



# **Report of the HHS Ombudsman**

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# Executive Summary

This is the first annual report for the Texas Health and Human Services Office of the Ombudsman (HHS Ombudsman).

Texas law requires that each ombudsman program within the HHS Ombudsman submit a report. Those individual reports are collected here for consistency and convenience and made available on the HHS Ombudsman website. The Long-Term Care Ombudsman and the Office of the Independent Ombudsman for State Supported Living Centers are not covered in this report.

In this report, each ombudsman program describes the specialized work it does by relaying data about complaints received and investigated during fiscal year 2023 (FY23), describing trends or systemic issues uncovered during the investigation of complaints and recommendations to address the challenges.

In FY23, the HHS Ombudsman received 102,081 total contacts, of which 39,396 were complaints.

# Introduction

There are two primary models of public-facing governmental ombudsman programs: legislative and executive. As there is no independent legislative ombudsman program receiving complaints about all state agencies, the Texas Legislature created executive ombudsman programs within several state agencies including Health and Human Services.

Executive ombudsman programs are not truly independent of their respective state agencies, since the ombudsman ultimately reports to the agency's leadership. Therefore, the executive ombudsman model depends on several factors to carry out principles that all governmental ombudsmen adhere to: independence, impartiality, confidentiality, and a credible review process<sup>1</sup>. These factors include:

- Structural independence within the agency, ensuring the ombudsman is not in the same chain of command as any of the programs of which they receive complaints.
- Authority to access records both documentary and testimonial within the agency to thoroughly investigate complaints, as well as the authority to make recommendations to agency leadership to address findings.
- Having public reporting authority to ensure the significant issues and recommendations for addressing them are brought to the public's attention.
- Understanding and support of ombudsman principles within the leadership of the agency to ensure these factors are put in place and enforced when necessary.

The HHS Ombudsman is also responsible for collecting, analyzing and reporting on complaint data from programs across the HHS system. Consumer contacts include inquiries and complaints from consumers, legislative staff on behalf of consumers, and other stakeholders.

Contact methods include phone, an online submission form, postal mail and fax. All consumer contacts received by the HHS Ombudsman are logged in the HHS Enterprise Administrative Report and Tracking System (HEART).

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<sup>1</sup> [\*Governmental Ombudsman Standards, United States Ombudsman Association 2003\*](#)

The HHS Ombudsman 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. The HHS Ombudsman reviews contact data for potential trends and shares recommendations to address trends with HHS programs.

Table 1 below provides an overview of complaint resolutions used by the HHS Ombudsman.

**Table 1: Complaint Resolution Determination**

<b>Determination Type</b>	<b>Definition</b>	<b>Example</b>
Substantiated	Research clearly indicates that agency policies or expectations were violated.	Consumer statement and records confirm a home health attendant didn't show up for a scheduled appointment.
Unable to Substantiate	Research cannot indicate whether agency policies or expectations were or were not violated.	Consumer reports a denial of service but is unresponsive to the ombudsman's attempts to contact.
Unsubstantiated	Research indicates that agency policies or expectations were not violated.	Consumer complains about a reduction in SNAP benefits, but proof of income justifies the level of benefits.
Referred	Research indicates the complaint must be addressed by another area.	Consumer complaint of not getting approved for social security disability.

The data contained in this report are exclusive to contacts received by the Ombudsman Complaint Services (OCS), Specialized Ombudsman Services (SOS), Ombudsman for Behavioral Health (OBH), Foster Care Ombudsman (FCO), Ombudsman for Individuals with Intellectual or Developmental Disability (IDD Ombudsman), and Ombudsman Managed Care Assistance Team (OMCAT).

This annual report fulfills not only a specific legislative mandate but demonstrates the agency's commitment to the core principles of the executive ombudsman model. In doing so, it fulfills the agency's stated ideals of transparency and responsiveness to the people it serves.

# Background

[House Bill 3462](#), 88th Legislature, Regular Session, 2023, consolidated existing ombudsman programs administered by the Texas Health and Human Services Commission (HHSC) which were established to provide information and investigate complaints regarding the agency's programs and services.

The bill requires the HHS Ombudsman to publish an annual report of its activities each December. The law specifically requires that the report addresses:

- A description of the ombudsman's work.
- Any changes made by the commission or department (or another HHS agency) in response to a substantiated complaint.
- A description of trends in complaints or systemic issues, recommendations to address them, and an evaluation of the feasibility of those recommendations.
- A glossary of terms used in the report.
- A description of methods used to promote awareness of the HHS Ombudsman and a plan for the next fiscal year.
- Any feedback from the public on the previous fiscal year report.

# Ombudsman Complaint Services and Specialized Ombudsman Services

The Ombudsman Complaint Services (OCS) and Specialized Ombudsman Services (SOS) teams work together to resolve consumer concerns.

