HHS Ombudsman Managed Care Assistance Team 4th Quarter FY 2022

As Required by
Section 531.0213 of the
Government code

Office of the Ombudsman
2022

TEXAS
Health and Human Services

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Executive Summary

In accordance with Government Code Chapter 531, Section 531.0213(d)(5), the Health and Human Services Commission (HHSC) is required to collect and maintain statistical information regarding calls received by the Ombudsman Managed Care Assistance Team (OMCAT), and publish quarterly reports that:

- list the number of calls received by the region;
- identify trends in delivery, access problems, and recurring barriers in the Medicaid system; and,
- indicate other problems identified with Medicaid managed care.

OMCAT categorizes contacts received from consumers as a complaint or an inquiry. A complaint is a contact in which a consumer expresses any dissatisfaction. An inquiry is a contact in which a consumer requests information about HHS programs or services.

During the fourth quarter of fiscal year 2022 (FY22), OMCAT received 6,878 contacts; of which, 2,534 were complaints and 4,344 were inquiries.

Complaints made up 37 percent of total contacts. Of the 2,534 complaints received, 2,516 complaints were resolved during the quarter with the remaining 18 pending resolution. Of those resolved complaints:

- 11.09 percent (or 279) were substantiated;
- 27.03 percent (or 680) were unable to substantiate;
- 46.42 percent (or 1,168) were referred and;
- 15.46 percent (or 389) were unsubstantiated.

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

Figure 1: Fourth Quarter Total Contacts Received

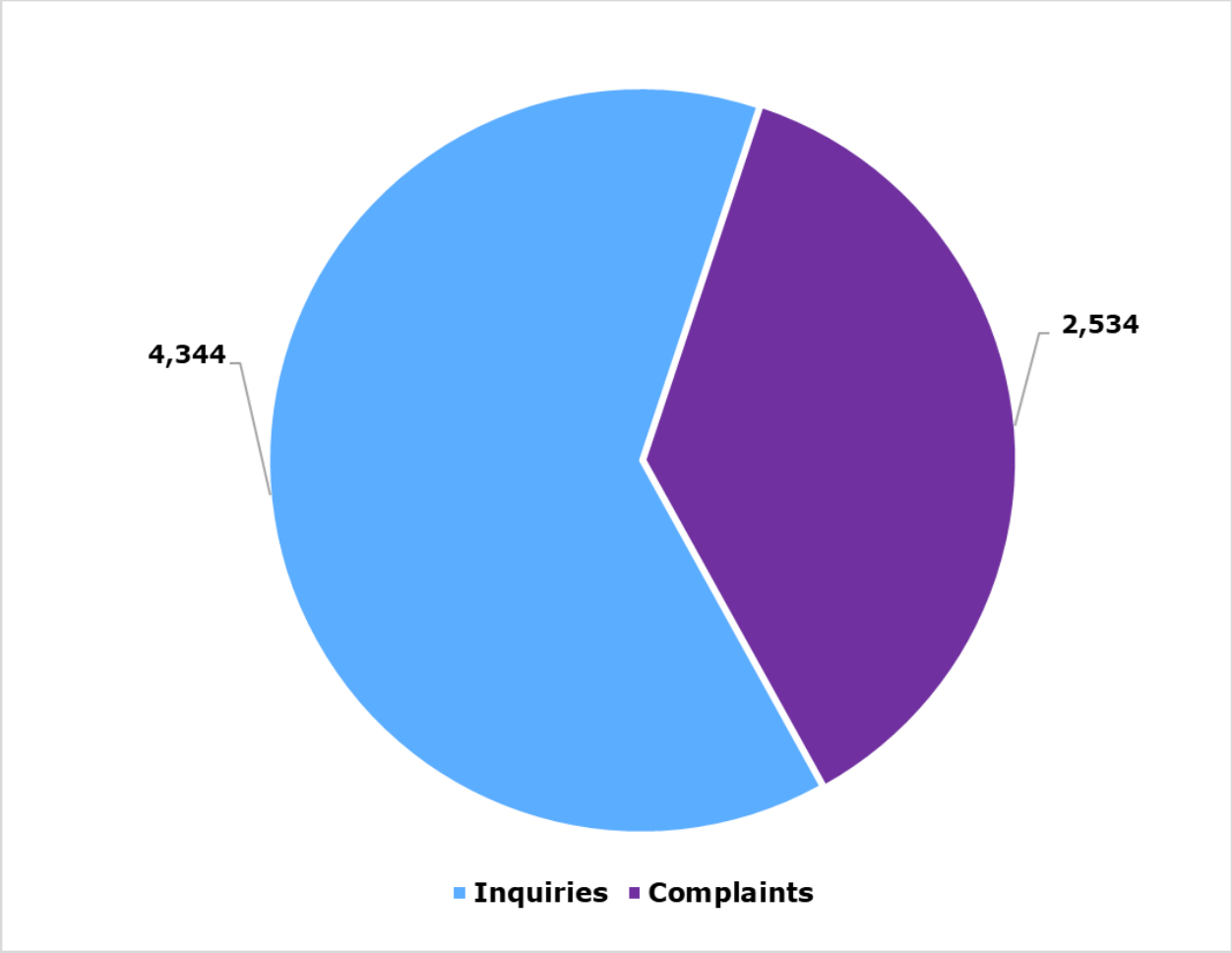
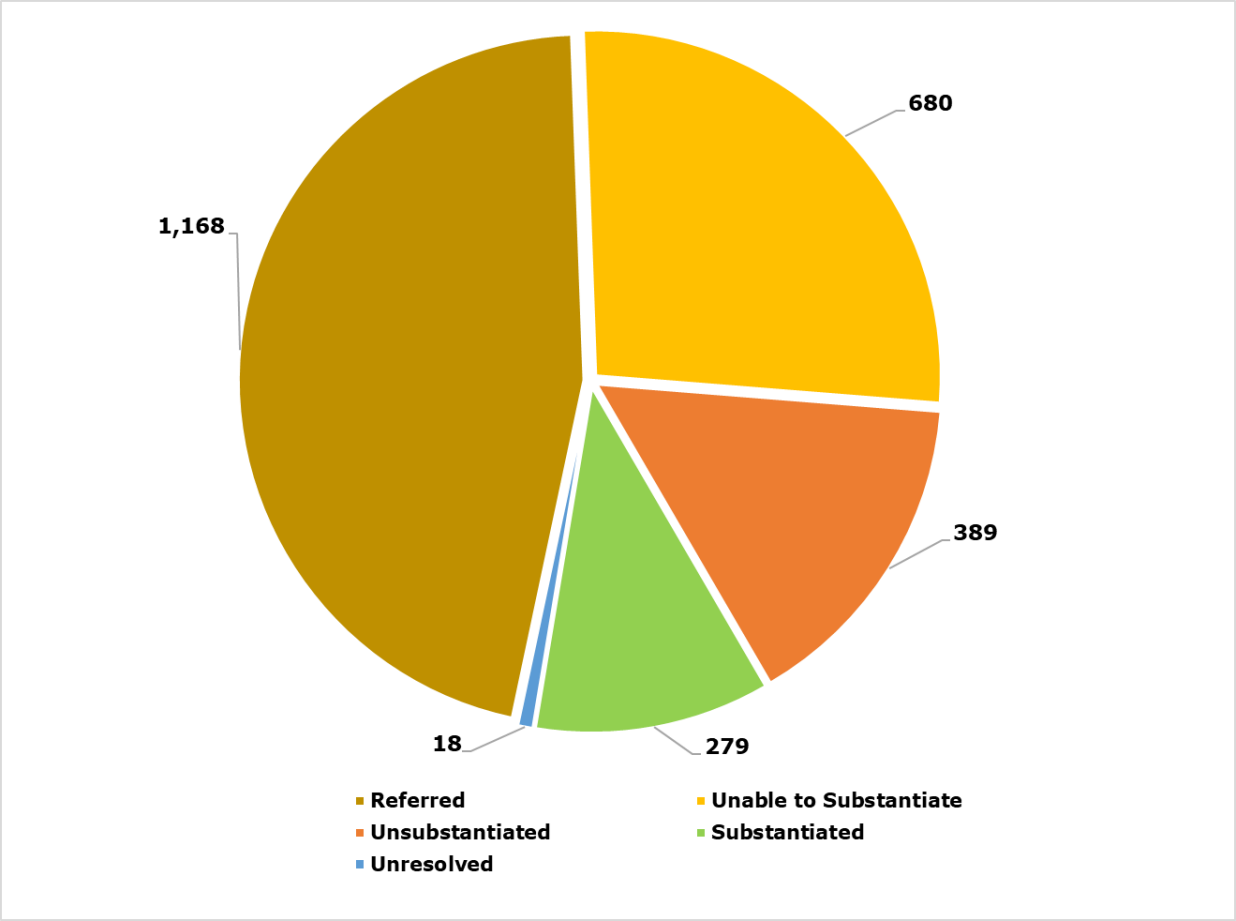


