Report of the HHS Ombudsman

As Required by

House Bill 3462, 88th Legislature,

Regular Session, 2023

Texas Health and Human Services

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TEXAS
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Executive Summary

Texas law requires that each ombudsman program within the Health and Human Services (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 the fiscal year 2024 (FY24), describing trends or systemic issues uncovered during the investigation of complaints, and recommendations made to address any deficiencies found.

In FY24, the HHS Ombudsman received 124,148 total contacts. Of those contacts, the HHS Ombudsman received 54,967 complaints and 69,181 inquiries. In FY24, the HHS Ombudsman saw an increase of 27% in total contacts which included a 11% increase in complaints and a 44% increase in inquiries in comparison to FY23.

Introduction

The HHS Ombudsman is responsible for collecting, analyzing, and reporting on complaint data from programs across the HHS system and from foster children and youth in the care of the Department of Family and Protective Services (DFPS). 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).

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

Determination Type	Definition	Example
Substantiated	Research clearly indicates that agency policies or expectations were violated.	Consumer statements 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 divisions within the Ombudsman Office - the Ombudsman Complaint Services (OCS), Specialized Ombudsman Services (SOS), Ombudsman Managed Care Assistance Team (OMCAT), Foster Care Ombudsman (FCO), Ombudsman for Individuals with Intellectual or Developmental Disability (IDD Ombudsman), and Ombudsman for Behavioral Health (OBH).

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 (OCS) and Specialized Ombudsman Services (SOS)

The OCS and SOS teams work together to resolve consumer concerns.

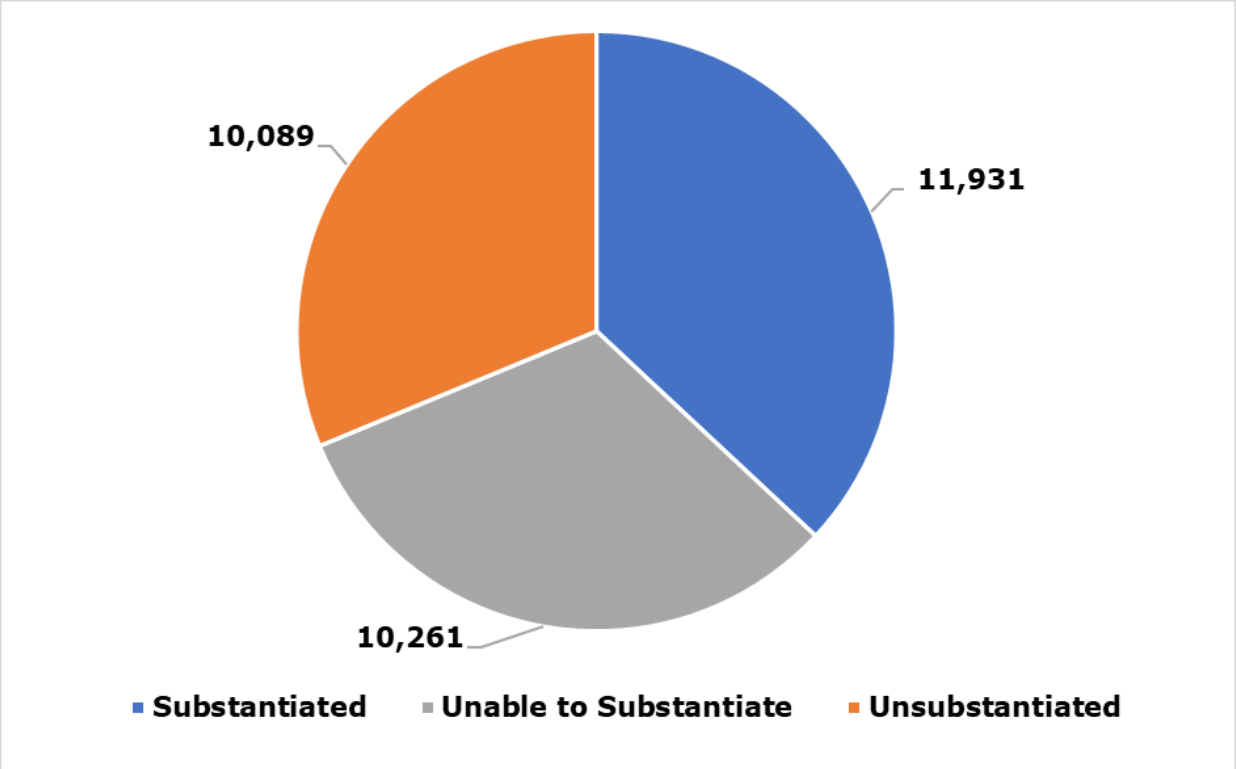
The OCS team answers the main Ombudsman toll-free line addressing inquiries and complaints about HHS programs and services. The team promotes and educates consumers on various HHS programs by referring consumers to the appropriate HHS area. It strives to resolve issues upon first contact. However, if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

In FY24, OCS and SOS received 82,498 inquiries and complaints from consumers, and legislative and federal officials. Of those contacts, OCS/SOS received 39,278 complaints and 43,220 inquiries. In FY24, OCS/SOS saw an increase of 37% in total contacts which included a 15% increase in complaints and a 67% increase in inquiries in comparison to FY23. The increase in contacts is attributed to the unwinding of continuous Medicaid coverage and the subsequent increase of eligibility applications.

Complaints by Determination Type

Of the 39,278 total complaints received in FY24, a total of 32,281 complaints were resolved, with 11,931 substantiated, 10,089 unsubstantiated, and 10,261 unable to substantiate. (Approximately 6,300 of the complaints received were non-jurisdictional and were referred to other entities, while the remainder were pending resolution at the end of FY24.) Figure 1 below shows the complaints by determination type.

Figure 1: Resolved Complaints by Determination Type, FY24



Substantiated Complaints

The three most common reasons for substantiated complaints were:

- Eligibility application not processed on time (7,249).
- Denial of eligibility application or case in error (2,432).
- Changes in household members, address, or income not processed in a timely manner (593).

