

HHS Ombudsman Managed Care Assistance Team 2nd Quarter FY 2022

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

**Office of the Ombudsman
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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.

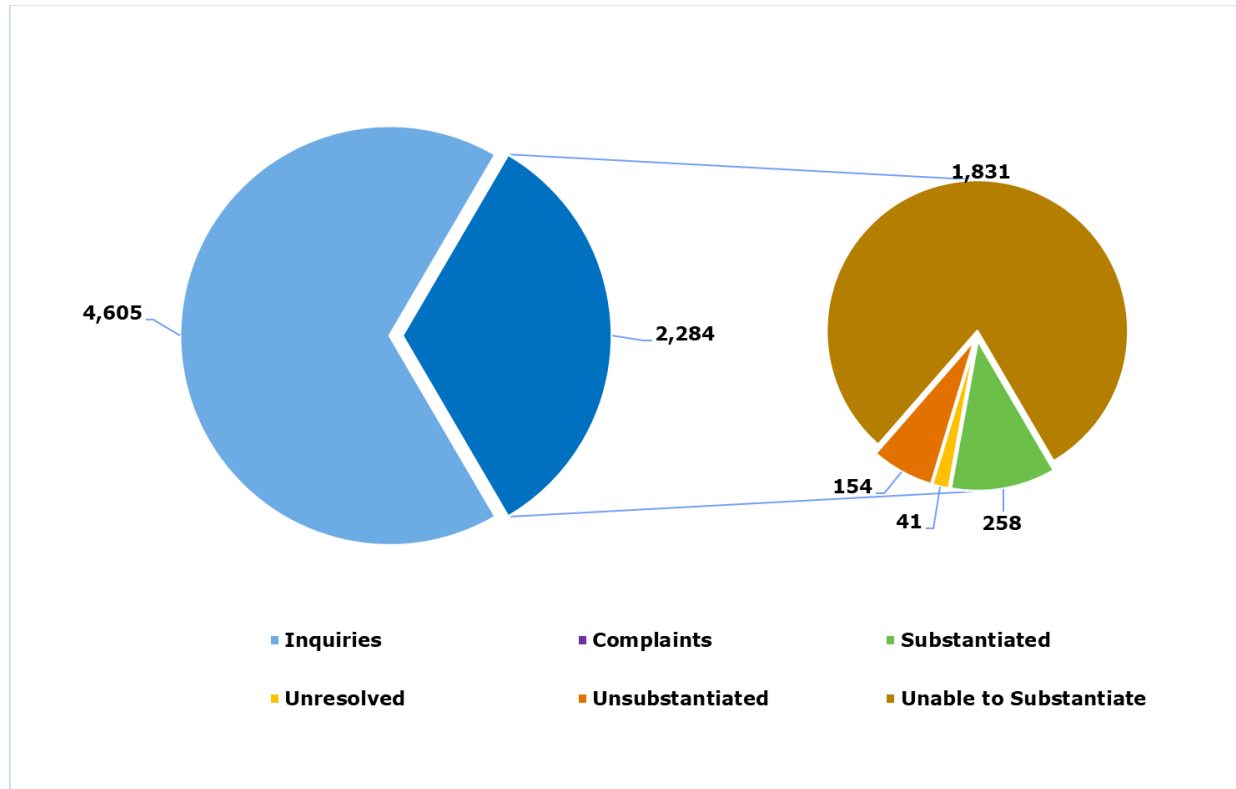
During the second quarter of fiscal year 2022 (FY22), OMCAT received 6,889 contacts; of which, 2,284 were complaints and 4,605 were inquiries.

Complaints made up 33 percent of total contacts. Of the 2,284 complaints received, 2,243 complaints were resolved with the remaining 41 pending investigation. Of those resolved complaints:

- 11.5 percent (or 258) were substantiated;
- 81.6 percent (or 1,831) were unable to substantiate and,
- 6.9 percent (or 154) were unsubstantiated.

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

Figure 1: Second Quarter Total Contacts Received



Introduction

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

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

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

OMCAT In Action

The following 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 member diagnosed with thyroid cancer in October 2021 which OMCAT continued to work until resolved in the second quarter of FY22. The member's endocrinologist ordered Thyrogen injections to help treat the cancer. The MCO reported that the Thyrogen injections were not a Medicaid covered prescription drug benefit.

OMCAT worked with the MCO and the Office of the Medical Director (OMD) to determine if the injections could be covered as a Medicaid covered medical benefit rather than a prescription drug benefit. HHSC determined that the Thyrogen injections would be covered as a medical benefit; however, due to the classification of the injections as a medical benefit, the member's endocrinologist would be required to participate in a "buy and bill" arrangement.

"Buy and bill" refers to a system in which a doctor buys the medication from the supplier, administers the medication and bills Medicaid directly. The member's endocrinologist advised the member they would also need to quarantine in a separate location from their children due to risk of transmission of iodine, a part of

the chemical composition of Thyrogen. Subsequently, the MCO rejected the member's request to fund a hotel room for the purpose of quarantine.

OMCAT continued to work with the MCO and the OMD to ensure the member could receive their injections in a timely manner and be funded for a hotel room for quarantine. Due to difficulties finding a contracted endocrinologist that was willing to participate in the "buy and bill" method, OMCAT assisted the member with switching MCOs in November 2021. After switching MCOs, OMCAT was able to assist the member in finding a contracted endocrinologist that was experienced with providing services under the "buy and bill" arrangement. In December 2021, the member began receiving Thyrogen injections from the new endocrinologist.

