

HHS Ombudsman Managed Care Assistance Team 3rd Quarter FY 2023

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

**Office of the Ombudsman
2023**



TEXAS
Health and Human
Services

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Executive Summary

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

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

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

During the third quarter of fiscal year 2023 (FY23), OMCAT received 7,573 contacts; of which, 2,382 were complaints and 5,191 were inquiries.

Complaints made up 31 percent of total contacts. Of the 2,382 complaints received, 2,340 complaints were resolved during the quarter with the remaining 42 pending resolution. Of those resolved complaints:

- 7 percent (or 174) were substantiated;
- 23 percent (or 540) were unable to substantiate;
- 57 percent (or 1,325) were referred and;
- 13 percent (or 301) were unsubstantiated.

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

Figure 1: Third Quarter Total Contacts Received

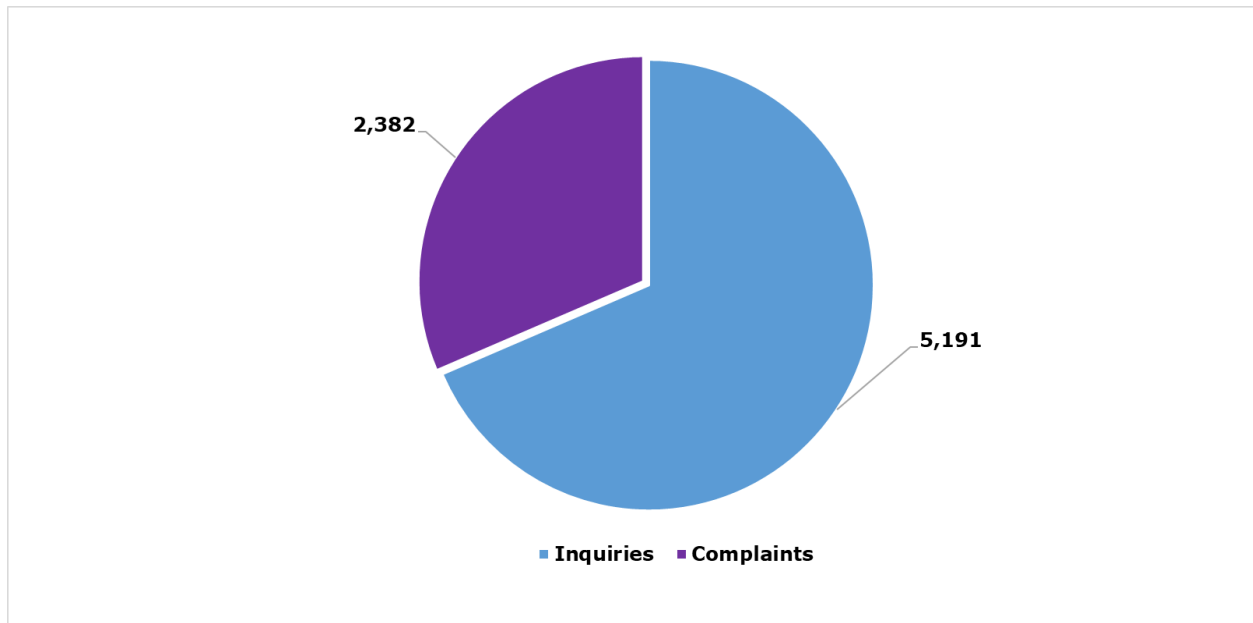
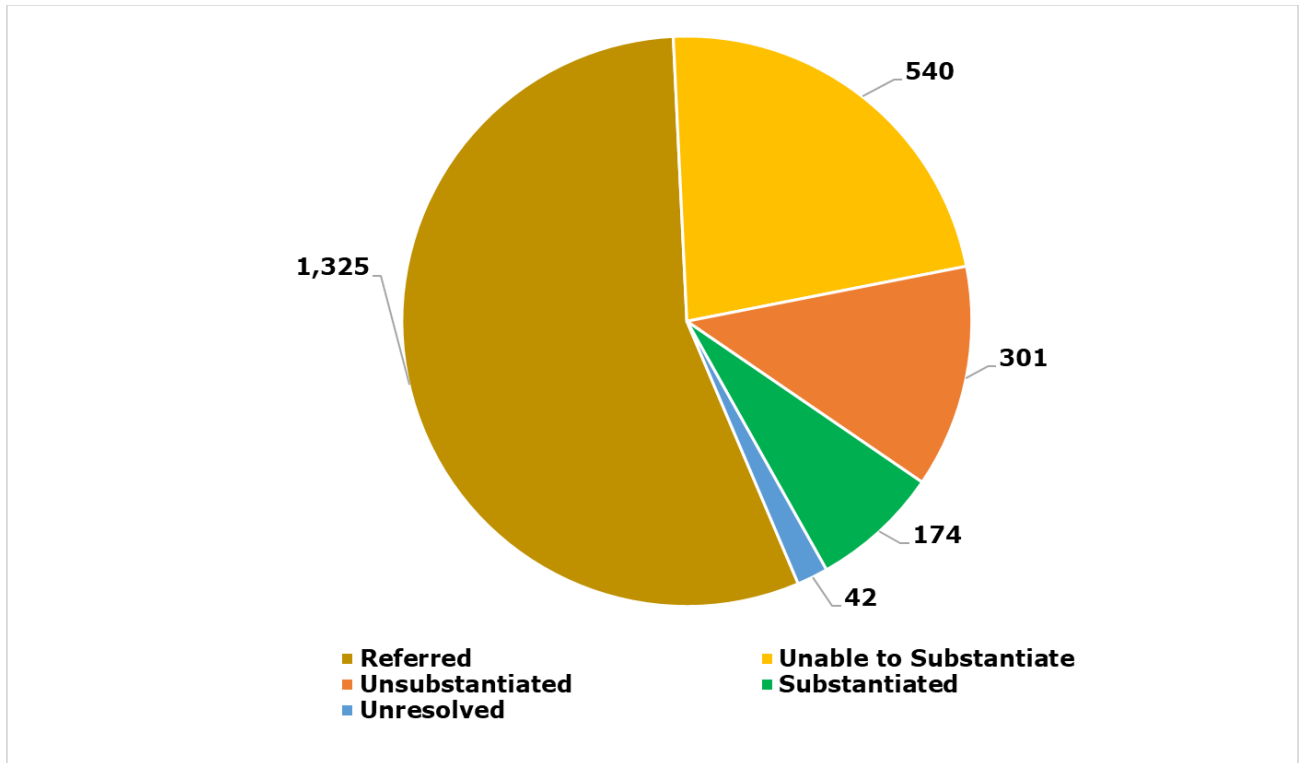


Figure 2 below shows the number of complaints with their determination of resolution as substantiated, unable to substantiate, unsubstantiated, or referred for the quarter.