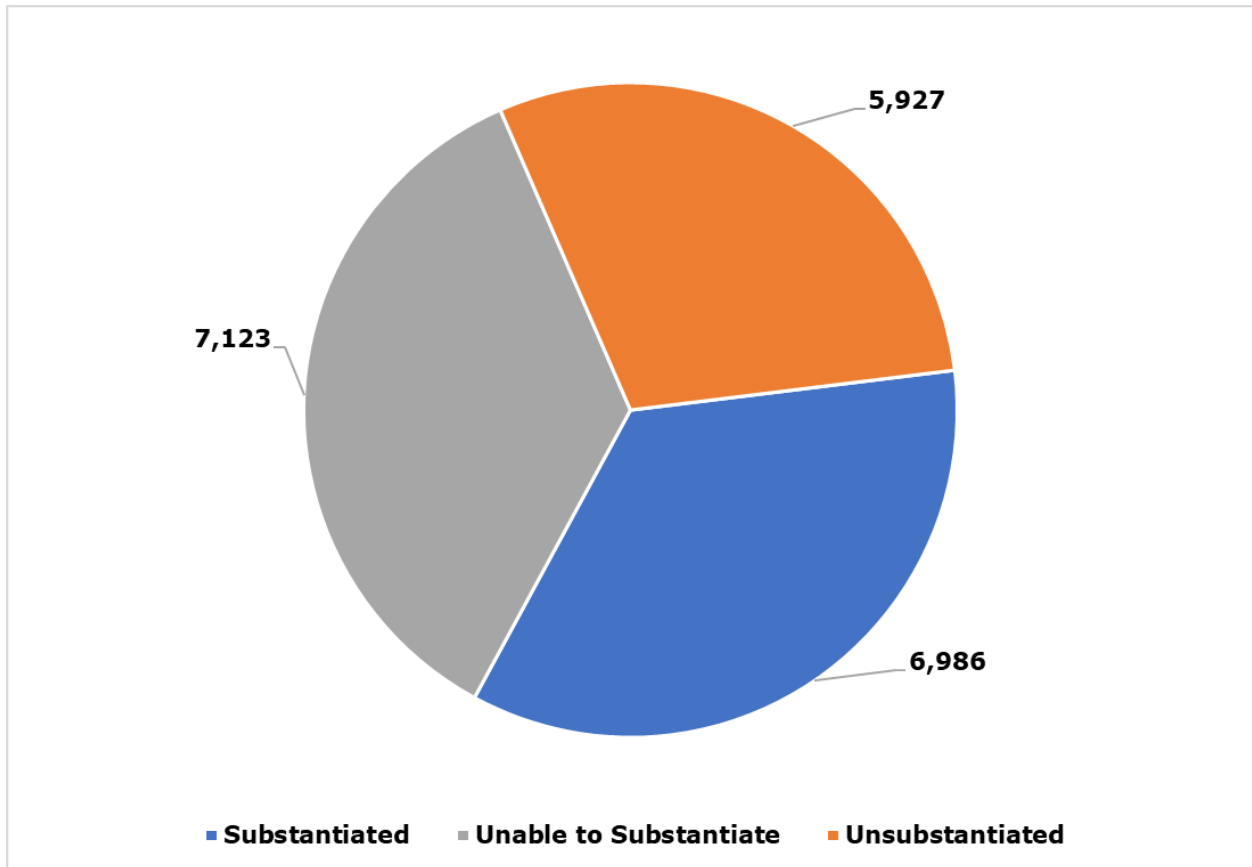
The OCS team answers the main Ombudsman toll-free line addressing inquiries and complaints about HHS programs and services. The team promotes and educates consumers on various HHS programs by referring consumers to the appropriate HHS area. It strives to resolve issues upon first contact. However, if the issue needs to be addressed further, OCS will escalate to the SOS team for resolution.

In FY23, OCS and SOS received 60,059 inquiries and complaints from consumers, legislative and federal officials. (Note: On or about March 22, 2023, the 2-1-1 Interactive Voice Response (IVR) platform experienced technical difficulties that prevented consumers from reaching ombudsman staff. This resulted in a 24% increase in call volume to the HHS Ombudsman's toll-free line from February 2023 to March 2023.)

## Complaints by Determination Type

In FY23, a total of 20,036 complaints were resolved, with 6,986 substantiated, 5,927 unsubstantiated and 7,123 unable to substantiate. Figure 1 below shows the complaints by determination type.

**Figure 1: Complaints by Determination Type, FY23**



## Substantiated Complaints

The three most common reasons for substantiated complaints were:

- Eligibility application not processed on time (2,940).
- Denial of eligibility application or case in error (1,741).
- Updated address or income not processed in a timely manner (644).

## Findings and Recommendations

### Medicaid coverage removal

In FY23, the HHS Ombudsman received 16 complaints from consumers requesting their Medicaid coverage be removed because it had been issued erroneously. Some consumers reported that having Medicaid caused the Office of Attorney General (OAG) to withhold medical support payments. Other consumers reported having Medicaid coverage prevented the household from obtaining health insurance



through the Health Insurance Marketplace or from the household being able to claim the premium tax credit on income tax forms.

**Recommendation:** Implement systemic change to remove erroneously issued Medicaid coverage.

**Feasibility of Recommendation:** Currently in progress. As of the date of this report, there are a few outstanding complaints still requiring the removal of Medicaid coverage.

## Erroneous Medicare Savings Program denial letters

In FY23, the HHS Ombudsman received 166 contacts from consumers who were denied benefits through the Medicare Savings Program effective November 2022 due to a system error. This denial caused two months of Medicare Part-B premium payments to be deducted from the consumers' Social Security check beginning in February 2023. The erroneous denials affected 43,765 clients.

**Recommendation:** Immediate action needed to resolve the error.

**Feasibility of Recommendation:** A system correction was implemented on January 6, 2023, reinstating the Medicare Part B coverage for the affected recipients to prevent deductions due to the error.

## Unclear client notices

In FY23, OCS and SOS received 2,519 inquiries from consumers who had questions about client notices. This was among the top three reasons consumers made a contact inquiry.

An example of this type of contact inquiry is a household who received the Request for Domicile Verification, Form H1155, and a notation stating "a person listed above has reported that you are not related to them but are familiar with their family." However, the person listed was a child.

Consumers also had questions about the comments section in the client notice for when a household's expenses exceed their income. Form H1020, Request for Information or Action, informs the household that expenses are greater than their income and to provide information as to how they are paying their bills. The form states that "acceptable verification is for the household to provide verification of how they are meeting their expenses or proof their expenses are not paid." This language is vague and provides no guidance as to what types of verification the consumer needs to provide.

**Recommendation:** HHSC Access and Eligibility Services (AES) should conduct a review of their notices to clarify information it requests from consumers.

**Feasibility of Recommendation:** Achievable.

## Inconsistent translation of denial letter

During the investigation of a complaint about termination of services, the HHS Ombudsman noticed inconsistencies between the English and Spanish versions of the letter sent to all clients notifying them of a denial of services and the right to appeal.

The Spanish version informed clients that they could request an appeal by calling 2-1-1 or 1-877-541-7905, or they could fill out and return the written appeal sheet on the next page. The next page states "This page intentionally left blank."

The English version, on the other hand, provided different information about the appeal process. It referred clients to call 2-1-1 and stated if they are unable to call 2-1-1, they may ask for a hearing by sending a letter or going to an HHSC benefits office. The English version provided information about what to include in the appeal letter along with a mailing address.

**Recommendation:** HHSC AES should review and revise the client notice and ensure information contained in the English and Spanish version is consistent.

