



**HHS Ombudsman
Managed Care Assistance
Team
3rd Quarter FY 2021**

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

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TEXAS
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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.

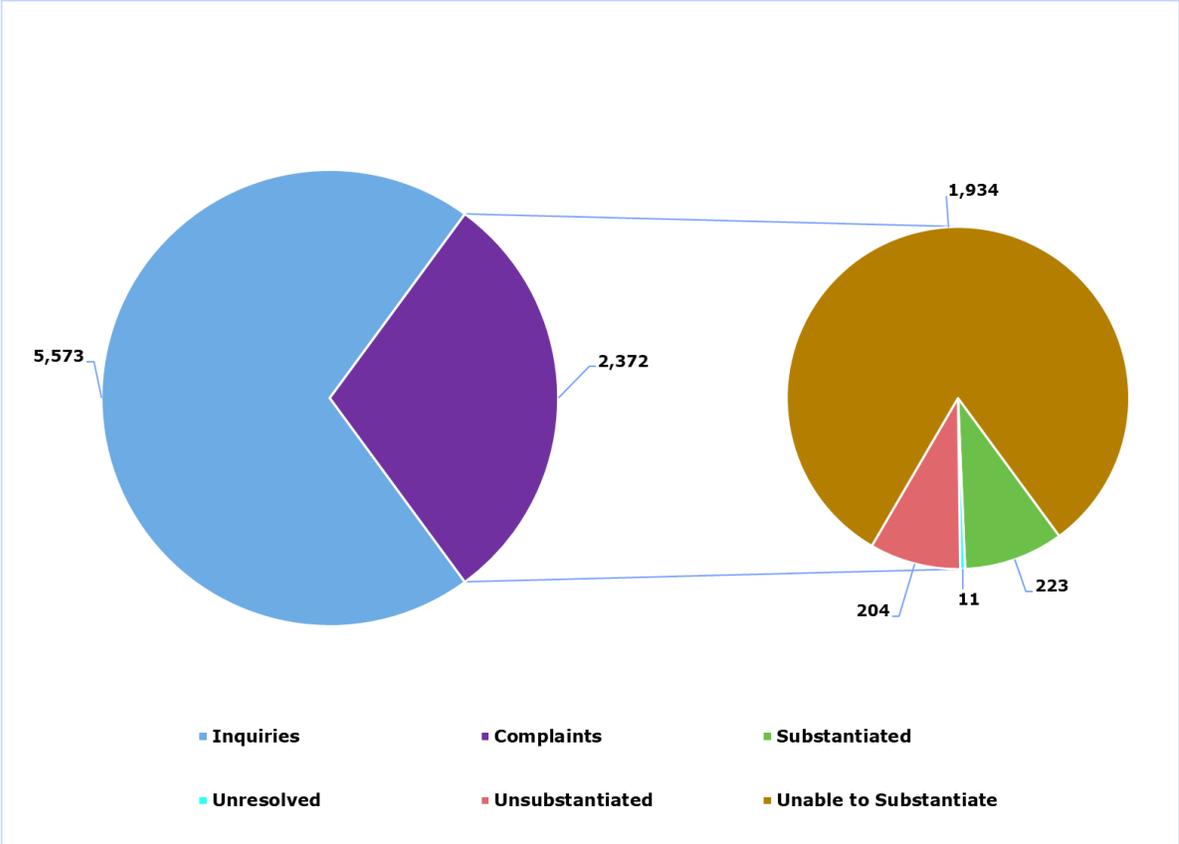
During the third quarter of fiscal year 2021 (FY21), OMCAT received 7,945 contacts; of which, 2,372 were complaints and 5,573 were inquiries.

Complaints made up 30 percent of total contacts. Of the 2,372 complaints received, 2,361 complaints were resolved with the remaining 11 pending investigation. Of those resolved complaints:

- nine percent (or 223) were substantiated;
- 82 percent (or 1,934) were unable to substantiate; and,
- nine percent (or 204) 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: Third 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.

In May of 2020, parents requested a generator as an adaptive aid for their child who required use of life sustaining, respiratory equipment and a feeding tube that needs continuous electricity. The parents and the physician recognized obtaining a generator as a critical need after the winter storm in February left the child vulnerable to extended power outages. Generators are covered as an adaptive aid in the STAR Plus Waiver Program, however the child was enrolled in STAR Kids Managed Care with the Medically Dependent Children's Program (MDCP) waiver. Generators are not authorized as an adaptive aid in STAR Kids or the MDCP waiver.

OMCAT worked with the health plan's Medical Director to obtain special authorization for the generator. As a result the child was able to receive special approval to obtain a generator ensuring the child's life saving respiratory and feeding tube equipment would no longer become vulnerable to future power outages.

Background

Consumers can contact OMCAT through either the toll-free Medicaid Managed Care Helpline (the helpline), which has been in operation since 2001 (pursuant to Senate Bill 601, 74th Texas Legislature, Regular Session), and online submission forms which can be found on the [OMCAT website](#).

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

There are three important data distinctions:

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

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

Finally, an important note related to unresolved cases:

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

Methodology

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

- Total number of inquiries and complaints received;