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

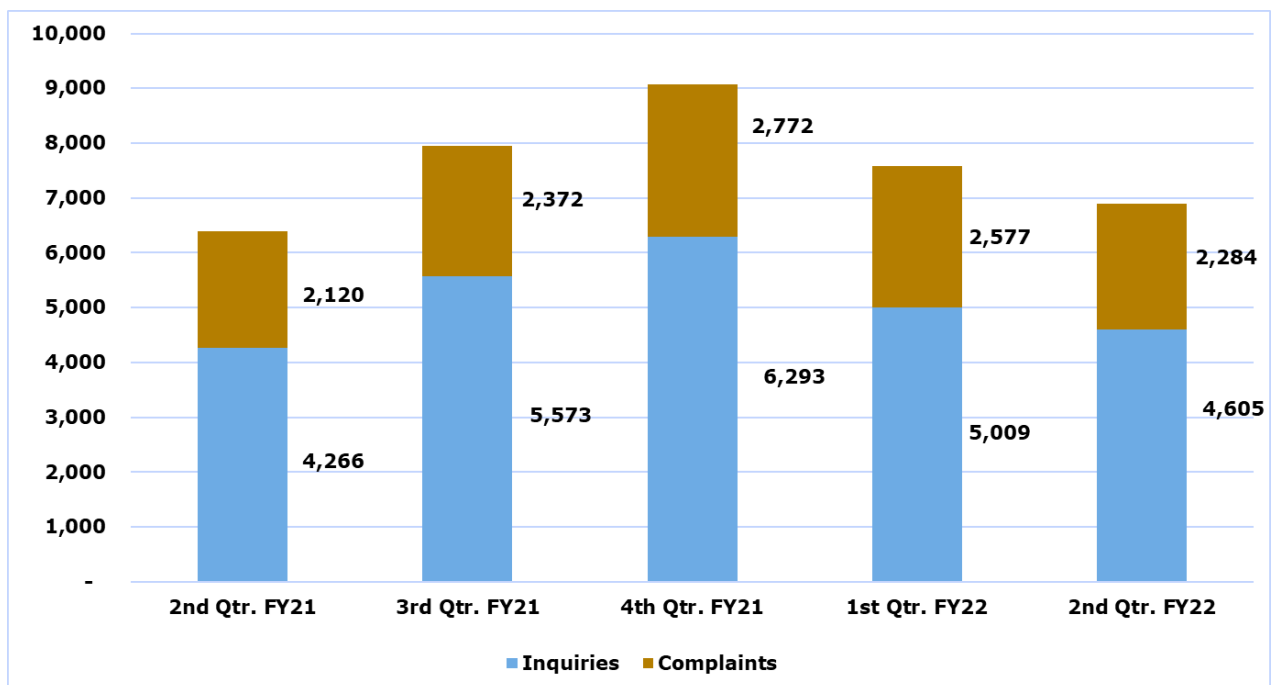
Consumer Contacts

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 four quarters.

Figure 2: All Contacts Received FY21 & FY22



In the second quarter of FY22, OMCAT received a total of 6,889 contacts. This is a nine percent decrease from the first quarter in FY22. The data show that total contacts for the second quarter of FY22 increased by eight percent compared to the second 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.

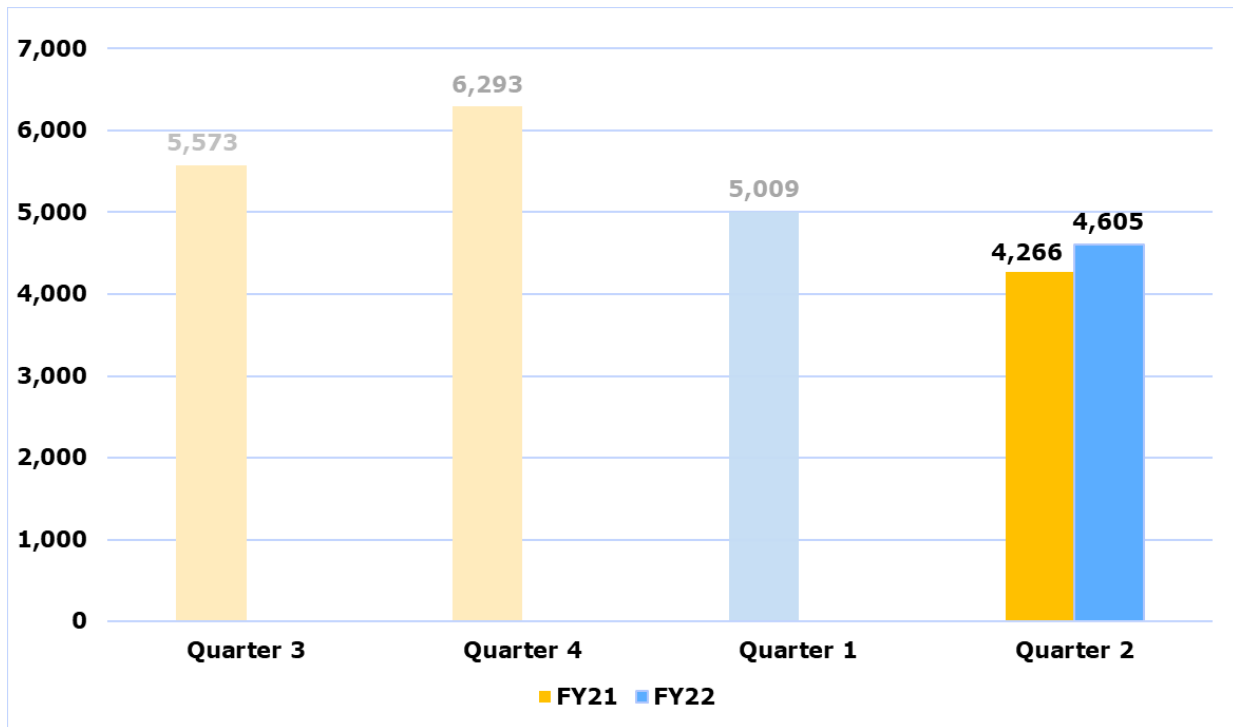
Inquiries Process

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 3 focuses on the comparison of the volume of inquiries received for the second quarter of FY22 with the same quarter of the previous year.