**Feasibility of Recommendation:** Currently in progress. HHSC AES agreed to correct the language in the Spanish section of the client notice by early 2024.

## Contract oversight for FMSAs

In FY23, the Ombudsman Office received 72 complaints from Consumer Directed Services (CDS) employers citing issues with payments from their Financial Management Services Agency (FMSA). CDS employers frequently receive services and could be impacted when payments to their attendants are not made or delayed.

FMSAs are contracted by managed care organizations (MCOs) to provide services to consumers, and disputes about payments can be worked out informally. However, when disputes cannot be resolved, the HHS Ombudsman has investigated what authority HHSC has to enforce contractual obligations for these entities. MCS advised the HHS Ombudsman that HHS has no oversight of how the funds are distributed by the FMSAs, as HHSC is not a party to the contract between the FMSA and CDS employer.

**Recommendation:** HHSC MCS should establish an ad hoc committee to review TAC, policy and contract elements to clarify HHSC's role in ensuring funds are used appropriately by FMSAs.

**Feasibility of Recommendation:** May require changes to policy or Texas Administrative Code (TAC) rules.

## Ombudsman for Managed Care Assistance

The Ombudsman for Managed Care Assistance Team (OMCAT) resolves Medicaid managed care inquiries and complaints through coordination with health plans, providers and HHS Medicaid program staff.

OMCAT provides support to consumers who report that their complaint about Medicaid services through their health plan — also referred to as a Managed Care Organization (MCO) — is unresolved.

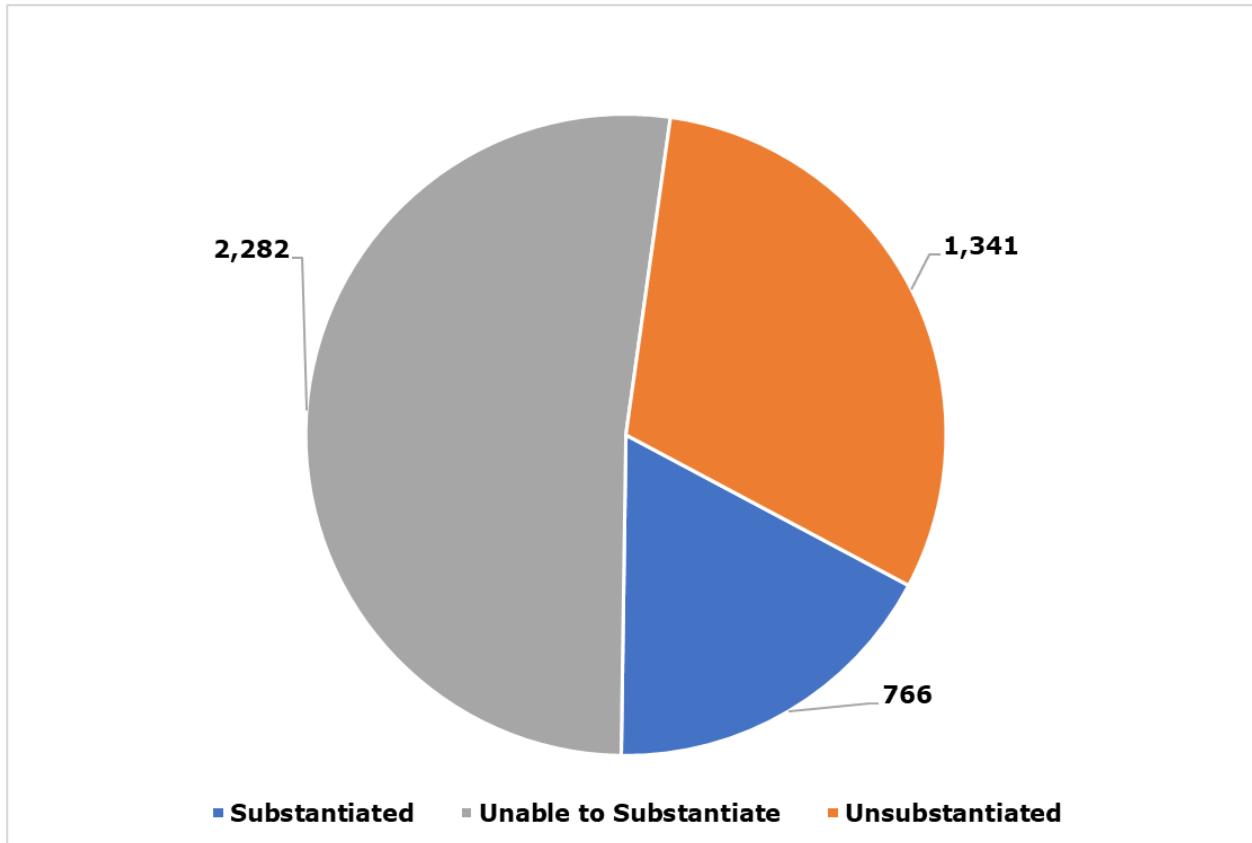
OMCAT provides information allowing consumers to advocate for themselves and investigates complaints to determine if the MCO or the appropriate entity is following HHSC policy.

In FY23, OMCAT received 29,049 contacts including inquiries and complaints.

### Complaint by Determination Type

In FY23, OMCAT resolved 4,389 complaints. Of these complaints, 766 were substantiated, 1,341 were unsubstantiated and 2,282 were unable to substantiate. Figure 2 below shows the complaints by determination type.

**Figure 2: Complaints by Determination Type, FY23**



## Substantiated Complaints

The three most common reasons for substantiated complaints were:

- Access to an in-network provider (non-PCP) (81).
- Case information error (57).
- Home health (57).

## Findings and Recommendations

### Erroneous secondary insurance affecting Medicaid services

In June 2019, OMCAT first noted this issue in its then-statutorily required quarterly public report. Consumers reported issues in receiving Medicaid services due to incorrectly showing third-party insurance as active on their Medicaid profile in HHSC and MCO systems. The most significant service affected by this was prescription medication. OMCAT made recommendations to correct the issue beginning in its

first quarter FY20 report. In FY22, HHSC implemented several changes that addressed this issue, and OMCAT reported a gradual decline in complaints.

