both inquiries and complaints) has continued to increase.

Resolved Complaints by Determination

Figure 6 below shows the total resolved complaints by determination received in the second quarter of FY21. OMCAT resolved 2,108 complaints out of 2,120 received. Twelve complaints were still being investigated at the end of the second quarter of FY21.

Figure 6: Complaints by Resolution Determination



Substantiated Complaints

In the second quarter of FY21, OMCAT substantiated 227, or 11 percent of resolved complaints. This is a decrease of 2 percentage points compared to the previous quarter (where OMCAT substantiated 13 percent of the complaints).

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

The second highest substantiated complaint for the quarter was also related to prescriptions and was reported by consumers who were not able to access prescriptions due to the MCO not showing the consumer as an active member with the health plan.

The third most common substantiated complaint for the quarter was related to consumers who had difficulty accessing home health services. Consumers reported reduction in attendant hours due to incorrect assessments, the health plan not being responsive to members' requests to hire attendants and delay of home health services due to the assessment not being completed in a timely manner by the MCO.

Top Complaint Categories

The complaints analyzed in this section are those that were resolved and determined to either be substantiated or unable to substantiate. Resolved complaints determined to be unsubstantiated are not included in the analysis of complaints in this report since investigation determined that policy was correctly followed in those cases. Although 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 fiscal year.

Figure 7: Top Complaint Categories Received FY20 & FY21

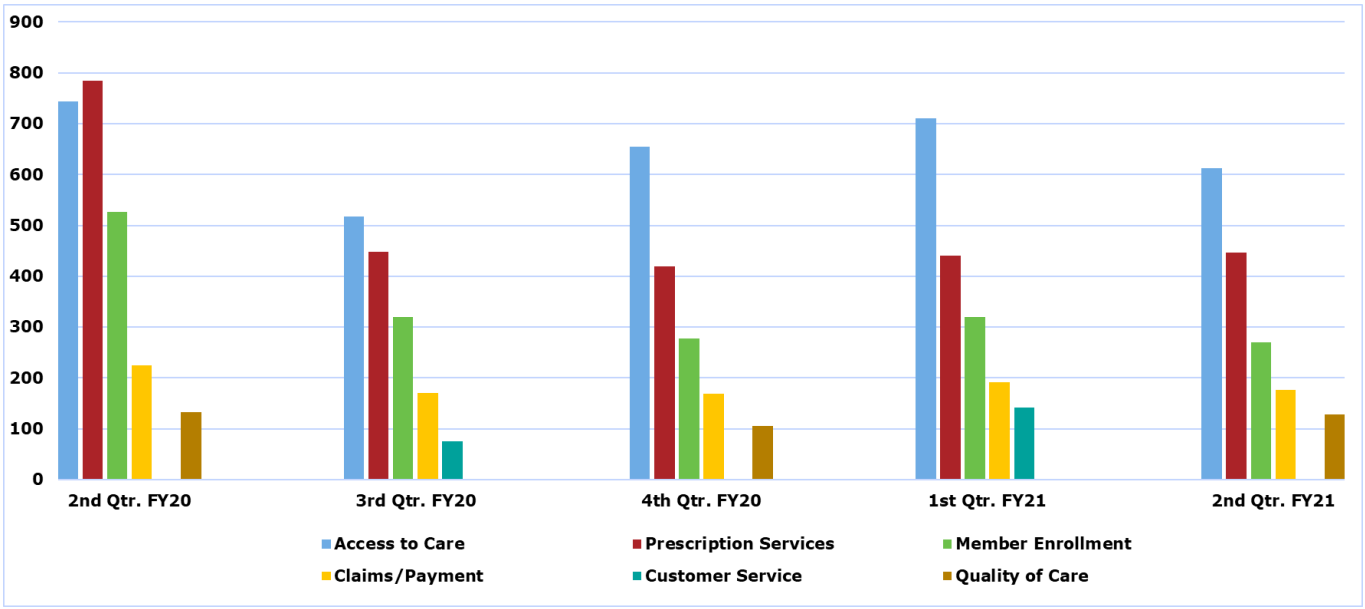


Figure 7 shows that complaints related to quality of care increased from the first to the second quarter of FY21. After review of the contact reasons, data show that there was an increase in complaints related to provider treatment being ineffective or inappropriate as well as complaints related to service coordination. A thorough review of case narratives revealed complaints of improper care including unnecessary procedures being performed, not performing a thorough examination and not treating all medical issues presented at time of service. There were no significant trends in complaints related to service coordination.