Figure 3: Inquiries Received FY21 & FY22

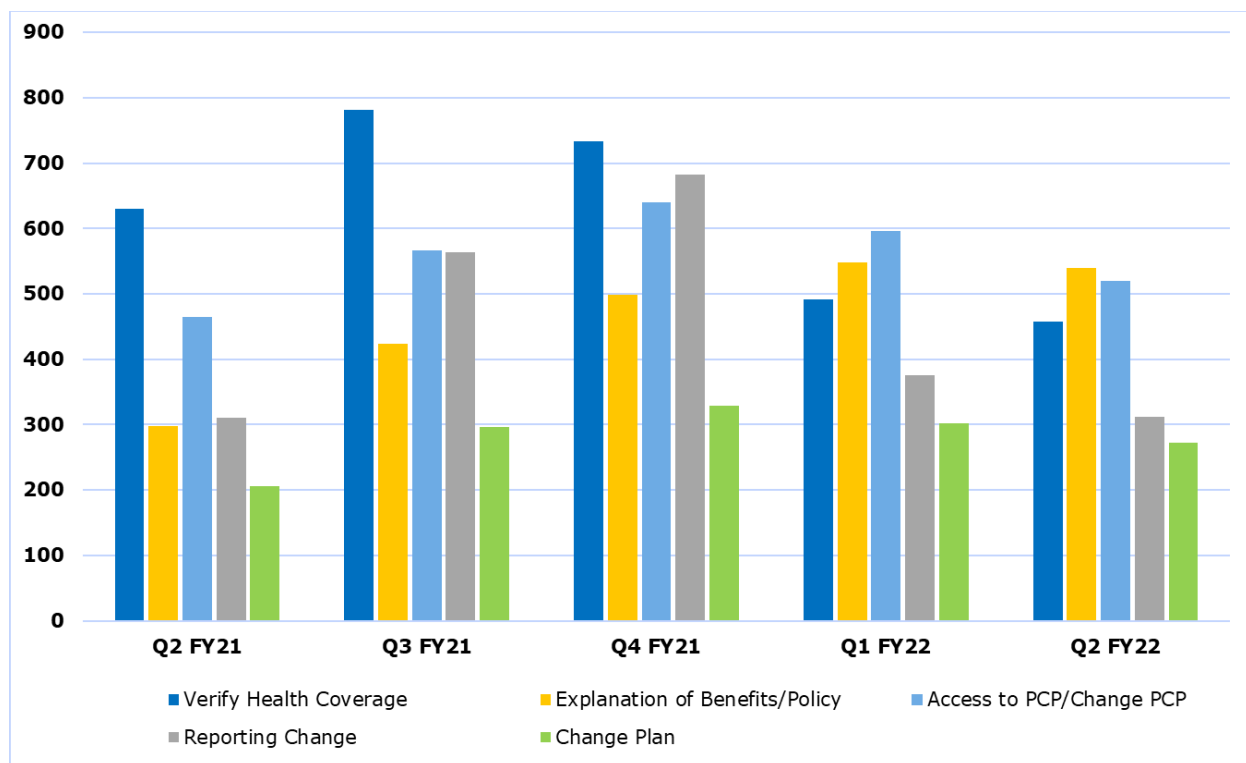


The data indicate that the volume of inquiries received for the second quarter of FY22 decreased by eight percent (or 404 fewer) as compared to the first quarter of FY22. However, when compared with the second quarter of FY21, the data show that the volume of inquiries received during the second quarter of FY22 increased by eight percent.

Top Inquiries

Figure 4 presents a comparison of the top reasons for inquiries for the second quarter of FY22 and previous four quarters.

Figure 4: Top Inquiries Received FY21 & FY22



The data shows 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 throughout FY21 and into FY22.

Figure 4 shows that in the second quarter of FY22 questions related to explanation of benefits and policy was the top inquiry. The second quarter of FY22 marks the first time in FY21 and FY22 that explanation of benefits and policy was the top inquiry. In the second quarter of FY22 members enrolled in the STAR+PLUS program had the most inquiries regarding explanation of benefits and policy, followed by individuals with no Medicaid and members enrolled in the STAR program. A review of case narratives showed consumers with dual coverage of Medicare and Medicaid had questions regarding which entity was responsible for coverage of medical benefits. Consumers also had questions regarding what services are covered for their child and questions related to Medicaid coverage of services related to pregnancy and childbirth.

The data show that accessing a PCP or changing the PCP was the second highest inquiry in the second quarter of FY22 and decreased by 12 percent from the first quarter of FY22. A review of case narratives indicates consumers had questions

regarding changing their child's PCP, updating their PCP in MCO data systems and consumers requesting assistance locating a PCP in their service area.

Figure 4 also shows that in the second quarter of FY22 questions related to verifying health coverage was the third highest inquiry and decreased by seven percent from the first quarter to the second quarter of FY22. A review of case narratives shows that consumers called to verify if their Medicaid coverage was still active and which MCO the consumer was enrolled in.

Resolved Complaints

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

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 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 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.

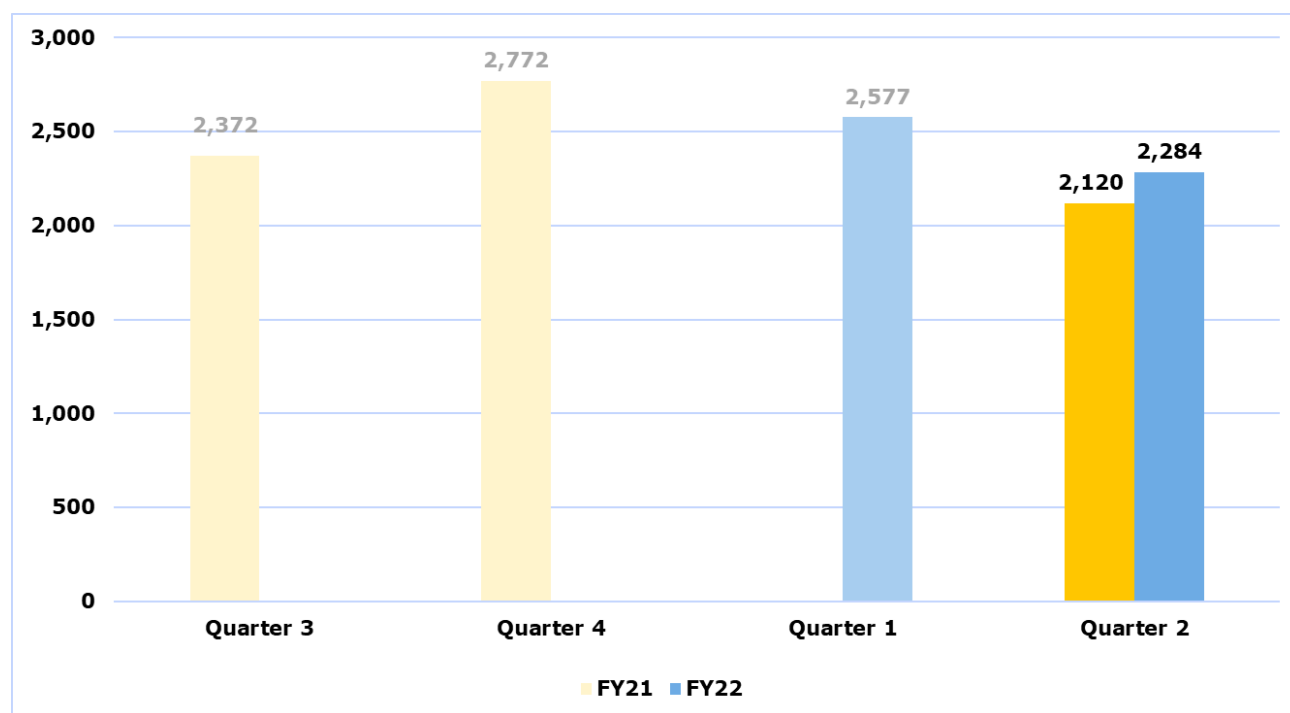
- Incomplete investigation – ombudsman may need more information from the consumer during the investigation but if the ombudsman is not able to reach the consumer after several attempts, the investigation is closed.
- Discrepant information - consumer complains that the MCO has not authorized a referral 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 second quarter with the same quarter of the previous fiscal year. In the second quarter of FY22, OMCAT received 2,284 complaints, which is an increase of eight percent (or 164 more) compared to the second quarter of FY21 and is a decrease of 11 percent (or 293 less) compared to the first quarter of FY22.