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

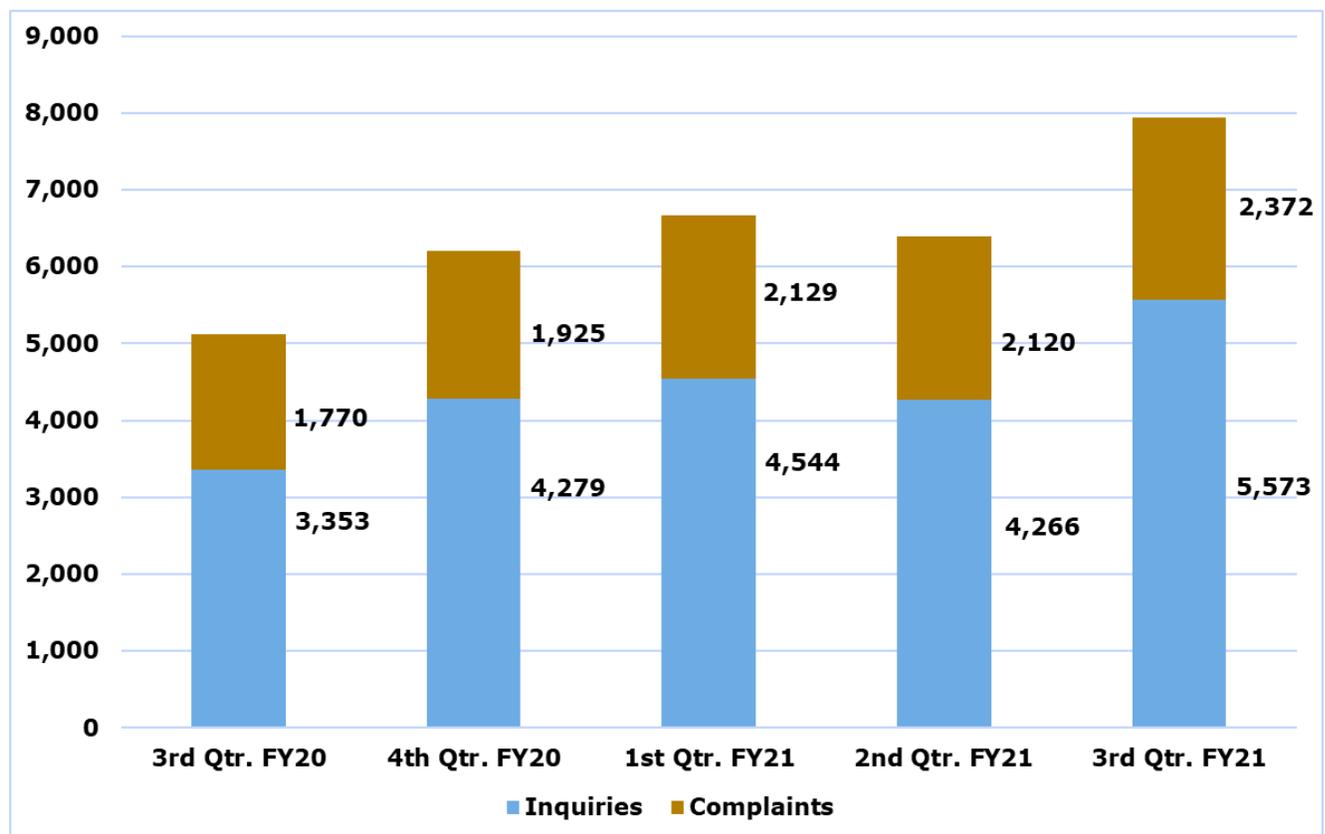
Consumer Contacts

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

All Contacts Received

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

Figure 2: All Contacts Received FY20 & FY21



In the third quarter of FY21, OMCAT received a total of 7,945 contacts. This is a 24 percent increase from the second quarter in FY21. The data show that total contacts for the third quarter of FY21 has increased by 55 percent compared to the third quarter of FY20. Total complaints increased 34 percent from the third quarter of FY20 to the third quarter of FY21. The largest increase from the third quarter of FY20 to the third quarter of FY21 included the following categories: complaints of policies and procedures, complaints of claims payment and complaints of access to care. Further analysis of

contact reasons showed an increase in complaints related to the fair hearing and appeals process, consumers being charged for Medicaid covered services, denial of services and consumers reporting difficulty locating in network specialists and facilities.

Total inquiries increased 66 percent from the third quarter of FY20 to the third quarter of FY21. The largest increase in inquiry types since the third quarter of FY20 were consumers verifying their health coverage, consumers requesting assistance with accessing a primary care physician and consumers calling to report a change of information to their Medicaid profile.

Note: The U.S. Health and Human Services Secretary Alex Azar declared a public health emergency (PHE) late in the second quarter of FY20. Due to this unprecedented event, restrictions were put into place and healthcare coverages were extended which may have caused the volume of contacts to temporarily decrease. As restrictions are slowly lifted, the total volume of contacts has steadily increased.

Inquiries

Inquiries are an important indicator of member’s 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.

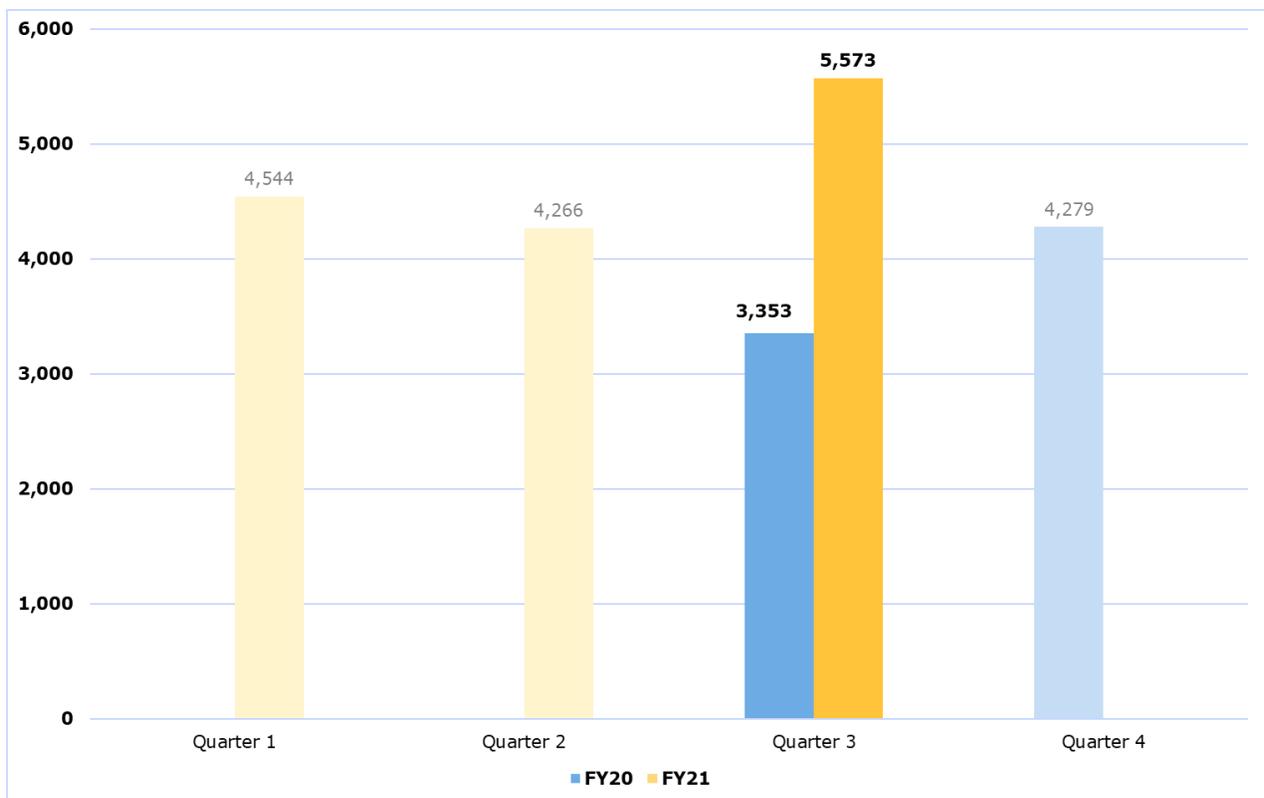
Inquiries Process

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 third quarter of FY21 with the same quarter of the previous year.

