HHS Ombudsman
Managed Care Assistance Team
1st Quarter FY 2022

As Required by
Section 531.0213 of the
Government code

Office of the Ombudsman
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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.

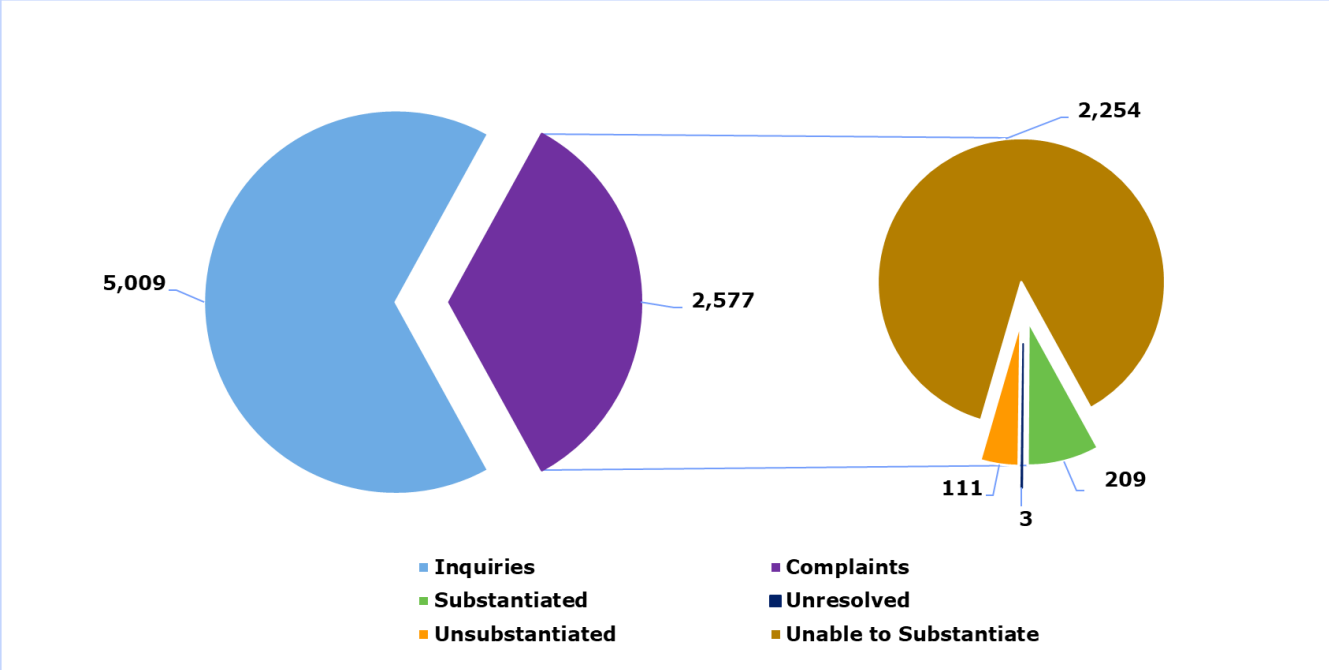
During the first quarter of fiscal year 2022 (FY22), OMCAT received 7,586 contacts; of which, 2,577 were complaints and 5,009 were inquiries.

Complaints made up 34 percent of total contacts. Of the 2,577 complaints received, 2,574 complaints were resolved with the remaining 3 pending investigations. Of those resolved complaints:

- eight percent (or 209) were substantiated;
- 88 percent (or 2,254) were unable to substantiate and,
- four percent (or 111) 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: First 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 Medicaid consumers.

In October 2021, OMCAT received a contact regarding a consumer who was hospitalized at Methodist Specialty Hospital in San Antonio. A multi-disciplinary team evaluated the consumer and deemed them to be a viable candidate for a liver transplant. The consumer's risk for mortality was extremely high if they did not receive the liver transplant in the next 90 days.

The consumer was covered by traditional Medicaid (FFS (fee for service) and was scheduled to be enrolled in STAR managed care program effective November 1, 2021. Traditional Medicaid has a limit of three prescriptions per month; however, the consumer required more than three prescriptions because of the liver transplant. The ombudsman contacted the MCO that the consumer was scheduled to be enrolled with in November to request enrollment effective as of October in order to obtain unlimited prescriptions under managed care. The consumer was denied retroactive enrollment for October by the MCO.

The OMCAT team and the Office of the Medical Director worked with Texas Medicaid Health Partnerships (TMHP) to ensure expedited review of the prior authorization for the liver transplant. Operations and Vendor Drug Program were able to waive

the prescription limit due to the consumer's life-threatening condition. The patient's liver transplant was approved, and the transplant was performed the following week. The MCO resumed coverage for aftercare of liver transplant effective November 1, 2021.

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.