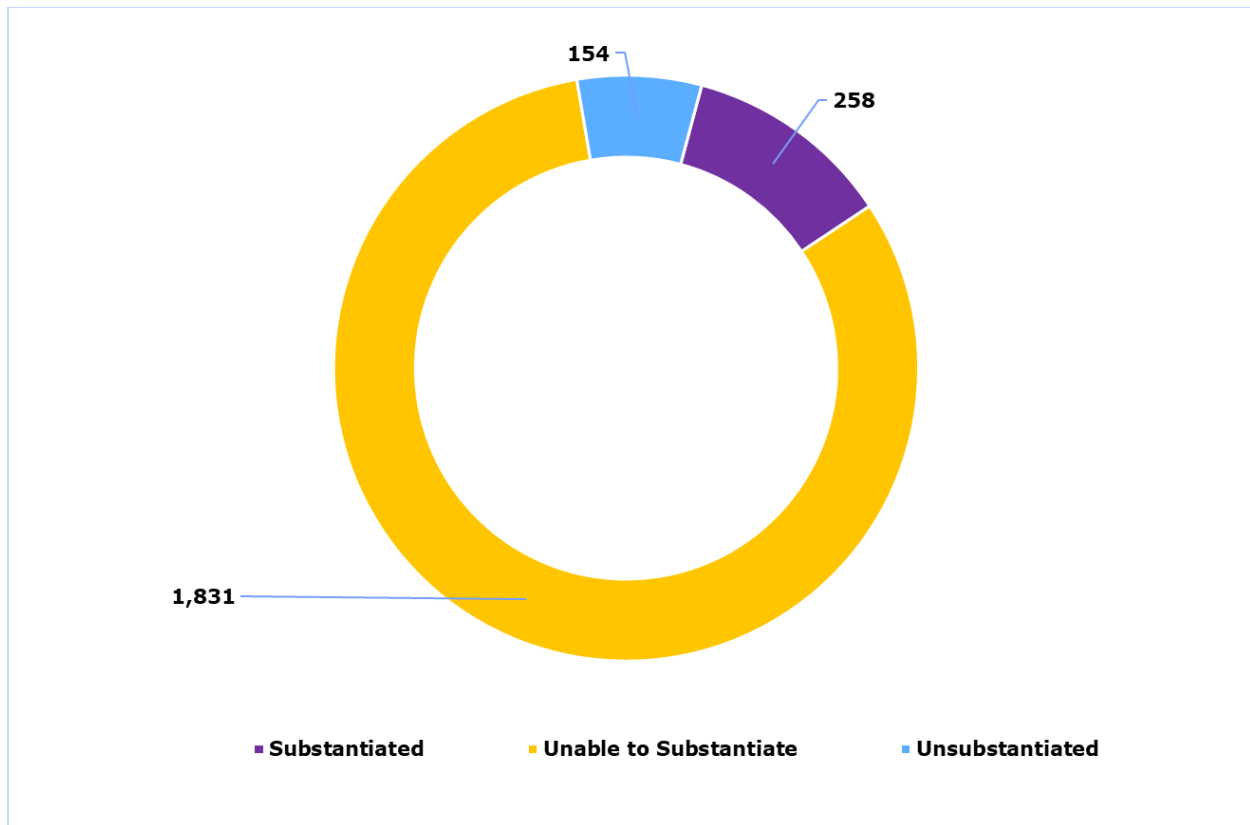
Figure 5: Complaints Received FY21 & FY22



Resolved Complaints by Determination

Figure 6 below shows the total resolved complaints by determination received in the second quarter of FY22. OMCAT resolved 2,243 complaints out of 2,284 received. Forty-one complaints were still being investigated at the end of the second quarter of FY22.

Figure 6: Complaints by Resolution Determination



Substantiated Complaints

In the second quarter of FY22, OMCAT substantiated 258, or 12 percent of resolved complaints. This is an increase of four percentage points compared to the previous quarter.

The top substantiated complaint reason for the quarter was complaints related to case information errors in HHSC data systems. Review of case summaries indicate consumers reported that they had requested name changes or a change of address, however requested changes were not showing as updated in HHSC systems.

The second highest substantiated complaint reason for the quarter was related to members who had difficulty receiving prescription medications 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 third most substantiated complaint reason for the quarter was related to members who were incorrectly billed for Medicaid covered services. Medicaid pays 100 percent for Medicaid covered services. Medicaid contracted providers must accept the Medicaid payment rate for reimbursement. Review of case summaries show that Medicaid providers mistakenly billed the consumer instead of the health plan for medical services.

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 four quarters.

Figure 7: Top Complaint Categories Received FY21 & FY22

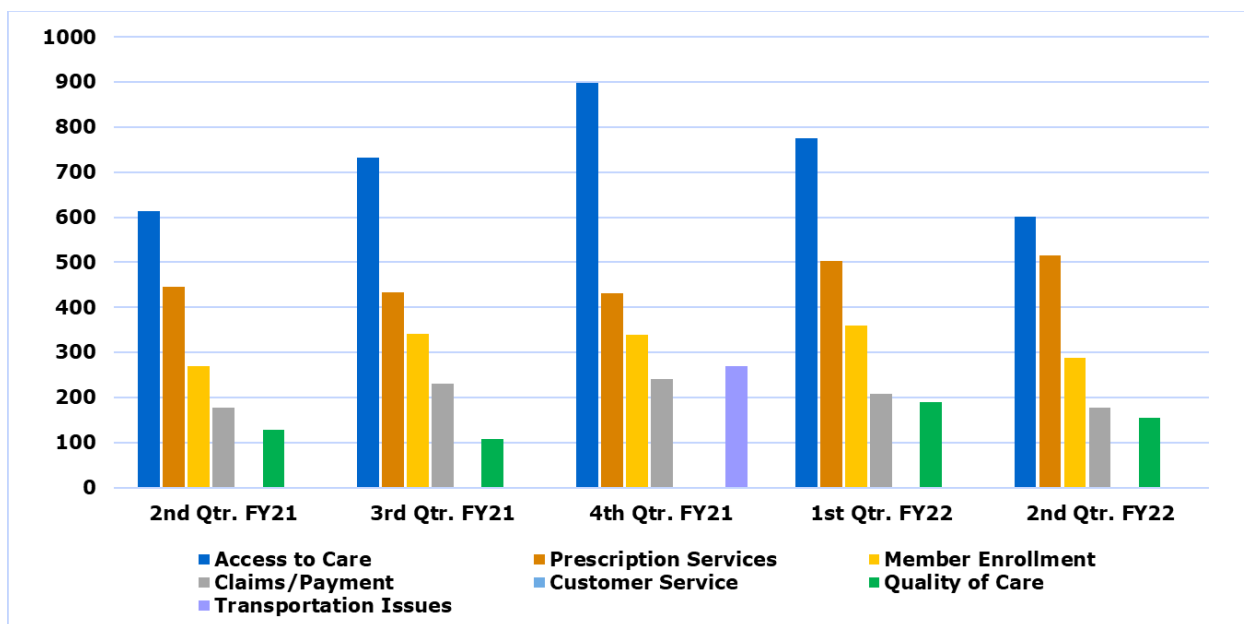


Figure 7 shows that complaints related to access to care remained the top complaint category in the second quarter of FY22. In addition, complaints related to access to care decreased 22 percent from the first to second quarter of FY22. The decrease in access to care complaints was evident in a decrease in the following complaint reasons: consumers having difficulty obtaining services because other insurance aside from Medicaid is showing in HHSC and MCO data systems, complaints related to consumers having issues accessing out-of-network providers, and complaints related to denial of services.