Figure 2: Third Quarter Complaint Determination



Introduction

Government Code Chapter 531, Section 531.0213(d)(5), directs OMCAT to publish quarterly reports that provide quantitative contact data, highlight trends, and identify issues affecting Texans who receive or inquire about Medicaid benefits and services through HHS programs, MCOs (Managed Care Organizations) and their vendors.

The data contained in the report are exclusive to contacts received by OMCAT, and do not include contacts received by other areas within HHS. Therefore, the report does not include all Medicaid managed care complaints received by the agency, vendors, or Managed Care Organizations (MCOs).

The report includes consumer contacts on fee-for-service Medicaid, Medicaid managed care, and those who do not have full Medicaid benefits or are in the process of applying for Medicaid.

OMCAT In Action

The following is a case received during the quarter that spotlights the impact that OMCAT can have on the Medicaid managed care system.

OMCAT received a contact regarding a consumer in need of an organ transplant. The consumer previously resided in a nursing facility and had recently been discharged to her home. Due to the nursing facility being in a different service area than the consumer's home, the MCO was automatically switched to a different MCO located in her new service area. If a consumer does not select a new health plan when they move service areas HHSC systems automatically assign the MCO.

The consumer discovered the change when she was in the process of treatment with a hepatologist. The consumer's health care team informed her that the hepatologist did not accept her current MCO. The consumer requested assistance locating an in-network organ transplant team and stated that she was unable to travel more than four hours from her home because she was dependent on continuous oxygen supply which would not last more than four consecutive hours.

OMCAT contacted the MCO and asked for assistance locating an in-network organ transplant specialist. OMCAT requested the MCO provide daily updates on the progress of obtaining the specialist needed. Once an agreement was obtained with

an out-of-network organ transplant specialist, the MCO assisted with the transfer of the consumers medical records and scheduling of the transplant.

OMCAT identified a potential contract violation of maintaining a sufficient provider network for one of the largest MCOs. This issue would impact any member of the MCO seeking an organ transplant specialist within this major metropolitan area. OMCAT provided a recommendation to the MCO contract oversight area within HHS to enforce the contract related to provider network adequacy. OMCAT will follow with contract oversight on its recommendation.

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 on the [OMCAT website](#).

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

There are three important data distinctions:

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

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

Finally, an important note related to unresolved cases:

- When data are extracted for report production, some investigations are not yet completed. The complaints presented in this report only analyze those investigations where the outcome has been resolved.

Methodology

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

- Total number of inquiries and complaints received;
- Types of inquiries and complaints received;
- Number and types of complaints by service area and managed care program; and,
- Number of complaints resolved that were substantiated, unable to be substantiated, and unsubstantiated.

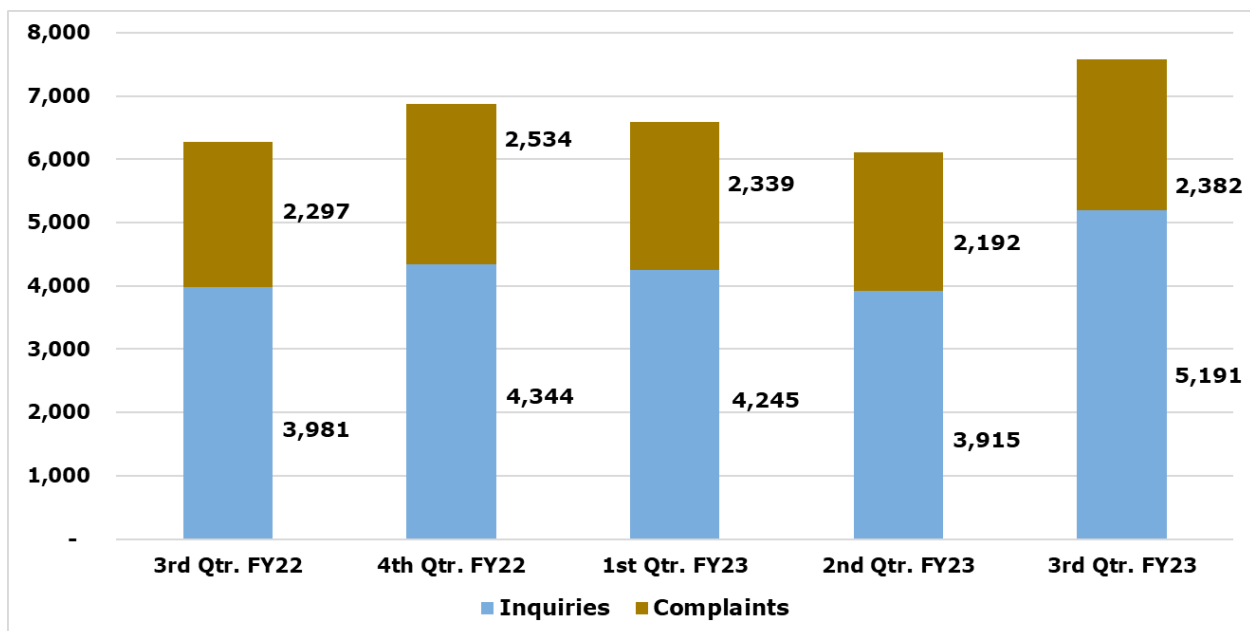
Consumer Contacts

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

All Contacts Received

Figure 3 shows the volume of all contacts received, including inquiries and complaints, over the previous four quarters.

Figure 3: Contacts Received FY22 & FY23



In the third quarter of FY23, OMCAT received a total of 7,573 contacts. This is a 24 percent increase from the second quarter in FY23. The data show that total contacts for the third quarter of FY23 increased by 21 percent compared to the third quarter of FY22.