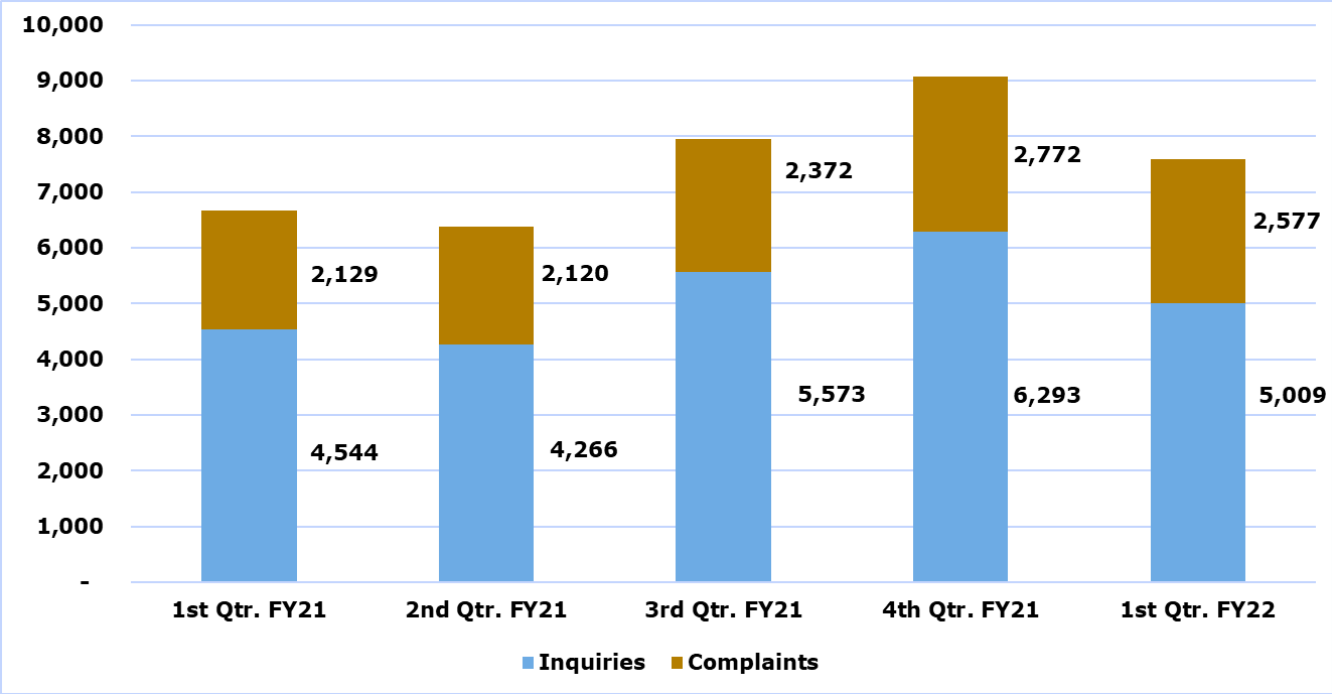
Consumer Contacts

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 FY21 & FY22



In the first quarter of FY22, OMCAT received a total of 7,586 contacts. This is a 16 percent decrease from the fourth quarter in FY21. The data show that total contacts for the first quarter of FY22 have increased by 14 percent compared to the first quarter of FY21.

Inquiries

Inquiries are an important indicator of members' needs 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.

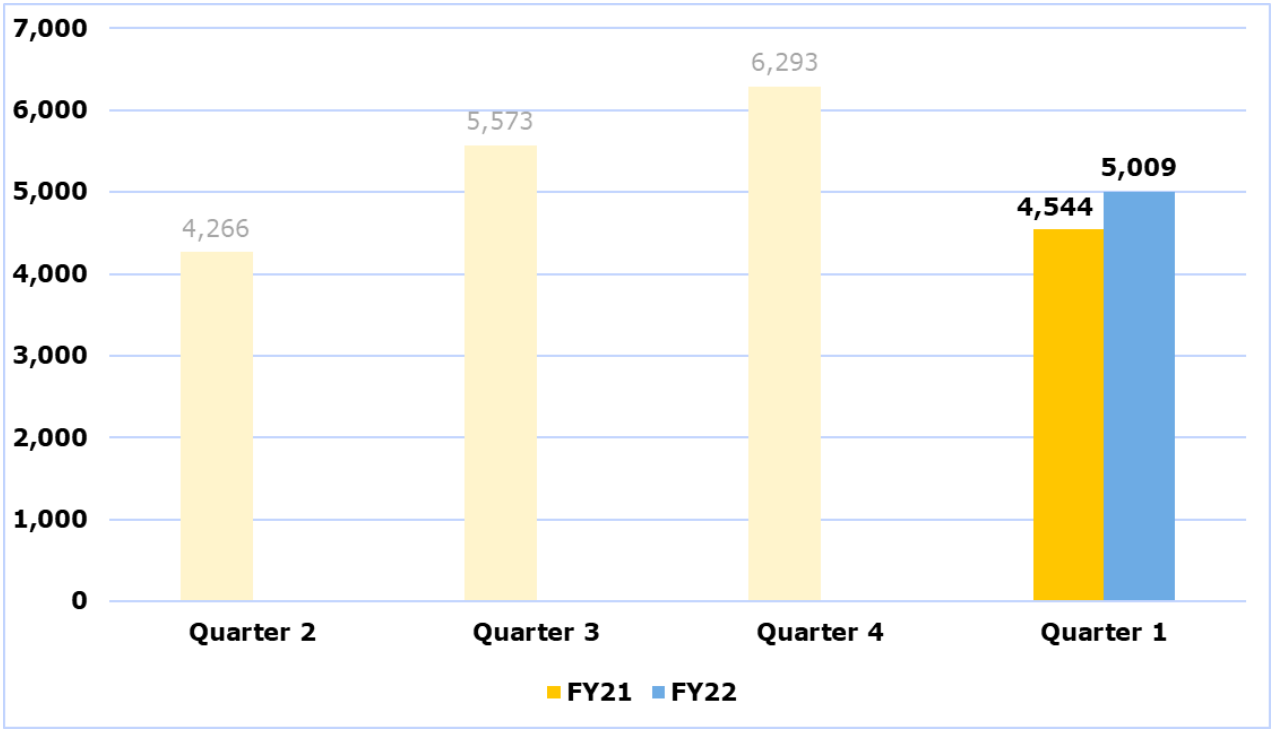
Inquiries Process

Questions or requests for information from consumers are tracked in the same database where 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 first quarter of FY22 with the same quarter of the previous year.