Figure 3 Inquire Received FY20 & FY21



The data indicate that the volume of inquiries received for third quarter of FY21 increased by 66 percent (or 2,220 more) as compared to the third quarter of FY20.

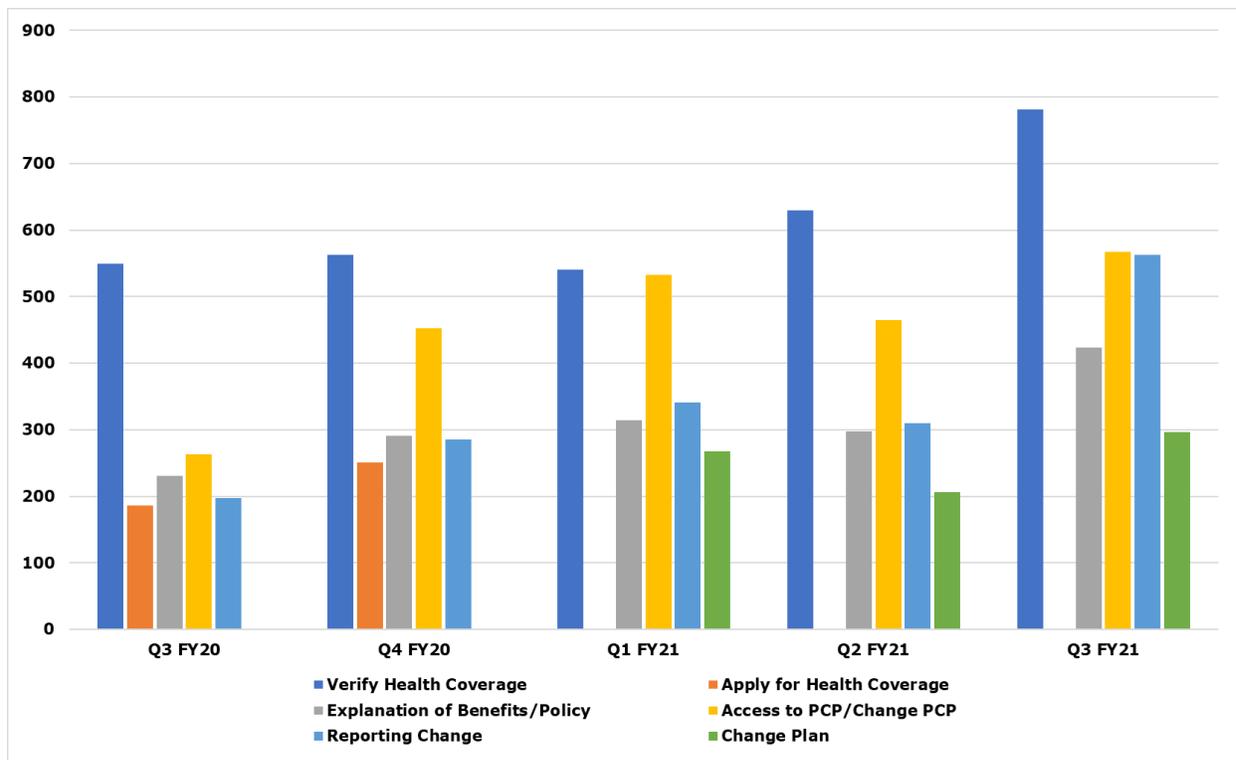
However, when compared with the second quarter of FY21, the data show that the volume of inquiries received during the third quarter of FY21 increased by 31 percent.

Data shows in the third quarter of FY21 as compared to the second quarter of the FY21 inquiries regarding consumers reporting a change to their case information increased 44 percent, explanation of benefits increased 29 percent and consumers verifying their health coverage increased 19 percent.

Top Inquiries

Figure 4 presents a comparison of the top reasons for inquiries for the third quarter of FY21 and previous fiscal year.

Figure 4: Top Inquiries Received FY20 & FY21



The data shows that inquiries related to verifying health coverage, access to a primary care provider (PCP)/changing PCP and reporting changes are among the top reasons for inquiries throughout FY20 and into FY21.

Figure 4 shows that in the third quarter of FY21 questions related to verifying health coverage was the top inquiry. A review of case narratives indicates that consumers needed to verify if their child’s health plan was active, obtain information about current health plan enrollment and obtain Medicaid IDs.

The data show that accessing a PCP or changing the PCP were among the top inquiries. A review of case narratives indicates that consumers inquired about changing their child's PCP, finding a PCP who accepted their health plan and finding a PCP out of the health plan's network because the consumer had moved to a different service delivery area.

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

Resolved Complaints

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

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

OMCAT 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.
Unable to Substantiate	Research cannot indicate whether agency policies or expectations were or were not violated.	Consumer complaint about accessing medical services.	Investigation confirms that consumer has not discussed complaint with MCO.	OMCAT referred the consumer to MCO per complaint resolution process.

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

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

Why “Unable to Substantiate” Matters

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

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

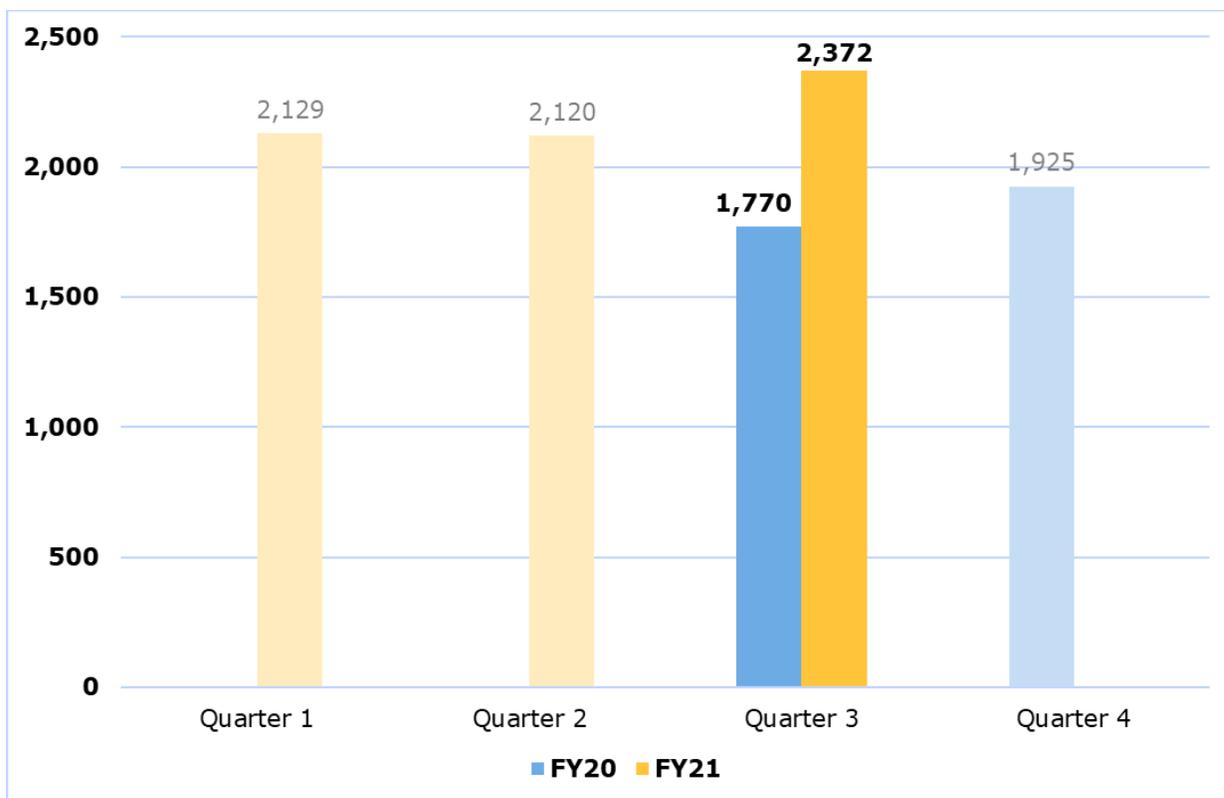
It is important to capture, analyze and report on all complaints reported to OMCAT, including those deemed as “unable to substantiate,” to facilitate a better understanding of trends in barriers that prevent consumers from accessing needed care.