Findings and Recommendations

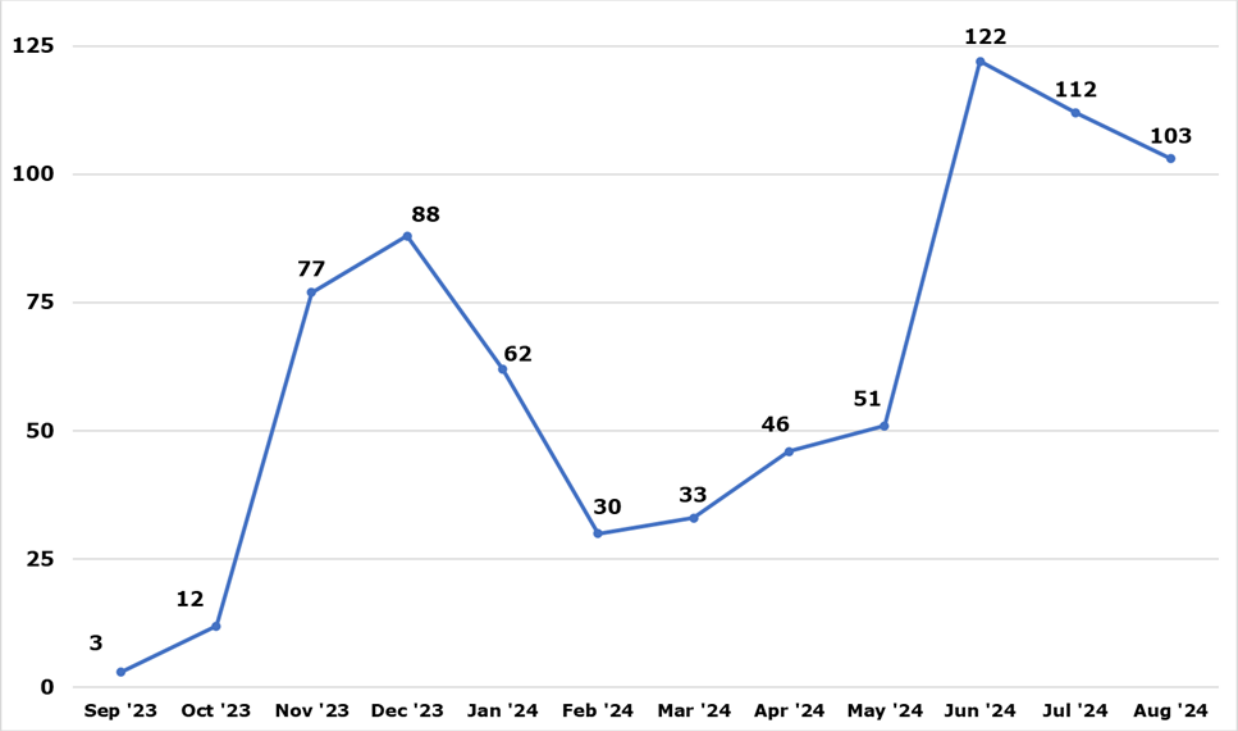
SNAP Stolen Benefits

In FY24, the OCS/SOS received 739 complaints from consumers reporting their Supplemental Nutrition Assistance Program (SNAP) food benefits were stolen electronically from their Electronic Benefits Transfer (EBT) card, called the Lone Star card in Texas.

Some consumers who were victims of this theft were using a third-party mobile phone application; however, that application was not supported by HHSC. The only application that HHSC supports for SNAP consumers is YourTexasBenefits.com (YTB).

OCS/SOS informed Access and Eligibility Services (AES), the area within HHSC responsible for determining eligibility for SNAP, Medicaid and Temporary Assistance for Needy Families (TANF) benefits, of spikes identified in complaints of stolen SNAP benefits in the months of December 2023 and June 2024, as shown in Figure 2 below.

Figure 2: SNAP Stolen Benefit Complaints, FY24



HHSC and Office of Inspector General (OIG) have taken efforts to educate clients on how they can protect themselves and be proactive about preventing fraud on their accounts, including sharing resources on how to delete any fraudulent applications, reset YTB passwords and PINs, and request new or lock existing Lone Star cards to avoid unauthorized users from accessing their account.

AES areas such as Lone Star Business Services (LSBS) and Integrity Support Services work together to identify unauthorized transaction activity at specific retailer locations and coordinate with the United States Department of Agriculture's (USDA) Food and Nutrition Service (FNS) and the electronic benefit contractor to mitigate loss.

A federal law was passed that allowed for reimbursement of stolen SNAP benefits based on when the fraud occurred and how much was stolen. However, the federal provision to replace stolen SNAP benefits will expire for benefits stolen at the end of this calendar year.

Despite efforts thus far made to educate consumers and strengthen the security of the Lone Star card, complaints of stolen benefits continued to increase in FY24. FNS encourages states to embrace chip-embedded cards as they are a more secure option against card skimming.[1]

Recommendation: The Office of the Ombudsman (OO) recommends HHSC consider implementing chip-embedded cards, as other states such as Oklahoma have.

Feasibility of Recommendation: This would require costs to contract with a vendor to upgrade and distribute new Lone Star cards.

Erroneous Medicare Savings Program (MSP) Denials

In FY24, OCS/SOS received 24 contacts from consumers who were denied benefits through the Medicare Savings Program (MSP) effective May 1, 2024, for failing to reapply. However, OCS/SOS identified that some consumers had already reapplied and were certified at the time of the mass denial. These clients were not due to reapply until the end of 2024 or 2025. A total of 10,000 consumers were impacted by erroneous denials.

The issue occurred because the file used contained outdated data from 2023. A correction was applied to the eligibility system to address to reinstate coverage for the affected consumers.

This is the second fiscal year that the OO has reported on mass erroneous MSP denials.

Recommendation: The OO recommends conducting preliminary testing of data files to ensure the accuracy of the change or action prior to uploading the files to the eligibility system.

Feasibility of Recommendation: This would require additional time prior to implementation to run tests and additional costs that may be associated with testing.

[1] SNAP EBT Modernization | Food and Nutrition Service (usda.gov)

Natural Disasters Strike Texans

Governor Greg Abbott issued a disaster proclamation due to multiple severe weather disasters that impacted the State of Texas from April 2024 to July 2024. The storms caused power outages for many consumers, destroying their food supplies. The OCS/SOS received 123 inquiries and 516 complaints related to the disasters.

SNAP Replacement Benefit Delays

In July 2024, in response to the disaster proclamation, HHSC received approval from FNS to:

- replace destroyed food purchased with SNAP food benefits;
- allow consumers to purchase hot food with SNAP benefits; and,
- mass replace SNAP benefits to impacted counties that were affected by Hurricane Beryl effective July 14, 2024.

However, OCS/SOS received 198 contacts from consumers who stated they had not received their replacement benefits. HHSC identified that individuals who had received their last SNAP benefit in June were inadvertently excluded from the mass replacement process. These individuals received their SNAP replacement benefits on July 21, 2024.

ONA Funding Delays

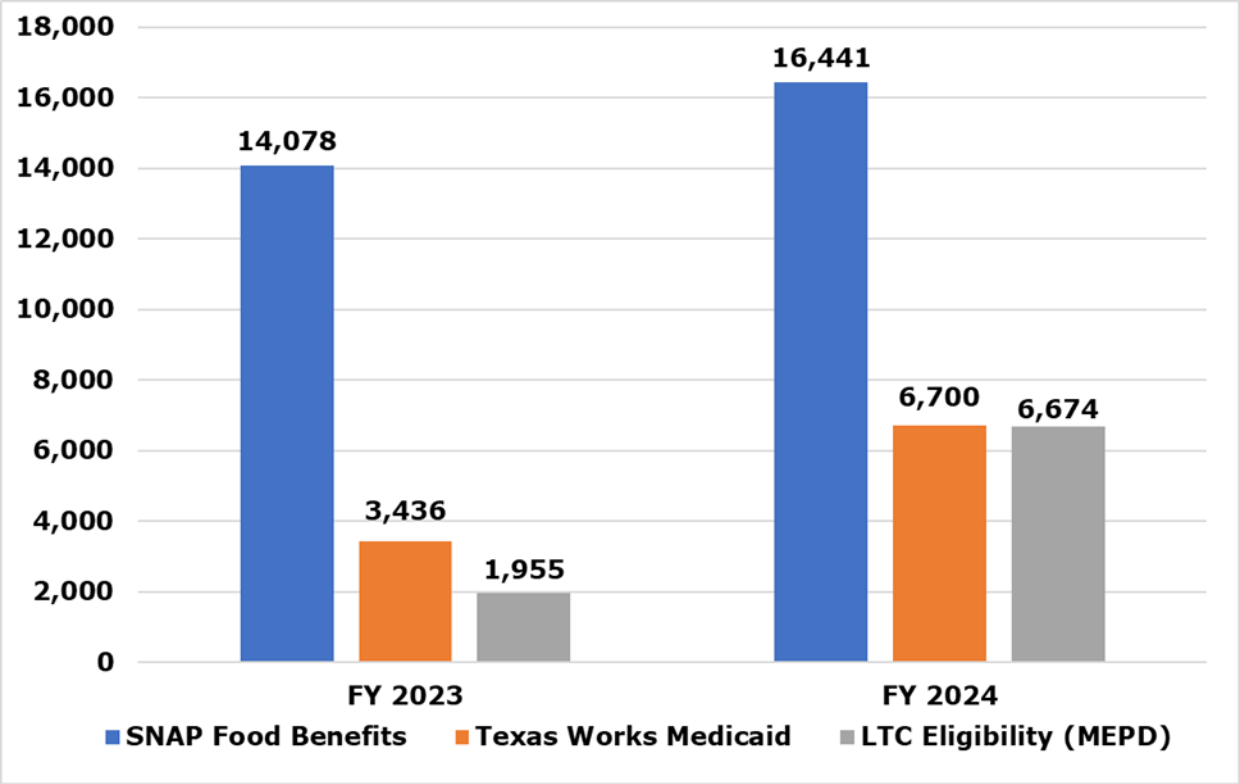
As part of the disaster relief, consumers were able to receive assistance through the Federal Emergency Management Agency (FEMA)'s Other Needs Assistance (ONA) program. This federal program is distributed by HHSC, and provides assistance for disaster related costs such as:

- furniture and appliances;
- vehicle repair and replacement;
- moving and storage;
- medical and dental needs;
- funeral needs; and,
- childcare.

OCS/SOS received 239 complaints related to delays in ONA funds or consumer's inability to get through the ONA toll-free line. HHSC identified delays in payment processing and staffing difficulties as the root cause of these challenges.

Application Workload and Impact on Consumers

Figure 3: Top Complaint Program Types, FY23 and FY24



During FY24, HHSC continues to experience delays in processing applications, redeterminations, and changes as shown in Figure 3 above. OCS/SOS received numerous complaints for SNAP, Texas Works Medicaid, and Medicaid for the Elderly and People with Disabilities (MEPD). These pending applications resulted in an increase of 37% in total contacts, which included a 15% increase in complaints and a 67% increase in inquiries in FY24 compared to FY23.

Delays in processing applications may have negative consequences on clients seeking assistance with food and medical services. For example, eligible households, the elderly and disabled may not have access to needed resources.

Although HHSC implemented various strategies to address the increased workload demand and timeliness throughout the fiscal year, as of August 2024 there were a

total of 345,012 program applications behind normal processing timeframes of 30 days for SNAP and 45 days for TANF and Medicaid programs.

Appeal Notices

During a review of complaints regarding client appeals in December 2023, the OO identified an opportunity for improving client appeal notices. The notices only offered clients options of calling 2-1-1, mailing in the request for appeal, or going to a local office. OCS/SOS recommends adding the fax number to the client notices as an additional option.

OCS/SOS also identified opportunities to improve language in client notices to provide clearer instructions and guidance in 2023.

HHSC is exploring options for a more comprehensive client notice revision initiative to improve readability, information and streamline layout. This would be a multiphase, long-term initiative as it would require redesigning the notices and eligibility system updates. In the meantime, AES is completing an ongoing review of client notices.

OCS/SOS will continue to track all opportunities to improve client notices.

Outreach

In FY24, the OCS and SOS teams reached out to the following programs to promote awareness of the Office of the Ombudsman and educate on the role of the Ombudsman:

- February 28, 2024 – AES Data Integrity Management;
- March 13, 2024 – HHS Civil Rights Office;
- May 21, 2024 – AES Region 07 Program Managers; and,
- August 28, 2024 – AES Customer Care Center Management.

The OO's outreach to HHS program areas benefits consumers because the OO reminds the areas that our office is here to assist consumers when the agency's internal complaint process does not resolve the consumer's concern. Each program area is also required to advise consumers on how to contact the OO.

FY25 Planned Activities

For FY25, OCS/SOS will conduct information sharing meetings with:

- AES Community Partners;
- Community Care Services;
- HHS Family Violence Program, and;
- Attend AES Customer Care Center (Supervisor Conference).

Program Response to 2023 Recommendations

Removal of erroneous Medicaid coverage

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

Feasibility of Recommendation: Would require changes to eligibility systems which may include costs.

Program Response: AES is working on the Texas Integrated Eligibility Redesign System (TIERS) Medicaid Segment Override project. The project workgroup consists of areas within AES, IT, Medicaid and CHIP Services (MCS). The project formally kicked off in July 2024. The workgroup is currently working on finalizing draft rules to submit to IT for IT assessment and discovery. The projected implementation date is February 2025.

Erroneous Medicare Savings Program denial letters

Recommendation: Immediate action is needed to resolve the error.

Program Response: 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

Recommendation: HHSC AES should conduct a review of their notices to clarify the information it requests from consumers.

Feasibility of Recommendation: Achievable.

Program Response: AES reported they will take advantage of opportunities that arise during current project implementation to update notices as federally required, and as possible. They also report that they are planning a more comprehensive notice revision project which will include feedback received on the Request for Domicile Verification (Form H1155) and the Request for Information or Action (Form H1020), as well as other forms, to update the language to provide clearer instructions and guidance.

Inconsistent translation of denial letter

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

Program Response: AES implemented the aligning of Spanish and English notices on January 27, 2024.

Contract oversight for FMSAs

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.

Program Response: MCS responded that they already conduct regular quality review team meetings where the results of FMSA measures are discussed, and the issue of contract oversight is often a topic of conversation. MCS reports they will continue to use these meetings to identify policy clarifications and training opportunities that might improve FMSA performance.

Ombudsman for Managed Care Assistance (OMCAT)

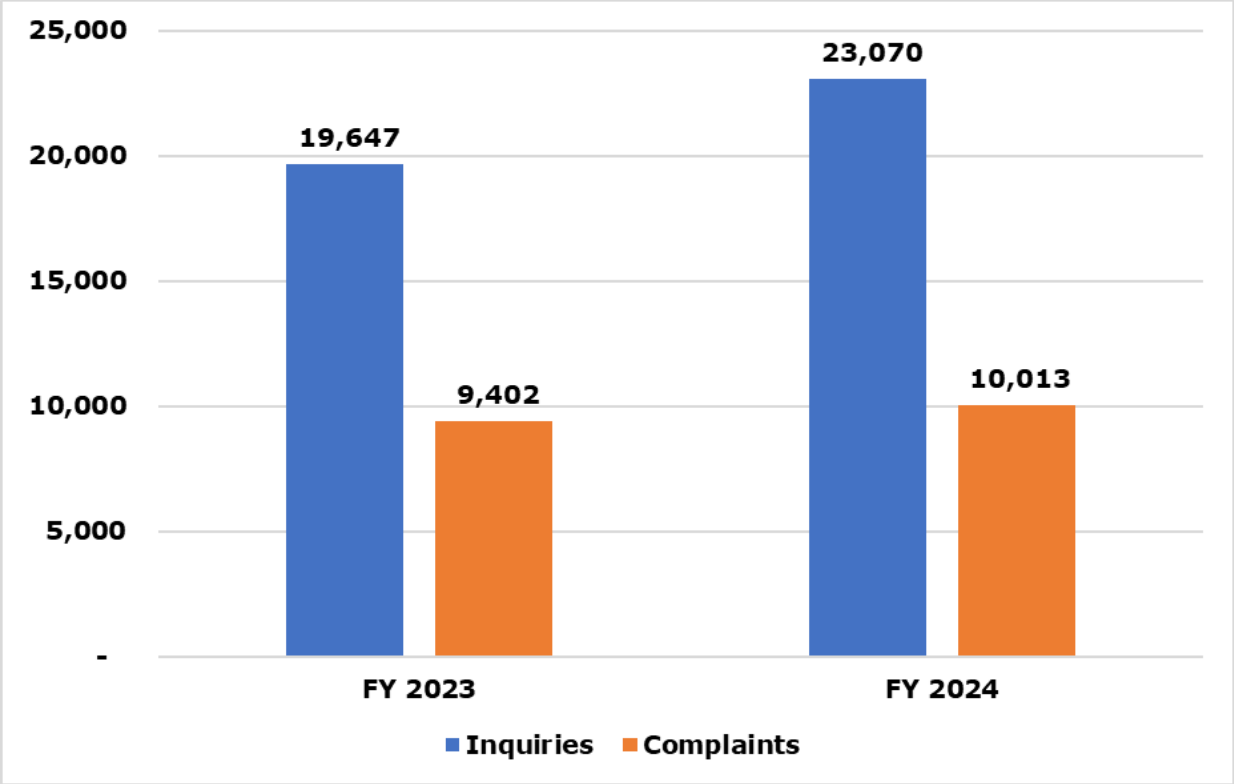
OMCAT resolves Medicaid managed care inquiries and complaints through coordination with health plans, providers, and HHS Medicaid program staff.