In FY23, OMCAT received 452 complaints from consumers stating they could not receive Medicaid services because their Medicaid profile incorrectly showed third-party insurance as active.

**Recommendation 1:** Office of the Inspector General (OIG) should prioritize this issue through its collaborative project plan with Texas Medicaid Healthcare Partnership (TMHP) that is expected to launch in FY24.

**Feasibility of Recommendation:** Currently in progress.

**Recommendation 2:** HHSC should notify Medicaid consumers whenever private insurance is identified as being active by adding a notice to the consumer's Your Texas Benefits account and on renewal applications with instructions on how to correct errors in third party insurance.

**Feasibility of Recommendation:** This would require system changes.

## **Expediting enrollment for consumers who have moved out of the service delivery area (SDA)**

OMCAT observed that Medicaid consumers who move out of their SDA experience challenges in accessing care when the new SDA is not serviced by their MCO. In FY23, OMCAT received 214 complaints from consumers with this contact reason.

**Recommendation:** HHSC Medicaid and CHIP Services (HHSC MCS) should review the feasibility of expediting enrollment in the new MCO retroactively during the month the new MCO is chosen and as soon as the consumer has updated the address for the new SDA.

**Feasibility of Recommendation:** Currently in progress. HHSC MCS is leading a workgroup that reviews and recommends changes to enrollment rules to expedite enrollment for consumers who move out of the SDA, change MCOs within the same SDA or will be new enrollees in Medicaid.

## **Denial and delay of services**

In FY23, OMCAT received 196 complaints regarding consumers reporting they were denied services by their MCO. Of those, OMCAT was able to substantiate 28 cases. A detailed review of the substantiated complaints shows that in some cases the MCO didn't follow policy in denying services, denied services within policy but

without making a reasonable attempt to assist the consumer and consider reasonable alternatives, or prevented the consumer from receiving services in a timely manner or at all due to an action or inaction. A review of case summaries shows, for example, that MCOs:

- overturned their denial for medical imaging after an internal appeal;
- failed to timely send Personal Assistance Service authorizations; or
- stopped communicating and assisting the consumer with authorizations for Personal Assistance Services.

**Recommendation:** HHSC MCS should conduct a review of service denials to determine the potential scope of errors. Further recommendations could be forthcoming after an analysis of data produced by this review.

**Feasibility of Recommendation:** Achievable.

## Outreach

OMCAT participates in quarterly meetings with the Children’s Health Care Coalition, an external stakeholder group that collaborates with HHSC.

OMCAT regularly participates in the State Medicaid Managed Care Advisory Committee’s (SMMCAC) subcommittee Complaints, Appeals and Fair Hearings quarterly meetings.

The SMMCAC subcommittee Complaints, Appeals and Fair Hearings focuses on more effectively leveraging complaint data to identify potential problems in the Medicaid program, opportunities for improved MCO contract oversight and increasing program transparency. OMCAT promotes awareness by providing data pertaining to topics of interest of the subcommittee and presentations of the most recent complaint and inquiry data for OMCAT.

## Foster Care Ombudsman

The Foster Care Ombudsman (FCO) assists foster youth with inquiries and complaints about Department of Family and Protective Services (DFPS) programs such as Child Protective Services (CPS) and Community-Based Care (CBC), and HHS programs and services such as Residential Child Care Regulation (RCCR).

Cases are reviewed to determine if DFPS policy and HHSC minimum standards were followed. Applicable policies include federal and state law, administrative rules, program handbooks, contracts, and internal program policies and procedures including DFPS and HHS Human Resources Policy Manual and Guidance Handbook.

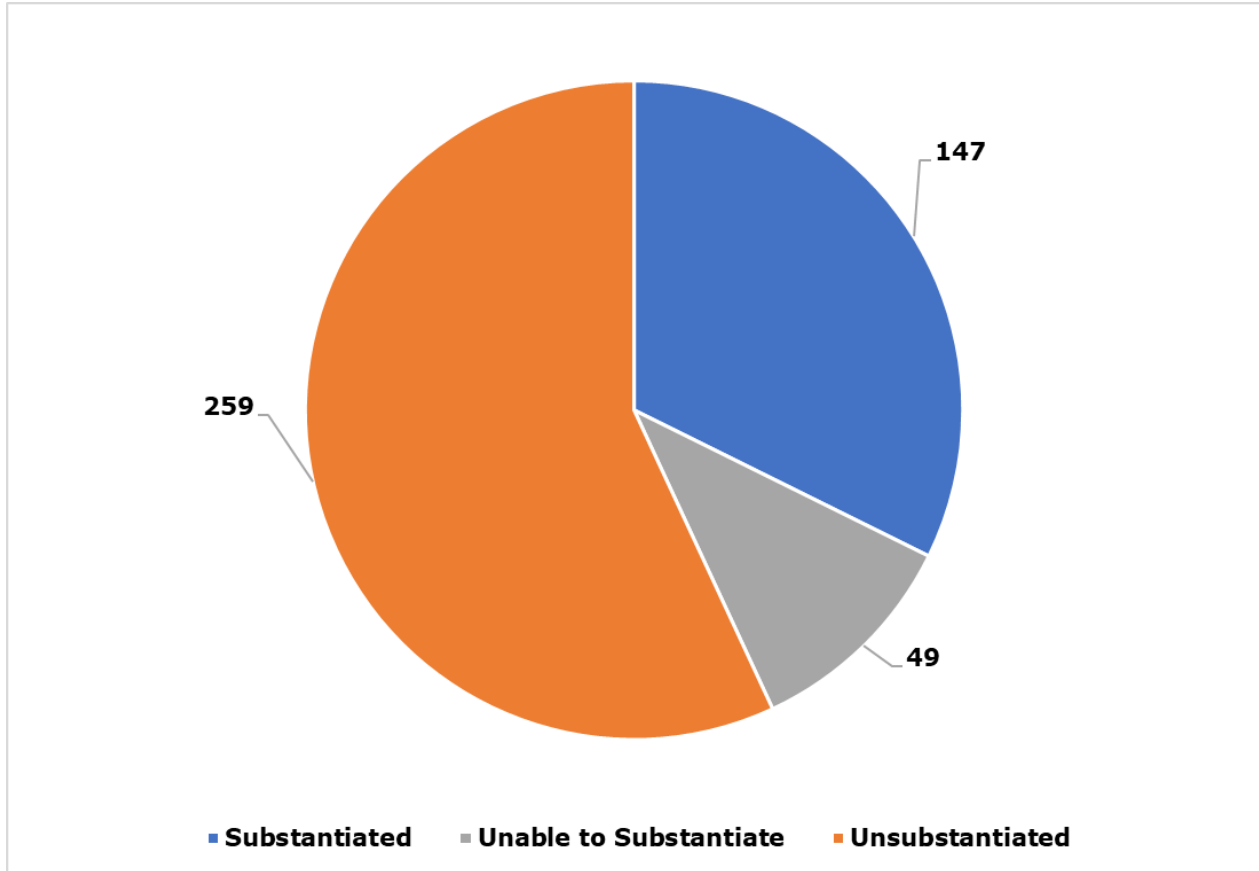
In FY23, FCO received a total of 1,361 contacts including inquiries and complaints. Among those, FCO resolved 455 complaints from youth, a decrease of 123 from FY22. The remaining contacts were from others, such as family members, from whom FCO is not authorized to receive complaints.