Inquiries

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

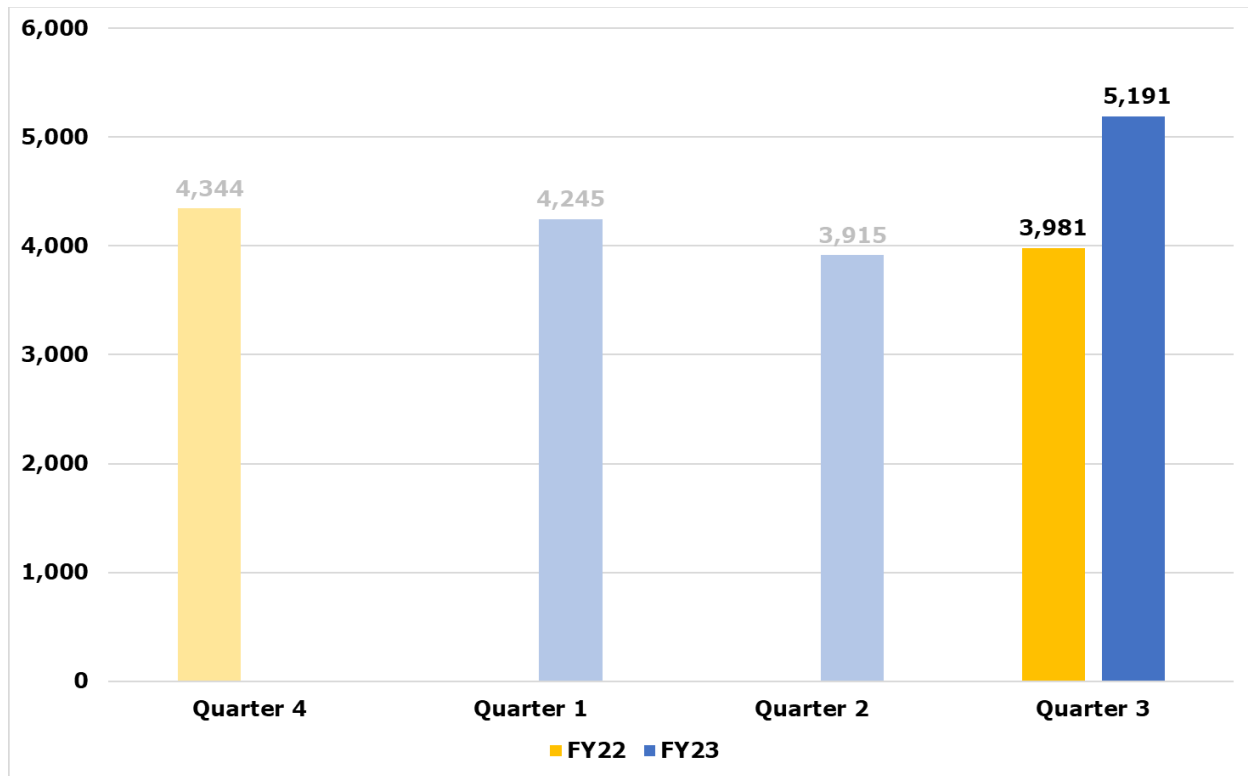
Inquiries Process

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

Inquiries Received

Figure 4 focuses on the comparison of the volume of inquiries received for the third quarter of FY23 with the same quarter of the previous year.

Figure 4: Inquiries Received FY22 & FY23



The data indicate that the volume of inquiries received for the third quarter of FY23 increased by 33 percent (or 1,276 additional) as compared to the second quarter of FY23. Additionally, when compared with the third quarter of FY22, the data show that the volume of inquiries received during the third quarter of FY23 increased by 30 percent.

The significant increase in inquiries from the second to third quarter of FY23 was the largest contributing factor to the increase in contact volume. The largest increase in inquiry types were:

- A 78 percent increase in consumer inquiries regarding Medicaid certification and eligibility (+94);
- A 44 percent increase in consumer inquiries related to accessing or changing a primary care physician (+137); and
- A 41 percent increase in consumers seeking to verify their health coverage (+156).

Consumers who inquired about Medicaid eligibility and recertification, asked for updates on their Medicaid application status, how to apply for Medicaid and if they were required to submit a Medicaid renewal.

Consumers who had questions relating to a primary care physician sought information on how to change their primary care physician.

Consumers who sought to verify their healthcare coverage largely consisted of consumers enrolled in the STAR program and people with no Medicaid. Active Medicaid consumers wanted to ensure their Medicaid was currently active and consumers with active Medicare and inactive Medicaid inquired if they were enrolled in Medicaid.

Resolved Complaints

Resolved complaints are categorized in HEART as: substantiated, unsubstantiated, unable to substantiate, and referred. A referred complaint is one that is either outside the scope of OMCAT's work or where the client has not yet attempted to resolve their issue with the HHS program area.

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

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

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

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

Table 1: Complaint Resolution Determination

RESOLUTION TYPE	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.

RESOLUTION TYPE	DEFINITION	EXAMPLE	FINDINGS	RESOLUTION
Unable to Substantiate	Research cannot indicate whether agency policies or expectations were or were not violated.	Consumer cannot access medical services.	Consumer does not respond to Ombudsman contacts to request information.	OMCAT closes complaint because information was needed from the consumer to process the complaint.
Unsubstantiated	Research indicates that agency policies or expectations were not violated.	Consumer's prescription was rejected at the pharmacy.	Investigation confirms that refill is not yet due.	OMCAT advised consumer of when the prescription will be ready for refill.
Referred	Research indicates the complaint must be addressed by another area.	Consumer cannot find a doctor in their area.	Consumer has not yet contacted their health plan for assistance in finding a provider.	Consumer is referred to their health plan for assistance in finding an in-network doctor.