Figure 2 below shows the number of complaints with their determination of resolution as substantiated, unable to substantiate, unsubstantiated, or referred for the quarter.

Figure 2: Fourth Quarter Complaint Determination



The report includes several trends identified in FY22 regarding:

- A decrease in inquiries related to verifying health coverage;
- An increase in complaints related to Medicaid application and recertification;
- A decrease in complaints related to consumers who had difficulty obtaining prescription medication due to other insurance showing in MCO, pharmacy and HHSC data systems; and
- An increase in complaints of difficulty accessing in-network specialists and facilities.

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 a representative from a legislative office on behalf of their constituent. The consumer experiences numerous health care needs that require a significant amount of Personal Assistance Services (PAS). At the time of contact, the member's PAS services were provided as part of the service array of the Community Living Assistance Support Services (CLASS) waiver. The member was contacted by their Local Intellectual and Developmental Disability Authority and was offered and accepted a Home and Community Services (HCS) waiver enrollment slot. HHSC policy does not allow simultaneous enrollment in two different waiver programs. As a result, the member was required to disenroll from the CLASS waiver and enroll in the HCS waiver. Due to required enrollment activities for the HCS waiver, the member faced a potential delay in service delivery which would have created a consequential void in PAS services.

OMCAT contacted the member's health plan to ensure that services could be provided as part of Medicaid's long-term services and supports service array while the member's family engaged in enrollment activities to establish HCS services. Two days prior to the individual being disenrolled from the CLASS waiver and facing

an undetermined delay of vital services, the health plan approved authorization of PAS services scheduled to begin on the first day of the month following the termination of the CLASS waiver and to continue for 2 additional months until the member was enrolled in HCS. The health plan also scheduled to reassess services prior to discontinuation of PAS services provided by Medicaid if HCS enrollment activities were delayed.

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.

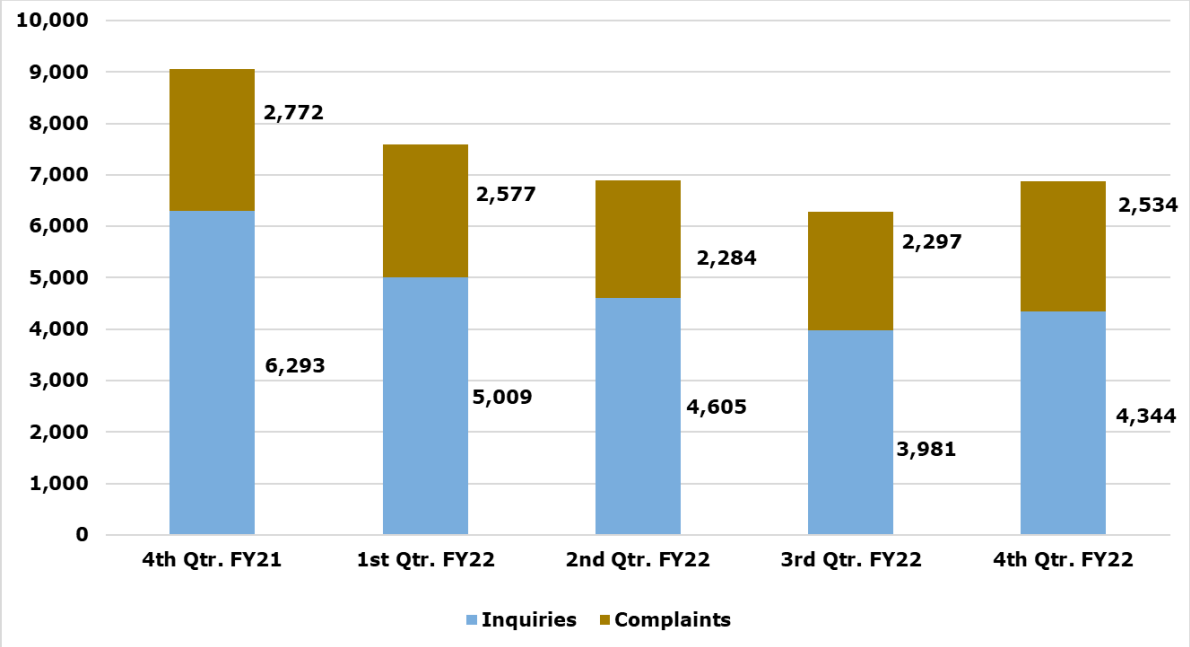
Consumer Contacts

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 FY21 & FY22



In the fourth quarter of FY22, OMCAT received a total of 6,878 contacts. This is a ten percent increase from the third quarter in FY22. The data show that total contacts for the fourth quarter of FY22 decreased by 24 percent compared to the fourth quarter of FY21.

Inquiries

Inquiries are an important indicator of a member's need for information. While complaints offer valuable insight regarding what issues are preventing the successful delivery of Medicaid services, inquiries inform the agency of potential gaps in information that consumers need to better understand the Medicaid managed care system.