### Complaint by Determination Type

Of the 455 complaints in FY23, 147 were substantiated, 259 were unsubstantiated, and 49 were unable to substantiate. Figure 3 below shows the complaints by determination type.



**Figure 3: Complaints by Determination Type, FY 2023**



## Substantiated Complaints

The three most common reasons for substantiated complaints were:

- Court (42)
- Case recording (40)
- Other (13)

## Findings and Recommendations

### Lack of adequate documentation in IMPACT

In each of the then-statutorily required annual public reports going back to 2017, FCO has noted a number of substantiated complaints regarding the lack of adequate documentation in the DFPS case management system, Information Management Protecting Adults and Children in Texas (IMPACT). Over the past four years, the FCO annual report notes the instances of inadequate documentation (“case recording”) complaints:

<b>Complaint Category</b>	<b>FY22 (257 Substantiated)</b>	<b>FY21 (273 Substantiated)</b>	<b>FY20 (274 Substantiated)</b>	<b>FY19 (250 Substantiated)</b>
Case Recording	77	64	43	37

The absence of documentation about medical appointments, placement changes and youth sibling visitation in a youth’s case can cause issues with the continuity of services and can impact a successful transition or transfer from one placement to another.

For example, FCO substantiated a complaint from a youth who reported missing items at their placement and was not allowed to call their caseworker. FCO’s review of the IMPACT system and DFPS responses found that it did not list an inventory of the youth’s belongings. DFPS also could not provide a document showing where the youth’s items were logged and stored.

During the investigation, FCO learned of nine additional policy violations related to missing, inaccurate and untimely documentation in IMPACT, including but not limited to:

- Not providing a completed Form 2071 (or supporting document in lieu of this document) listing a communication plan in place with the Attorney Ad-Litem and Guardian Ad-Litem.
- Not providing documentation of communication with the child and their family, court personnel (or legal parties) and consultations between supervisors and caseworkers.
- Not documenting all health appointments and concerns such as the youth’s medical and dental information on the Medical/Mental Assessment page in a timely manner. DFPS also didn’t update the child’s Medical/Developmental History when initiating the Child Plan of Service or review and file copies of relevant documents in external documentation.
- Not updating inaccurate information about the youth’s history of juvenile justice involvement.

In June 2023, FCO met with DFPS to discuss this finding and recommended CPS include these common issues in the new caseworker training. CPS agreed to share information with its internal and contracted staff. CPS also committed to have FCO assist with developing training that explains the role of FCO and common reasons foster youth contact the FCO.

**Recommendation 1:** CPS and CBC caseworkers and supervisors should complete refresher training regarding policies under 6133 Case Recording, emphasizing the need for adequately documenting case data. The training should be targeted as appropriate.

**Feasibility of Recommendation:** A webinar will need to be produced and disseminated.

**Recommendation 2:** CPS should include FCO information in their new caseworker training to address common concerns identified through FCO investigations. This should include the importance of all case documentation and providing Form 2071 to youth initially and anytime there are contact information changes.

**Feasibility of Recommendation:** Achievable.

## Outreach

FCO travels across the state to increase awareness among youth in care and providers. Visiting with Child Placing Agencies helps build rapport, fosters a better understanding of FCO, and opens lines of communication.

FCO participated in 21 virtual and in-person outreach events, reaching 208 youth in foster care and 140 foster parents and caregivers. Presentations were held at the Statewide Youth Leadership Council, Prom Rack, Preparation for Adult Life (PAL) and Aging-Out events, RTC, unlicensed placements and emergency shelters.

FCO traveled to the Child Crisis Center of El Paso and met with children, placement staff and providers in the area. Many of the children were aware of the FCO and appeared safe and comfortable in their environment. FCO also observed what appeared to be a closeknit community of CPS staff, community providers and representatives from the judicial system who collaborate to meet foster children's needs. Compared to other areas of the state, El Paso has a smaller community to serve. However, it appears the efforts made by the center, CPS and providers contributed to their historically low contact volume (one contact in four years).

## FY24 Planned Activities

For FY24, FCO will:

- Distribute the FCO Activity Book to CPS and CBC regions and catchments.
- Develop training material with DFPS to help promote FCO.

- Develop a job aid to provide information to CPS and the CBCs regarding what to expect during an investigation and what is needed when responding to the FCO during an investigation.
- Continue in-person outreach efforts to meet with youth in RTCs and speak with RTC staff to educate them regarding the FCO program and services.
- Initiate contact to foster youth in out-of-state placements such as RTCs.
- Increase outreach to Single Source Continuum Contractors (SSCC) catchment areas to coordinate regional tours.
- Consider visits to out-of-state placements.

FCO received no public comments relating to the 2022 Annual Report.

# Ombudsman for Individuals with Intellectual or Developmental Disability

The Ombudsman for Individuals with Intellectual or Developmental Disabilities (IDD Ombudsman) addresses issues related to individuals with IDD seeking and receiving Home and Community-based Services (HCS) and Texas Home Living (TxHmL) Medicaid waiver services, or services from Local Intellectual and Developmental Disability Authorities (LIDDAs). They also promote HHS services for people with IDD by referring individuals and their legally authorized representatives to the appropriate HHS divisions or LIDDAs to apply for those services.