Figure 3: Inquiries Received FY21 & FY22

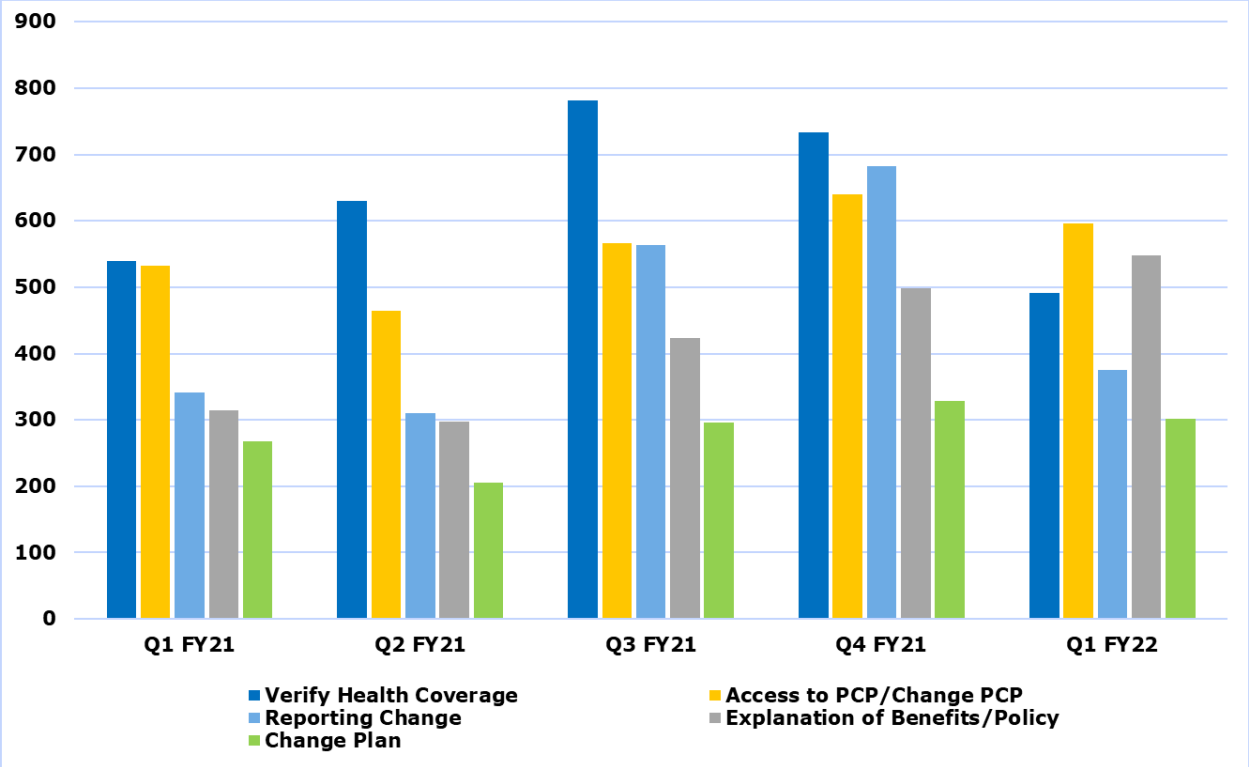


The data indicate that the volume of inquiries received for the first quarter of FY22 increased by ten percent (or 465 more) as compared to the first quarter of FY21. However, when compared with the fourth quarter of FY21, the data show that the volume of inquiries received during the first quarter of FY22 decreased by 20 percent.

Top Inquiries

Figure 4 presents a comparison of the top reasons for inquiries for the first quarter of FY22 and previous fiscal year.

Figure 4: Top Inquiries Received FY21 & FY22



The data shows that inquiries related to verifying health coverage, access to a primary care provider (PCP)/changing PCP and explanation of benefits and policy are among the top reasons for inquiries throughout FY21 and into FY22.

Figure 4 shows that accessing a PCP or changing the PCP was the top inquiry for the first quarter of FY22. Inquiries related to accessing or changing a PCP decreased by six percent from the fourth quarter of FY21 to the first quarter of FY22. The major decrease was experienced in the STAR program. A review of case

narratives indicates that consumers inquired about changing their child's PCP and finding a PCP who accepted their health plan.

Data show inquiries related to benefits and policy were among the top inquiries of the first quarter of FY22. Consumer questions related to benefits and policy increased by 10 percent from the fourth quarter of FY21 to the first quarter of FY22. A review of case narratives showed that consumers had questions related to what benefits were covered by Medicaid and how to obtain them as well as how to navigate Medicaid managed care. An increase in inquiries related to benefits and policy also occurred the previous year from the fourth quarter of FY20 to the first quarter of FY21.

Figure 4 also shows that in the first quarter of FY22 consumers needing to verify health coverage was among the top inquiries. Inquiries related to verifying health coverage decreased by 33 percent in the first quarter of FY22 as compared to the fourth quarter of FY21. The decrease was due to fewer contacts from consumers in the STAR program and from consumers who did not have Medicaid at the time of contact. A review of case narratives indicates that consumers needed to verify if their child's health plan was active, how to obtain their Medicaid ID number and information about current health plan enrollment.

Data also show that in the first quarter of FY22 consumers requesting a change to the Medicaid case decreased by 45 percent. A review of case narratives indicates that there was a decrease in consumers calling to add a newborn child to the Medicaid case, reporting an address change and terminating Texas Medicaid benefits.

Resolved Complaints

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

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

OMCAT requests the review and interpretation of Medicaid policy and managed care rules and regulations with the appropriate HHS program area or MCO.

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

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

Table 1: Complaint Resolution Determination

	DEFINITION	EXAMPLE	FINDINGS	RESOLUTION
Substantiated	Research clearly indicates that agency policies or expectations were violated.	Consumer complaint that home health attendant did not show up for duty.	Investigation confirms that home health agency attendant did not appear for work that day.	OMCAT worked with MCO to ensure that home health agency will send a replacement when the attendant is not available.

	DEFINITION	EXAMPLE	FINDINGS	RESOLUTION
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.
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 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 "Unable to Substantiate" Matters

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

- Incomplete investigation – ombudsman may need more information from the consumer during the investigation but if the ombudsman is not able to reach the consumer after several attempts, the investigation is closed.
- Discrepant information - consumer complains that the MCO has not authorized a referral for an MRI. The MCO states the request for

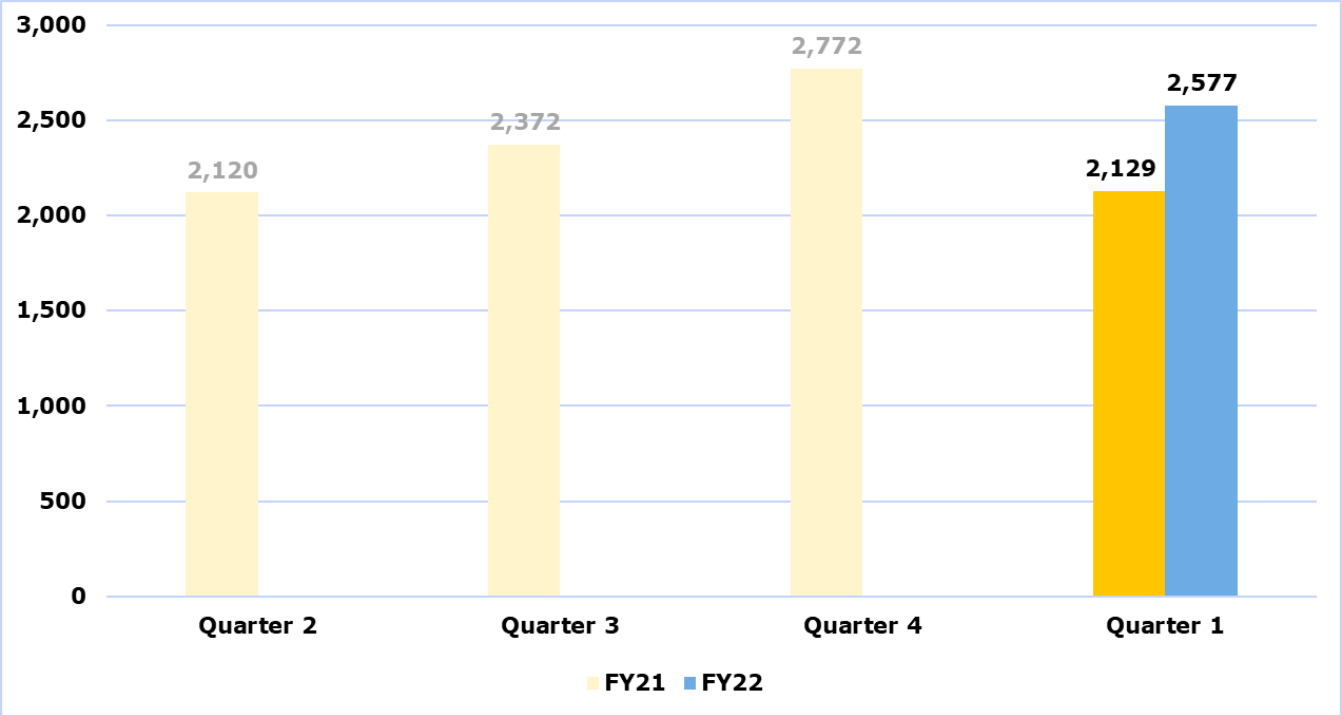
authorization was never received and the referring physician claims the request was sent to the MCO.