The data show that complaints related to customer service decreased from the first to the second quarter of FY21. After review of contact reasons, data show that there was a decrease in complaints related to staff behavior.

Complaints related to access to care remained the top complaint category throughout all quarters and into the second quarter of FY21. After review of the contact reasons, data show that complaints related to accessing home health services, access to in-network specialists and facilities and issues related to consumers having other insurance aside from Medicaid are the top complaint reasons for the second quarter of FY21.

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

Figure 7 also shows that complaints related to member enrollment remained the third highest complaint throughout all quarters and into the second quarter of FY21. A review of contact reasons shows that complaints related to problems regarding Medicaid eligibility, case information errors in HHSC and MCO data systems and consumers not wanting managed care were the top complaint reasons for member enrollment.

Complaints by Managed Care Program

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

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

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

STAR+PLUS

The STAR+PLUS program serves healthy children, pregnant women, and some parents of children on Medicaid[2]. In the second quarter of FY21, OMCAT received 657 complaints of which 62 (or nine percent) were substantiated. Figure 8 shows a comparison of the top complaint categories for the current quarter and previous fiscal year.

[2] The average monthly enrollment for the STAR+PLUS program in the second quarter of FY21 is 530,029.

Figure 8: Top STAR+PLUS Complaint Categories FY20 & FY21

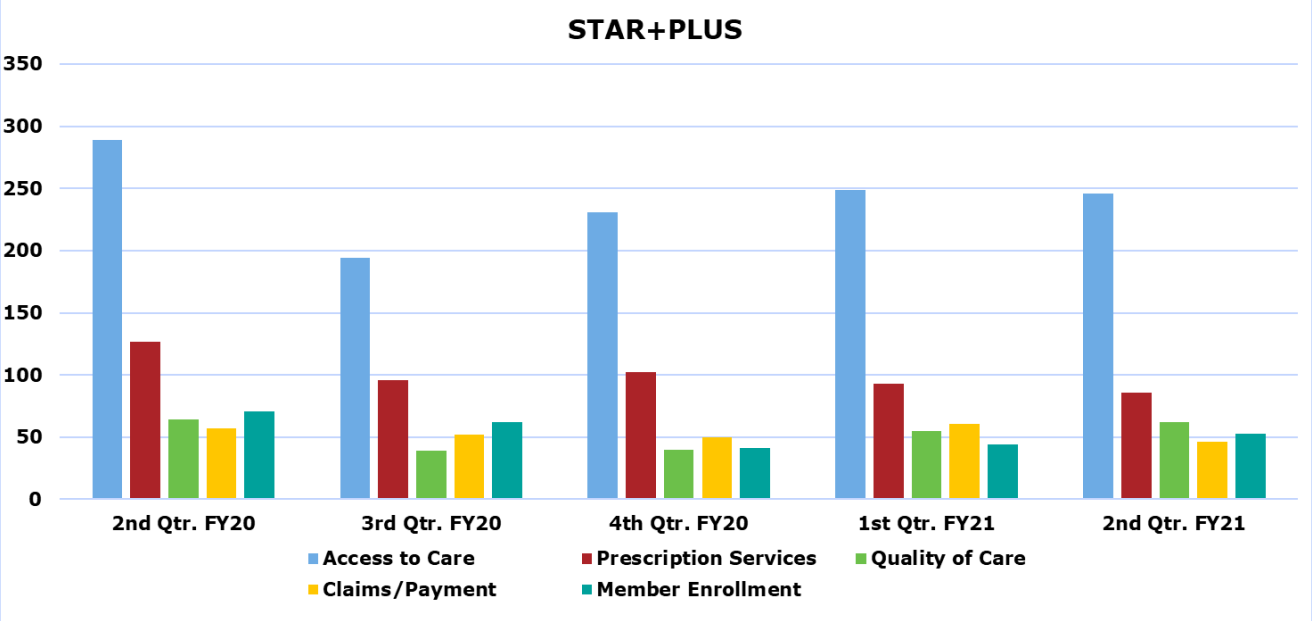


Figure 8 shows that complaints related to access to care remained the top complaint category throughout all quarters and into the second quarter of FY21. After review of the contact reasons, data show the top complaint reasons for the second quarter of FY21 were complaints of access to home health services, access to durable medical equipment and access to in-network specialists and facilities.