The IDD Ombudsman doesn't investigate allegations of abuse, neglect or exploitation, as these fall under the jurisdiction of HHS Regulatory Services Provider Investigations (PI).

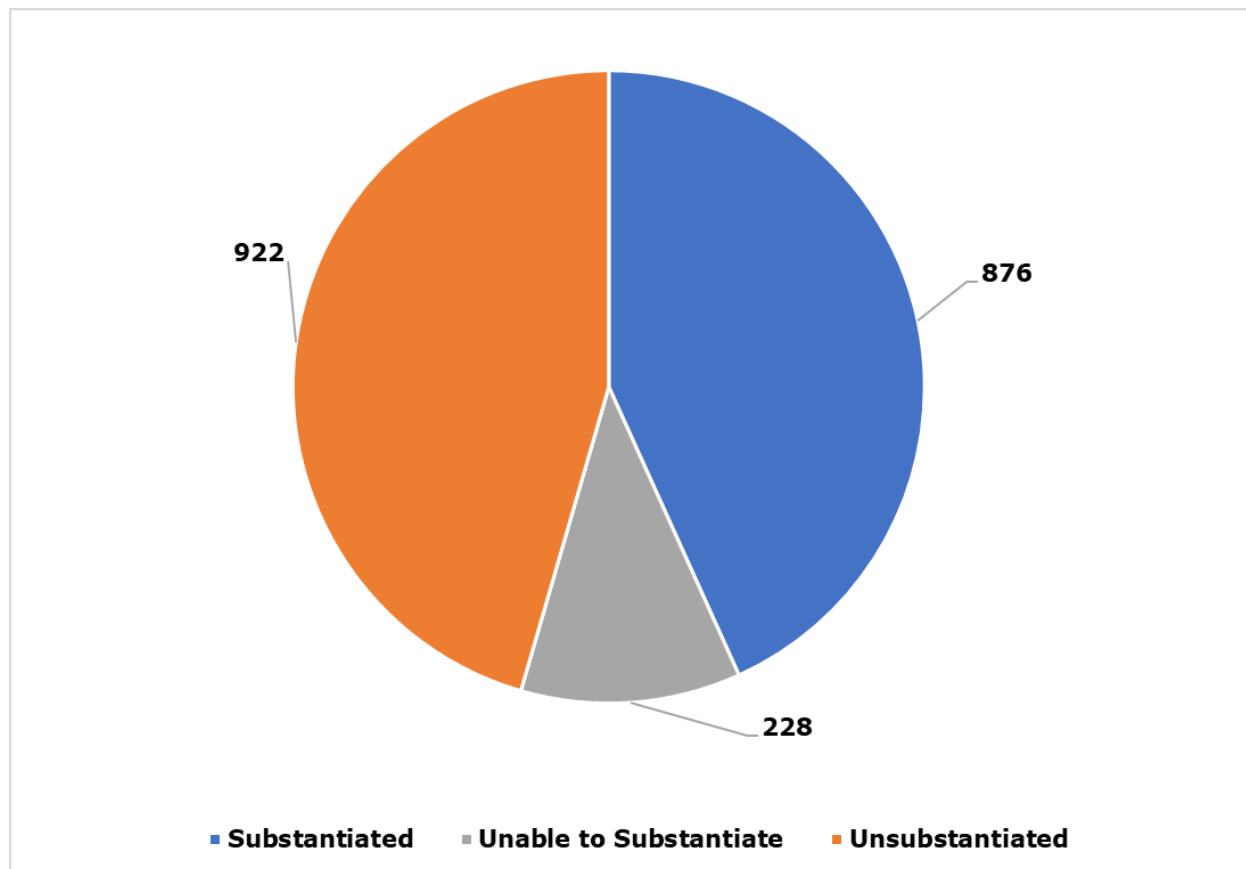
Any allegations of abuse, neglect or exploitation reported to the IDD Ombudsman are referred to DFPS Statewide Intake for assignment to PI. When PI receives an allegation of abuse, neglect or exploitation involving individuals in HCS or TxHmL, they notify IDD Ombudsman that the allegation is being investigated. If PI determines an allegation is outside their statutory jurisdiction and there may be rights violations or administrative issues, it is referred to the IDD Ombudsman and investigated as a complaint.

In FY23, PI referred 881 allegations to the IDD Ombudsman because they didn't meet the PI definition of abuse, neglect or exploitation. These referrals are included in the overall numbers below.

## Complaint by Determination Type

In FY23, the IDD Ombudsman resolved 2,026 complaints. Of these complaints 876 were substantiated, 922 were unsubstantiated, and 228 were unable to substantiate. Figure 4 below shows the complaints by determination type.

**Figure 4: Complaints by Determination Type, FY 2023**



## Substantiated Complaints

The three most common reasons for substantiated complaints were:

- CARE to TMHP transition (508).
- Services (146).
- Rights (68).

## Findings and Recommendations

### CARE to TMHP transition

In May 2022, HHS migrated HCS and TxHmL forms and claims from the legacy Client Assignment and Registration (CARE) system to the Texas Medicaid Healthcare Partnership (TMHP) Long-Term Care Online Portal (LTCOP).

Individuals or their representatives reported the following issues:

- Delays in service authorization and billing.

- Financial hardships for individuals and service and program providers due to the inability to receive payment for services, including threats of eviction, utilities being cut off, and individuals and family members paying out of pocket for services when funds from the agency were not paid due to system issues.
- Loss of Medicaid or changes to Medicaid coverage due to individual plans of care (IPCs) expiring in TMHP, sometimes causing billing issues and out of pocket expenses for individuals.
- Provider contract expirations preventing entry of forms for individuals enrolled with a provider whose contract expired.
- Providers and LIDDAs not receiving responses from HHSC staff when attempting to work with appropriate areas to resolve TMHP issues.

**Recommendation:** In April 2023, the IDD Ombudsman met with HHSC MCS staff to discuss observed complaint trends with transition from CARE to TMHP and to urge timely responsive actions to address the issues.