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

Complaints Received

Figure 5 focuses on the comparison of the total complaints received for the first quarter with the same quarter of the previous fiscal year. In the first quarter of FY22, OMCAT received 2,577 complaints, which is an increase of 21 percent (or 448 more) compared to the first quarter of FY21 and is a decrease of seven percent (or 195 less) compared to the fourth quarter of FY21.

Figure 5: Complaints Received FY21 & FY22

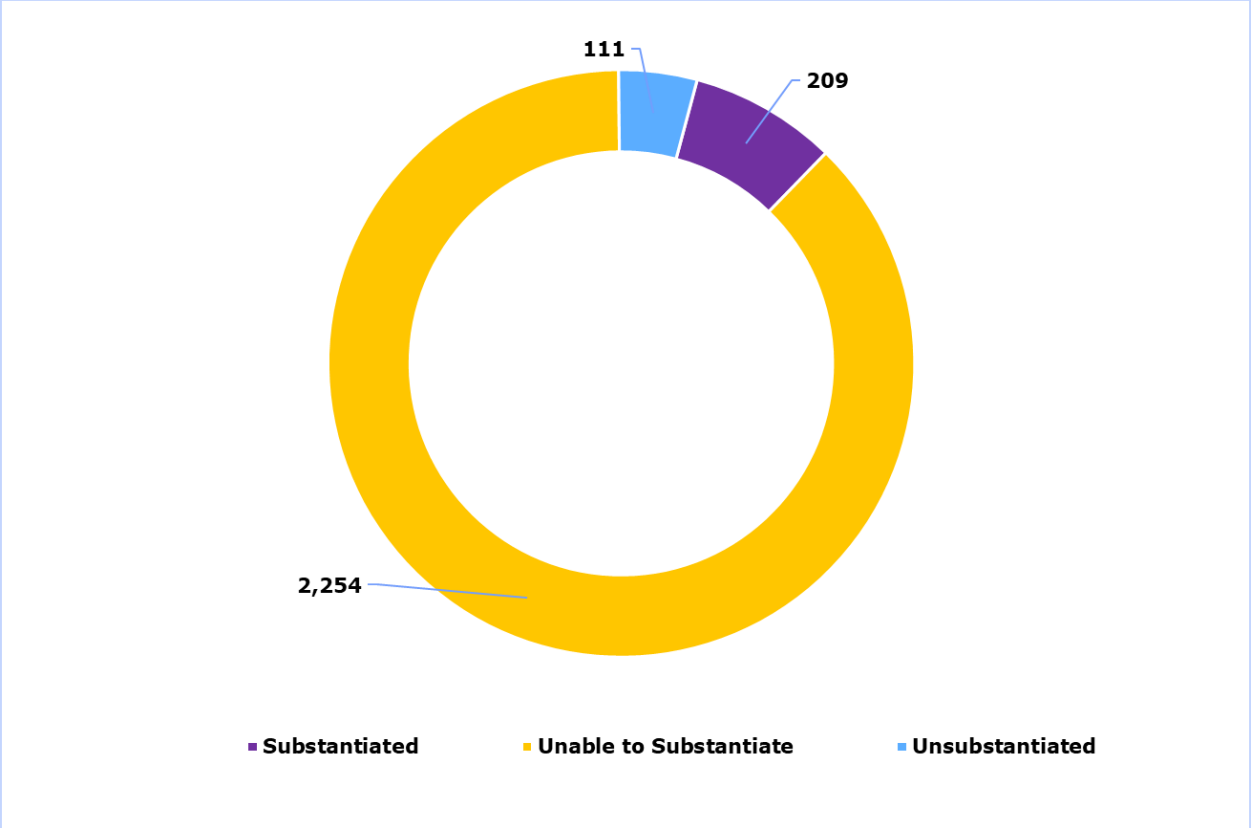


In comparison to the first quarter of FY21, the complaint categories that experienced the greatest increase in the first quarter of FY22 were access to care, prescription services and member enrollment.

Resolved Complaints by Determination

Figure 6 below shows the total resolved complaints by determination received in the first quarter of FY22. OMCAT resolved 2,574 complaints out of 2,577 received. Three complaints were still being investigated at the end of the first quarter of FY22.

Figure 6: Complaints by Resolution Determination



Substantiated Complaints

In the first quarter of FY22, OMCAT substantiated 209, or eight percent of resolved complaints. This is a decrease of one percentage point compared to the previous quarter.

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 related to consumers showing case information errors in HHSC systems. Consumers reported requesting changes such as updating address and name changes, however requested changes were not processed timely in HHSC data systems.

The third most common substantiated complaint for the quarter was related to consumers not being transported to medical appointments after they had scheduled transportation through their 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 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 fiscal year.