Complaints Received

Figure 5 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 FY21, OMCAT received 2,372 complaints, which is an increase of 34 percent (or 602 more) compared

to the third quarter of FY20 and is an increase of 12 percent (or 252 more) compared to the second quarter of FY21.

Figure 5: Complaints Received FY20 & FY21

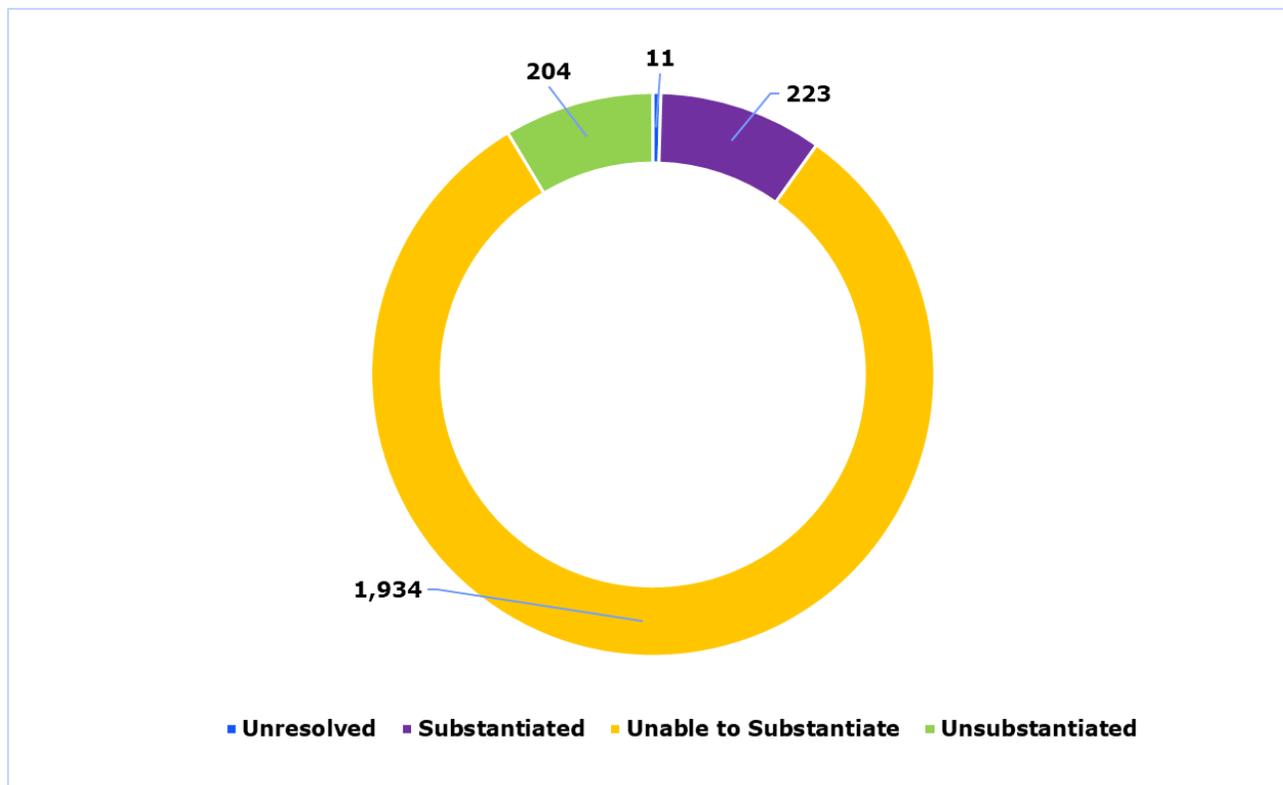


The increase in complaints volume seen in quarter three of FY21 compared to the third quarter of FY20 is due to the impact that the PHE had on contact volume in FY20 as mentioned above.

Resolved Complaints by Determination

Figure 6 below shows the total resolved complaints by determination received in the third quarter of FY21. OMCAT resolved 2,361 complaints out of 2,372 received. Eleven complaints were still being investigated at the end of the third quarter of FY21.

Figure 6: Complaints by Resolution Determination



Substantiated Complaints

In the third quarter of FY21, OMCAT substantiated 223, or nine percent of resolved complaints. This is a decrease of 2 percentage points compared to the previous quarter (where OMCAT substantiated 11 percent of the complaints).

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

The second highest substantiated complaint for the quarter was related to consumers showing case information errors in HHSC systems. Consumers reported requesting changes such as updating address and name changes however requested changes were not entered timely in HHSC systems.

The third most common substantiated complaint for the quarter was related to consumers being incorrectly billed for medical services covered by Medicaid. Consumers

reported receiving a bill for services covered by Medicaid from physicians, anesthesiologists and hospitals, which is prohibited.

Top Complaint Categories

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

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

Figure 7 shows a comparison of the top complaint categories for the current quarter and previous fiscal year.