**Feasibility of Recommendation:** Currently in progress. HHSC MCS reports it plans to hire additional staff, provide ongoing, monthly training opportunities for program providers and LIDDAs, and remind program providers and LIDDAs on actions needed to prevent form processing delays. HHSC MCS stated that TMHP was developing enhancements to address trending issues. These system enhancements were released in July 2023.

## Delays related to direct service provider shortages

In FY23, the IDD Ombudsman substantiated 146 out of 888 complaints about services and service refusal. At least 99 of these cases referred to an inability to hire and retain staff as a reason for delaying services or refusing to serve individuals.

Many of these complaints affect multiple people because HCS residential settings have three to four individuals living in each residence, depending on certification. Individuals and providers reported having to combine residences because the provider didn't have enough staff for each home.

Individuals reported delays in obtaining Community First Choice and transportation services despite providers posting ads on job search engines. People also reported having trouble finding specialized providers because those providers would be unable to maintain required staffing ratios.

**Recommendation:** IDD Ombudsman recommends HHSC evaluate available data sources to determine the feasibility of tracking the opening and closure of HCS three- and four-person residences and providers choosing to voluntarily terminate their HCS contracts due to the inability to retain staff.

**Feasibility of Recommendation:** HHSC has already begun evaluating available data sources. IDD Ombudsman recommends this work continue and that HHSC evaluate additional ways to gather data.

## Outreach

IDD Ombudsman staff attend conferences organized by IDD stakeholders and advocates, training sessions organized by LIDDA staff, and other such events that relate to the IDD population. On September 22, 2022, the IDD Ombudsman presented information at the Quality Management Consortium.



# Ombudsman for Behavioral Health

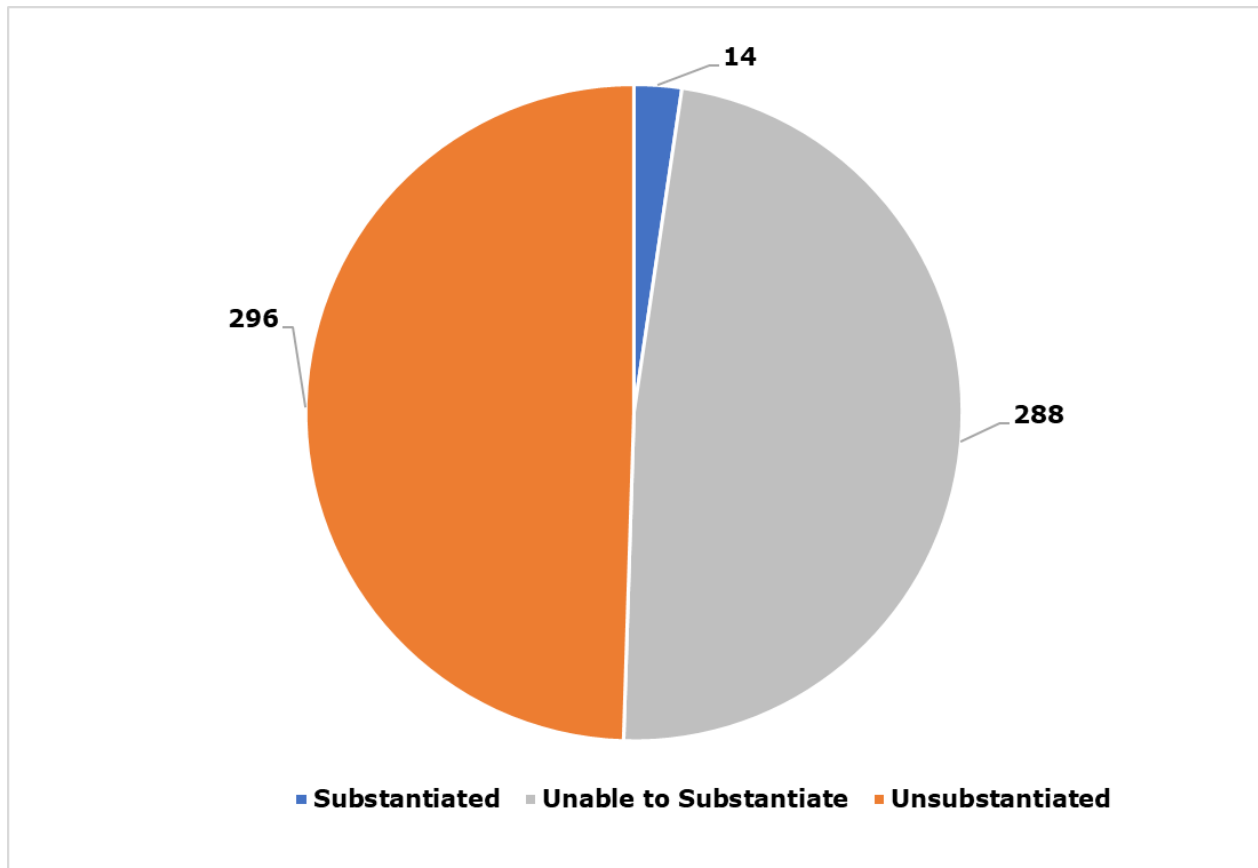
The Ombudsman for Behavioral Health (OBH) helps consumers seeking services for mental health conditions and substance use disorders at state hospitals, 37 local mental health authorities (LMHAs), two local behavioral health authorities (LBHAs), or through a health plan. Any allegation of abuse, neglect or exploitation reported to OBH is referred to DFPS Statewide Intake.

In FY23, OBH received 1,765 inquiries and complaints.

## Complaint by Determination Type

In FY23, OBH resolved 598 complaints. Of those complaints, 14 were substantiated, 296 were unsubstantiated and 288 were unable to substantiate. Figure 5 below shows the OBH investigated complaints by determination type.

**Figure 5: Complaints by Determination Type FY 2023**



## Substantiated Complaints

The three most common reasons for substantiated complaints were:

- Parity (5).
- Discharges (2).
- Injury/abuse/neglect referral to DFPS (2).