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

Complaints related to quality of care is the third highest complaint category in the second quarter of FY21. After review of the contact reasons, data show the top complaint reasons for the second quarter of FY21 were complaints of consumers receiving inappropriate or ineffective treatment, issues related to service coordination and issues related to coordination of care by the consumer's medical provider.

STAR

The STAR program serves healthy children, pregnant women, and some parents of children on Medicaid[3]. In the second quarter of FY21, OMCAT received 721 complaints of

[3] The average monthly enrollment for the STAR program in the second quarter of FY21 is 3,657,888.

which 88 (or 12 percent) were substantiated. Figure 9 shows a comparison of the top complaint categories for the current quarter and previous fiscal year.

Figure 9: Top STAR Complaint Categories FY20 & FY21

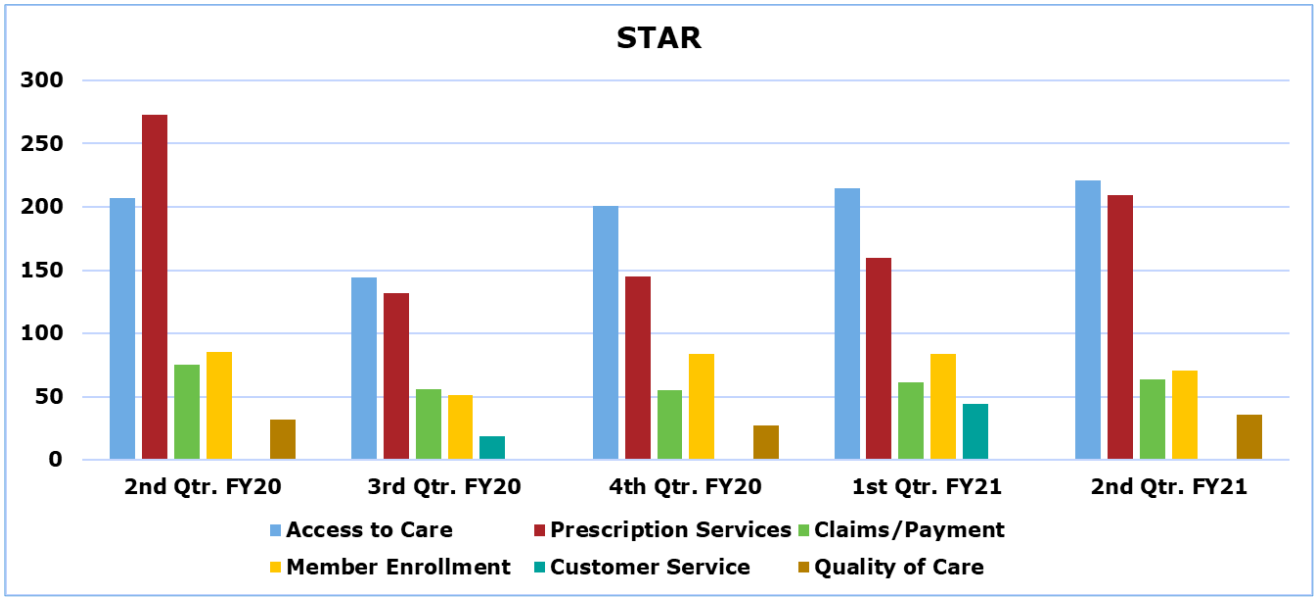


Figure 9 shows that complaints related to access to care is the top complaint category beginning in the third quarter of FY20 and into the second quarter of FY21. After review of the contact reasons, data show the top complaint reasons for the second quarter of FY21 were reports of consumers having issues with other insurance, access to out-of-network providers and access to in-network specialists and facilities.

Data show complaints related to prescription services is the second highest complaint category beginning in the third quarter of FY20 and into the second quarter of FY21. The data show the top complaint reasons for the second quarter of FY21 were complaints of consumer issues related to having other insurance aside from Medicaid, consumers not showing active in MCO and pharmacy data bases and consumers requiring prior authorization for medication that is not on the preferred drug list.