Figure 7: Top Complaint Categories Received FY21 & FY22

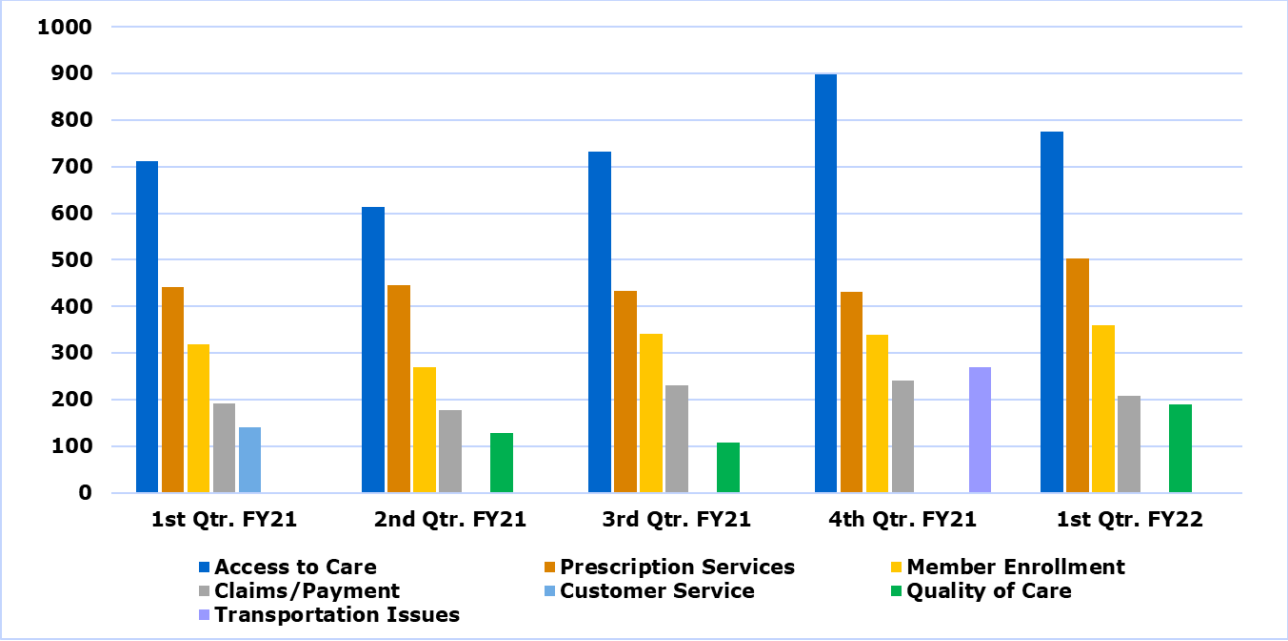


Figure 7 shows that complaints related to access to care decreased 13 percent from the fourth quarter of FY21 to the first quarter of FY22 and remained the top complaint category in the first quarter of FY22. The decrease in complaints from the fourth quarter of FY21 to the first quarter of FY22 can be attributed to a decrease in complaints regarding accessing home health services, out-of-network providers and consumers having insurance other than Medicaid on file in the HHS and MCO systems. The top complaint of access to care in the first quarter of FY22 were complaints related to consumers accessing in-network specialists and facilities, consumers having difficulty accessing home health services and consumers accessing out-of-network providers.

The data also show that complaints related to accessing prescription services remained the second highest complaint throughout all quarters and into the first quarter of FY22. Top complaint contact reasons relating to access to prescription services included consumers having difficulty accessing prescription services due to having other insurance on their Medicaid profile in HHSC, MCO or pharmacy systems and consumers not showing as active with coverage in MCO or pharmacy systems.

Figure 7 also shows that complaints related to member enrollment remained the third highest complaint throughout all quarters and into the first quarter of FY22. Data show the top complaint reasons of member enrollment for the first quarter of

FY22 were related to problems regarding Medicaid eligibility and recertification and complaints of case information errors in HHSC and MCO data systems.

The data show that quality of care was among the top complaint categories in the first quarter of FY22 and increased by 30 percent from the fourth quarter of FY21. The increase in complaints of quality of care can be attributed to an increase in complaints related to consumers receiving inappropriate or ineffective treatment from Medicaid providers.

Complaints by Managed Care Program

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

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

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

STAR

The STAR program serves healthy children, pregnant women, and some parents of children on Medicaid[1]. In the first quarter of FY22, OMCAT received 887 complaints of which 73 (or eight percent) were substantiated.

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

[1] The average monthly enrollment for the STAR program in the fourth quarter of FY21 is 4,113,880.

Figure 8: Top STAR Complaint Categories FY21 & FY22

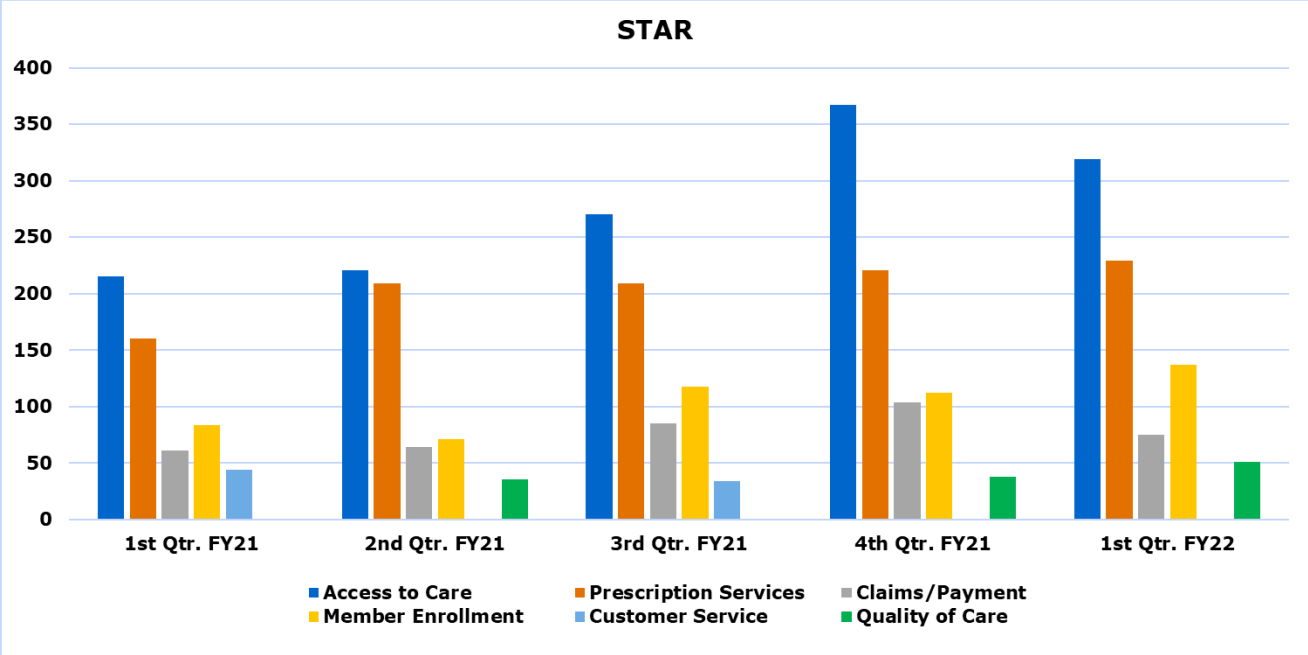


Figure 8 shows that consumers consistently complained of not being able to access care, access prescription services and had difficulty with member enrollment from the first quarter of FY21 through the first quarter of FY22.

Complaints related to access to care is the top complaint category in the first quarter of FY22. Complaints related to access to care also decreased by 13 percent from the fourth quarter FY21 to the first quarter of FY22. The decrease in complaints, which amounted to 48 fewer complaints, is attributed to fewer reports of consumers having difficulty accessing services due to having other insurance aside from Medicaid. The top complaint reasons of access to care for the first quarter of FY22 included consumers having problems accessing out-of-network providers, PCPs and in-network specialists and facilities.

Complaints related to prescription services is the second highest complaint category beginning in the first quarter of FY21 and into the first quarter of FY22. Top complaint contact reasons related to access to prescription services included consumers having difficulty accessing prescription services due to other insurance on their Medicaid profile in HHSC, MCO or pharmacy systems and consumers not showing as active with coverage in MCO or pharmacy systems.