Figure 7: Top Complaint Categories Received FY20 & FY21

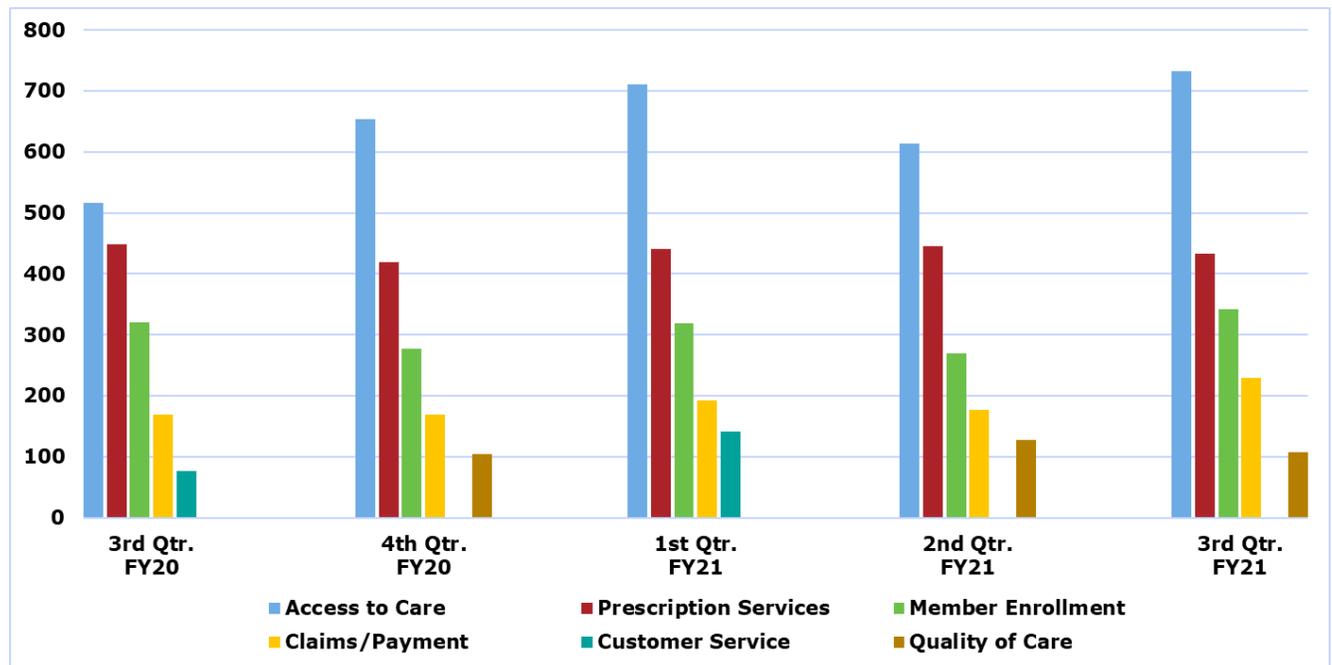


Figure 7 shows that complaints related to access to care increased from the second to the third quarter of FY21 and remained the top complaint category in the third quarter of FY21. After review of the contact reasons, data show that there was an increase in complaints related to access to in-network specialists and facilities and home health. A thorough review of case narratives revealed consumers had difficulty finding in-network

OBGYN providers that were contracted with the consumer's health plan, consumers had difficulty accessing Personal Assistance Services due to lack of available attendants and consumers reporting that home health attendants were not being paid by the provider agency.

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

Figure 7 also shows that complaints related to member enrollment remained the third highest complaint throughout all quarters and into the third quarter of FY21. A review of contact reasons shows that complaints related to problems regarding Medicaid eligibility and case information errors in HHSC systems were the top complaint reasons for member enrollment.

Complaints by Managed Care Program

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

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

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

STAR

The STAR program serves healthy children, pregnant women, and some parents of children on Medicaid¹. In the third quarter of FY21, OMCAT received 878 complaints of which 98 (or 11 percent) were substantiated.

Figure 8 shows a comparison of the top complaint categories for the current quarter and previous fiscal year. (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 third quarter of FY21 is 4,158,187.

Figure 8: Top STAR Complaint Categories FY20 & FY21

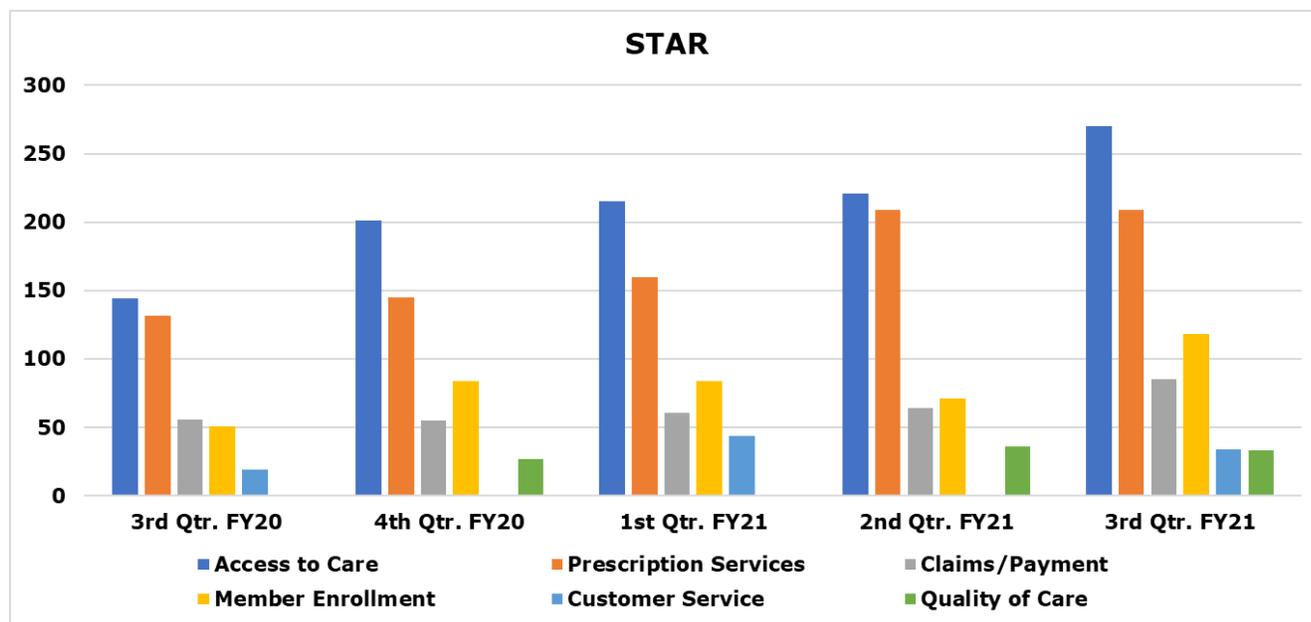


Figure 8 shows that consumers consistently complained of not being able to access care, access prescription services and had difficulty with member enrollment from the third quarter of FY20 through the third quarter of FY21.