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, agency or vendor is following HHSC policy.

In FY24, OMCAT received 33,083 total contacts. Of those contacts, OMCAT received 10,013 complaints and 23,070 inquiries. In FY24, OMCAT saw an increase of 14% in total contacts which included a 6% increase in complaints and a 17% increase in inquiries in comparison to FY23, as shown in Figure 4 below. The increase in contacts is attributed to the unwinding of continuous Medicaid coverage and the subsequent increase of eligibility applications.

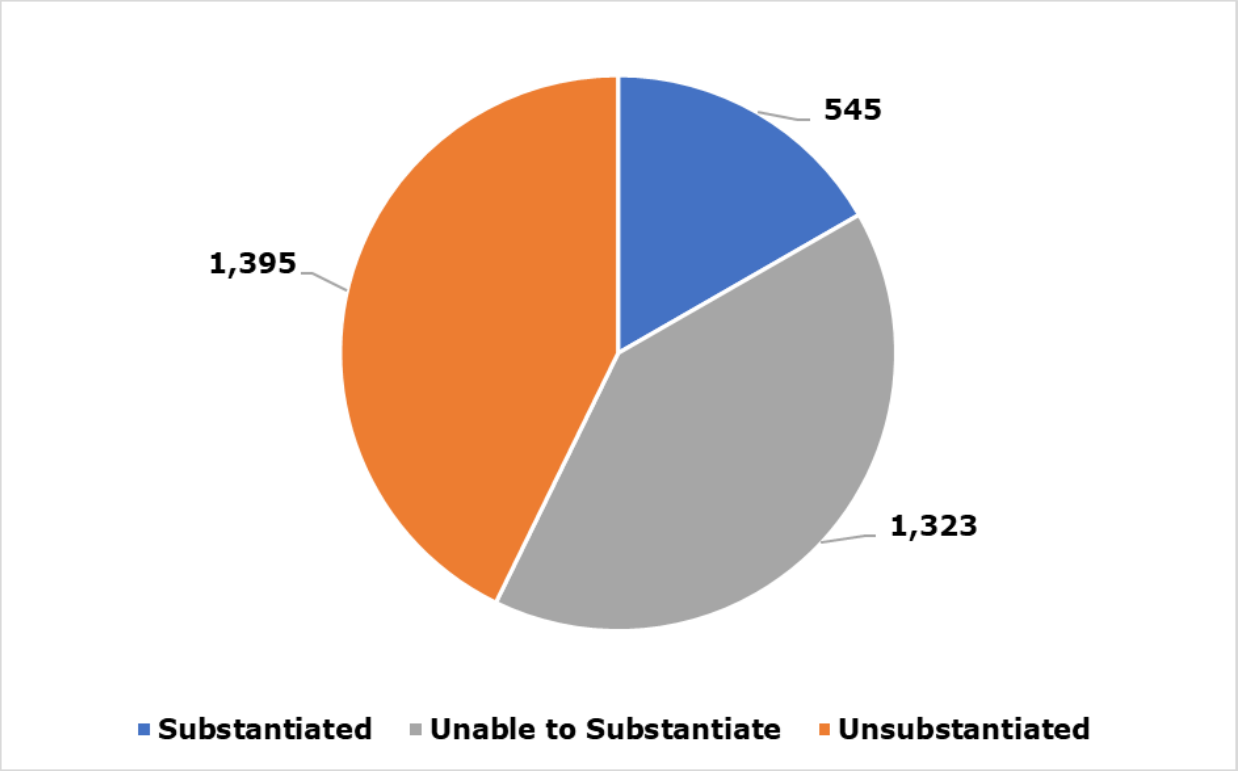
Figure 4: Contact Comparison, FY23 and FY24



Complaint by Determination Type

In FY24, OMCAT resolved 3,263 complaints. Of these complaints, 545 were substantiated, 1,395 were unsubstantiated and 1,323 were unable to substantiate. Figure 5 below shows the complaints by determination.

Figure 5: Resolved Complaints by Determination Type, FY24



Substantiated Complaints

The three most common reasons for substantiated complaints were:

- Access to prescription medication because the member is not showing active in HHSC or pharmacy data systems (64);
- Access to home health services (54); and,
- Case information errors on the consumer's Medicaid profile (36).

Findings and Recommendations

New Pharmacy Benefits Manager transition issues

On March 30, 2024, HHSC transitioned to a new pharmacy benefits administrator, which is responsible for processing pharmacy claims for traditional Medicaid consumers.

OMCAT received 34 complaints related to the transition. The primary complaints were:

- HHSC transfer of consumer eligibility files did not successfully update for some consumers in the new vendor's database on March 30, 2024;
- Consumers reported that their prescribing physician showed as a non-Medicaid provider in Pharmacy data systems, although their physician was confirmed to be a Medicaid provider; and,
- HHSC did not update Prescription Bank Identification Numbers (BIN) on the YTB, Texas Medicaid Health Partnership, and HHSC websites. HHSC did not send new Texas Medicaid cards with an updated BIN to traditional Medicaid consumers.

Recommendation: HHSC should update all websites that list outdated Prescription BIN information and send new Medicaid cards to all traditional Medicaid consumers.

Feasibility of Recommendation: Achieved. HHSC confirmed that all websites were updated with the correct BIN and new Medicaid cards had been mailed to consumers on April 22, 2024.

Outreach

OMCAT participates in quarterly meetings with the Children's Health Care Coalition (CHCC), 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 reviewing complaint data to identify potential problems in MCO service delivery, discovering opportunities to increase program transparency, and focusing on review of the appeals and fair hearing process. OMCAT promotes awareness by providing data about topics of interest to the subcommittee and presentations of the most recent complaint and inquiry data for OMCAT.

FY25 Planned Activities

For FY25, OMCAT will:

- Continue to participate in SMMCAC and CHCC meetings, and;
- Conduct information sharing meetings with Area Agencies on Aging/Aging Disability Resource Centers (AAA/ADRC).

Program Response to 2023 Recommendations

Erroneous secondary insurance affecting Medicaid services

The OMCAT Quarterly Report published in June 2019 noted consumer complaints regarding accessing prescription medication due to third-party insurance showing incorrectly as active on their Medicaid profile in HHSC and MCO systems.

The Office of the Inspector General Third Parties Recovering Team (OIG TPR) has reported an increase in efforts to reduce incorrect third-party insurance showing on consumer's Medicaid profiles. Subsequently, OMCAT has seen a gradual decrease in complaints related to accessing prescriptions due to erroneous third-party insurance on the Medicaid profile.