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

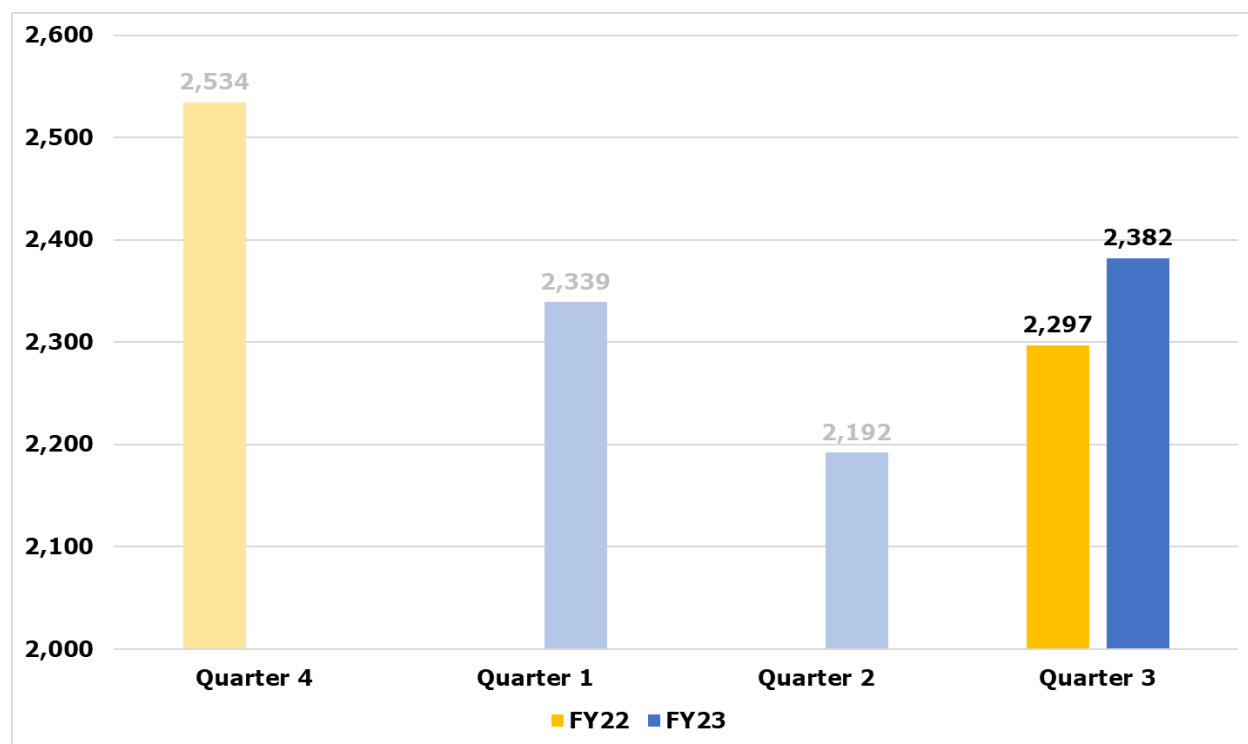
Why We Include More than Substantiated Complaints

The OMCAT report includes complaints determined to be "substantiated," "unable to substantiate," and "referred" in its analysis to better understand the totality of consumer experiences. Having a holistic view of complaints allows the Office of the Ombudsman to better identify trends and provide recommendations to address potential barriers to accessing care.

Complaints Received

Figure 5 focuses on the comparison of the total complaints received for the third quarter with the same quarter of the previous fiscal year. In the third quarter of FY23, OMCAT received 2,382 complaints, which is an increase of nine percent (or 190 additional) compared to the second quarter of FY23 and an increase of four percent (or 85 additional) compared to the third quarter of FY22.

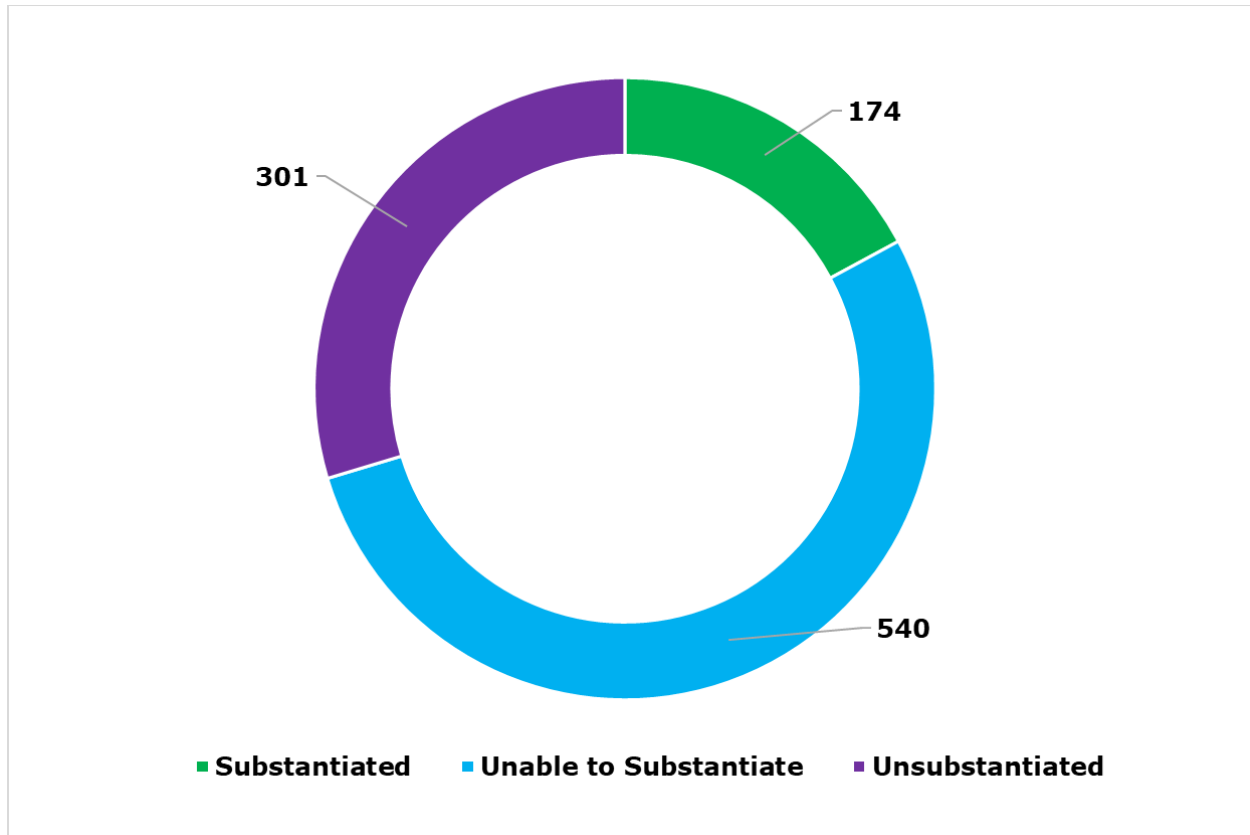
Figure 5: Complaints Received FY22 & FY23



Resolved Complaints by Determination

Figure 6 below shows total resolved complaints by determination received in the third quarter of FY23. Figure 6 does not include referred complaints as these must be investigated by a different area. OMCAT investigated and resolved 1,015 complaints out of 2,382 received. 42 complaints were still being investigated at the end of the third quarter of FY23.

