Quarterly Report from the HHS Ombudsman Managed Care Assistance Team 3rd Quarter FY 2020

As Required by

Section 531.0213 of the

Government Code

Office of the Ombudsman

November 2020

TEXAS
Health and Human Services

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Executive Summary

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

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

The data provided in this report is exclusive to contacts received by OMCAT and does not include contacts received by any other areas within Health and Human Services (HHS).

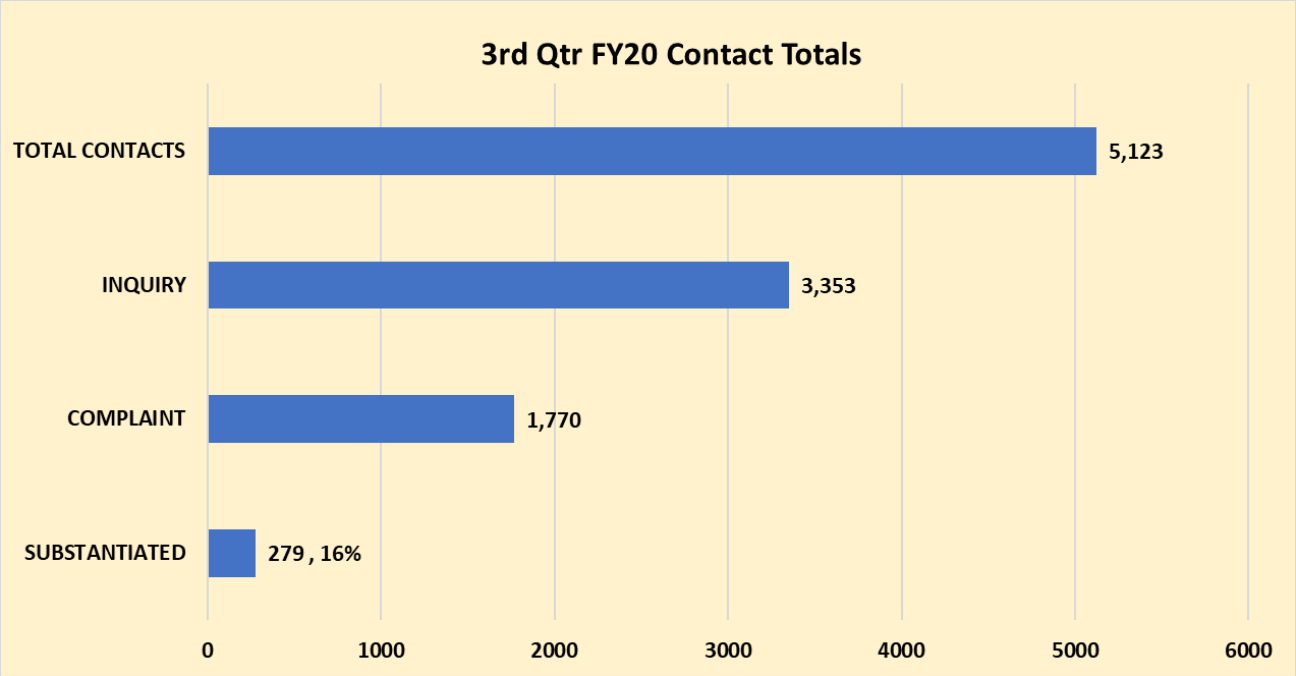
OMCAT received 5,123 contacts during the third quarter of fiscal year 2020. Of these contacts, 1,770 were complaints and 3,353 were inquiries.

The complaints that were received are categorized as follows:

- 279 were substantiated;
- 206 were unsubstantiated; and,
- 1,282 were unable to be substantiated (e.g. there was not enough evidence to determine whether agency policy or expectations were violated).

Figure 1 below shows the total number of inquiries and complaints received which make up the total number of contacts received by OMCAT during the third quarter. Figure 1 also includes the number of complaints that were substantiated during the quarter.