A review of contact reasons related to access to care shows that complaints regarding consumers accessing home health services and in-network specialists and facilities remained among the top complaint reasons in the second quarter of FY22. Case summaries show consumers needed assistance initiating personal attendant services and had difficulty receiving authorized hours for personal attendant services. Consumers also reported needing assistance locating an in-network OBGYN in their service area.

The data show that complaints related to accessing prescriptions remained the second highest complaint category in FY21 and into the second quarter of FY22. Complaints related to accessing prescriptions increased slightly from the first to the second quarter of FY22. No trend was noted regarding the increase in complaints from the first to second quarter of FY22. The top complaint reasons include consumers complaints of erroneous additional insurance showing on their Medicaid profile in HHSC data systems and consumers reporting not showing active with Medicaid in HHSC, MCO or pharmacy data systems.

Figure 7 also shows that complaints related to member enrollment remained the third highest complaint category in FY21 and into the first and second quarters of FY22. Complaints related to member enrollment decreased 20 percent from the first to second quarter of FY22. No trend was noted as there was a general decrease across several contact reasons. The top complaint reasons for member enrollment include complaints related to case information errors in HHSC data systems and Medicaid eligibility. Review of case summaries show callers reported: incorrect names, addresses and dates of birth in HHSC data systems; needing assistance with Medicaid enrollment for newborn children; and reporting their child as not showing eligible for Medicaid in HHSC data systems. Consumers also reported complaints related to denial of their Medicaid application.

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 children, pregnant women, and some parents of children on Medicaid¹. In the second quarter of FY22, OMCAT received 741 complaints of which 103 (or 14 percent) were substantiated.

Figure 8 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 second quarter of FY22 is 4,246,752.

Figure 8: Top STAR Complaint Categories FY21 & FY22

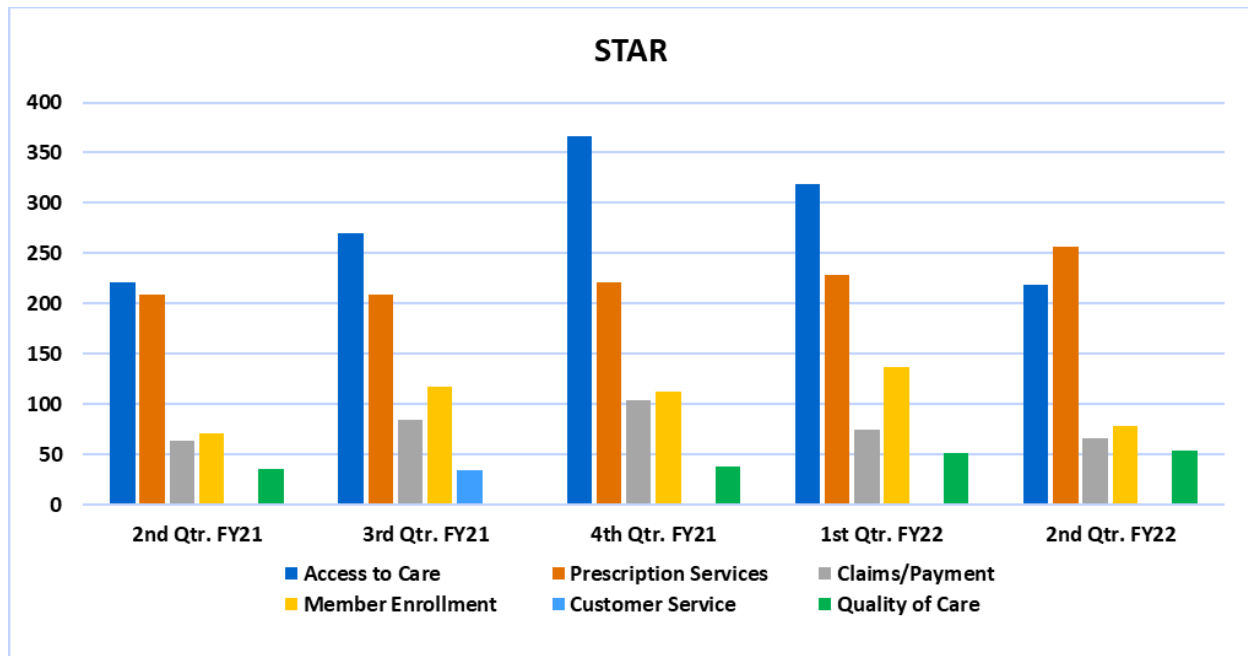


Figure 8 shows that the top three complaint categories for STAR members in the second quarter of FY21 into the second quarter of FY22 were complaints related to: accessing care, accessing prescription services, and consumers who had problems with member enrollment.

Total complaints also decreased from the first to second quarter of FY22. The top complaint categories that decreased included a 43 percent decrease in complaints related to member enrollment and a 31 percent decrease in complaints related to access to care. While total complaint volume decreased from the first to second quarter of FY22, complaints related to prescription services increased 12 percent during the same period. Data show the greatest decrease (41 percent) in complaints of access to care from the first to second quarter of FY22 was related to members having difficulty accessing out-of-network providers. A review of case narratives indicates the decrease was found in complaints of members who had moved out of their service area. When members move out of their service area and the address is not updated in HHSC data systems, their current MCO may not be available in the new service area subsequently causing a need to access out-of-network providers.

The second quarter of FY22 marks the first time in FY21 and FY22 that prescription services is the top complaint category for STAR members. The complaint category prescription services increased 12 percent from the first to second quarter of FY22. A review of contact reasons shows consumers having difficulty accessing

prescription due to other insurance on their Medicaid profile in HHSC, MCO or pharmacy data systems increased by 23 percent from the first to second quarter of FY22 and was also the top complaint reason in the second quarter of FY22. A review of case narratives shows that consumers primarily had difficulty obtaining medication for their children who showed as having other insurance on their Medicaid profile.