Figure 6: Complaints by Resolution Determination



Substantiated Complaints

Of the 1,015 complaints investigated in the third quarter of FY23, OMCAT substantiated 174, or 17 percent of total investigated complaints.

The top substantiated complaint reason for the third quarter of FY23 was consumers who reported case information errors on their Medicaid profile in HHSC and MCO data systems (22). Most case information errors included incorrect date of birth, address, or name on the Medicaid profile. A review of case summaries also show that HHSC sent incorrect eligibility files to MCOs for enrolled members, the error caused members to be terminated in MCO data systems and simultaneously show active in HHSC data systems (7). Case summaries related to this error show that MCOs did not update their eligibility files sent from HHSC which caused members' demographic information to be incorrect in MCO data systems (3). HHSC determined that the root cause of the issue was Texas Medicaid Health Partnership (TMHP) data systems did not perform automatic updates.

The second highest substantiated complaint reason was related to consumers who had difficulty accessing in-network specialists and facilities (15). A review of case summaries shows that consumers encountered difficulties accessing various types of specialists and four consumers specifically reported difficulty accessing in-network OBGYNs.

The third highest substantiated complaint reason was consumers who reported difficulty accessing home health services (12). A review of case summaries shows that consumers reported difficulty receiving assessments for personal attendant services (4), PAS services not started or interrupted after being assessed (3), not obtaining nursing services due to lack of nursing staff (2), and consumers who reported home health attendants were not being paid by their home health agency (2).

Complaints by Managed Care Program

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

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

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

STAR

The STAR program serves children, pregnant women, and some parents of children on Medicaid¹. In the third quarter of FY23, OMCAT received 666 complaints of which 60 (or nine percent) were substantiated.

Figure 7 shows a comparison of the top complaint categories for the current and previous four quarters.

¹ The average monthly enrollment for the STAR program in the third quarter of FY23 is 4,917,973.

Figure 7: Top STAR Complaint Categories FY22 & FY23

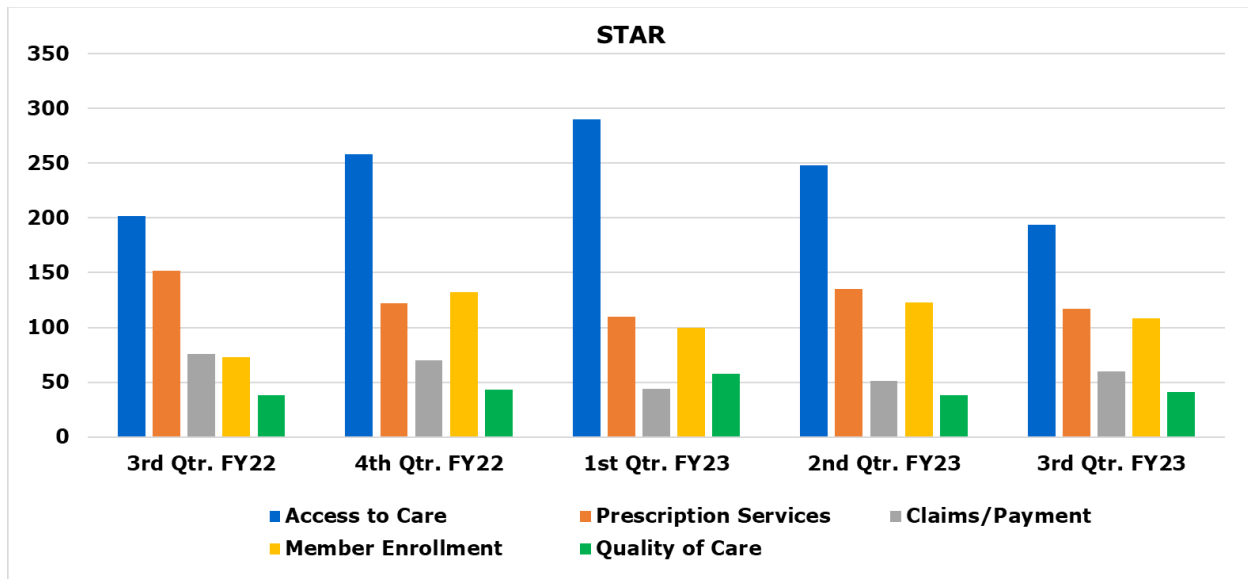


Figure 7 shows that the top three complaint categories for STAR consumers in the third quarter of FY23 and in three of the previous four quarters were complaints related to: accessing care, difficulty accessing prescription services and problems with member enrollment.

Access to care is the top complaint category in the third quarter of FY23. The top three complaint reasons in FY23 were consumers who reported difficulty receiving services due to insurance other than Medicaid being active on their Medicaid profile, consumers complaints regarding difficulty accessing out-of-network providers and access to a primary care provider (PCP).

Complaints for consumers who reported difficulty receiving services due to insurance other than Medicaid being active on their Medicaid profile increased 48 percent (14) from the second to the third quarter of FY23. A detailed review of data did not reveal a trend in a specific service area, health plan or related entity. A review of case summaries showed that consumers reported that private insurance was incorrectly listed as their primary insurance on their Medicaid profile. OMCAT refers consumers who have incorrect private insurance on their Medicaid profile to the Texas Medicaid Health Partnership, Third Party Liability hotline as they are the only entity that can remove third party insurance from a consumers Medicaid profile. Regarding accessing out-of-network providers, case summaries showed that consumers who moved service areas had difficulty accessing OBGYN services during the period in which they were waiting for their health plan to update to the new service area. Consumers that report a change of address which results in a health

plan change are required to wait 30-45 days for the health plan change to become effective. Regarding accessing a PCP, case summaries revealed that consumers reported the list of in-network PCPs provided by their health plan was out of date and members' preferred PCPs did not accept their health plan.

Complaints of prescription services is the second highest complaint category in the third quarter of FY23. The top complaint reasons included: consumers who reported difficulty receiving prescription medication due to erroneous insurance showing on HHSC, MCO or pharmacy data systems; consumers whose Medicaid profile was not active in HHSC, MCO or pharmacy data systems; and consumers whose medication was not listed on the Medicaid formulary. No trend was found among the top complaint reasons.