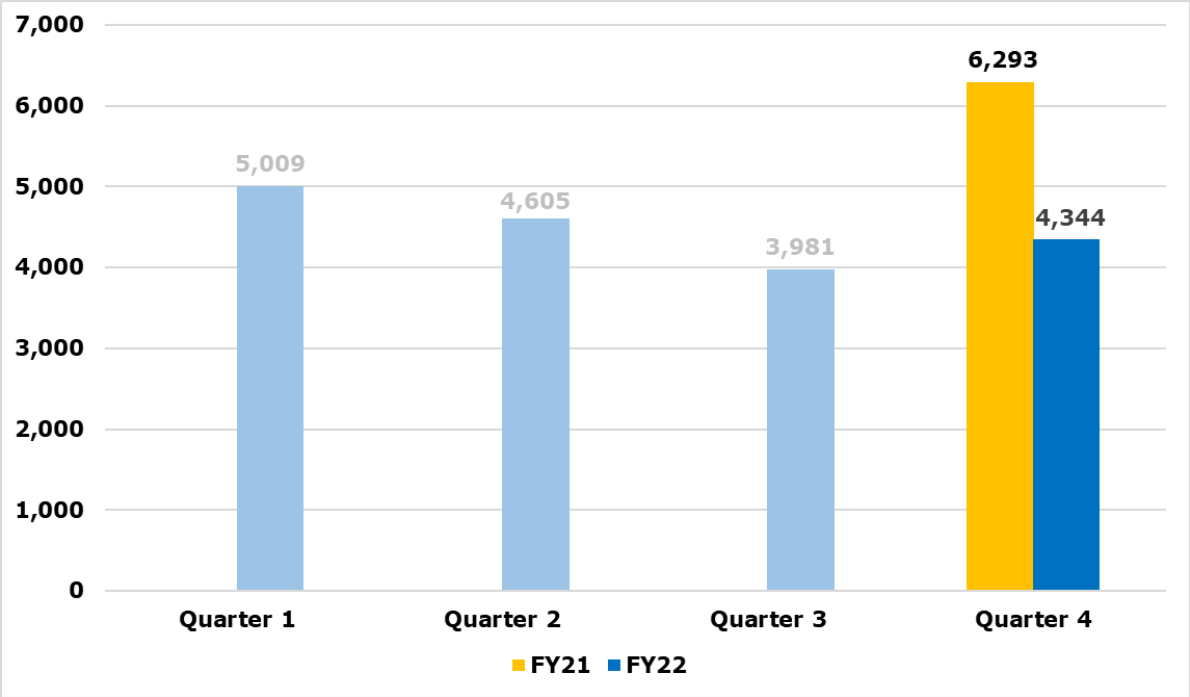
Inquiries Process

Questions or requests for information from consumers are tracked in the same database that complaints are captured. Ombudsmen assist with answering questions, providing information about accessing Medicaid services and educating and empowering consumers on how to advocate for themselves in the Medicaid managed care system.

Inquiries Received

Figure 4 focuses on the comparison of the volume of inquiries received for the fourth quarter of FY22 with the same quarter of the previous year.

Figure 4: Inquiries Received FY21 & FY22

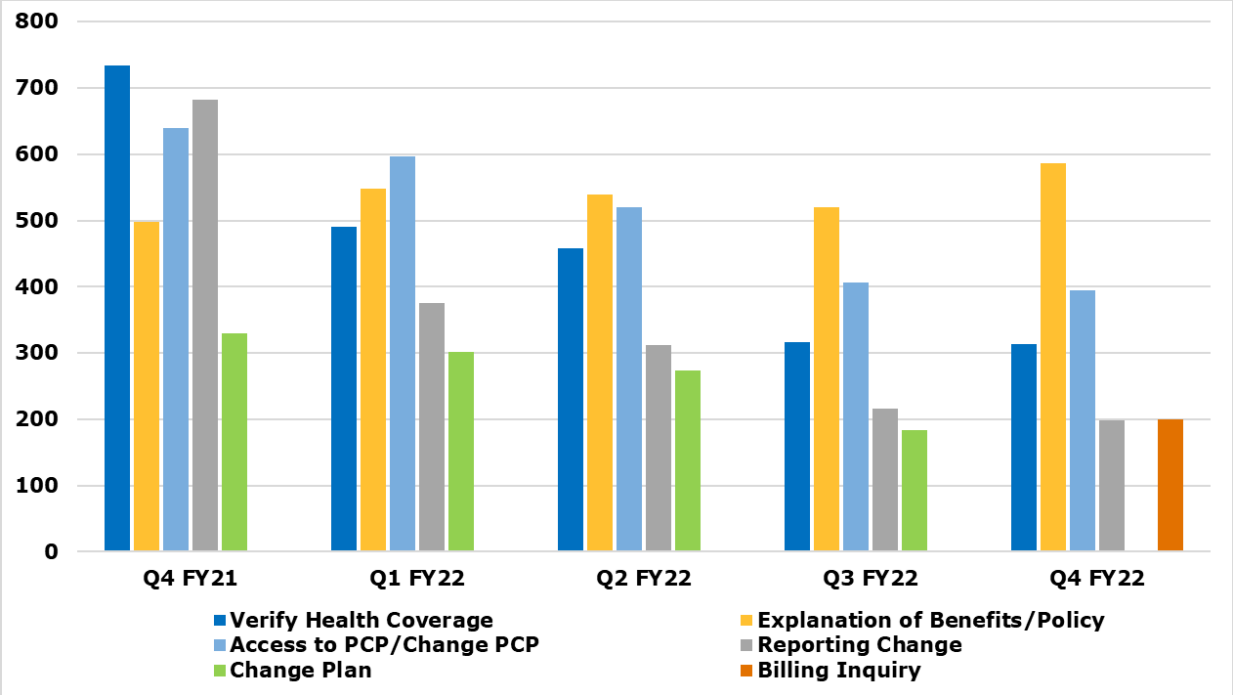


The data indicate that the volume of inquiries received for the fourth quarter of FY22 increased by nine percent (or 363 more) as compared to the third quarter of FY22. However, when compared with the fourth quarter of FY21, the data show that the volume of inquiries received during the fourth quarter of FY22 decreased by 31 percent.

Top Inquiries

Figure 5 presents a comparison of the top reasons for inquiries for the fourth quarter of FY22 and the previous four quarters.

Figure 5: Top Inquiries Received FY21 & FY22



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

Figure 5 shows that questions related to explanation of benefits and policy remain the top inquiry for the second, third and fourth quarter of FY22. Questions related to explanation of benefits increased 13 percent from the third to fourth quarter of FY22. Members enrolled in STAR+PLUS and individuals with no Medicaid had the most inquiries regarding explanations of benefits. A review of case summaries showed consumers had questions regarding how to apply for Medicaid, the status of their Medicaid applications and the status of their Medicaid renewals. Consumers

with Medicare and Medicaid also had questions about the order of payment for their respective health insurances. Medicare serves as the primary insurance for acute care services for individuals who are enrolled in Medicare and Medicaid. Medicaid covers long term services and support, such as home health services and nursing facilities for members who possess both Medicare and Medicaid health insurance.