Complaints related to access to care is the second highest complaint category in the second quarter of FY22. The complaint category of access to care decreased by 31 percent from the first to second quarter of FY22. The top complaint reasons related to access to care in the second quarter of FY22 include members having difficulty accessing: in-network specialists and facilities, out-of-network providers, and primary care physicians. A complete review of case summaries shows members had difficulty accessing in-network OBGYNs and out-of-network OBGYNs because the member had moved to a different service area. Members also reported complaints of physicians not accepting their health plan.

Complaints related to member enrollment is the third highest complaint category beginning in FY21 and into the second quarter of FY22. Figure 8 shows that complaints related to member enrollment decreased by 43 percent from the first quarter to the second quarter of FY22. Further analysis of contact reasons shows complaints related to case information errors in HHSC systems decreased 34 percent and complaints related to Medicaid eligibility decreased 58 percent from the first to second quarter of FY22. Case summaries show that consumers complained their new address was not entered into HHSC data systems after being reported and consumers who needed to add their newborn child to their Medicaid profile in HHSC data systems.

STAR+PLUS

The STAR+PLUS program serves adults who have disabilities or are age 65 or older². In the second quarter of FY22, OMCAT received 728 complaints of which 95 (or 13 percent) were substantiated. Figure 9 shows a comparison of the top complaint categories for the current quarter and previous four quarters.

² The average monthly enrollment for the STAR+PLUS program in the second quarter of FY22 is 548,598.

Figure 9: Top STAR+PLUS Complaint Categories FY21 & FY22

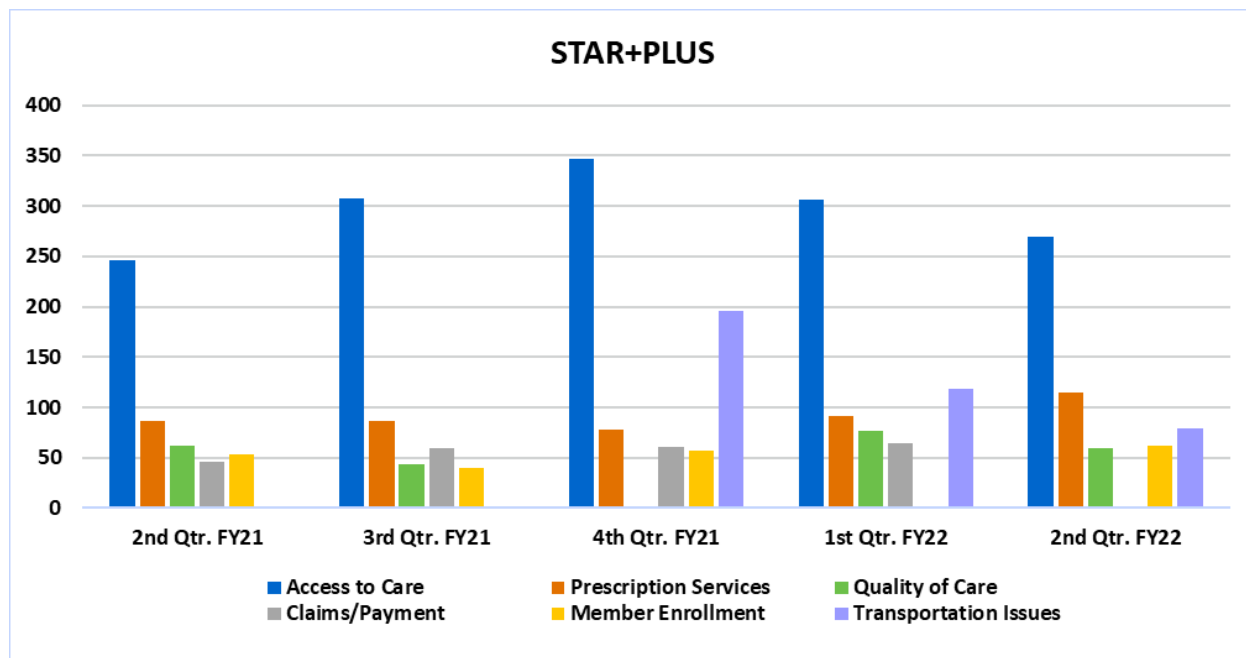


Figure 9 shows that complaints related to access to care is the top complaint category for five consecutive quarters beginning in FY21 and into the second quarter of FY22. Data show that complaints related to access to care decreased by 11 percent from the fourth quarter of FY21 to the second quarter of FY22. A review of contact reasons from the first quarter to second quarter of FY22 show the greatest decrease occurred in the following contact reasons: a 41 percent decrease in complaints related to accessing in-network specialists and facilities and a 7 percent decrease in complaints related to difficulty accessing home health services. A review of case summaries shows there was a decrease in complaints related to consumer's health plan providing an inaccurate list of in-network providers who accept the health plan.

The top contact reasons related to access to care for the second quarter of FY22 are complaints related to problems accessing home health services, difficulty accessing durable medical equipment (DME) and members being denied services. A review of case summaries showed that consumer complaints included consumers not receiving authorized hours for personal attendant services (PAS) and consumers who needed assistance initiating PAS services. Consumer also reported complaints regarding difficulty obtaining DME such as wheelchairs and wheelchairs supplies because of problems with continuity of care between their physician and the DME company. Consumer's complaints also indicated difficulty receiving DME such as incontinence supplies upon discharge from a nursing facility.

The data show that complaints related to prescription services is the second highest complaint category beginning in the second quarter of FY21 and into the second quarter of FY22. Complaints related to prescription services increased by 25 percent from the first quarter to the second quarter of FY22. This increase can be attributed to a 34 percent increase in complaints related to consumers having difficulty accessing prescription services due to other insurance on their Medicaid profile in HHSC, MCO or pharmacy systems. The top complaint reasons for the second quarter FY22 are complaints related to consumers having difficulty accessing prescription services due to other insurance on their Medicaid profile in HHSC, MCO or pharmacy systems and complaints related to denial of medication not listed on the prescription drug formulary and the preferred vendor drug list. Review of case summaries indicate consumers who had Medicare and Medicaid had difficulty obtaining prescriptions because medication was processed under their Medicaid health plan. When a consumer has dual coverage under Medicare and Medicaid, Medicare acts as the primary payor for medical services and prescription medication.

Complaints related to transportation issues is the third highest complaint category in the second quarter of FY22. Since the implementation of service delivery of non-emergency medical transportation provided by consumers' MCOs, complaints have decreased by 59 percent from the fourth quarter of FY21 to the second quarter of FY22. The top complaint reasons that decreased the most were complaints of consumers not being transported and consumers reporting being picked up later than 1 hour past their scheduled pickup time. After review of the complaint reasons, data show the top complaint reasons for the second quarter of FY22 were complaints related to consumers not being transported and consumer complaints related to difficulty receiving payment for the cost of transporting themselves to their medical appointments. Review of case summaries indicate consumers had complaints that they were not picked up at the scheduled time from their residence for medical appointments or picked up at the scheduled time from their doctor's office for their return trip back to their residence.