Complaints of member enrollment is the third highest complaint category in the third quarter of FY23. The top complaint reasons related to member enrollment are consumer reports of case information errors on their Medicaid profile and complaints related to Medicaid eligibility. Consumers reported that their information such as address, name or date of birth was not updated on their Medicaid profile after being reported to HHSC. OMCAT does not investigate case information errors; case information complaints are transferred to the Specialized Ombudsman Services unit for review and determination.

STAR+PLUS

The STAR+PLUS program serves adults who have disabilities or are age 65 or older². In the third quarter of FY23, OMCAT received 571 complaints of which 71 (or 12 percent) were substantiated. Figure 8 shows a comparison of the top complaint categories for the current quarter and the previous four quarters.

² The average monthly enrollment for the STAR+PLUS program in the third quarter of FY23 is 578,920.

Figure 8: Top STAR+PLUS Complaint Categories FY22 & FY23

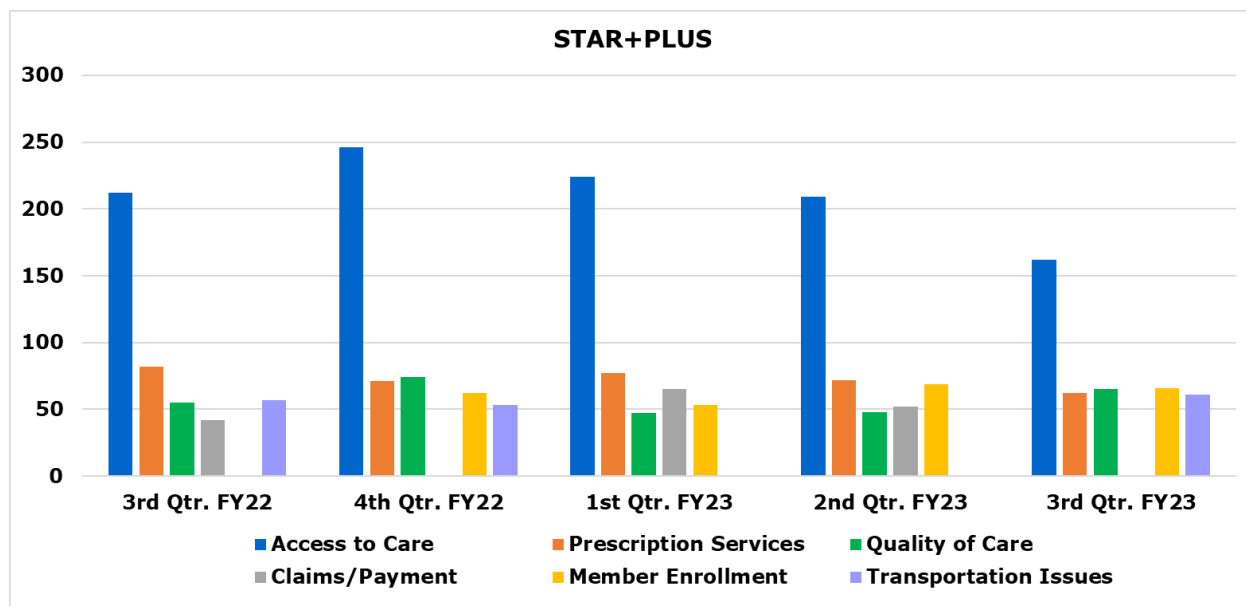


Figure 8 shows that complaints related to consumers who reported experiencing barriers to accessing care is the top complaint category for five consecutive quarters.

The top complaint reasons related to accessing care for the third quarter of FY23 include consumers who reported problems receiving home health services, consumers who had issues receiving durable medical equipment (DME) and consumers who reported disagreement with denial of Medicaid services. A review of case summaries shows that consumers reported difficulty receiving their initial or annual assessment for determination of personal attendant hours and consumers who had issues receiving a re-assessment of personal attendant hours because their health condition changed since their last assessment. Consumers reported complaints that home health agencies were not paying attendants which caused delay in the consumer receiving services. Consumer complaints regarding problems accessing DME included difficulty receiving hearing aids and wheelchairs. Consumers also reported disagreement with being denied the STAR+PLUS Waiver.

Member enrollment is the second highest complaint category in the third quarter of FY23. In the third quarter of FY23 member enrollment complaints were among the top three complaint categories for the second consecutive quarter. In comparison to the previous five quarters, member enrollment has only been in the top 3 complaint categories in the second and third quarters of FY23.

The top complaint reasons related to member enrollment were consumers who reported case information errors on their Medicaid profile and consumers who reported difficulty with Medicaid eligibility and recertification.

A review of case summaries shows complaints of address being incorrect in HHSC data systems. A subset of consumers with this complaint had not yet notified HHSC of a change of address.

Consumers reported difficulty navigating the Medicaid renewal and application process for which consumers needed to provide additional information to HHSC to complete the application or renewal for Medicaid. Complaints were also related to the receipt of Medicaid termination notices. Effective April 2023, HHSC began the unwinding of continuous Medicaid which was initiated by the Federal Public Health Emergency (PHE). As a result, Medicaid consumers determined to be ineligible for Medicaid after the PHE ended, began receiving denial notices in May 2023 for terminations effective June 2023.

Quality of Care is the third highest complaint category for the third quarter of FY23. The third quarter of FY23 marks the first time in FY23 that quality of care related complaints are among the top three complaint categories for STAR+PLUS consumers. The top complaint reasons related to quality of care were inappropriate or ineffective health care treatment and difficulty receiving service coordination from the health plan. A review of case summaries showed consumers reported unprofessional patient treatment at hospitals and unprofessional treatment by attendants providing personal assistance services in the consumer's home. Consumers who required personal assistant services reported difficulty contacting health plan service coordinators to receive assessments to determine the amount of personal assistant services hours and to file complaints against home health agencies not paying attendants.

STAR Kids

The STAR Kids program serves children and adults 20 years of age and younger who have disabilities³. In the third quarter of FY23, OMCAT received 96 complaints of which 16 (or 17 percent) were substantiated. Figure 9 shows a comparison of the top complaint categories for the current quarter as well as the previous four quarters.