The data show that accessing a PCP or changing a PCP was the second highest inquiry in the fourth quarter of FY22. A review of the data and case summaries reveals that consumers enrolled in STAR had the most questions related to accessing a PCP or changing a PCP and members and consumers had questions regarding obtaining a list of PCPs in their county of residence, who accepted their Health Plan.

Figure 5 also shows that consumer questions related to verifying health coverage was the third highest inquiry in the fourth quarter of FY22. A further review of data shows that members enrolled in STAR and individuals with no Medicaid had the most inquiries regarding verifying health coverage. A review of case narratives shows that consumers called to verify if their Medicaid coverage was still active. Consumers also called to obtain Medicaid case information such as which health plan the member was enrolled in and their Medicaid ID number.

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 is one where the client has not yet attempted to resolve their issue with the HHS program area.

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

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

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

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

Table 1: Complaint Resolution Determination

	DEFINITION	EXAMPLE	FINDINGS	RESOLUTION
Substantiated	Research clearly indicates that agency policies or expectations were violated.	Consumer 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 indicated 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.

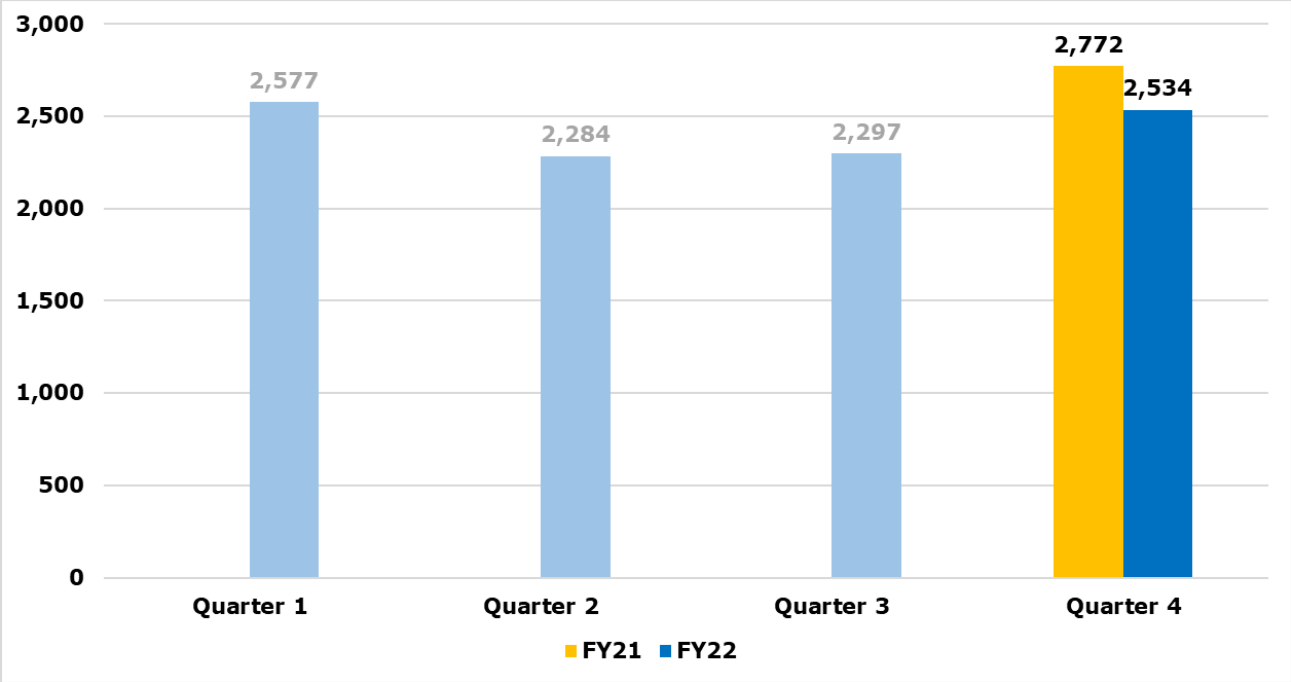
Why We Include More than Substantiated Complaints

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 6 focuses on the comparison of the total complaints received for the fourth quarter with the same quarter of the previous fiscal year. In the fourth quarter of FY22, OMCAT received 2,534 complaints, which is an increase of ten percent (or 237 additional) compared to the third quarter of FY22 and is a decrease of nine percent (or 238 fewer) compared to the fourth quarter of FY21.

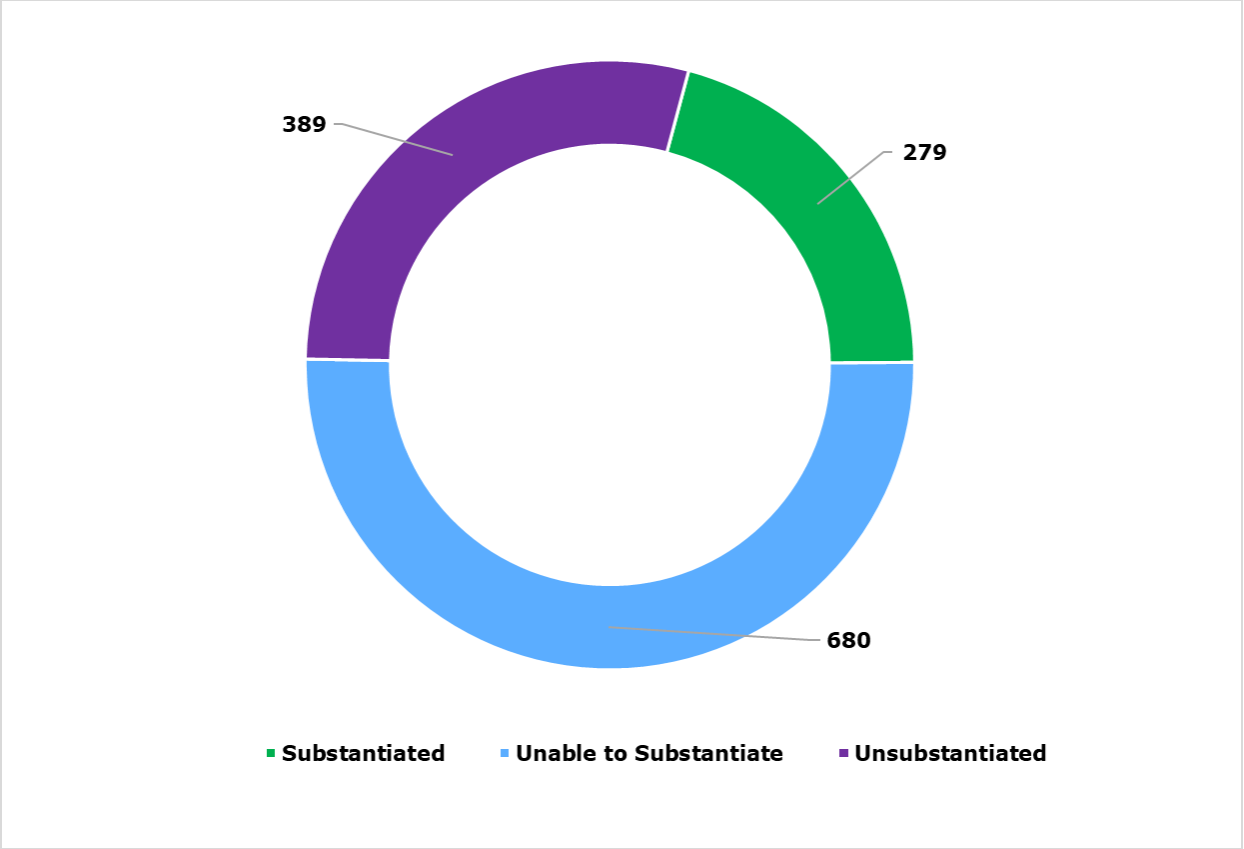
Figure 6: Complaints Received FY21 & FY22