Figure 1 3rd Quarter FY20 Contacts by Type



The most common reasons for complaints received by consumers during the third quarter of fiscal year 2020 were related to:

- Medicaid Eligibility/Recertification
- Balance Billing
- Home Health
- Case Information Error
- Access to Prescriptions – Other Insurance

This report contains recommendations to mitigate issues related to erroneous insurance information on Medicaid cases, and an inability to access prescriptions due to consumers not showing as active members in the Managed Care Organization (MCO) pharmacy system. These issues continue to be frequent and ongoing barriers to care that drive Medicaid managed care consumers to contact OMCAT.

1. Introduction

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

The report provides high-level information regarding consumer inquiries and complaints reported to OMCAT during the third quarter of fiscal year 2020. It provides data and analysis of the contacts received by OMCAT, identifies barriers and problems with the managed care system, and provides recommendations to address the most frequent complaints. The report includes contacts from consumers on fee-for-service Medicaid, Medicaid managed care, and those who do not have any Medicaid benefits at the time of contacting OMCAT.

The contact data in this report provides analysis regarding:

- Total number of inquiries and complaints received;
- Types of inquiries and complaints received;
- Top complaints by entity against which the complaints are made;
- Number and types of inquiries and complaints by region and managed care delivery model; and,
- Number of complaints resolved that were substantiated, and summaries of cases that illustrate relevant patterns or trends.

2. Background

Government Code 531.0171 requires the HHS Office of the Ombudsman to provide dispute resolution services for the health and human services system and perform consumer protection and advocacy functions related to health and human services. This assistance includes assisting a consumer or other interested person with raising a matter within the health and human services system that the person feels is being ignored, obtaining information regarding a filed complaint, and collecting inquiry and complaint data related to the health and human services system.

The Medicaid Managed Care helpline began operations on January 2, 2001, under a non-profit organization, Texas HEART, contracted by the Texas Department of Health. On September 1, 2007, HHSC transitioned the helpline into the HHS Office of the Ombudsman. The helpline was originally created during the 74th Texas Legislative Session through SB 601, which required HHSC to operate a helpline to assist consumers with urgent medical needs who experience barriers to receiving Medicaid and Medicaid managed care services.

OMCAT receives contacts from the public via a toll free helpline and an online submission form, which can be accessed at HHS Ombudsman Managed Care Help. Contacts are captured in the HHS Enterprise Administrative Report and Tracking System (HEART), a web-based system that tracks inquiries and complaints for several HHS programs. HEART tracks consumer specific information, consumer issues, regional and program data, as well as the findings and resolutions of OMCAT investigations.

3. Message from the Managed Care Ombudsman

This is a publicly available quarterly report that OMCAT publishes on its website at HHS Ombudsman Managed Care Help as well as on the HHS Reports and Presentations website at HHS Reports and Presentations.

This report offers our program an opportunity to identify and highlight trends and emergent issues reported by consumers who contact our office. The report contains regional data, Medicaid program specific data, as well as recommendations that the Office of the Ombudsman has for resolving problem trends. It should be noted that the data in this report only represents contacts received by OMCAT. Therefore, it will not include all Medicaid managed care complaints received by the agency, vendors, or MCOs during the quarter.

OMCAT is comprised of highly trained and experienced professionals who, collectively, possess 35 years of Medicaid managed care experience. As ombudsmen, staff educate consumers on their rights and responsibilities, help consumers navigate the Medicaid managed care system, and resolve complaints. OMCAT investigates consumer complaints, works with Medicaid and CHIP Services to determine compliance with state and agency rules and policies, determines if agency expectations were met, and provides recommendations for resolution with the goal of preventing future occurrences.

OMCAT welcomes feedback from stakeholders to improve this report in its ability to reflect the experience of Medicaid consumers who have contacted OMCAT.

OMCAT In Action

During the third quarter of fiscal year 2020, OMCAT received and resolved a total of 82 complaints from consumers with issues related to COVID-19.

The following is a case study that highlights the OMCAT team's work.