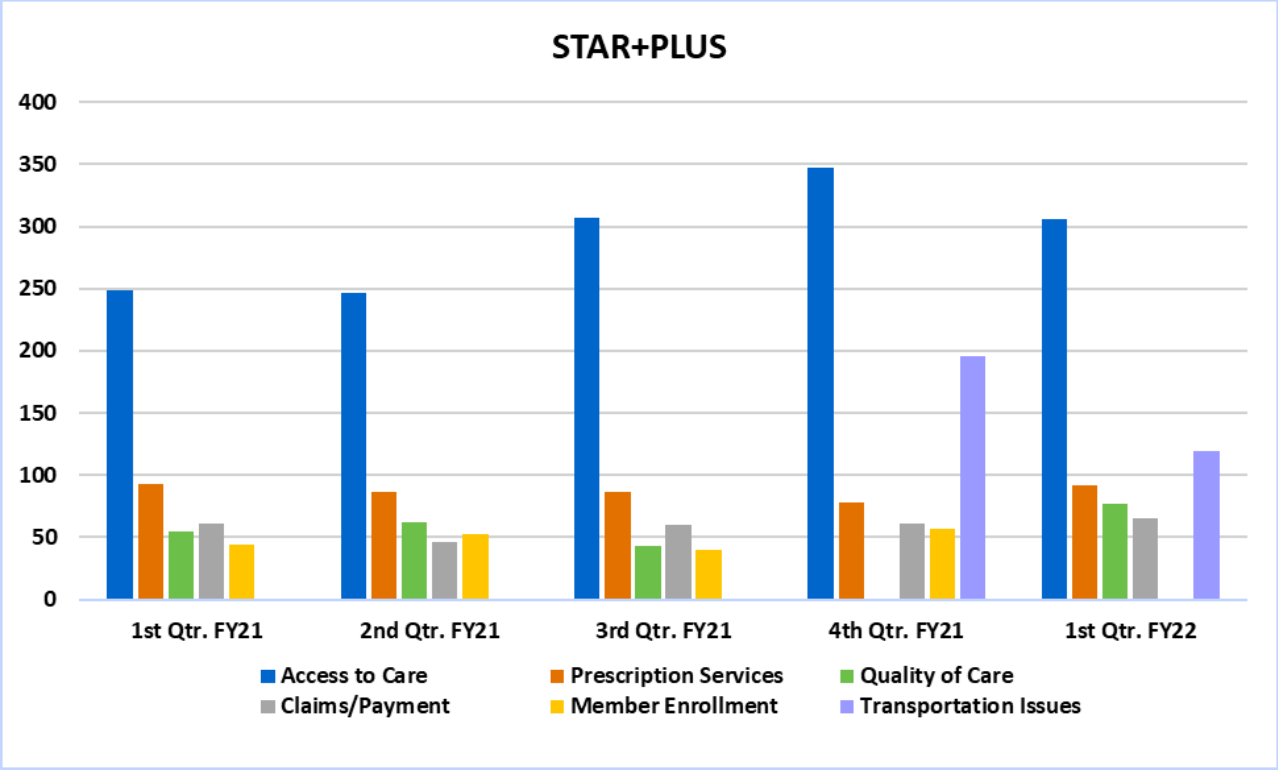
Complaints related to member enrollment is the third highest complaint category beginning in the first quarter of FY21 and into the first quarter of FY22. Complaints

related to member enrollment also increased from the fourth quarter of FY21 to the first quarter of FY22. The increase in complaints from the fourth quarter of FY21 to the first quarter of FY22 can be attributed to a 27 percent increase in complaints related to problems regarding Medicaid eligibility and recertification and an 18 percent increase in complaints related to Medicaid profile errors in HHSC and MCO data systems. Member enrollment complaints related to Medicaid eligibility and Medicaid profile errors in HHSC and MCO data systems were also the top complaint reasons for the first quarter of FY22.

STAR+PLUS

The STAR+PLUS program serves adults who have disabilities or are age 65 or older[2]. In the first quarter of FY22, OMCAT received 801 complaints of which 92 (or 11 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+PLUS Health Complaint Categories FY21 & FY22



[2] The average monthly enrollment for the STAR+Plus program in the third quarter of FY21 is 544,869.

Figure 9 shows that complaints related to access to care is the top complaint category for five consecutive quarters beginning in the first quarter of FY21 and into the first quarter of FY22. Complaints related to access to care decreased from the fourth quarter of FY21 to the first quarter of FY22. After a review of complaint reasons, the decrease in complaints can be attributed to a 61 percent decrease in complaints related to consumers having problems accessing out-of-network providers, a 41 percent decrease in complaints related to adults having difficulty accessing dental services and a 18 percent decrease in complaints related to consumers having issues accessing home health services. The top contact reasons of access to care for the first quarter of FY22 included complaints related to home health services, access to durable medical equipment (DME) and denial of services.

The data show that complaints related to transportation issues is the second highest complaint category beginning in the fourth quarter of FY21 and into the first quarter of FY22. Complaints related to transportation decreased from the fourth quarter of FY21 to the first quarter of FY22. After a review of complaint reasons, the decrease in complaints can be attributed to a 64 percent decrease in complaints related to scheduling errors when attempting to schedule transportation, a 26 percent decrease in complaints regarding consumers not being picked up within one hour of their requested pick-up time and a 46 percent decrease in complaints in which consumers reported not being transported after scheduling transportation services. The top complaint reasons for the first quarter of FY22 include consumers who reported that they were not transported after scheduling transportation services and consumers who had problems getting reimbursed for individual transportation participant claims (ITP).

Figure 9 also shows that complaints of access to prescription services is the third highest complaint category beginning in the fourth quarter of FY21 and into the first quarter of FY22. Complaint reasons related to accessing prescriptions for the first quarter of FY22 were consumers having other insurance aside from Medicaid and consumers not showing active with coverage in pharmacy and MCO systems.

STAR Kids

The STAR Kids program serves children and adults 20 and younger with a disability[3]. In the first quarter of FY22, OMCAT received 142 complaints of which 11

[3] The average monthly enrollment for the STAR Kids program in the fourth quarter of FY21 is 168,872.

(or eight percent) were substantiated. Figure 10 shows a comparison of the top complaint categories for the current quarter as well as the previous 4 quarters.