Resolved Complaints by Determination

Figure 7 below shows the total resolved complaints by determination received in the fourth quarter of FY22. OMCAT resolved 2,516 complaints out of 2,534 received. Eighteen complaints were still being investigated at the end of the fourth quarter of FY22. (Note: Referred complaints are not included in figure 7 to focus on fully investigated complaints)

Figure 7: Complaints by Resolution Determination



Substantiated Complaints

In the fourth quarter of FY22, of the 1,348 complaints investigated, OMCAT substantiated 279, or 21 percent of total investigated complaints.

The top substantiated complaint reason for the fourth quarter of FY22 was related to consumers who had difficulty accessing in-network specialists and facilities. Complaints related to access to in-network specialists and facilities increased by 19 from the third to fourth quarter of FY22. A review of case summaries shows that 16 out of 31 substantiated complaints of access to in-network providers in the fourth quarter were consumers who needed assistance locating an OBGYN in their service area. Seventy percent of substantiated complaints related to in-network specialists and facilities were from consumers who live in Harris, Tarrant, and Dallas counties.

The data show that the second highest substantiated complaint reason is difficulty accessing out-of-network providers. Complaints related to accessing out-of-network providers increased by 19 from the third to the fourth quarter of FY22. A review of case summaries shows that most consumers who had problems accessing out-of-

network providers were due to having moved outside of their service area. There were several substantiated complaints of consumers who sought authorization for out of network providers due to not being able to access a certain type of provider within the network.

The data also show that the third highest substantiated complaint reason is members who reported problems accessing DME. Complaints related to accessing DME increased by 9 from the third to the fourth quarter of FY22. Review of case summaries show that consumers had difficulty obtaining incontinence supplies.

Top Complaint Categories

The complaints analyzed in this section are those that were resolved and determined to either be substantiated, referred or unable to substantiate. Resolved complaints determined to be unsubstantiated are not included in the analysis of complaints in this report since the investigation determined that policy was correctly followed in those cases. Although the analysis of complaints determined to be unsubstantiated are not included in this report, OMCAT does review unsubstantiated complaints to determine if there is policy that may need to be reviewed for the way it is applied and has an impact on the delivery of services.

As previously mentioned, contact reasons (or the nature of the complaint) are grouped into larger complaint categories for complaints that share a commonality.

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

Figure 8: Top Complaint Categories Received FY21 & FY22

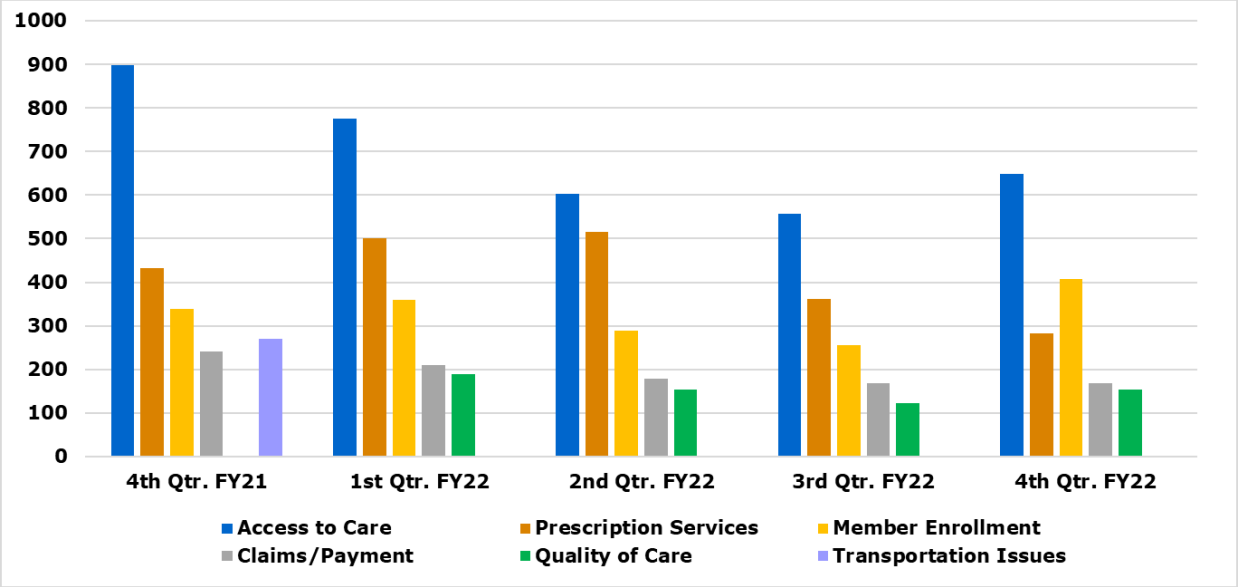


Figure 8 shows that complaints related to access to care remain the top complaint category in the fourth quarter of FY22. The top complaint reasons relating to access to care include consumers who had problems accessing in-network specialists and facilities and consumers who had difficulty accessing out-of-network providers.

A review of case summaries regarding access to in-network specialists and facilities shows that members reported problems locating OBGYNs, neurologists and ENTs in their service area. No trend was found regarding a specific health plan that lacked in-network specialists.

Complaints related to accessing out of network providers were due to consumers that had moved out of their service area and needed to access a provider in an area where their health plan was not available. Consumers who report an address change to a different service area and switch to a health plan in their new service area are required to wait 30-45 days for their new health plan to become effective.

Complaints related to member enrollment is the second highest complaint category in the fourth quarter of FY22. The top complaint reasons related to member enrollment are consumers who reported problems related to Medicaid eligibility and recertification and case information errors in HHSC data systems. Individuals reported excessive length of time to process Medicaid applications and denial of Medicaid applications. Consumers also reported incorrect demographic information in HHSC data systems such as incorrect name, date of birth and address. OMCAT does not investigate member enrollment complaints related to Medicaid applications

and case information errors, these complaints are referred to another team within the office.