STAR Kids

The STAR Kids program serves children and adults 20 and younger who have disabilities³. In the second quarter of FY22, OMCAT received 115 complaints of which 18 (or 16 percent) were substantiated. Figure 10 shows a comparison of the

³ The average monthly enrollment for the STAR Kids program in the second quarter of FY22 is 169,121.

top complaint categories for the current quarter as well as the previous four quarters.

Figure 10: Top STAR Kids Complaint Categories FY21 & FY22

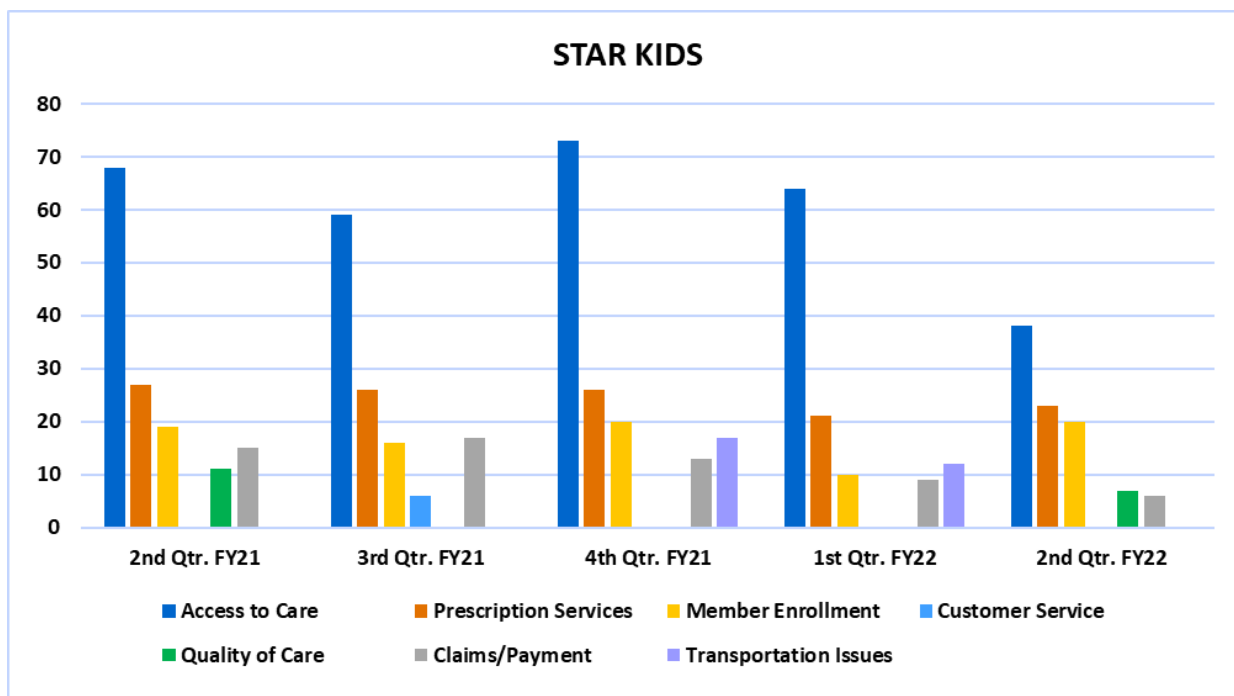


Figure 10 shows complaints related to access to care is the top complaint category beginning in the second quarter of FY21 and into the second quarter of FY22. The complaint category access to care decreased by 47 percent from the fourth quarter of FY21 to the second quarter of FY22. The decrease in complaints from the first to second quarter of FY22 can be attributed to a decrease in complaints related to consumers having difficulty accessing durable medical equipment (DME). Review of case summaries indicated that there were fewer complaints regarding difficulty obtaining DME supplies such as incontinence supplies and wheelchair equipment.

Consumers also had fewer complaints regarding difficulty accessing care in the second quarter FY22 in comparison to the first quarter of FY22. The following contact reasons decreased from the first to second quarter of FY22: consumers having difficulty accessing multiple health services continuously; problems with service delivery related to having other insurance in their Medicaid profile in HHSC and MCO data systems; difficulty accessing vision and dental services; and problems with minor home modifications. The data show the top complaint reasons for the second quarter of FY22 were related to consumers having difficulty accessing in-network specialists and facilities and consumers that were denied

services. A review of case summaries shows consumers reported receiving an inaccurate list of in-network providers from their health plan.

Data show that complaints related to prescription services is the second highest complaint category beginning in the second quarter of FY21 and into the second quarter of FY22 for STAR Kids. After a review of the contact reasons the top complaints for the second quarter FY22 were related to consumers having problems accessing prescription medication due to having other insurance aside from Medicaid. Further analysis shows that consumers incorrectly showed as having private insurance in HHSC, MCO or pharmacy data systems. When a consumer has private insurance on their Medicaid profile, the pharmacy is unable to bill Medicaid for the prescription medication.

Complaints related to member enrolment is the third highest complaint category in the second quarter of FY22. The data show the top complaint reason for the second quarter of FY22 were complaints of consumers who had errors on their Medicaid profile in HHSC data systems. A review of case summaries shows authorized representatives of STAR Kids members reported that their address was incorrectly showing in HHSC data systems.

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 second quarter of FY22, OMCAT received 160 complaints, of which 24 (or 15 percent) were substantiated. Figure 11 shows a comparison of the top complaint categories for the current quarter as well as the previous four quarters.

⁴ The average monthly enrollment for the Fee for Service/Traditional Medicaid program in the second quarter of FY22 is 161,623.