Complaints related to prescription services increased 38 percent from the first quarter to the second quarter of FY21 for STAR. After review of the contact reasons, data show that there was an increase in complaints related to problems with consumers accessing prescriptions due to other insurance showing in MCO and HHSC systems.

Complaints related to member enrollment is the third highest complaint category beginning in the fourth quarter of FY20 and into the second quarter of FY21. Data show the top complaint reasons for the second quarter of FY21 were complaints of consumers regarding case information errors in HHSC and MCO data systems, problems regarding Medicaid eligibility and recertification and consumers not wanting managed care.

Figure 9 also shows that complaints related to quality of care increased 41 percent from the first quarter to the second quarter of FY21. After review of the contact reasons, data show that there was an increase in complaints related to provider treatment being ineffective or inappropriate. A thorough review of case narratives revealed that consumers reported provider staff using improper medical techniques and not adhering to safety protocols.

STAR Kids

The STAR Kids program serves healthy children, pregnant women, and some parents of children on Medicaid[4]. In the second quarter of FY21, OMCAT received 175 complaints of which 35 (or 20 percent) were substantiated. Figure 10 shows a comparison of the top complaint categories for the current quarter and previous fiscal year.

Figure 10: Top STAR Kids Complaint Categories FY20 & FY21

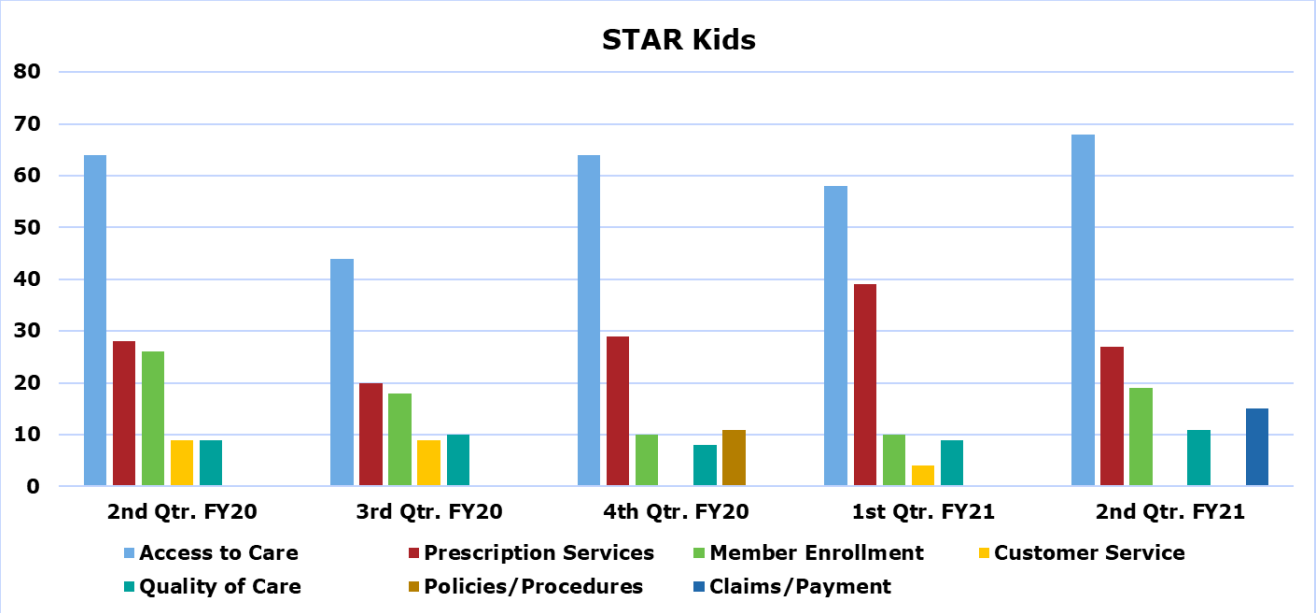


Figure 10 shows complaints related to access to care is the top complaint category beginning in the second quarter of FY20 and into the second quarter of FY21. The data show the top complaint reasons for the second quarter of FY21 were consumers having issues with accessing home health services, access to out-of-network providers and access to in-network specialists and facilities.