³ The average monthly enrollment for the STAR Kids program in the third quarter of FY23 is 170,075.

Figure 9: Top STAR Kids Complaint Categories FY22 & FY23

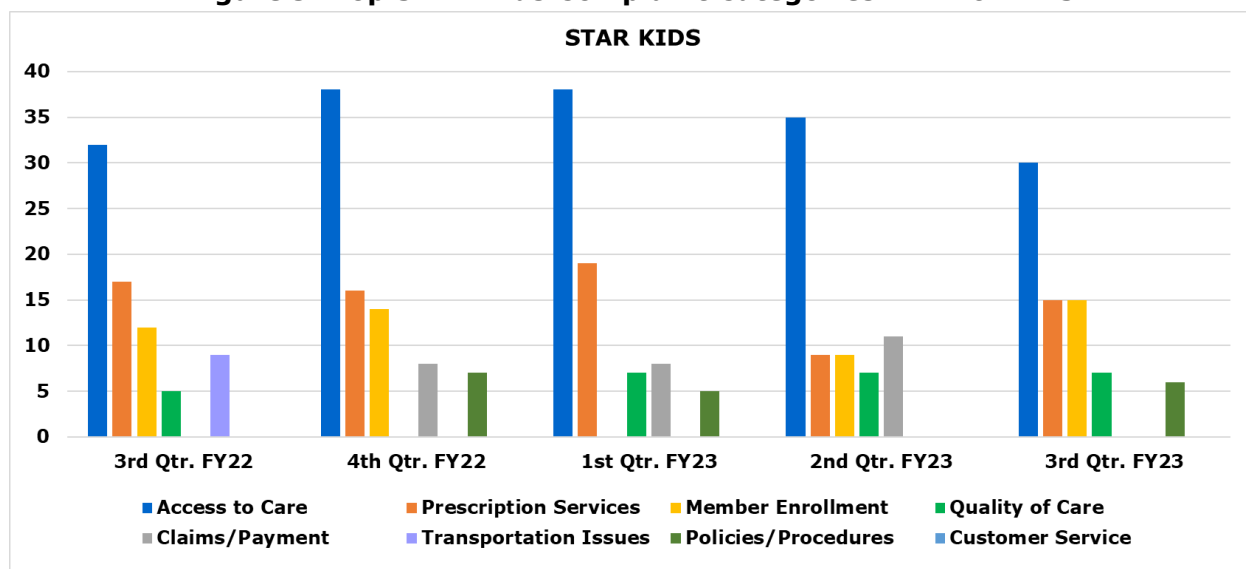


Figure 9 shows that complaints related to access to care continue to be the top complaint category for STAR Kids consumers in the third quarter of FY23.

The top complaint reasons related to access to care include difficulty accessing in-network specialists and facilities, denials for Medicaid services and difficulty obtaining durable medical equipment. Case summaries revealed that consumers reported difficulty obtaining authorizations for power wheelchairs and receiving wheelchair repairs. No trend was found regarding complaints of difficulty accessing in-network specialists and facilities or denials for Medicaid services.

Complaints related to member enrollment and complaints related to prescription services are tied for the second highest complaint category in the third quarter of FY23.

The top complaint reason related to member enrollment complaints includes case information errors on consumer Medicaid profiles. A review of case summaries shows that consumers reported difficulty updating their address and updating guardianship in situations in which the legal guardian had changed.

The top complaint reason related to prescription services was difficulty receiving medication due to erroneous third-party insurance showing in HHSC, MCO or pharmacy data systems. No trend was found regarding erroneous third-party insurance.

Fee for Service/Traditional Medicaid

Fee for service, also known as traditional Medicaid, is the population of Medicaid recipients that are not enrolled in any managed care program⁴. OMCAT assists all consumers on Medicaid, as such, it is important to capture complaints for all populations of Medicaid consumers.

In the third quarter of FY23, OMCAT received 129 complaints, of which 16 (or 12 percent) were substantiated. Figure 10 shows a comparison of the top complaint categories for the current quarter as well as the previous four quarters.

Figure 10: Top Fee for Service/Traditional Medicaid Complaint Categories FY22 & FY23

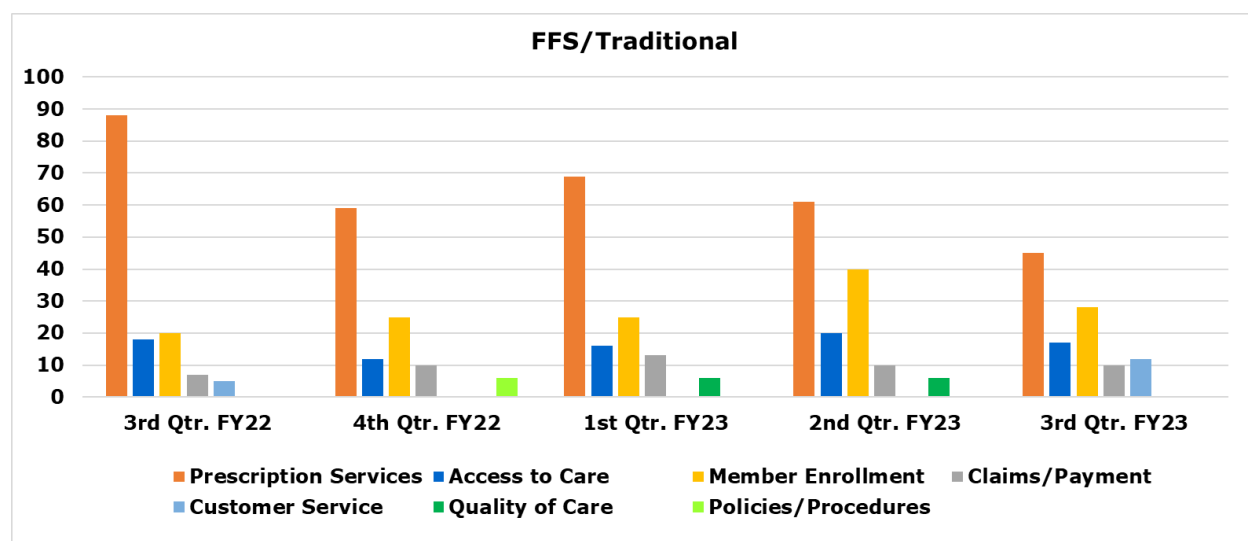


Figure 10 shows complaints related to accessing prescription services, member enrollment and access to care continue to be the top complaint categories in the third quarter of FY23.