Complaints related to prescription services is the third highest complaint category in the fourth quarter of FY22. The top complaint reasons related to prescriptions services were consumer complaints of erroneous additional insurance showing on their Medicaid profile in HHSC, MCO or pharmacy data systems, consumers reporting not showing active with Medicaid in Pharmacy systems and consumers who reported difficulty receiving medication because their prescribed medication requires a clinical prior authorization.

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 fourth quarter of FY22, OMCAT received 726 complaints of which 94 (or 13 percent) were substantiated.

Figure 9 shows a comparison of the top complaint categories for the current quarter and previous four quarters. Please note that the top complaint categories represented in the chart below are a subset of the total complaints received for the STAR program.

[1] The average monthly enrollment for the STAR program in the fourth quarter of FY22 is 4,509,590.

Figure 9: Top STAR Complaint Categories FY21 & FY22

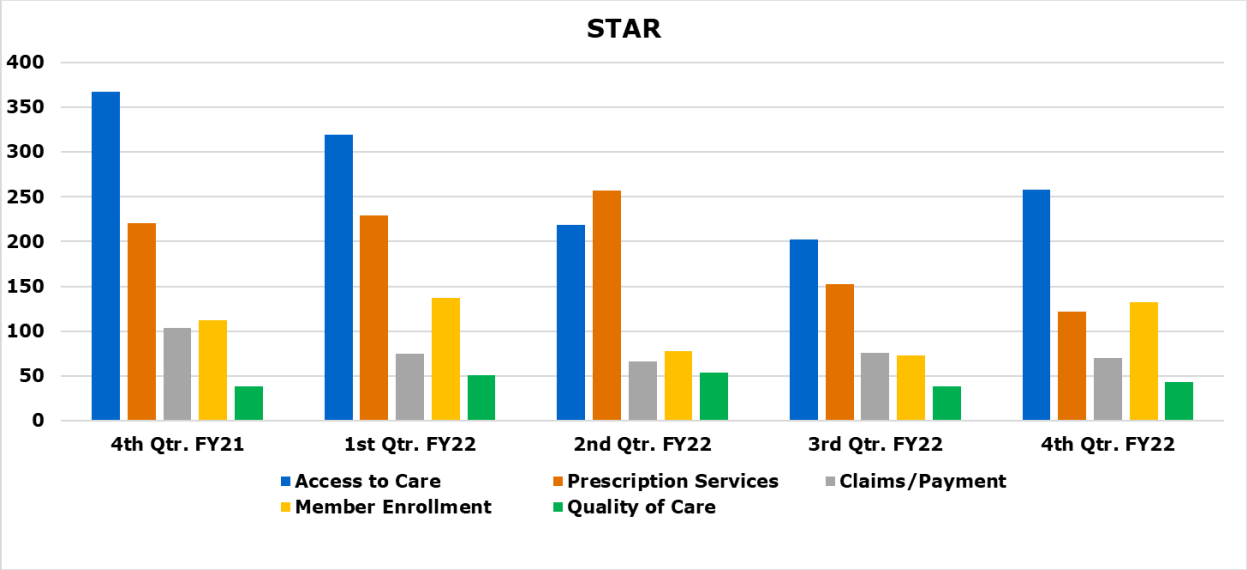


Figure 9 shows that the top three complaint categories for STAR members in the fourth quarter of FY22 were complaints related to: accessing care, problems with member enrollment and difficulty accessing prescription services.

Access to care is the top complaint category in the fourth quarter of FY22. The top complaint reasons include members who reported difficulty accessing in-network specialists and facilities, out-of-network providers, and primary care providers. A review of case summaries shows that members had difficulty locating in-network specialists that were either taking new patients or still accepted the member's health plan. Consumers also reported difficulty accessing in-network neurologists, ENTs, behavioral health specialists and dermatologists. The majority of complaints related to accessing out of network specialists and PCPs were due to consumers that had moved service areas but had not yet enrolled with an MCO serving their new service area.

Complaints of member enrollment return as the second highest complaint category in the fourth quarter of FY22. The top complaint reasons related to member enrollment include complaints related to case information errors in HHSC data systems and complaints regarding Medicaid eligibility and recertification. Review of case summaries show that members reported incorrect names and addresses in HHSC data systems.

Complaints of access to prescription services dropped from the second highest in the third quarter of FY22 to the third highest complaint category in the fourth quarter of FY22. The top complaint reason related to prescription service were

members who reported difficulty receiving medications due to erroneous insurance information in HHSC, MCO or pharmacy data systems. No trend was found regarding reports of erroneous insurance in HHSC, MCO or pharmacy data systems.

STAR+PLUS

The STAR+PLUS program serves adults who have disabilities or are age 65 or older[2]. In the fourth quarter of FY22, OMCAT received 647 complaints of which 109 (or 17 percent) were substantiated. Figure 10 shows a comparison of the top complaint categories for the current quarter and the previous four quarters.

Figure 10: Top STAR+PLUS Complaint Categories FY21 & FY22

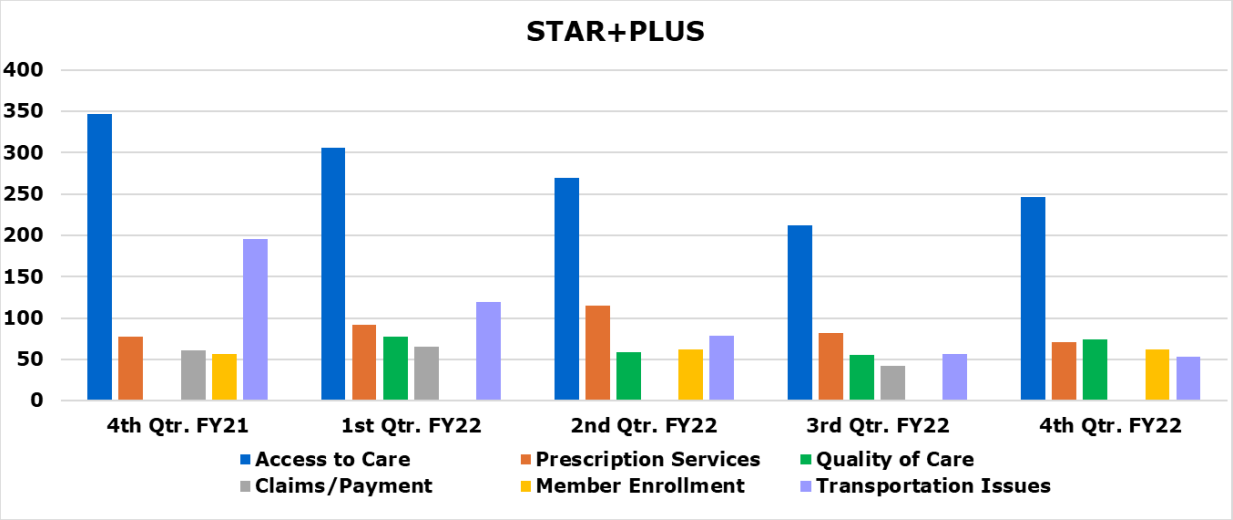


Figure 10 shows that complaints related to consumers who reported experiencing barriers to accessing care is the top complaint category for the last five consecutive quarters.