Complaints related to access to care increased by 19 percent from the first quarter to the second quarter of FY21. After review of the contact reasons, data show that there was an increase in complaints related to consumers accessing home health services. Case narratives revealed that consumers reported receiving a denial or reduction in

[4] The average monthly enrollment for the STAR Kids program in the second quarter of FY21 is 170,935.

home health services and a delay in services due to untimely assessments for home health services.

Data show that complaints related to prescription services is the second highest complaint category beginning in the second quarter of FY20 and into the second quarter of FY21 for STAR Kids. After review of the contact reasons, data show the top complaint reasons for the second quarter of FY21 were consumer issues related to having other insurance aside from Medicaid, pharmacies billing the incorrect health plan and other complaints related to prescription services.

Complaints related to prescription services decreased 19 percent from the first quarter to the second quarter of FY21. After review of the contact reasons data show that there was a decrease in complaints related to consumers having other insurance aside from Medicaid. A thorough review of case narratives revealed that there was also a decrease in consumers reporting Medicare as their other insurance aside from Medicaid.

Data shows that complaints related to member enrollment is the third highest complaint category beginning in the first quarter of FY21 and into the second quarter of FY21. The data show the top complaint reasons for the second quarter of FY21 were complaints of consumers regarding case information errors in HHSC and MCO systems, problems regarding Medicaid eligibility and recertification and consumers not wanting managed care.

Complaints related to member enrollment increased by 50 percent from the first quarter to the second quarter of FY21. After review of the contact reasons data show that there was an increase in complaints related to case information errors.

Figure 10 also shows that complaints related to claims payment increased by 30 percent from the first quarter to the second quarter of FY21 A review of the contact reasons shows that there was an increase in complaints related to consumers receiving a bill for services rendered while active with Medicaid.

Dental Managed Care

The Dental Managed Care program provides all dental services to children on Medicaid under the age of 21[5]. In the second quarter of FY21, OMCAT received 43 complaints, of which 4 (or nine percent) were substantiated. Figure 11 shows a comparison of the top complaint categories for the current quarter and previous fiscal year.

[5] The average monthly enrollment for the Dental Managed Care program in the second quarter of FY21 is 3,428,565.

Figure 11: Top Dental Managed Care Complaint Categories FY20 & FY21

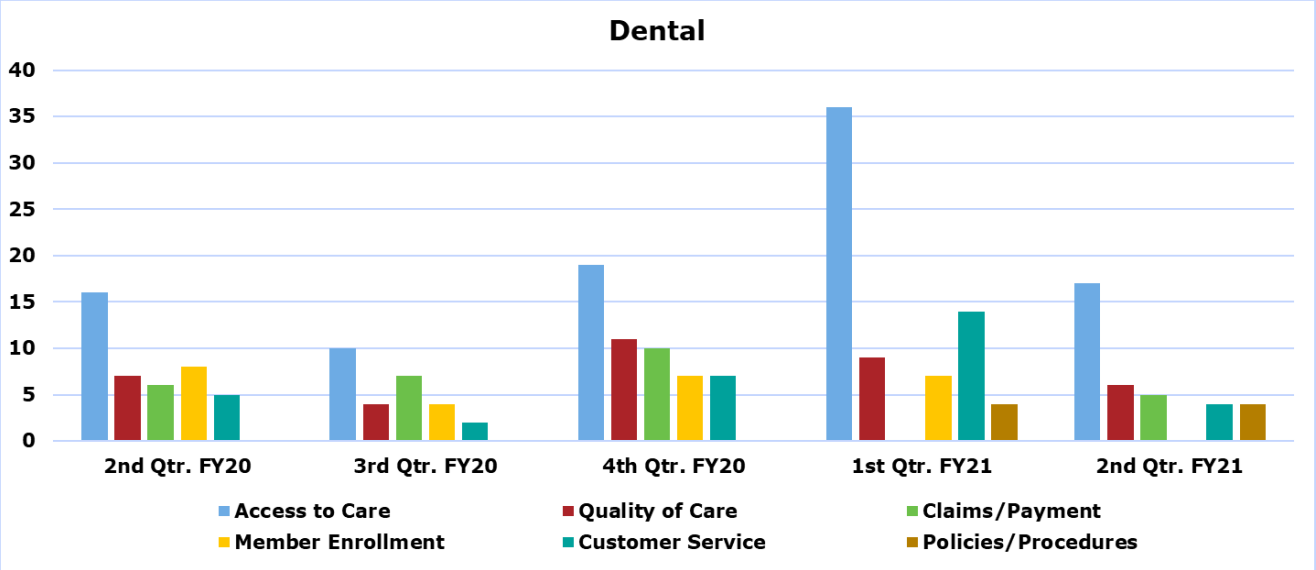


Figure 11 shows complaints related to access to care is the top complaint category beginning in the second quarter of FY20 and into the second quarter of FY21. Data show the top complaint reasons for this category were complaints related to consumers being denied services, access to dental services and issues related to consumers having other insurance.