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

Program Response: OIG TPR reports that they continue to improve the pharmacy escalation processes to reduce instances of erroneous third-party insurance. In FY24, OIG TPR began to include MCO contacts in all pharmacy escalation correspondence. OIG TPR reports that collaborating with MCO contacts has yielded an immediate and positive impact on consumers receiving prescriptions without delay. OIG TPR reports the following additional initiatives have been put in place to further improve processes:

- Continue to collaborate with the Medicaid pharmacy claims vendor to identify additional steps in the process that will prevent delays in consumers receiving medication;
- Deliver and resolve urgent escalations within 24 hours; and,
- Review and monitor escalations to determine the root cause for further improvement opportunities.

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

Program Response: MCS responded that consumer renewal notices currently provide notification to consumers if they have other insurance active on their Medicaid profile and instructions on how to update other insurance, and that other insurance can currently be viewed and updated on consumers' YTB accounts.

Expediting enrollment into an MCO for consumers who have moved out of the service delivery area (SDA)

In FY23, OMCAT received 214 complaints from consumers with this contact reason. A common problem reported by consumers in this situation is difficulty accessing primary care and obstetrics and gynecology physicians in the new area because the physicians are not in-network with the consumers' current MCO.

Recommendation: 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.

Program Response: The formal project and workgroup exploring ways to expedite enrolling consumers into an MCO has ended, but HHSC continues to evaluate the feasibility of this recommendation as there are potential impacts to hospital payment programs.

Denial and delay of services

In the FY23 Ombudsman Annual Report, OMCAT substantiated 28 complaints from consumers who reported that they were denied services by their MCO.

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.

Program Response: MCS reported that service denial data is not an element required to be reported to HHSC by the contracted MCOs. The external medical review process does involve independent review organization's (IRO) review of denials. The IRO upholds or overturns denials based on findings of the review.

Foster Care Ombudsman

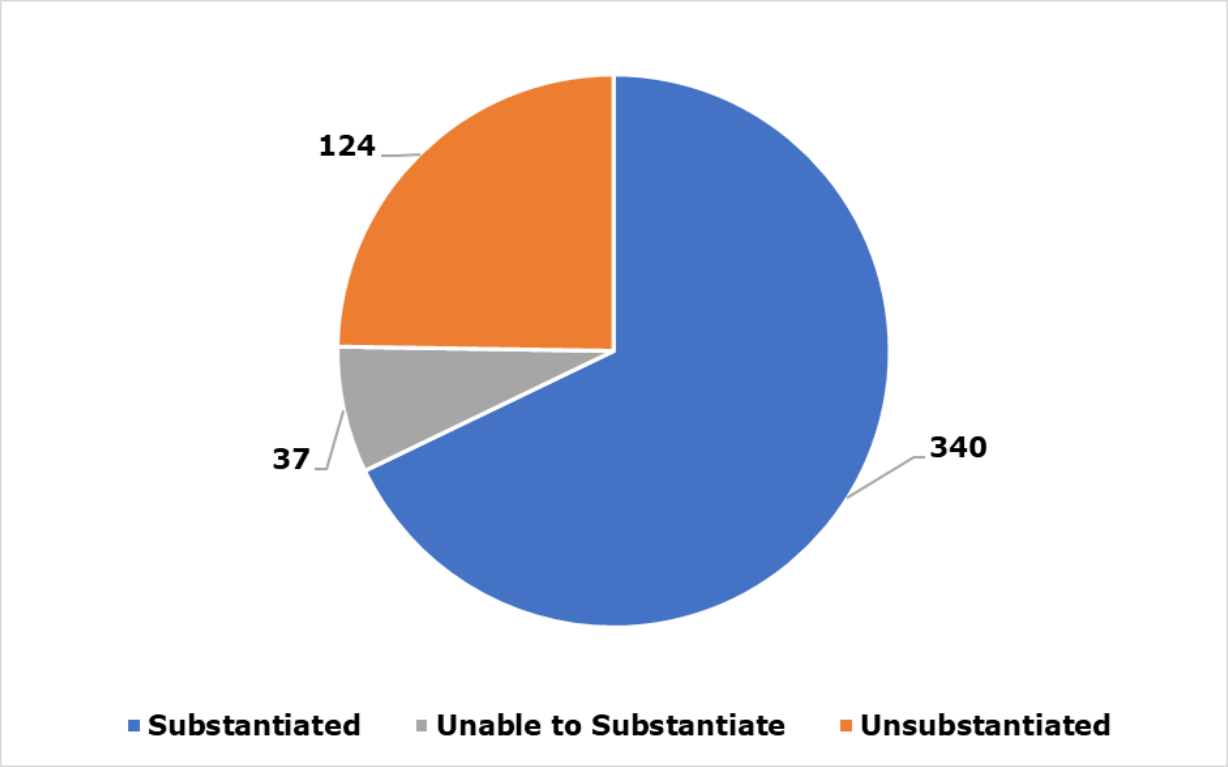
FCO assists foster youth with inquiries and complaints about DFPS programs such as Child Protective Services (CPS) and Community-Based Care (CBC), and HHSC programs and services such as Residential Child Care Regulation (RCCR).

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. If FCO discovers unreported violations of rules and policies during the investigation of a complaint, the ombudsman will open a new investigation for each reported violation. In FY24, FCO received 1,587 inquiries and complaints. Among those, FCO resolved 501 complaints from youth and those discovered during an investigation, an increase of 46 (or 10%) from FY23. 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 501 complaints from youth and those discovered during an investigation in FY24, 340 were substantiated, 124 were unsubstantiated, and 37 were unable to substantiate. Figure 6 below shows the complaints by determination.

Figure 6: Resolved Complaints by Determination Type, FY24



Substantiated Complaints

The three most common reasons for and number of substantiated complaints were:

- Case Recording (case documentation) (91) *DFPS Policy 6133*;
- Substitute Care (general duties) (88) *DFPS Policy 6000*; and,
- Legal Functions (and court activities) (27) *DFPS Policy 5000*.

Findings and Recommendations

Policy clarification

During investigations in 2024, FCO reviewed DFPS policies (6170, 6127 and 1480) pertaining to caseworker and supervisor expectations.

The policies outline key elements of case actions, as well as address responsibilities of a supervisor and caseworker. However, they do not clearly identify a timeframe in which a supervisor is required to review case decisions that would inform next

steps to be completed in a case by a caseworker. Without frequent review by a supervisor, case decisions or actions cannot move forward.

FCO sees an opportunity for strengthening policy requirements in this area.

Recommendation: Update CPS policy to include a timeframe expectation of supervisory review of case actions be added to DFPS policies *6170 Actions Requiring Supervisor Approvals* and *1433 Supervisor Approval Process in IMPACT.*

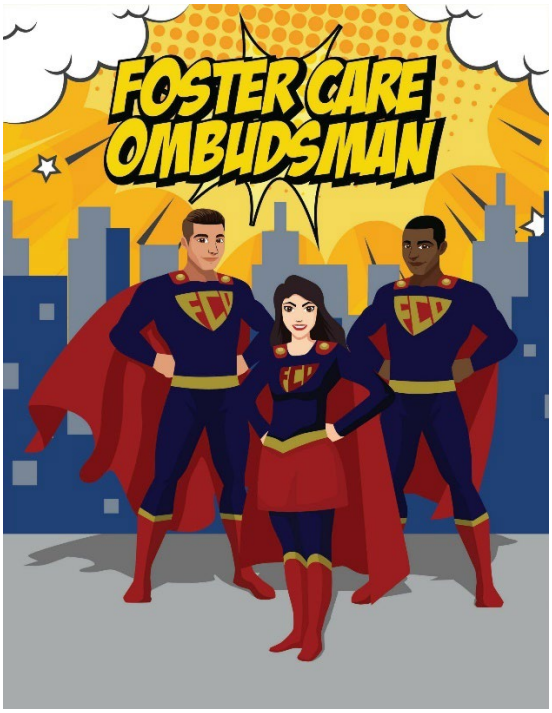
FCO also recommends the frequency of scheduled case staffing in DFPS Policy *1480 Workload Management—Case Conferences and Supportive Supervision* be updated to monthly meetings rather than the less specific "at least 10 times each year."