The top complaint reason related to accessing prescription services was related to pharmacies unable to process consumers' medication claims due to missing or inaccurate information provided by the consumer.

The top complaint reasons for member enrollment complaints were case information error on consumers' Medicaid profile and issues with Medicaid eligibility and recertification. A review of case summaries shows that HHSC data systems

⁴ The average monthly enrollment for the Fee for Service/Traditional Medicaid program in the third quarter of FY23 is 179,379.

listed the incorrect gender, misspelled name, incorrect status of deceased, or incorrect effective date for Medicaid. No trend was identified for consumer complaints regarding Medicaid eligibility and recertification.

The top complaint reason regarding access to care related complaints was difficulty receiving durable medical equipment. Consumers reported difficulty obtaining shower chairs and diabetic and incontinence supplies.

Conclusion

The 88th Texas Legislature, Regular Session, 2023, brought forth impactful legislation for the Office of the Ombudsman in the form of House Bill 3462 (HB 3462). HB 3462 removed the requirement for quarterly publication of managed care complaints and inquiries (OMCAT Quarterly Report). In conjunction with the removal of the OMCAT quarterly report, HB 3462 codified new requirements for the Office of the Ombudsman to publish an annual comprehensive report which will include analysis and recommendations of issues investigated by the OMCAT team.

The first annual Office of the Ombudsman report will be released December 1, 2023. The Office of the Ombudsman looks forward to providing contact information to the public regarding Medicaid and HHSC programs and service-related complaints and inquiries in the new annual Office of the Ombudsman report.

OMCAT experienced substantial contact volume in the third quarter of FY23. In the third quarter of FY23 OMCAT experienced the largest contact volume since the first quarter of FY22.

In the third quarter of FY23 OMCAT attributes the significant increase in contact volume to an increase in Medicaid eligibility related inquiries. The third quarter of FY23 also marked the beginning of HHSC efforts to redetermine eligibility for all consumers currently enrolled in Medicaid. Consumers who were determined eligible for Medicaid on or preceding January 27, 2020, maintained continuous Medicaid coverage due to the federal government's declaration of a public health emergency caused by the COVID-19 virus.

While consumer contacts in the third quarter of FY23 did not reveal a direct correlation to consumer questions or complaints related to HHSC efforts to unwind continuous Medicaid coverage, data does appear to show increased awareness of Medicaid eligibility related questions among the public. HHSC has made coordinated and concerted efforts over the past six months to inform Texans of the end of continuous Medicaid unwinding process.

Appendix A: Managed Care Program Tables

Table 2 includes the top resolved complaints determined to either be substantiated, unable to be substantiated or referred for all managed care programs. Please note that the top complaint categories represented in the table below are a subset of the total complaints received for the managed care programs.

Table 2: Complaint Categories by Managed Care Program Q3 FY23

COMPLAINT CATEGORY	STAR+PLUS	STAR	STAR Kids	STAR+PLUS Dual-Demo	STAR Health	Dental	FFS	No Medicaid
Access to Care	162	194	30	8	6	12	17	42
Member Enrollment	66	108	15	2	5	5	28	149
Non-Medicaid /CHIP Services	35	76	1	1	0	1	9	160
Prescription Services	62	117	15	0	4	1	45	16
Claims/ Payment	45	60	5	2	2	13	10	26
Quality of Care	65	41	7	2	0	13	2	21
Customer Service	34	34	5	4	1	3	12	32
Transportation Issues	61	3	5	2	0	1	1	4
Policies/ Procedures	32	17	6	0	1	2	5	11
Fraud	3	8	1	0	0	1	0	6
Therapy	3	4	5	0	2	0	0	0
Member Health and Safety	2	0	1	0	0	0	0	3
Value-Added Services	1	4	0	0	0	0	0	1

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

Table 3: Average Monthly Enrollment by Managed Care Program Q3 FY23

Managed Care Program	Average Monthly Enrollment
STAR	4,917,973
Dental	4,252,063
STAR+PLUS	578,920
FFS	179,379
STAR Kids	170,075
STAR Health	47,089
STAR+PLUS Dual-Demo	32,613

Appendix B: Complaints by Service Area

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

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

Table 4 includes the top complaints that were resolved and determined to either be substantiated or unable to substantiate by service area. The complaints represented in Table 4 are a subset of the total complaints received for the service areas.

Table 4. Complaints by Service Area Q3 FY23

Complaint Category	Bexar	Dallas	El Paso	Harris	Hidalgo	Jefferson	Lubbock	MRSA Central	MRSA Northeast	MRSA West	Nueces	Tarrant	Travis
Access to Care	31	73	8	81	28	15	5	24	25	17	13	45	29
Prescription Services	21	27	4	51	9	10	3	5	15	9	8	20	12
Member Enrollment	32	36	1	34	6	2	5	13	13	8	3	25	13
Quality of Care	8	26	3	24	10	5	0	1	10	8	3	16	1
Non-Medicaid /CHIP	12	21	5	23	5	5	3	7	8	2	1	17	4
Claims /Payment	6	16	5	29	6	1	3	8	7	8	2	15	6
Customer Service	12	10	1	12	7	3	3	4	2	2	7	10	4
Transportation Issues	3	5	2	14	7	3	2	2	13	5	6	3	6
Policies /Procedures	8	9	1	12	1	1	0	4	4	0	3	8	4
Therapy	0	0	0	2	2	0	1	0	2	0	0	4	1
Fraud	2	2	1	4	0	1	1	0	0	0	0	0	1
Value-Added Services	0	0	0	0	1	0	0	3	0	0	0	1	0
Member Health and Safety	0	0	0	0	0	0	0	0	2	0	0	0	1

Glossary

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

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

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

Complaint – A contact regarding an expression of dissatisfaction.

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

Fiscal Year 2023 – The 12-month period from September 1, 2022, through August 31, 2023, covered by this report.

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

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

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

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

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

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

List of Acronyms

CHIP – Children’s Health Insurance Program

MCO – Managed Care Organization

MDCP – Medically Dependent Children’s Program

MRSA – Medicaid Rural Service Area

PCP – Primary Care Provider

PHE – Public Health Emergency

PDL – Preferred Drug List

SA – Service Area