The top complaint reasons related to accessing care for the fourth quarter of FY22 include members who reported problems receiving home health services, members who had problems accessing durable medical equipment (DME) and members who had difficulty accessing in-network specialists and facilities. Review of case summaries revealed that members reported difficulty receiving their authorized hours of Personal Assistance Services (PAS) and problems receiving assessments to determine the member's need for PAS. Members also reported problems receiving wheelchair repairs, new wheelchairs and incontinence supplies due to coordination

[2] The average monthly enrollment for the STAR+PLUS program in the fourth quarter of FY22 is 558,195.

issues between their PCP and the DME supplier. No trend was found regarding member reports of difficulty accessing in-network specialists and facilities.

Complaints related to quality of care is the second highest complaint category for STAR+PLUS members. The top complaint reasons related to quality of care include complaints related to member's provider treatment being ineffective or inappropriate and complaints related to problems receiving service coordination. Review of case summaries show that members complained about their PCP treatment being ineffective or inappropriate, including their PCP providing poor customer service. Members also reported that their service coordinator was not available and did not return calls within the timeframe stated by their health plan.

Prescription services dropped from the second highest complaint category in the third quarter of FY22 to the third highest complaint category in the fourth quarter of FY22. The top complaint reasons related to difficulty obtaining prescriptions due to erroneous insurance showing in HHSC, MCO or Pharmacy data systems, members who had trouble receiving medication that required clinical prior authorization and members who had problems receiving medication that required prior authorization because the medication was not listed on the preferred drug list. Review of case summaries did not reveal a trend regarding prescription service-related complaints.

STAR Kids

The STAR Kids program serves children and adults 20 and younger who have disabilities[3]. In the fourth quarter of FY22, OMCAT received 103 complaints of which 21 (or 20 percent) were substantiated. Figure 11 shows a comparison of the top complaint categories for the current quarter as well as the previous four quarters.

[3] The average monthly enrollment for the STAR Kids program in the fourth quarter of FY22 is 169,711.

Figure 11: Top STAR Kids Complaint Categories FY21 & FY22

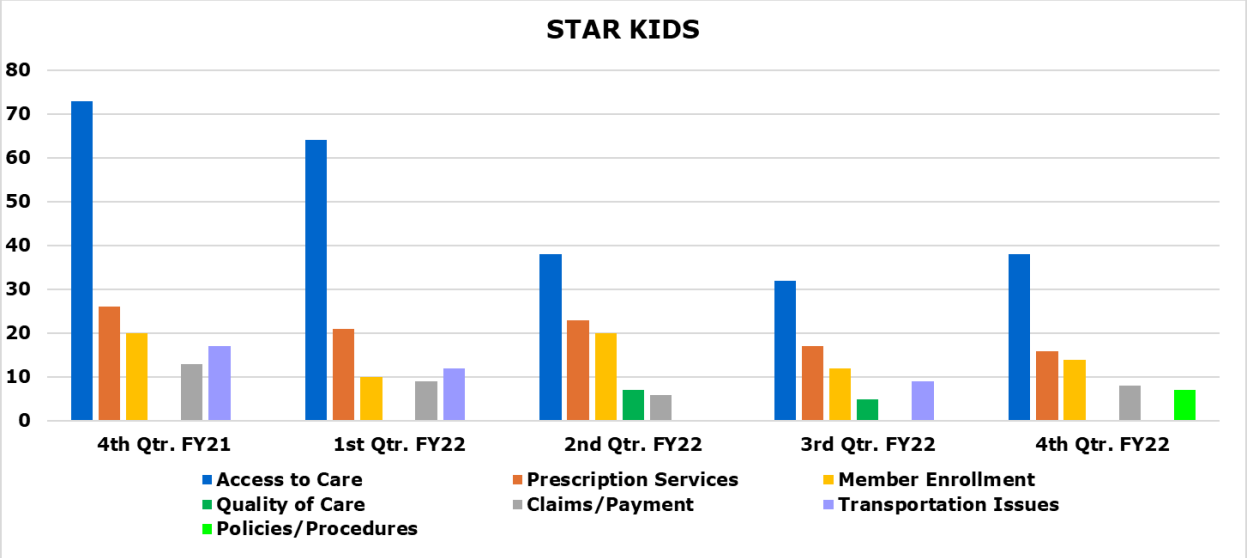


Figure 11 shows that complaints related to access to care continue to be the top complaint category for STAR Kids members in the fourth quarter of FY22. The top complaint reason related to access to care was access to out-of-network providers; however, a review of case narratives did not reveal a trend for this complaint reason.

Access to prescription services is the second highest complaint category in the fourth quarter of FY22. The top complaint reason for complaints related to prescription services was members who reported having difficulty obtaining medication because of erroneous secondary insurance showing in HHSC, MCO or pharmacy data systems. A review of case summaries did not reveal any trends.

Complaints related to member enrollment is the third highest complaint category in the fourth quarter of FY22. The top complaint reasons related to member enrollment were complaints of case information error in HHSC data systems and complaints related to Medicaid eligibility and recertification. A review of case summaries shows that members complained of incorrect termination or expiration of their Individual Plan of Care (IPC) for the Home and Community based Services (HCS) waiver. OMCAT refers complaints related to the HCS waiver to Intellectual Developmental Disability Ombudsman (IDDO), who research the complaint and provide a resolution in accordance with HHSC policy.

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 fourth quarter of FY22, OMCAT received 132 complaints, of which 22 (or 17 percent) were substantiated. Figure 12 shows a comparison of the top complaint categories for the current quarter as well as the previous four quarters.

Figure 12: Top Fee for Service/Traditional Medicaid Complaint Categories FY21 & FY22