Complaints related to access to care decreased by 51 percent from the first quarter to the second quarter of FY21. A review of contact reasons shows that there was a decrease in complaints related to accessing dental services. A thorough review of case narratives revealed a decrease in complaints related to consumers having difficulty accessing orthodontic services.

Complaints related to quality of care is the second highest complaint category in the second quarter of FY21. After review of the contact reasons, data show the top complaint reasons for the second quarter of FY21 were complaints of consumers receiving inappropriate or ineffective treatment.

Complaints related to claims and payment is the third highest complaint category in the second quarter of FY21. A review of contact reasons shows the top complaint reasons were complaints of consumers receiving bills for services rendered while active with Medicaid and authorization issues.

Figure 11 also shows that customer service complaints decreased 73 percent from the first quarter to the second quarter of FY21. A review of contact reasons shows there was a decrease in complaints related to staff behavior. A thorough review of case narratives did not reveal a significant trend.

Fee for Service/Traditional Medicaid

Fee for service, also known as traditional Medicaid[6], is the population of Medicaid recipients that are not enrolled in any managed care program. 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 FY21, OMCAT received 209 complaints, of which 33 (or 16 percent) were substantiated. Figure 12 shows a comparison of the top complaint categories for the current quarter and previous fiscal year.

Figure 12: Top Fee for Service/Traditional Medicaid Complaint Categories FY20 & FY21

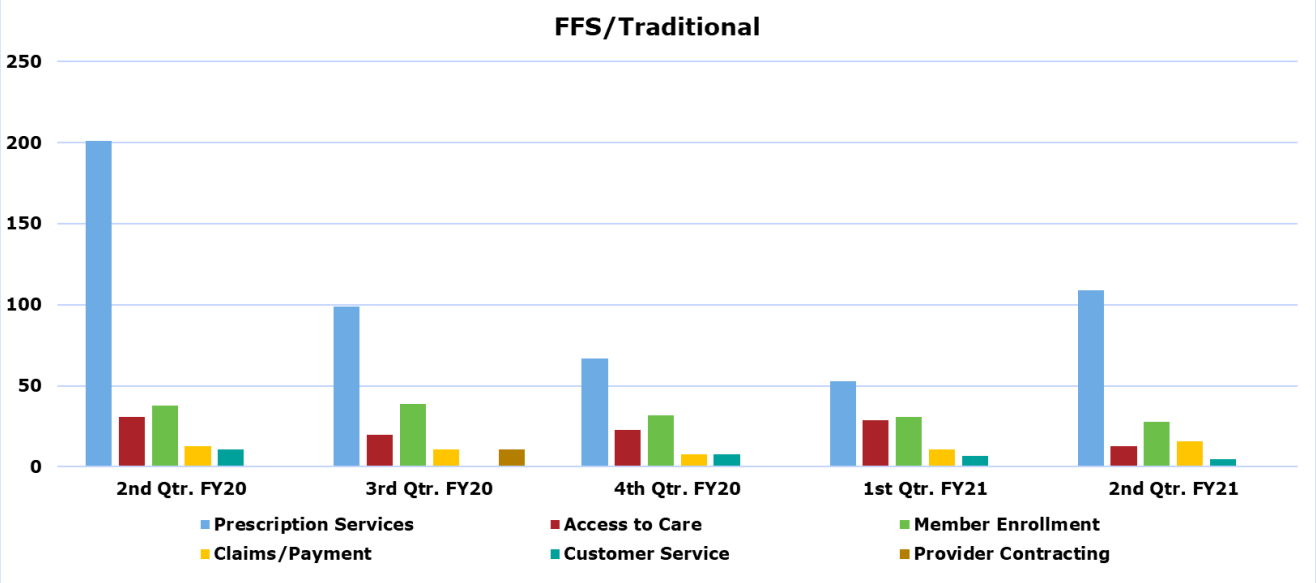


Figure 12 shows complaints related to Prescription Services is the top complaint category beginning in the second quarter of FY20 and into the second quarter of FY21. A review of contact reasons shows the top complaint reasons were issues related to consumers showing as having other insurance aside from Medicaid, members not showing active with Medicaid in pharmacy systems and consumers having problems accessing prescriptions after they had reached their three-prescription limit for the month.