Feasibility of Recommendation: DFPS noted TAC/Minimum Standards require "at least 10 times each year." Scheduling monthly meetings would comply with this requirement.

Outreach

This year, the annual outreach project expanded to areas of the state that had yet to be visited physically. FCO was invited to present before panels such as the Children's Commission and Court Appointed Child Advocates STAR Monthly Meeting. CPS and CBC provider meetings were also attended to inform providers and stakeholders about the FCO program. Over 191 foster youth and 433 providers and staff members were outreached in FY24.

During the presentations with foster youth throughout the state, 24 complaints and inquiries were addressed by the youth present. FCO distributed 58 activity books, which were created to help youth learn about the office and their rights as youth in care. FCO made the booklets accessible to CPS so they can request copies to help distribute them to youth.



Foster Care Ombudsman Activity Booklet

FY25 Planned Activities

For FY25, FCO will:

- Participate in "A Day in the Life," a Foster Parent training program hosted by El Paso community stakeholders;
- Distribute the FCO Activity Book to CPS and CBC regions and catchments;
- Continue in-person outreach efforts to meet with youth in Residential Treatment Centers (RTCs) and speak with RTC staff to educate them regarding the FCO program and services; and,
- Continue outreach to Single Source Continuum Contractors (SSCC) catchment areas.

Program Response to 2023 Recommendations

Lack of adequate documentation in IMPACT

In FY 2023, the FCO noted that DFPS policy *6133 Case Recording* issues were among the top three contact reasons found to be out of compliance within case records reviewed during research of complaints called in by foster youth. During

last year's annual report, the FCO recommended that CPS and CBC caseworkers and supervisors complete refresher training regarding policies under DFPS policy *6133 Case Recording.* This training should emphasize the need for caseworkers to document case data adequately and can significantly improve case continuity and the services provided to foster care youth. The FCO's focus on the youth's case record was due to the importance of the information entered into a child's case as not just data but as a crucial tool that helps to highlight case-specific issues of safety, legal, education, medical, or behavioral, placements issues, and expectations the placements are meant to provide to the children in their care.

Recommendation 1: CPS and CBC caseworkers and supervisors should complete refresher training regarding policies under DFPS policy *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.

CPS Response: DFPS responded that they routinely provide training to staff regarding quality documentation. Examples of this training related to effective documentation, such as courses on Effective Documentation and Writing Skills, Strength Based Documentation, and other trainings specific to specific conservatorship topics. In addition, DFPS has recently launched a new microlearning series, including sessions related to documentation, and will be expanding this in the future. Additional counseling/training is provided to individual staff through staffings and other counseling or training opportunities when identified by the FCO or through other routine review.

Additionally, in July 2024, CPS released a Meeting in a Box announcing the release of the FCO training entitled:

Empowering Children: Role of the Foster Care Ombudsmen

This 6-part training introduces staff to FCO and includes a section on the importance of case documentation. This training was mandatory for all CPS caseworkers, to be completed by August 31, 2024.

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 contact information changes.

Feasibility of Recommendation: Achievable.

CPS Response: In collaboration with DFPS, the FCO created training videos for CPS and CBC caseworkers that addressed common concerns identified through FCO investigations. The course also discussed the importance of caseworkers documenting foster youth's cases thoroughly and the impact of documentation on an FCO complaint investigation. The training was released to tenured caseworkers in the July 2024 Meeting in A Box and disseminated to new caseworkers through the department's training program.

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.

In FY24, IDD Ombudsman received 5,432 inquiries and complaints.

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).

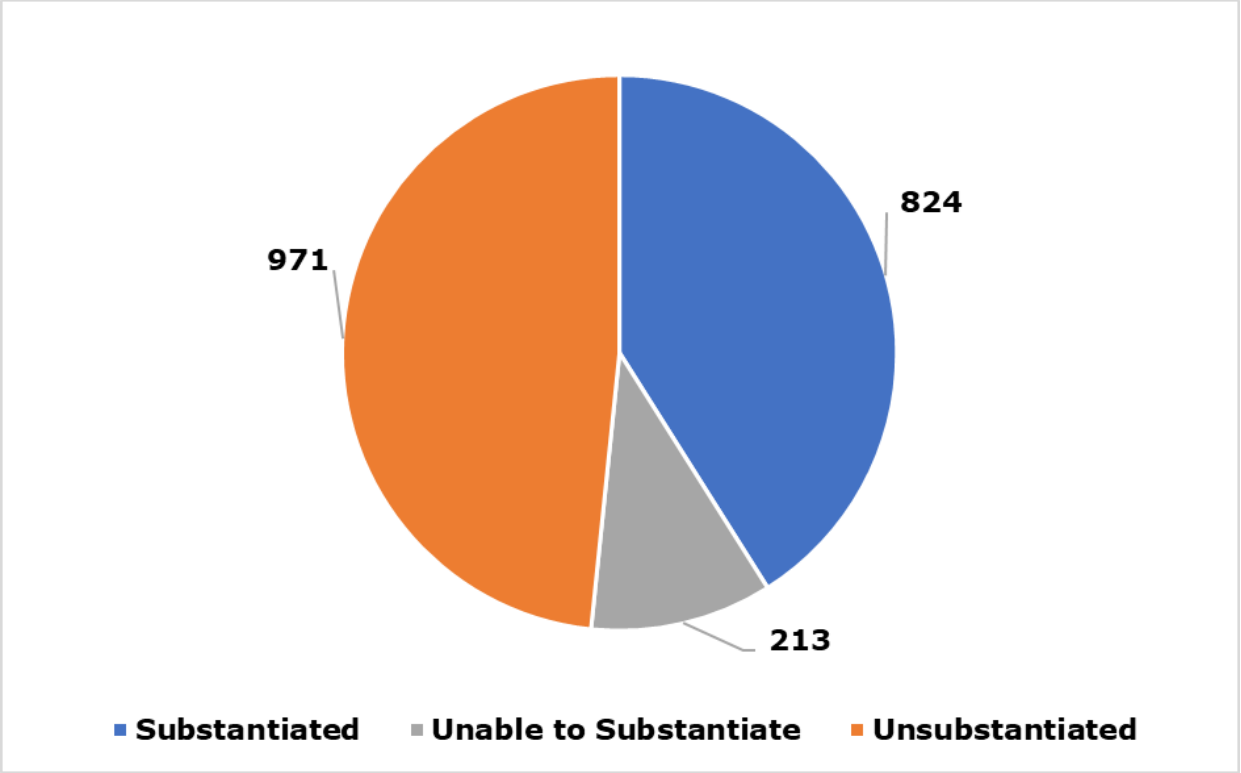
Any allegations of abuse, neglect, or exploitation reported to the IDD Ombudsman are referred to DFPS Statewide Intake for assignment to PI. When PI receives an allegation of abuse, neglect, or exploitation involving individuals in HCS or TxHmL, they notify the IDD Ombudsman that the allegation is being 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 FY24, PI referred 195 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 FY24, the IDD Ombudsman resolved 2,008 complaints. Of these complaints 824 were substantiated, 971 were unsubstantiated, and 213 were unable to substantiate. Figure 7 below shows the complaints by determination.