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

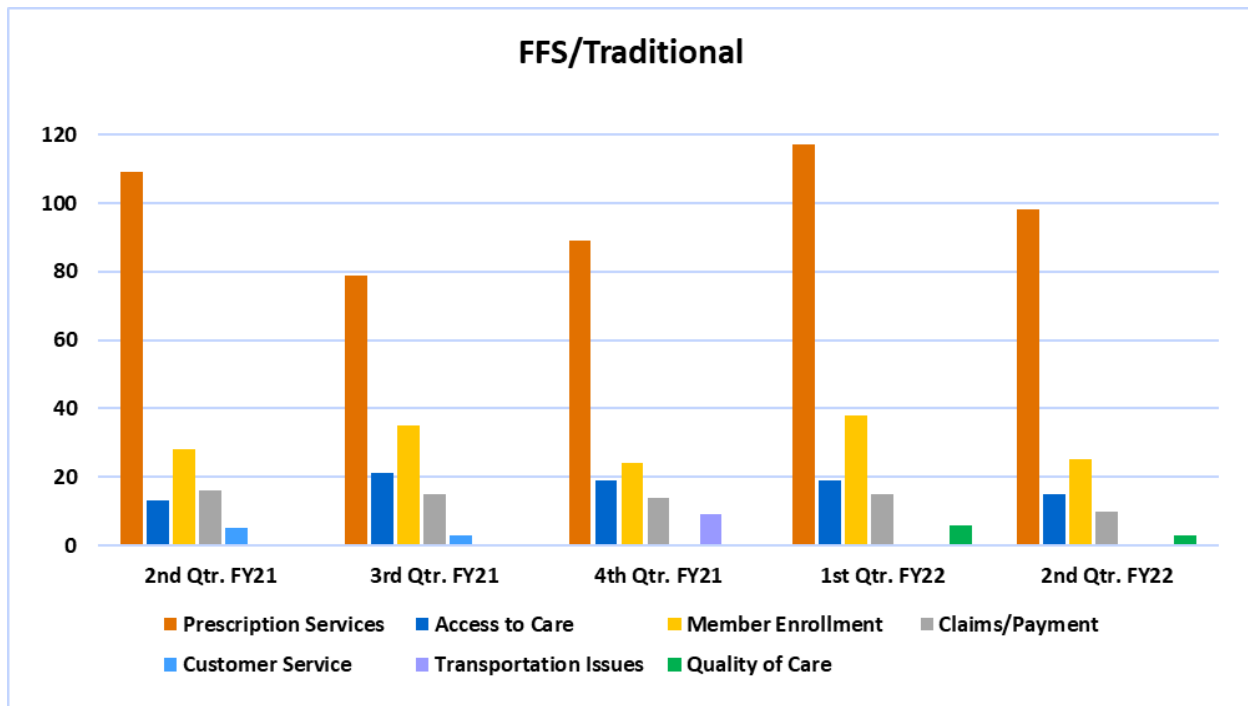


Figure 11 shows complaints related to prescription services is the top complaint category beginning in the second quarter of FY21 and into the second quarter of FY22. The top complaint reason in the second quarter of FY22 included consumers who had difficulty accessing prescription medication due to having other insurance aside from Medicaid and complaints related to consumers not showing active in HHSC data systems. A review of case summaries shows consumers reported having difficulty obtaining prescription medication because private insurance was showing incorrectly in HHSC or pharmacy data systems and difficulty receiving medications because their primary insurance was Medicare. In these cases, related to consumers that had Medicare, the pharmacy only processed the medication through Medicaid because the individual only presented their Medicaid card at the time of purchase. When an individual has Medicare and Medicaid, Medicare is the sole payer for prescriptions.

Complaints related to member enrollment is the second highest complaint category beginning in the second quarter of FY21 and into the second quarter of FY22. Top complaint reasons for the second quarter of FY22 were related to case information errors in HHSC data systems and Medicaid eligibility. A review of case summaries shows members in transition between traditional Medicaid and managed care had difficulty with managed care enrollment, such as difficulty selecting a health plan

and difficulty receiving services with Medicaid prior to their health plan begin date because of errors in their Medicaid profile in HHSC data systems.

Figure 11 also shows that complaints related to access to care is the third highest complaint category in the second quarter of FY22. The top complaint reason for the second quarter of FY22 was related to consumers having difficulty accessing durable medical equipment. A review of case summaries shows consumers had difficulty obtaining incontinence supplies.

Conclusion

In the second quarter of FY22 OMCAT experienced a slight decrease in contact volume in comparison to the first quarter of FY22. The contact volume has steadily decreased since the peak of contact volume in the fourth quarter of FY21. Contact volume in the second quarter of FY22 is comparable to the second quarter of FY21. It should also be noted that the substantiation rate of complaints increased by four percentage points from the first to second quarter of FY22. In addition, the rate of unsubstantiated complaints increased by three percentage points in comparison to the first quarter of FY22. The Office of the Ombudsman is working on a project to help ombudsmen make determinations of substantiated or unsubstantiated on all cases that are investigated; in turn this will also create fewer determinations of unable to substantiate. The project includes creating determination guidelines for ombudsmen to assist in making the final determination of a complaint. OMCAT will continue to monitor substantiation rates to identify potential problem trends.

Recommendations

There are no new recommendations for this quarter.

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 Q2 FY22

	STAR+PLUS	STAR	STAR Kids	STAR+PLUS Dual-Demo	STAR Health	Dental	FFS	No Medicaid
Access to Care	270	219	38	6	4	19	15	29
Prescription Services	115	257	23	1	2	0	98	16
Member Enrollment	62	78	20	2	3	8	25	88
Claims/ Payment	50	66	6	4	5	5	10	30
Quality of Care	59	54	7	5	0	11	3	15
Transportation Issues	79	11	6	2	0	0	3	3
Customer Service	37	27	4	3	1	4	1	21
Non-Medicaid /CHIP	13	7	0	0	0	0	0	35
Policies/ Procedures	28	4	4	1	0	0	1	6
Therapy	8	9	7	0	0	0	1	1

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

Table 3: Average Monthly Enrollment by Managed Care Program Q2 FY22

Managed Care Program	Average Monthly Enrollment
STAR	4,246,752
Dental	3,849,855
STAR+PLUS	548,598
STAR Kids	169,121
FFS	161,623
STAR HEALTH	45,166
STAR+PLUS Dual-Demo	36,163

Appendix B: Average Enrollment by Service Area

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

Table 4: Average Enrollment by Service Area

Service Area	Average Enrollment
Bexar	442,531
Dallas	656,426
El Paso	190,021
Harris	1,202,391
Hidalgo	544,092
Jefferson	145,813
Lubbock	126,013
MRSA Central	242,866
MRSA Northeast	304,682
MRSA West	272,989
Nueces	148,916
Tarrant	470,767
Travis	253,127

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 Q2 FY22

	Bexar	Dallas	El Paso	Harris	Hidalgo	Jefferson	Lubbock	MRSA Central	MRSA Northeast	MRSA West	Nueces	Tarrant	Travis
Access to Care	46	91	16	127	28	22	8	30	36	31	18	57	26
Prescription Services	47	37	15	94	23	8	14	13	32	32	11	40	30
Member Enrollment	14	24	3	43	8	6	1	7	12	5	4	20	16
Claims /Payment	9	17	2	31	8	4	1	6	11	6	2	21	8
Quality of Care	10	13	9	29	20	3	3	9	7	2	5	11	4
Transportation Issues	6	16	3	14	10	2	0	9	23	0	2	9	4
Customer Service	10	8	2	15	6	1	0	8	3	1	2	11	4
Policies /Procedures	3	4	1	7	0	1	0	4	0	3	3	11	0
Therapy	1	2	0	14	1	0	0	1	1	1	0	2	1
Non-Medicaid /CHIP	3	4	3	3	0	1	0	1	0	0	0	3	2

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