Complaints related to prescription services increased by 31 percent from the first quarter to the second quarter of FY21. A review of contact reasons shows that there was an increase in complaints related to consumer's prescribing physician not being enrolled

[6] The average monthly enrollment for the Fee for Service/Traditional Medicaid program in the second quarter of FY21 is 168,345.

as a Medicaid provider. Medicaid consumers can only be prescribed services through a Medicaid enrolled provider.

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

Figure 12 also shows that complaints related to claims and payment is the third highest complaint category in the second quarter of FY21. A review of contact reasons shows the top complaint reasons were consumers receiving bills for services rendered while active with Medicaid, authorization issues and errors on the Medicaid case.

Complaints by Service Area

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

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

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

Table 2: Top Complaints by Service Area Q2 FY21

	Bexar	Dallas	El Paso	Harris	Hidalgo	Jefferson	Lubbock	MRSA Central	MRSA Northeast	MRSA West	Nueces	Tarrant	Travis
Access to Care	65	95	27	115	39	18	9	27	26	28	16	55	27
Claims/ Payment	4	28	6	30	7	4	2	5	14	7	3	13	9
Customer Service	6	9	4	15	6	3	1	4	2	3	1	8	3
Fraud	1	3	1	1	0	2	0	0	0	1	0	0	0
Member Enrollment	11	27	4	27	3	2	2	13	13	12	5	16	10
Member Health and Safety	2	1	2	2	0	1	0	0	1	0	0	2	0

	Bexar	Dallas	El Paso	Harris	Hidalgo	Jefferson	Lubbock	MRSA Central	MRSA Northeast	MRSA West	Nueces	Tarrant	Travis
Non-Medicaid /CHIP Services	0	2	0	4	2	0	0	2	0	0	1	2	4
Policies	5	2	1	9	4	2	0	8	4	4	0	1	2
Prescription Services	33	35	7	72	19	10	16	17	32	30	11	31	16
Quality of Care	13	18	6	28	3	2	1	8	6	5	5	11	5
Therapy	4	1	2	4	2	1	0	2	1	1	0	2	1
Transportation Issues	1	8	0	5	0	1	0	5	3	0	0	2	0
Value-Added Services	1	1	1	5	0	1	0	1	0	1	0	2	1

Conclusion

OMCAT experienced a slight decrease in contact in the second quarter of FY21 as compared to the first quarter of FY21. The decrease in contacts was mostly due to the OMCAT helpline not being operational the week of February 15th through the 19th due to power outages caused by the winter storm.

Recurring complaints in this report included:

- Issues with accessing providers when consumers move out of their service area while still being active with the MCO that they had in their former service area.
- Inability to access prescriptions due to erroneous secondary insurance on Medicaid profiles;
- Inability to access prescriptions due to consumers not showing as having active coverage in the HHSC, MCO, or pharmacy systems;

Some complaint data trends may not result in policy or contractual changes. OMCAT will continue to collaborate with HHSC programs and MCOs to identify and resolve issues affecting Medicaid consumers.

Recommendations

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

In the prior quarterly report (first quarter of FY21), OMCAT observed that Medicaid consumers who move out of their service area experience challenges in accessing care when the new service area is not serviced by their MCO.

OMCAT recommended that MCS review the feasibility of expediting enrollment retroactively during the month the new MCO is chosen, as soon as the consumer has updated the address for the new service area.

Discussions with MCS regarding this recommendation are ongoing.

Erroneous Secondary Insurance

In previous quarterly reports, OMCAT provided recommendations to mitigate incorrect insurance information on consumer cases in HHSC systems and recommendations to add language in the managed care contracts to address consumers not showing as active in MCO systems. HHSC MCS has undertaken initiatives to address issues with system accuracy.