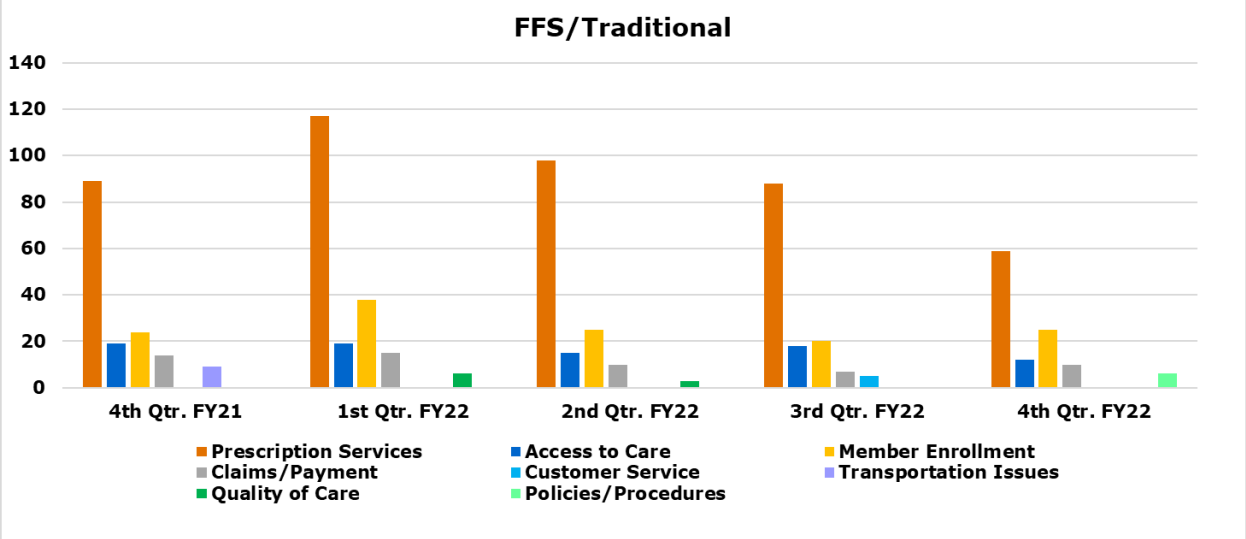


Figure 12 shows complaints related to accessing prescription services continue to be the top complaint category in the fourth quarter of FY22. The top complaint reasons for prescription services include complaints related to consumers showing as inactive in HHSC data systems, consumers who reported the pharmacy billing the incorrect insurance plan and individuals who had problems accessing prescriptions because they had other insurance showing in HHSC or Pharmacy data systems. A review of case narratives did not reveal any trends.

Member enrollment is the second highest complaint category for the fourth quarter of FY22. The top contact reason related to member enrollment was complaints

[4] The average monthly enrollment for the Fee for Service/Traditional Medicaid program in the fourth quarter of FY22 is 161,602.

related to Medicaid eligibility and recertification. A review of case summaries did not reveal any trends.

Complaints of access to care is the third highest complaint category for the fourth quarter of FY22. The top contact reason for complaints related to access to care was difficulty receiving home health services. No trend was found regarding access to home health services.

Conclusion

The fourth quarter of FY22 marked the second highest total complaint volume of FY22, slightly behind the first quarter of FY22. Thorough data analysis of the fourth quarter of FY22 showed a 42 percent increase (125 more) in the complaint category of member enrollment from the previous quarter. This was primarily due to an increase in complaints related to Medicaid eligibility.

The inquiry contact reason verifying health coverage decreased 56 percent (177 fewer) from the first to fourth quarter of FY22. In the fourth quarter of FY22 verifying health coverage had the lowest volume of inquiries for the last three fiscal years. This could be related to the ongoing extension of Medicaid coverage since the public health emergency was declared in March of 2020.

Complaints related to Medicaid application and recertification increased 73 percent (102 more) from the second to the fourth quarter of FY22. A review of case summaries shows that consumers reported excessive wait times for processing Medicaid applications and denials of Medicaid applications.

In the first quarter of FY22, TMHP transitioned to a new pharmacy data match subcontractor in the first quarter of FY22, as well as collaborated with HHSC and the health plans to identify process improvements for situations when pharmacies incorrectly identify consumers' other insurance. This resulted in a decrease by 60 percent (192 fewer) complaints of other insurance on consumers' Medicaid profiles from the second through the fourth quarter of FY22.

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 Q4 FY22

	STAR+PLUS	STAR	STAR Kids	STAR+PLUS Dual-Demo	STAR Health	Dental	FFS	No Medicaid
Access to Care	246	258	38	13	3	19	12	58
Member Enrollment	62	132	14	5	6	4	25	158
Prescription Services	71	122	16	2	1	0	59	7
Non-Medicaid /CHIP	34	36	1	0	0	0	9	92
Claims/ Payment	45	70	8	3	4	12	10	15
Quality of Care	74	43	6	3	2	8	2	15
Customer Service	22	32	4	3	1	5	4	35
Transportation Issues	53	12	6	0	0	0	3	3
Policies/ Procedures	29	7	7	0	0	4	6	17
Therapy	5	8	3	2	1	0	2	1
Value-Added Services	4	3	0	0	0	1	0	0
Fraud	1	1	0	1	0	0	0	3
Member Health and Safety	1	2	0	0	0	0	0	2

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

Table 3: Average Monthly Enrollment by Managed Care Program Q4 FY22

Managed Care Program	Average Monthly Enrollment
STAR	4,509,590
Dental	4,018,632
STAR+PLUS	558,195
STAR Kids	169,711
FFS	161,602
STAR HEALTH	46,061
STAR+PLUS Dual-Demo	34,611

Appendix B: Average Enrollment by Service Area

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

Table 4: Average Enrollment by Service Area

Service Area	Average Enrollment
Bexar	466,912
Dallas	693,779
El Paso	198,926
Harris	1,271,873
Hidalgo	565,018
Jefferson	154,599
Lubbock	132,815
MRSA Central	255,487
MRSA Northeast	320,272
MRSA West	288,115
Nueces	155,195
Tarrant	501,114
Travis	268,002

Appendix C: Complaints by Service Area

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

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

Table 5 includes the top complaints that were resolved and determined to either be substantiated or unable to substantiate by service area. The complaints represented in Table 5 are a subset of the total complaints received for the service areas.

Table 5. Complaints by Service Area Q4 FY22

	Bexar	Dallas	El Paso	Harris	Hidalgo	Jefferson	Lubbock	MRSA Central	MRSA Northeast	MRSA West	Nueces	Tarrant	Travis
Access to Care	48	81	9	136	28	20	10	30	35	19	17	74	48
Member Enrollment	20	32	6	52	5	4	3	16	10	14	6	30	15
Prescription Services	17	18	2	66	11	5	9	15	17	16	8	15	13
Claims /Payment	17	17	3	30	8	1	3	8	9	3	2	19	6
Quality of Care	16	20	7	24	21	2	2	5	8	6	1	10	4
Transportation Issues	8	8	2	16	3	6	1	7	10	3	0	6	1
Non-Medicaid /CHIP	6	7	1	20	5	2	4	5	5	5	3	4	4
Customer Service	7	7	6	20	2	1	1	0	3	2	4	5	3
Policies /Procedures	3	3	0	12	6	2	1	4	2	2	1	5	2
Therapy	0	0	3	7	2	0	0	0	0	1	0	1	4
Member Health and Safety	1	1	1	0	0	0	0	0	0	0	0	0	0
Fraud	0	1	0	0	0	0	0	0	0	0	0	1	1
Value-Added Services	2	0	0	2	0	0	0	0	0	0	0	2	1

Glossary

Category – A description of the types of complaints that are related to one another because of a similar issue.

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

Contact reason – A specific description of the nature of the inquiry or complaint received.

Complaint – A contact regarding an expression of dissatisfaction.

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

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

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

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

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

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

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

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

List of Acronyms

CHIP – Children's Health Insurance Program

MCO – Managed Care Organization

MDCP – Medically Dependent Children's Program

MRSA – Medicaid Rural Service Area

PCP – Primary Care Provider

PHE – Public Health Emergency

PDL – Preferred Drug List

SA – Service Area