During the same time frame further analysis shows there was an increase in consumer complaints related to accessing in-network and out-of-network providers. Consumer complaints regarding difficulty accessing prescription medication because of other insurance in HHSC or MCO systems increased. Consumer complaints related to case information entered incorrectly in HHSC systems.

Complaints also increased from the second quarter to the third quarter of FY21. Complaints related to access to care increased and complaints related to member enrollment increased from the second quarter to the third quarter of FY21. Further analysis shows consumers who had difficulty accessing in-network specialists and facilities increased. Analysis of case summaries show that consumers had difficulty accessing OBGYN providers and behavioral health services including behavioral health residential treatment centers. Consumers who had complaints about case information entered incorrectly in HHSC systems.

Complaints related to prescription services is the second highest complaint category beginning in the third quarter of FY20 and into the third quarter of FY21. Top complaint contact reasons relating to access to prescription services included consumers having difficulty accessing prescription services due to other insurance on their Medicaid profile in HHSC, MCO or pharmacy systems and consumers not showing as active with coverage in MCO or pharmacy systems.

Complaints related to member enrollment is the third highest complaint category beginning in the fourth quarter of FY20 and into the third quarter of FY21. Data show the top complaint reasons for the third quarter of FY21 were complaints of case information errors in HHSC and MCO data systems and problems regarding Medicaid eligibility and recertification.

Figure 8 also shows that complaints related to member enrollment increased from the second to third quarter of FY21. Further analysis of contact reasons shows an increase in complaints related to case information errors and problems related to Medicaid eligibility/recertification. Case summaries indicate that the most common complaints are related to incorrect consumer names and addresses in HHSC systems, consumers who want to terminate Medicaid due to receiving private insurance or because the consumer had moved out of state and consumers who have received notification that their benefits will be terminated due to incomplete application.

STAR+PLUS

The STAR+PLUS program serves adults who have disabilities or are age 65 or older². In the third quarter of FY21, OMCAT received 706 complaints of which 62 (or nine percent) were substantiated. Figure 9 shows a comparison of the top complaint categories for the current quarter and previous fiscal year.

² The average monthly enrollment for the STAR+Plus program in the third quarter of FY21 is 533,445.

Figure 9: Top STAR+PLUS Health Complaint Categories FY20 & FY21

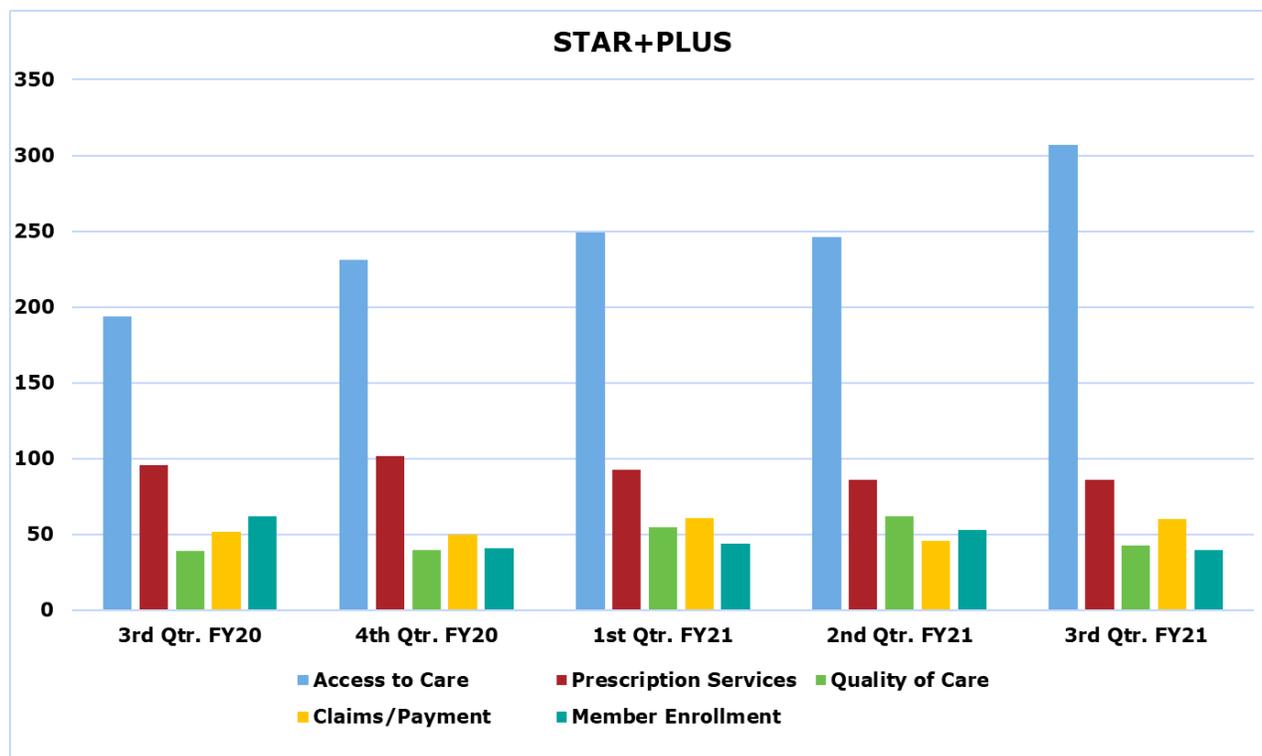


Figure 9 shows that complaints related to access to care is the top complaint category for five consecutive quarters beginning in third quarter of FY20 and into the third quarter of FY21. Complaints related to access to care increased from the second to third quarter of FY21. The increase in complaints from the second to third quarter of FY21 can be attributed to an increase in complaints related to denial of services and an increase in complaints related to access to in-network specialists and facilities. Case summaries indicate that the most common consumer complaints were related to termination and denial of the STAR+PLUS HCBS waiver, medical imaging denials and difficulties accessing neurologists who contract with the consumers’ health plan. Complaints related to consumers’ difficulty accessing home health services increased from the second to third quarter of FY21 and remained the top complaint reason in the second and third quarter of FY21. A review of case summaries showed that consumers reported needing assistance initiating home health services and consumers having difficulty receiving home health services due to lack of available attendants.

The data show that complaints related to prescription services is the second highest complaint category beginning in the third quarter of FY20 and into the third quarter of FY21. The data show the top complaint reasons for the third quarter of FY21 were complaints of consumer issues related to having other insurance aside from Medicaid, consumers not showing active in pharmacy and MCO systems and consumers having issues related to accessing prescriptions for other reasons.

Complaints related to claims payment is the third highest complaint category in the third quarter of FY21. After review of the contact reasons, data show the top complaint reasons for the third quarter of FY21 were complaints related to consumers receiving a bill for services rendered while active with Medicaid and complaints related to consumers requiring prior authorization for services.