To streamline systems used by HHSC and MCOs, OMCAT continues to consider options for evaluation to inform future recommendations. Currently consumer information is kept in a multitude of systems, at times the information in each system can conflict due to different interfacing systems and information not being current. OMCAT continues to evaluate ways in which consumers can receive additional communication and instruction on how to update their other insurance when their insurance status changes or is incorrectly entered in the HHSC or MCO systems.

Consumers Not Showing Active in MCOs

In previous quarterly reports, OMCAT provided recommendations to mitigate incorrect insurance information on consumer cases in HHSC systems and recommendations to add language in the managed care contracts to address consumers not showing as active in MCO systems. OMCAT will provide updates on these recommendations as they become available.

OMCAT worked with MCS to add language to the managed care contracts which will requires MCOs, when receiving a member's enrollment on a daily file, to upload the file into the MCO's system within 24 hours of receipt. This change will ensure that members will show active in the MCO's system as soon as possible after having been recertified for Medicaid. The contract change was effective September 1, 2021.

The HHS Office of the Ombudsman welcomes feedback from stakeholders and is committed to finding ways to improve our business practices to better serve our clients.

Appendix A: Managed Care Program Tables

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

Table 3: Complaint Categories by Managed Care Program Q2 FY21

	STAR+PLUS	STAR	STAR Kids	STAR PLUS Dual-Demo	STAR Health	Dental	FFS	No Medicaid
Access to Care	246	221	68	12	8	17	13	28
Claims/ Payment	46	64	15	7	3	5	16	21
Customer Service	25	33	6	1	3	4	5	23
Fraud	6	3	0	0	0	0	1	9
Member Enrollment	53	71	19	2	5	4	28	88
Member Health and Safety	8	3	0	0	0	0	1	3
Non-Medicaid /CHIP Services	9	7	1	0	0	0	0	17
Policies/ Procedures	23	11	7	1	0	4	3	12
Prescription/ Services	86	209	27	1	6	0	109	16
Quality of Care	62	36	11	2	0	6	3	8
Therapy	8	8	4	1	0	0	1	1
Transportation Issues	21	1	2	1	0	1	0	0
Value Added Services	4	9	1	0	0	0	0	1

Table 4 includes the monthly average of Medicaid consumers enrolled for managed care program for the second quarter of FY21.

Table 2: Average Monthly Enrollment by Managed Care Program Q2 FY21

Managed Care Program	Average Monthly Enrollment
Dental	3,428,565
FFS	168,345
STAR+PLUS Dual-Demo	39,328
STAR	3,657,888
STAR HEALTH	41,638
STAR Kids	170,935
STAR+PLUS	530,029
Grand Total	8,036,728

Appendix B: Average Enrollment by Service Area

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

Average Enrollment by Service Area

Quarter 1 FY21	Average Enrollment
Bexar	390,399
Dallas	572,671
El Paso	170,031
Harris	1,049,424
Hidalgo	495,952
Jefferson	127,592
Lubbock	111,145
MRSA Central	214,269
MRSA Northeast	269,621
MRSA West	239,749
Nueces	134,414
Tarrant	403,152
Travis	219,762

Glossary

Category – A designation that describes the nature of the contact.

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

Complaint – A contact regarding an expression of dissatisfaction.

Fiscal Year 2020 - The 12-month period from September 1, 2019 through August 31, 2020.

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

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

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

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

Provider - An individual such as a physician or nurse, or group of physicians and nurses such as a clinic or hospital, that delivers health care directly to patients.

Resolution – The point at which a determination is made as to whether a complaint is substantiated, and no further action is necessary by the OMCAT.

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

List of Acronyms

AR – Authorized Representative

CHIP - Children's Health Insurance Program

CLASS - Community Living Assistance and Support Services

DBMD – Deaf Blind and Multiple Disabilities

DME - Durable Medical Equipment

FFCRA - Families First Coronavirus Response Act

HCS – Home and Community-based Services

LTSS - Long Term Services and Supports

MCO - Managed Care Organization

MCCO - Managed Care Compliance Operations

MDCP - Medically Dependent Children's Program

MRSA - Medicaid Rural Service Area

PAS - Personal Attendant Services

PCP - Primary Care Provider

PHE – Public Health Emergency

PDL - Preferred Drug List

PDN - Private Duty Nursing

SA – Service Area

TDD - Telephonic Device for the Deaf

YES - Youth Empowerment Services