## Findings and Recommendations

### The role of Rights Protection Officers

Each state hospital, LMHA and LBHA employs a Rights Protection Officer (RPO) who is responsible for protecting and advocating for the legal and human rights of people receiving services. RPO responsibilities include:

- Receiving and investigating all complaints and allegations of violations of rights, inadequate provision of services and sharing results of investigations with members.
- Advocating for the resolution of grievances.
- Conducting periodic training to educate facility and center personnel on the rights of individuals receiving assistance.
- Reviewing all policies, procedures and rules that affect the rights of persons receiving services.

Other duties required of the RPO are specified by the head of the state hospital, LMHA or LBHA. However, in accordance with Texas Administrative Code (TAC) Title 25, Part 1, Chapter 404, Rule §404.164, the RPO must be able to perform their duties without any conflicts of interest.

The OBH learned that currently 11 of the 39 RPOs at a LMHA or LBHA served in other roles that may present a conflict of interest. A dual role in risk or quality management, for example, where the needs of the organization are a priority, could potentially come into conflict with client's rights advocacy responsibilities.

**Recommendation:** HHSC Behavioral Health Services, with the oversight of LMHAs and LBHAs, should review dual roles held by RPOs to determine if a conflict of interest exists, and take appropriate action to correct any situation where a dual role violates TAC.

**Feasibility of Recommendation:** Achievable. Most LMHAs and LBHAs don't require their RPOs to take on duties that may conflict with their role in assisting persons with concerns about their rights.

## **Outreach**

In FY23, OBH attended the RPO monthly meetings with the HHSC State Hospital Section to discuss the role of the Behavioral Health Ombudsman.

On September 22, 2022, the OBH presented information at the Texas Council of Community Centers' Quality Management Consortium for LMHAs and LBHAs.

On July 12, 2023, the OBH served as a panelist during the HHSC Long-Term Care Conference as the subject matter expert for behavioral health.

## Conclusion

The HHS Ombudsman tackled a wide range of issues in FY23. Each ombudsman program identified specific issues and made recommendations for HHSC or DFPS to consider.

**Ombudsman Complaint Services and Specialized Ombudsman Services:**

Revise client notices for clarity and consistency, correct the denial letter to consumers to ensure equal information goes to all clients regardless of language spoken, and implement a review to ensure contract oversight of FMSAs.

**Ombudsman for Managed Care Assistance:** Implement system changes to notify consumers of possible erroneous third-party insurance reports, explore the feasibility of ways to expedite certain enrollment, and devise a study to analyze denial of care issues.

**Foster Care Ombudsman:** Emphasize case documentation requirements in various trainings and adopt foster care ombudsman information through web-based information sessions.

**Ombudsman for Behavioral Health:** Review dual roles held by RPOs in LMHAs and LBHAs to ensure TAC requirements are met.

**Ombudsman for Individuals with IDD:** Address continuing issues regarding the transition to the TMHP database and issues with service provider difficulties in attaining adequate staffing levels.

The HHS Ombudsman will continue to work with agency program leadership and staff to follow up on recommendations and assess the efficacy of any implemented solutions.

The HHS Ombudsman will collaborate with program areas and DFPS to devise and implement methods to promote awareness of the HHS Ombudsman as required in statute. Since this is the first year of the requirements, the outreach plan has not been finalized.

## **Public Feedback**

As this is the first annual report, the HHS Ombudsman received no public feedback.

# Glossary

**Community-Based Care (CBC)** – Community-based programs that contract with DFPS and CPS to provide foster care and case management services.

**Complaint** – Any expression of dissatisfaction by a consumer about HHS or DFPS benefits or services.

**Consumer** – An applicant or a client of HHS programs, as well as a member of the public seeking information about HHS programs.

**Contact** – Any method of communication wherein a client, youth, stakeholder, legislative liaison or advocate communicates with the ombudsman.

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

**Fiscal Year 2023 (FY23)** – The 12-month period beginning September 1, 2022, and ending 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 received by FCO.

**Information Management Protecting Adults and Children in Texas (IMPACT)** – The DFPS system used by CPS staff for case management, including documentation of abuse and neglect investigations.

**Inquiry** – A contact regarding a request by a youth for information about HHS or DFPS programs or services.

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

**Legislative Contacts** – Inquiries and complaints received from congressional or state legislative offices. This category of contacts may also include federal agency and other high-profile contacts such as those received from HHS executive staff.

**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.

**Referred** – A contact where no investigation was done because a referral was made instead.

**Residential Child Care Regulations (RCCR)** – Regulates all child-care operations and child-placing agencies to protect the health, safety and well-being of children in care, largely by reducing the risk of injury, abuse and communicable disease.

**Resolution** – The point at which a determination can be made as to whether a complaint is substantiated and further action is unnecessary.

**Single Source Continuum Contractors (SSCC)** – A child welfare service provider contracted with DFPS that is responsible for managing catchment areas under the community-based foster care system to provide a full continuum of services.

**Substantiated** – A complaint determination where research clearly indicates agency policy was violated or agency expectations were not met.

**Texas Medicaid Healthcare Partnership (TMHP)** – An HHS contractor that administers secondary insurance information for HHS Medicaid related systems and the Long-Term Care Online Portal used for submitting and authorizing HCS and TxHmL forms and claims.

**Unable to Substantiate** – A complaint determination where research doesn't clearly indicate if agency policy was violated or agency expectations were met.

**Unsubstantiated** – A complaint determination where research clearly indicates agency policy was not violated or agency expectations were met.

**Youth** – Children and youth under the age of 18 in the conservatorship of DFPS.

## List of Acronyms

CBC – Community-Based Care

CDS – Consumer Directed Services

CDSA – Consumer Directed Services Agency

CHIP – Children’s Health Insurance Program

CPI – Child Protective Investigations

CPS – DFPS Child Protective Services

DFPS – Department of Family and Protective Services

FMSA – Financial Management Services Agencies

HEART – HHS Enterprise Administrative Report and Tracking System

HHSC – Texas Health and Human Services Commission

IMPACT – Information Management Protecting Adults and Children in Texas

MCO – Managed Care Organization

PAL – Preparation for Adult Living

PCP – Primary Care Provider

RCCR – HHS Residential Child Care Regulation

RTC – Residential Treatment Center

SSCC – Single Source Continuum Contractors

TAC – Texas Administrative Code