STAR Kids

The STAR Kids program serves children and adults 20 and younger who have disabilities³. In the third quarter of FY21, OMCAT received 161 complaints of which 15 (or nine percent) were substantiated. Figure 10 shows a comparison of the top complaint categories for the current quarter as well as the previous 4 quarters.

Figure 10: Top STAR Kids Complaint Categories FY20 & FY21

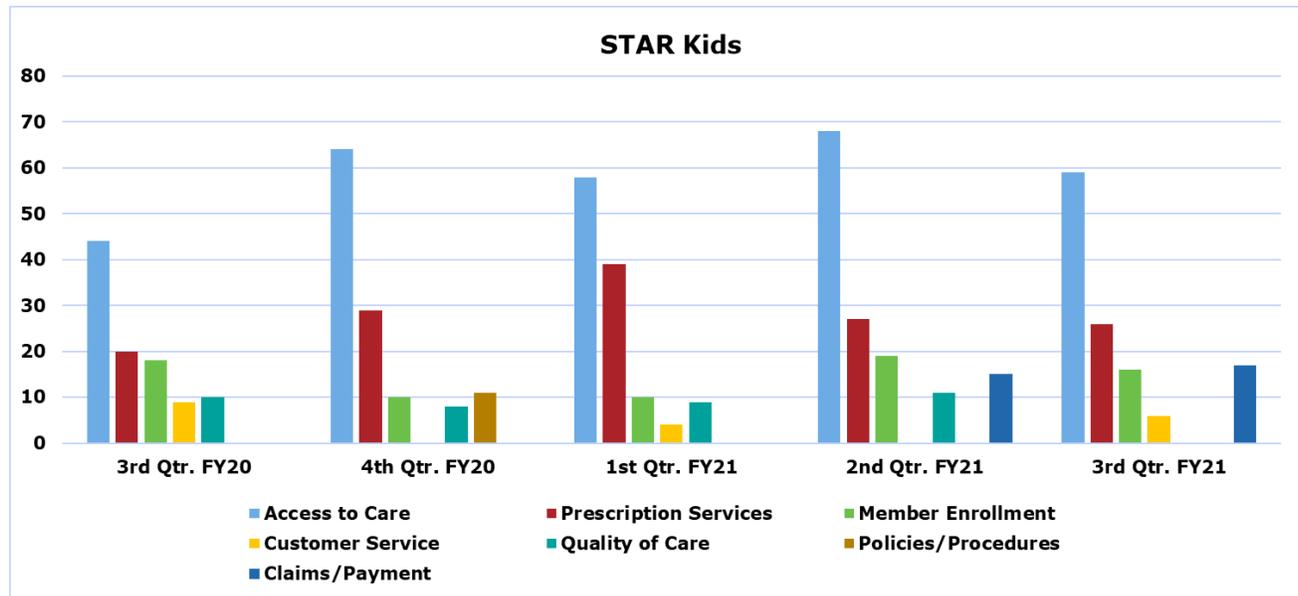


Figure 10 shows complaints related to access to care is the top complaint category beginning in the third quarter of FY20 and into the third quarter of FY21. The data show the top complaint reasons for the third quarter of FY21 were related to consumers having issues accessing home health services, access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

Data show that complaints related to prescription services is the second highest complaint category beginning in the third quarter of FY20 and into the third quarter of FY21 for STAR Kids. After a review of the contact reasons, data show the top complaint reasons were related to consumers having other insurance aside from Medicaid, prior

³ The average monthly enrollment for the STAR Kids program in the third quarter of FY21 is 169,458.

authorizations related to drugs listed on the preferred drug list and other complaints related to prescription services.

Complaints related to claims/payment is the third highest complaint category in the third quarter of FY21. The data show the complaint reasons for the third quarter of FY21 were complaints of consumers receiving a bill for services rendered while active with Medicaid and issues with authorizations.

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 FY21, OMCAT received 187 complaints, of which 26 (or 14 percent) were substantiated. Figure 11 shows a comparison of the top complaint categories for the current quarter as well as the previous 4 quarters.

Figure 11: Top Fee for Service/Traditional Medicaid Complaint Categories FY20 & FY21

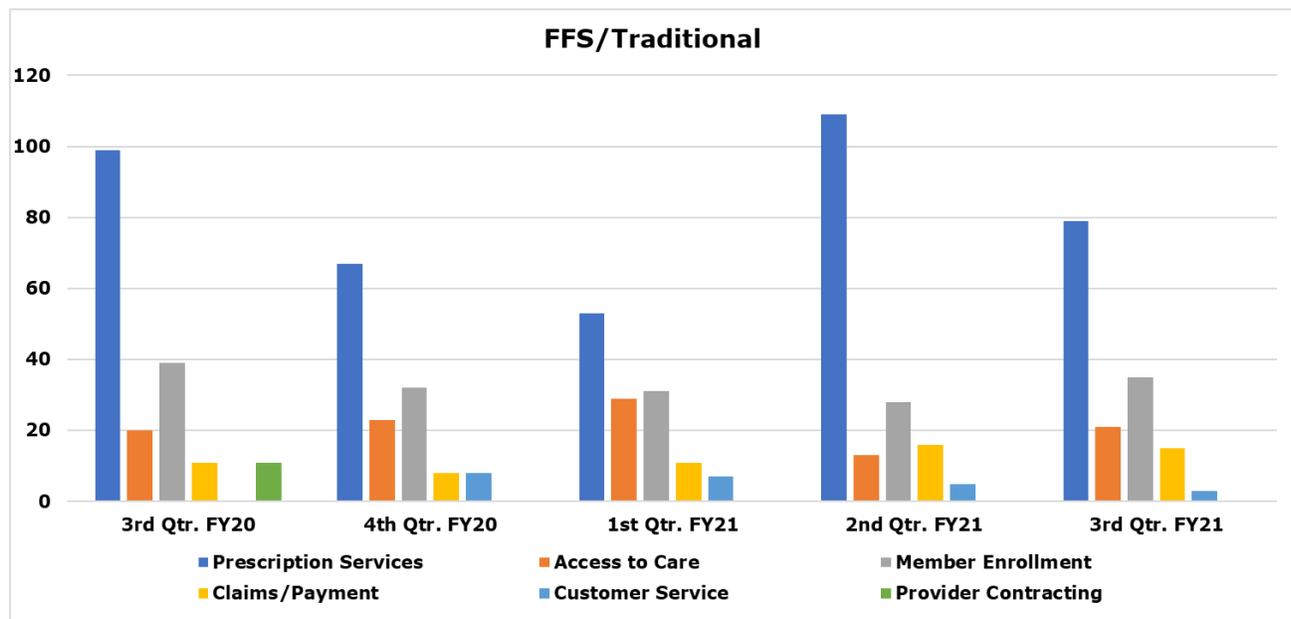


Figure 11 shows complaints related to prescription services is the top complaint category beginning in the third quarter of FY20 and into the third quarter of FY21. A review of contact reasons shows the top complaint reasons were issues related to consumers showing as having other insurance aside from Medicaid, consumers not showing active with Medicaid in pharmacy systems and complaints related to consumers prescribing

⁴ The average monthly enrollment for the Fee for Service/Traditional Medicaid program in the third quarter of FY21 is 161,251.

physician not being enrolled as a Medicaid provider. Medicaid consumers can only be prescribed services through a Medicaid enrolled provider.