Figure 10: Top STAR Kids Complaint Categories FY21 & FY22

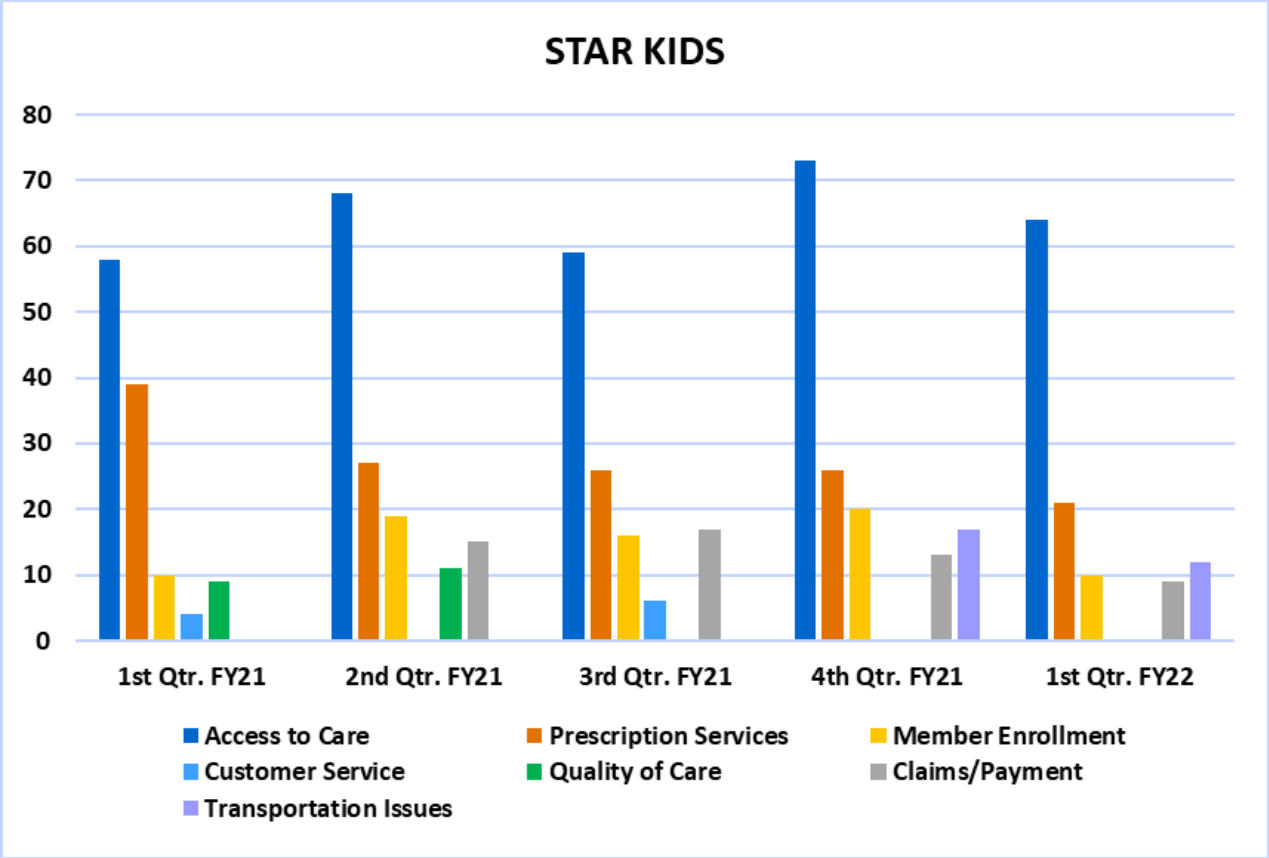


Figure 10 shows complaints related to access to care is the top complaint category beginning in the first quarter of FY21 and into the first quarter of FY22. The data shows that the top complaint reasons for the first quarter FY22 were related to consumers having problems accessing in-network specialists and facilities, denial of services and access to DME.

Data show that complaints related to prescription services is the second highest complaint category beginning in the first quarter of FY21 and into the first quarter of FY22 for STAR Kids. The top complaint reasons for the first quarter of FY22 were related to consumers having other insurance aside from Medicaid and consumers who were unable to obtain their medication because a refill had been requested too soon.

Complaints related to transportation issues is the third highest complaint category in the first quarter of FY22. The top complaint reasons for the first quarter of FY22

were complaints of consumers not being transported after scheduling rides and consumers having difficulty receiving ITP claims.

Fee for Service/Traditional Medicaid

Fee for service, also known as traditional Medicaid, is the population of Medicaid recipients that are not enrolled in any managed care program[4]. OMCAT assists all consumers on Medicaid, as such, it is important to capture complaints for all populations of Medicaid consumers.

In the first quarter of FY22, OMCAT received 209 complaints, of which 17 (or eight percent) were substantiated. Figure 11 shows a comparison of the top complaint categories for the current quarter as well as the previous fiscal year.

[4] The average monthly enrollment for the Fee for Service/Traditional Medicaid program in the fourth quarter of FY21 is 162,707.