Figure 7: Resolved Complaints by Determination Type, FY24



Substantiated Complaints

The three most common reasons for substantiated complaints were:

- CARE to TMHP transition (358);
- Services (134); and,
- Rights (64).

Findings and Recommendations

TMHP Long-Term Care (LTC) Online Portal

In the FY23 Ombudsman Annual Report, the IDD Ombudsman reported on issues resulting from the migration of HCS and TxHmL forms and claims from a legacy system (Client Assignment and Registration or CARE) to the TMHP Long-Term Care Online Portal (LTCOP). In FY24, the HHS Ombudsman continued to receive a high volume of contacts (624 complaints) related to the migration. These contacts included:

- Requests for clarification of who to contact for various forms;
- Reports providers and LIDDAs had contacted the area identified in the Quick Reference Contact Guide multiple times without response or resolution. In some cases, the provider or LIDDA reported receiving notification their case was assigned to MCS staff, but they received no further follow-up;
- Reports that providers and LIDDAs have been sent back and forth between HHS departments without resolution;
- Forms, including annual service plans, transfers, and level of need determinations, pending in TMHP for three weeks or more; and,
- Service and billing delays caused by delays in authorization of one form because forms must be entered in chronological order, and each form must be authorized before another form can be entered.

The amount of time taken to resolve TMHP-related cases increased due to longer response times from HHSC staff and coordinating resolution between HHSC teams when multiple forms were involved.

In FY23, TMHP cases were open for an average of 34 days, however, the average resolution time in FY24 was 60 days.

Recommendation 1: MCS should implement a centralized hotline for providers and LIDDAs to request assistance with TMHP LTCOP.

Feasibility of Recommendation: This would likely require funding and IT support.

Program Response: MCS will explore the recommendation to implement a centralized hotline, though it may not be feasible.

Recommendation 2: MCS should develop a process to assign and track requests for assistance, especially those needing coordination across multiple teams.

Feasibility of Recommendation: Achievable.

Program Response: MCS reports the Provider Quick Reference Contact List for HCS and TxHmL was updated on September 13, 2024, and MCS staff have been advised to ensure that messages are directed to the appropriate area.

Recommendation 3: MCS should implement a process to identify enrollment, revision, and renewal forms stalled due to Medicaid eligibility pending longer than

timelines defined in HHSC policy and proactively reach out to the responsible LIDDA, provider, or AES staff to assist in resolving the issue.

Feasibility of Recommendation: Achievable.

Program Response: The MCS response indicates the recommendations to develop documentation and tracking processes and to implement a proactive process of contacting providers and LIDDAs are feasible. MCS added they are working on system enhancements to reduce the administrative burden and hiring additional staff to increase the capacity of form processing.

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 February 15, 2024, the IDD Ombudsman presented information to LIDDA staff at the monthly LIDDA Webinar hosted by HHSC IDD Services.

FY25 Planned Activities

For FY25, IDD Ombudsman will:

- Participate in monthly IDD Coordination meetings;
- Regularly communicate via email with LIDDAs about the availability of the rights booklets available to order;
- Participate in internal quarterly meetings with PI, OIG, State Hospital (SH), and State Supported Living Center (SSLC) staff; and,
- Attend IDD System Redesign Advisory Committee (IDD SRAC) meetings.

Program Response to 2023 Recommendations

CARE to TMHP transition

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

Feasibility of Recommendation: Achievable. HHSC MCS reported it planned 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.

Program Response: In February 2024, HHSC MCS reported additional staff had been hired, and they continued to provide monthly training for LIDDAs. HHSC MCS reported the ongoing training for providers was transitioned to "Technical Assistance Hours" in January 2024. These are monthly sessions for Program Providers and Financial Management Services Agencies (FMSAs), who use LTCOP for the HCS and TxHmL waiver programs. During these sessions, TMHP and HHSC staff will be available to troubleshoot and potentially resolve issues with forms and claim submissions in the LTC online portal.

Delays related to direct service provider shortages

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: Achievable. HHSC had already begun evaluating available data sources. IDD Ombudsman recommends this work continue and HHSC evaluate additional ways to gather data.

Program Response: In September 2024, MCS reported HCS three- and four-person residence closures are tracked manually by MCS staff, but the reason for closure is not obtained. Long-Term Care Regulatory (LTCR) advised that the department is drafting rules to require HCS providers to notify LTCR when closing HCS three- and four-person residences. LTCR has not determined what data will be collected related to closures, and there is no estimated date for implementation of the rule.

Ombudsman for Behavioral Health

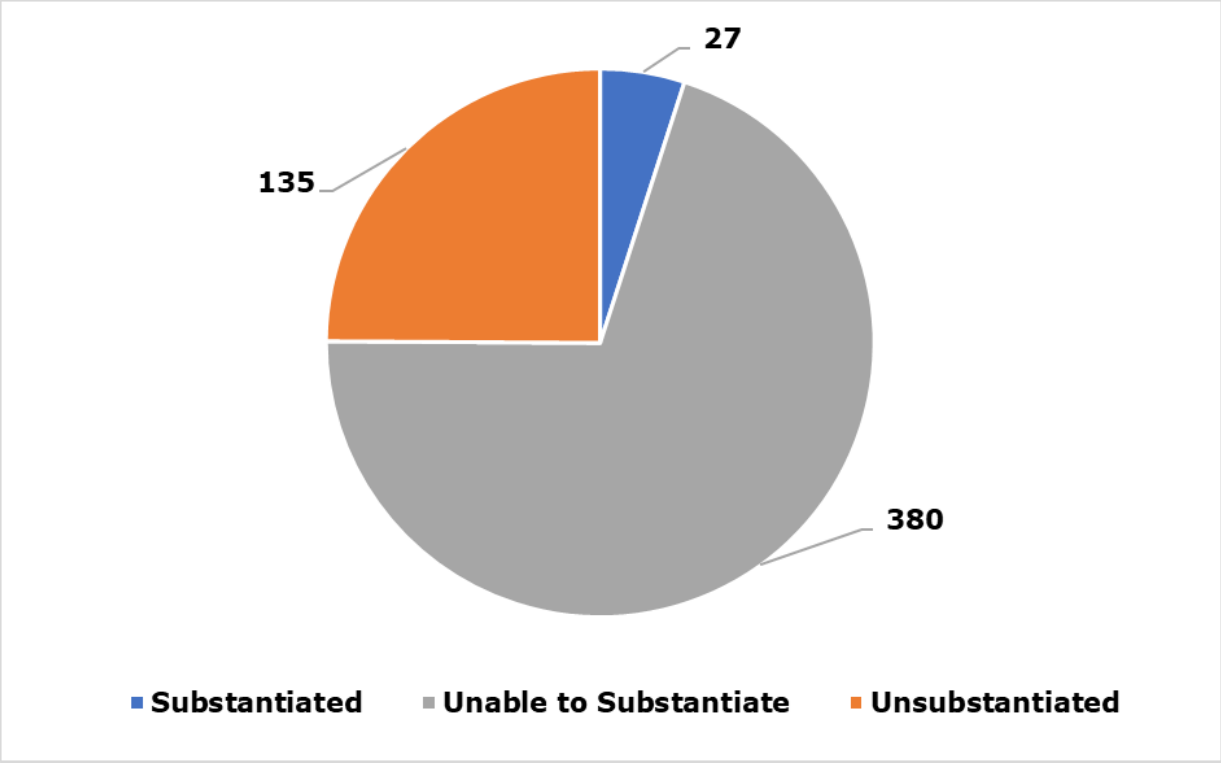
The OBH helps consumers seeking services for mental health conditions and substance use disorders at SHs, 37 local mental health authorities (LMHAs), two local behavioral health authorities (LBHAs), or through a health plan. Any allegation of abuse, neglect or exploitation reported to OBH is referred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

In FY24, OBH received 1,548 inquiries and complaints.