Figure 11 also shows complaints related to prescription services decreased. A review of contact reasons shows that there was a decrease in complaints related to consumers not showing active with Medicaid in pharmacy systems and consumers having problems accessing prescriptions after they had reached their three-prescription limit for the month.

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

Figure 11 also shows that complaints related to access to care is the third highest complaint category in the third quarter of FY21. A review of contact reasons shows the top complaint reasons were consumers having issues with accessing home health services, access to in-network specialists and facilities and access to primary care physicians.

Complaints related to access to care increased from the second quarter to the third quarter of FY21. A review of contact reasons shows that there was an increase in complaints related to consumers accessing in-network specialists and facilities. A thorough review of case narratives did not reveal a trend.

Complaints by Service Area

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

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

Table 2 includes the top complaints that were resolved and determined to either be substantiated or unable to substantiate by service area. The complaints represented in Table 2 are only those where 10 or more complaints were received in the service area and are a subset of the total complaints received for the service areas. The number of enrolled Medicaid consumers by service area is provided in Appendix B.

Table 2: Top Complaints by Service Area Q3 FY21

	Bexar	Dallas	El Paso	Harris	Hidalgo	Jefferson	Lubbock	MRSA Central	MRSA North east	MRSA West	Nueces	Tarrant	Travis
Access to Care	53	134	17	119	49	23	8	30	50	25	27	68	42
Claims/ Payment	16	32	13	36	11	4	3	11	8	7	1	17	10
Customer Service	5	20	2	12	5	1	3	4	0	3	2	9	2
Member Enrollment	9	41	4	37	9	3	8	10	14	8	4	22	10
Policies	12	8	0	13	6	2	1	3	4	1	1	4	3

	Bexar	Dallas	El Paso	Harris	Hidalgo	Jefferson	Lubbock	MRSA Central	MRSA North east	MRSA West	Nueces	Tarrant	Travis
Prescription Services	37	50	6	95	21	10	15	16	17	16	9	29	11
Quality of Care	12	12	3	23	2	2	1	6	3	3	3	12	2
Therapy	3	3	2	12	1	0	1	1	0	0	0	0	4

Conclusion

In the third quarter of FY21 OMCAT experienced the highest contact rate since the declaration of the PHE late in the second quarter of FY20. The increase in contacts for the third quarter of FY21 shows the contact volume returning to levels experienced prior to the declaration of the PHE.

Complaint trends noted in this report included:

- Difficulty accessing prescriptions due to having other insurance aside from Medicaid; and
- Consumers having difficulty accessing home health services

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

Recommendations

There are no new recommendations for this quarter, however data analysis has shown an increase in complaints related to consumers having difficulty accessing home health services in the STAR+PLUS program. At this time there is insufficient data to identify a trend as to what is causing consumers difficulty in accessing home health services. OMCAT will continue to review data from the fourth quarter of FY21 and the first quarter of FY22 to identify trends regarding barriers to accessing home health services.

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

Appendix A: Managed Care Program Tables

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

Table 3: Complaint Categories by Managed Care Program Q3 FY21

	STAR+PLUS	STAR	STAR Kids	STAR+PLUS Dual-Demo	STAR Health	Dental	FFS	No Medicaid
Access to Care	307	270	59	8	6	22	21	36
Claims/ Payment	60	85	17	7	3	16	15	26
Customer Service	24	34	6	4	1	5	3	23
Fraud	2	4	0	0	0	0	0	4
Member Enrollment	40	118	16	5	8	6	35	114
Member Health and	4	7	3	1	0	3	0	8
Non-Medicaid /CHIP	11	7	1	2	0	0	0	18
Policies/ Procedures	35	17	5	1	1	4	4	13
Prescription/ Services	86	209	26	11	4	0	79	18
Quality of Care	43	33	3	5	1	4	2	17
Therapy	7	12	7	1	0	0	1	0
Transportation Issues	11	3	3	0	0	1	0	3
Value Added Services	2	5	0	0	0	0	0	0

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

Table 4: Average Monthly Enrollment by Managed Care Program Q3 FY21

Managed Care Program	Average Monthly Enrollment
Dental	3,550,935
FFS	161,251
STAR+PLUS Dual-Demo	38,800
STAR	4,158,187
STAR HEALTH	43,455
STAR Kids	169,458
STAR+PLUS	533,445
Grand Total	4,904,545

Appendix B: Average Enrollment by Service Area

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

Table 5: Average Enrollment by Service Area

Service Area	Average Enrollment
Bexar	405,198
Dallas	866,358
El Paso	234,390
Harris	1,093,688
Hidalgo	509,865
Jefferson	132,961
Lubbock	115,488
MRSA Central	222,388
MRSA Northeast	279,728
MRSA West	249,207
Nueces	138,766
Tarrant	422,528
Travis	229,324

Appendix C: Recommendations and Updates from Previous Reports

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

In prior quarterly reports (first and second quarter of FY21), OMCAT observed that Medicaid consumers who move out of their service area experience challenges in accessing care when the new service area is not serviced by their MCO. OMCAT recommended that MCS review the feasibility of expediting enrollment retroactively during the month the new MCO is chosen, as soon as the consumer has updated the address for the new service area.

OMCAT has shared case examples regarding consumers who have moved out of a service delivery area to determine the length of time before the member's case information was updated in the HHSC and MCO systems after the move was reported to HHSC. OMCAT is using this information to better inform the Medicaid CHIP Services program regarding the feasibility of expediting retroactive enrollment when a member moves to a different service delivery area and chooses a new MCO.

Erroneous Secondary Insurance on Consumer Medicaid Cases

In previous quarterly reports, OMCAT provided recommendations to mitigate incorrect secondary insurance information on consumer cases in HHSC systems. HHSC took several actions to reduce occurrences of incorrect secondary insurance on consumer's cases including; TMHP transitioning to a new pharmacy data match subcontractor effective October, 1 2021, collaboration between HHSC and the health plans to identify process improvements for situations when pharmacies incorrectly identify consumer's other insurance and correction of over 80,000 pharmacy records that were incorrect or duplicate records.

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 2020 – The 12-month period from September 1, 2019 through August 31, 2020, covered by this report.

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

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

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

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

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

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

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

List of Acronyms

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