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

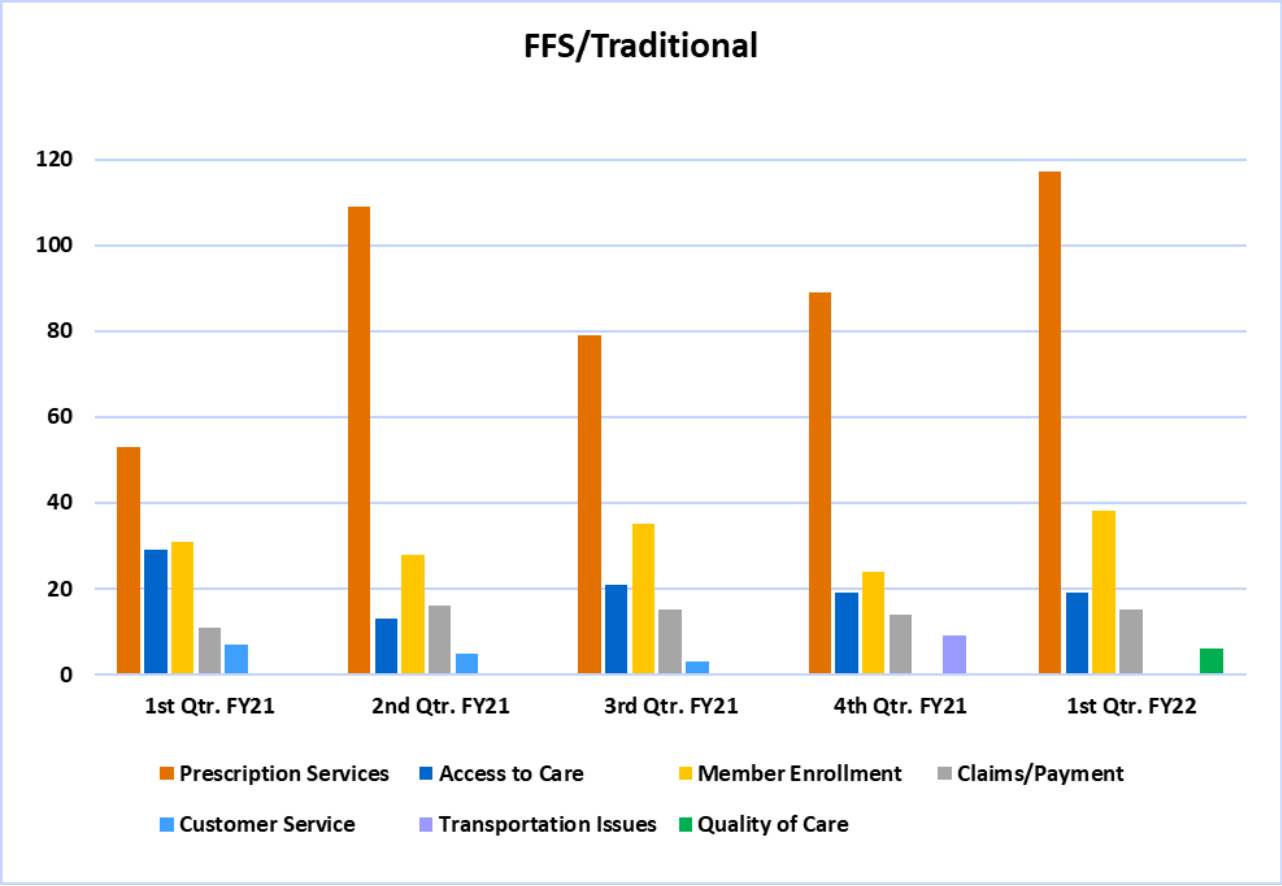


Figure 11 shows complaints related to prescription services is the top complaint category beginning in the first quarter of FY21 and into the first quarter of FY22. Complaints related to prescription services increased from the fourth quarter of FY21 to the first quarter of FY22. A review of contact reasons shows the increase can be attributed to a 42 percent increase in complaints related to consumers having other insurance aside from Medicaid in HHSC and pharmacy systems and a 40 percent increase in contact related to members not showing active with coverage in HHSC and pharmacy systems. The top complaint reasons which attributed to the increase in complaints from the fourth quarter of FY21 to the first quarter of FY22, were also the top complaint reasons for the first quarter of FY22.

Complaints related to member enrollment is the second highest complaint category beginning in the first quarter of FY21 and into the first quarter of FY22. A review of contact reasons shows the top complaint reasons were problems regarding Medicaid eligibility and case information errors in HHSC systems.

Figure 11 also shows that complaints related to access to care is the third highest complaint category in the first quarter of FY22. A review of contact reasons shows the top complaint reasons were consumers having issues accessing DME and having difficulty accessing services because they showed having other insurance aside from Medicaid.

Conclusion

OMCAT experienced a slight decrease in contacts in the first quarter of FY22 as compared to the fourth quarter of FY21. Fewer business days due to four state holiday office closures and a decrease in transportation complaints contributed to the decrease in contacts in the first quarter of FY22. In the fourth quarter of FY21 MCOs began providing transportation services. The rate of complaints decreased in the first quarter of FY22 as MCOs adjusted to providing the new service. Average contact volume per day also decreased in the first quarter of FY22 compared to the fourth quarter of FY21. However, overall contacts did increase in the first quarter of FY22 in comparison to the first quarter of FY21.

Recommendations

There are no new recommendations for this quarter.

Recommendations from previous reports as well as updates to those recommendations are included in Appendix D.

Appendix A: Managed Care Program Tables

Table 2 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 2: Complaint Categories by Managed Care Program Q1 FY22

	STAR+PLUS	STAR	STAR Kids	STAR+PLUS Dual-Demo	STAR Health	Dental	FFS	No Medicaid
Access to Care	306	319	64	6	4	24	19	33
Prescription/Services	92	229	21	5	7	1	117	19
Member Enrollment	55	137	10	3	6	5	38	102
Claims/ Payment	65	75	9	2	2	10	15	31
Quality of Care	77	51	8	3	5	17	6	22
Transportation Issues	119	11	12	0	2	0	3	5
Customer Service	36	31	4	3	3	3	4	19
Non-Medicaid /CHIP Services	13	6	0	1	0	0	3	37
Policies/Procedures	20	10	9	0	1	5	1	13
Therapy	10	6	2	1	0	0	1	0

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

Table 3: Average Monthly Enrollment by Managed Care Program Q1 FY22

Managed Care Program	Average Monthly Enrollment
Dental	3,750,777
FFS	162,707
STAR+PLUS Dual-Demo	36,927
STAR	4,113,880
STAR HEALTH	45,568
STAR Kids	168,872
STAR+PLUS	544,869

Appendix B: Average Enrollment by Service Area

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

Table 4: Average Enrollment by Service Area

Service Area	Average Enrollment
Bexar	430,398
Dallas	637,274
El Paso	185,488
Harris	1,167,477
Hidalgo	533,397
Jefferson	141,850
Lubbock	122,826
MRSA Central	236,365
MRSA Northeast	296,935
MRSA West	265,637
Nueces	145,933

Service Area	Average Enrollment
Tarrant	455,368
Travis	245,599

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 only those where 10 or more complaints were received in the service area and are a subset of the total complaints received for the service areas. The number of enrolled Medicaid consumers by service area is provided in Appendix B.

Table 5: Top Complaints by Service Area Q1 FY22

	Bexar	Dallas	El Paso	Harris	Hidalgo	Jefferson	Lubbock	MRSA Central	MRSA Northeast	MRSA West	Nueces	Tarrant	Travis
Access to Care	55	141	19	155	29	19	11	48	34	42	24	73	45
Prescription Services	49	35	13	94	15	15	10	17	24	22	4	32	18
Member Enrollment	18	39	8	45	16	1	6	7	17	15	5	21	9
Claims/ Payment	14	18	4	34	14	1	4	14	14	7	5	15	7
Transportation	7	25	2	26	6	12	2	13	22	3	4	19	2
Quality of Care	14	24	0	31	7	6	0	10	7	7	3	16	14
Customer Service	10	17	3	16	3	2	1	7	2	3	5	4	1

Appendix D: Recommendations and Updates from Previous Reports

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

In FY21 quarterly reports, 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 Medicaid CHIP Services (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.

This recommendation has been included in the Enrollment at Eligibility project headed by MCS. OMCAT is being represented in the project which will explore how to enroll consumers into MCOs upon being determined eligible for Medicaid. OMCAT will seek opportunities to find alignment between the project and the recommendation to expedite enrollment of consumers that have moved out of their service area into an MCO of their new service area.

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.

Individual Transportation Participant - A benefit of the non-emergency medical transportation service that allows the consumer to choose a driver authorized by the health plan to transport the consumer to medical appointments and receive reimbursement for gas mileage used for transport.

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

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

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

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

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

List of Acronyms

CHIP – Children's Health Insurance Program

ITP - Individual Transportation Participant

MCO – Managed Care Organization

MCS – Medicaid CHIP Services

MDCP – Medically Dependent Children's Program

MRSA – Medicaid Rural Service Area

NEMT - Non-emergency medical transportation

PCP – Primary Care Provider

PDL – Preferred Drug List

SA – Service Area