Complaint by Determination Type

In FY24, OBH resolved 542 complaints. Of those complaints, 27 were substantiated, 135 were unsubstantiated and 380 were unable to substantiate. Figure 8 below shows the OBH investigated complaints by determination.

Figure 8: Resolved Complaints by Determination Type, FY24



Substantiated Complaints

The three most common reasons for substantiated complaints were:

- Restraint & Seclusion (6);
- Service Coordination/Continuity (4); and,
- Discharges (4).

Findings and Recommendations

Rights Protection Officer (RPO) Duties

Each SH, LMHA and LBHA employs a Rights Protection Officer (RPO) who is responsible for protecting and advocating for the rights of people receiving services. RPO responsibilities[2] 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; and,
- 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 SH, 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.

In FY23, the OO identified 11 out of 39 RPOs at the LMHA and LBHAs served in other roles that may present a conflict of interest and made recommendations to HHSC Behavioral Health Services (BHS), with the oversight of LMHAs and LBHAs, to review dual roles held by RPOs and take appropriate action to correct any situation where a dual role violates TAC.

[2] Title 25 Health Services Part 1 Department of State Health Services Chapter 404 §404.164 Rights Protection Officer at Department Facilities and Community Centers.

In FY24, the OO identified two instances where the RPO's dual role created conflict of interest, as determined by the ombudsman. The OO worked with both organizations to ensure that the RPOs do not take on duties that may conflict with their role in assisting persons with concerns about their rights.

In the first case, after learning the LMHA's RPO also served as an ombudsman, OBH recommended they discontinue using the title of "ombudsman" for the RPO to avoid confusion for consumers. The LMHA accepted the recommendation and made appropriate changes to their website.

In the second case, a consumer complained the LMHA did not have an RPO to assist with his issues. The consumer did not realize the Health Insurance Affordability and Accountability Act (HIPAA) Privacy Officer (PO) also served as the RPO. After investigating the issue, OBH learned the RPO was also serving as the Director of Quality Assurance (DOA).

The OBH reviewed the job description for the RPO/PO/DOA and found it prioritized the role of the DOA and provided minimal information on the responsibilities of the RPO. It also contained a potential conflict of interest with the RPO's responsibility to advocate for the individual when investigating complaints about issues associated with areas under the purview of the DOA and PO roles. The OBH recommended having an independent role for the RPO to avoid a conflict of interest and confusion for consumers.

The LMHA accepted part of the recommendation and moved the HIPAA PO role to another workforce location. The LMHA declined to separate the RPO and DOA roles stating both are committed to and prioritize the advocacy and protection of individual rights. They also committed to updating the job description for the DOA and RPO to outline the full responsibilities of the RPO including following up on all complaints/allegations of violations and its role during the complaint process to thoroughly investigate each complaint received.

Outreach

In FY24, the Managing Ombudsman for Behavioral Health continued to attend the HHS State Hospital Section Monthly Rights Protection Officer meetings to provide updates on the OBH team and complaints filed with OBH.

OBH continues to engage in the HHSC workgroup as the subject matter expert during revisions of the Rights Rule, Chapter 404 E, and the State Hospital Grievance Policy and Process.

FY25 Planned Activities

For FY25, OBH will:

- Participate in internal quarterly meetings with PI, OIG, SH, and SSLC staff; and,
- Continue to explore ways to provide information and outreach to LMHAs.

Program Response to 2023 Recommendations

The role of Rights Protection Officers (RPOs)

Recommendation: HHSC BHS, 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.

Program Response: BHS stated they will review LMHA RPO policies on dual roles and consider whether further guidance is needed for providers. They also stated they would provide additional technical assistance if they assess that it is required.

Conclusion

In FY24, the HHS Ombudsman received 124,148 total contacts. Of those contacts, the HHS Ombudsman received 54,967 complaints and 69,181 inquiries. In FY24, the HHS Ombudsman saw an increase of 27% in total contacts which included a 11% increase in complaints and a 44% increase in inquiries in comparison to FY23. As noted in this report, the increase in contacts is attributed to the unwinding of continuous Medicaid coverage and the subsequent increase of eligibility applications.

Each ombudsman program identified specific issues and made recommendations for HHSC or DFPS to consider. Ombudsman recommendations are a result of research of policy, best practices, and discussions with the program area to identify feasible and actionable solutions. Programs are required to respond in writing to recommendations. Their responses are tracked and progress on pending recommendations continues to be reported until resolved.

Public Feedback

The HHS Ombudsman received no public feedback on the 2023 Annual Report.

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 2024 (FY24) – The 12-month period beginning September 1, 2023, and ending August 31, 2024, is 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 agencies and other high-profile contacts such as those received from HHS executive staff.

Provider – An individual such as a physician or nurse, or a 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

AAA – Area Agencies on Aging

ADRC – Aging Disability Resource Centers

AES – Access and Eligibility Services

BHS – Behavioral Health Services

BIN – Bank Identification Numbers

CARE – Client Assignment and Registration

CBC – Community-Based Care

CHCC – Children's Health Care Coalition

CHIP – Children's Health Insurance Program

CPS – DFPS Child Protective Services

DFPS – Department of Family and Protective Services

DOA – Director of Quality Assurance

EBT – Electronic Benefits Transfer

FCO - Foster Care Ombudsman

FEMA – Federal Emergency Management Agency

FMSA – Financial Management Services Agencies

FNS – Food and Nutrition Services

HCS – Home and Community-based Services

HEART – HHS Enterprise Administrative Report and Tracking System

HHSC – Texas Health and Human Services Commission

HIPAA - Health Insurance Affordability and Accountability Act

IDD – Intellectual or Developmental Disability

IDD Ombudsman – Ombudsman for Individuals with Intellectual or Developmental Disability

IDD SRAC – IDD System Redesign Advisory Committee

IMPACT – Information Management Protecting Adults and Children in Texas

IRO – Independent Review Organization

LBHA – Local Behavioral Health Authority

LIDDA – Local Intellectual and Developmental Disability Authority

LMHA – Local Mental Health Authority

LTCR – Long-Term Care Regulatory

LSBS – Lone Star Business Services

LTCOP – Long-Term Care Online Portal

LTCR – Long-Term Care Regulatory

MCO – Managed Care Organization

MCS – Medicaid and CHIP Services

MEPD – Medicaid for the Elderly and People with Disabilities

MSP – Medicare Savings Program

OBH – Ombudsman for Behavioral Health

OCS – Ombudsman Complaint Services

OIG – Office of the Inspector General

OIG TPR – Office of the Inspector General Third Parties Recovering Team

OMCAT – Ombudsman Managed Care Assistance Team

ONA – Other Needs Assistance Program

OO – Office of the Ombudsman

PI – Provider Investigations

PO – Privacy Officer

RCCR – HHS Residential Child Care Regulation

RPO – Rights Protection Officer

RTC – Residential Treatment Center

SDA – Service Delivery Area

SH – State Hospital

SMMCAC – State Medicaid Managed Care Advisory Committee

SOS – Specialized Ombudsman Services

SSCC – Single Source Continuum Contractors

SSLC – State Supported Living Center

SNAP – Supplemental Nutrition Assistance Program

TAC – Texas Administrative Code

TANF – Temporary Assistance for Needy Families

TIERS – Texas Integrated Eligibility Redesign System

TMHP – Texas Medicaid Healthcare Partnership

TxHml – Texas Home Living

USDA – United States Department of Agriculture

YTB – YourTexasBenefits.com