In April 2020, a family wanting to bring their relative home from the nursing facility was denied an assessment for a waiver to allow them to take care of the consumer in their home.

The MCO informed the family that all assessments for Money Follows the Person (the process allowing consumers to receive a Medicaid waiver that provides in home services in lieu of being in a facility) were suspended due to COVID-19. However, at the time the family requested the assessment, HHSC had allowed MCOs to conduct telehealth assessments in such circumstances.

OMCAT provided updated policy to the MCO and the consumer was able to receive the assessment and start home health services.

Additional examples of complaints received and resolved by the OMCAT team, include:

- Consumers not able to obtain assessments for the STAR+PLUS Waiver due to MCOs not being able to perform in person or telehealth assessments at the time of the request;
- Provider offices closed due to COVID-19;
- Providers not seeing patients in person, but treatment needed must be performed in person;
- Consumers seeking providers that can provide services via telehealth;
- Consumers not able to get Texas Health Steps (THS) checkups due to providers only taking sick patients during the public health emergency (PHE);
- Consumers due to get THS checkups but parents are not willing to take them to a doctor's office for fear of exposure to COVID-19;
- Providers cancelling appointments due to COVID-19;
- Consumers' adult children pulling them from nursing facilities before home health services can be arranged for fear of contracting COVID-19;
- Consumers' home health attendants not providing services in consumers' homes for fear of contracting Covid-19;
- Medicaid cases erroneously terminated during the PHE;
- Facilities not taking new patients due to Covid-19;
- Providers not offering telehealth appointments;
- Providers requiring in person visits despite the consumer's hesitation to visit a facility for fear of contracting Covid-19; and,
- Consumers that contracted Covid-19 while residing in a nursing facility.

4. Contacts and Complaints

Contact Data Analysis

OMCAT received 5,123 contacts in the third quarter of fiscal year 2020. Compared to the second quarter of fiscal year 2020, the third quarter of fiscal year 2020 saw a decrease of 36 percent (or 2,936 fewer) in total contacts. Total contacts include general inquiries and complaints from consumers, legislative staff on behalf of consumers, and other stakeholders related to Medicaid benefits and services.

Inquiry Data Analysis

OMCAT received 3,353 inquiries, which is a decrease of 36 percent (or 1,914 fewer inquiries), in the third quarter of fiscal year 2020 compared to the second quarter of fiscal year 2020. Inquiries remain an important indicator of member's educational needs and requests for information.

During the third quarter OMCAT experienced a decrease in inquiries regarding:

- Verifying health care coverage;
- Applying for health care coverage;
- Changing health plan;
- Accessing long term care services;
- Billing questions; and
- Explanations of benefits/policy.

Top 10 Inquiries

Out of all inquiries received during the third quarter, below are the top ten inquiries received. The top ten inquiries listed below represent 62 percent (2,076) of the total number of inquiries received during the third quarter.

Table 1 Top 10 Inquiries

Inquiry Reason	Count	Percent of Total
Verify Health Coverage	550	16%
Access to PCP/Change PCP	263	8%
Explanation of Benefits/Policy	231	7%
Reporting Change	197	6%
Apply for Health Coverage	186	6%

Inquiry Reason	Count	Percent of Total
Change Plan	156	5%
Billing Inquiry	143	4%
Other/NA	133	4%
COVID-19	123	4%
Access to Long Term Care	94	3%

Complaint Data Analysis

OMCAT received 1,770[1] complaints, which is a decrease of 37 percent (or 1,022 fewer complaints), in the third quarter of fiscal year 2020 compared to the second quarter of fiscal year 2020.

OMCAT experienced decreases in complaints regarding:

- Medicaid eligibility;
- Inability to access prescriptions due to other insurance;
- Inability to access prescriptions due to consumer not showing in HHSC or MCO systems;
- Case information errors);
- Denial of services; and
- Inability to access prescriptions due to pharmacies billing the incorrect health care coverage.

Substantiated Complaints

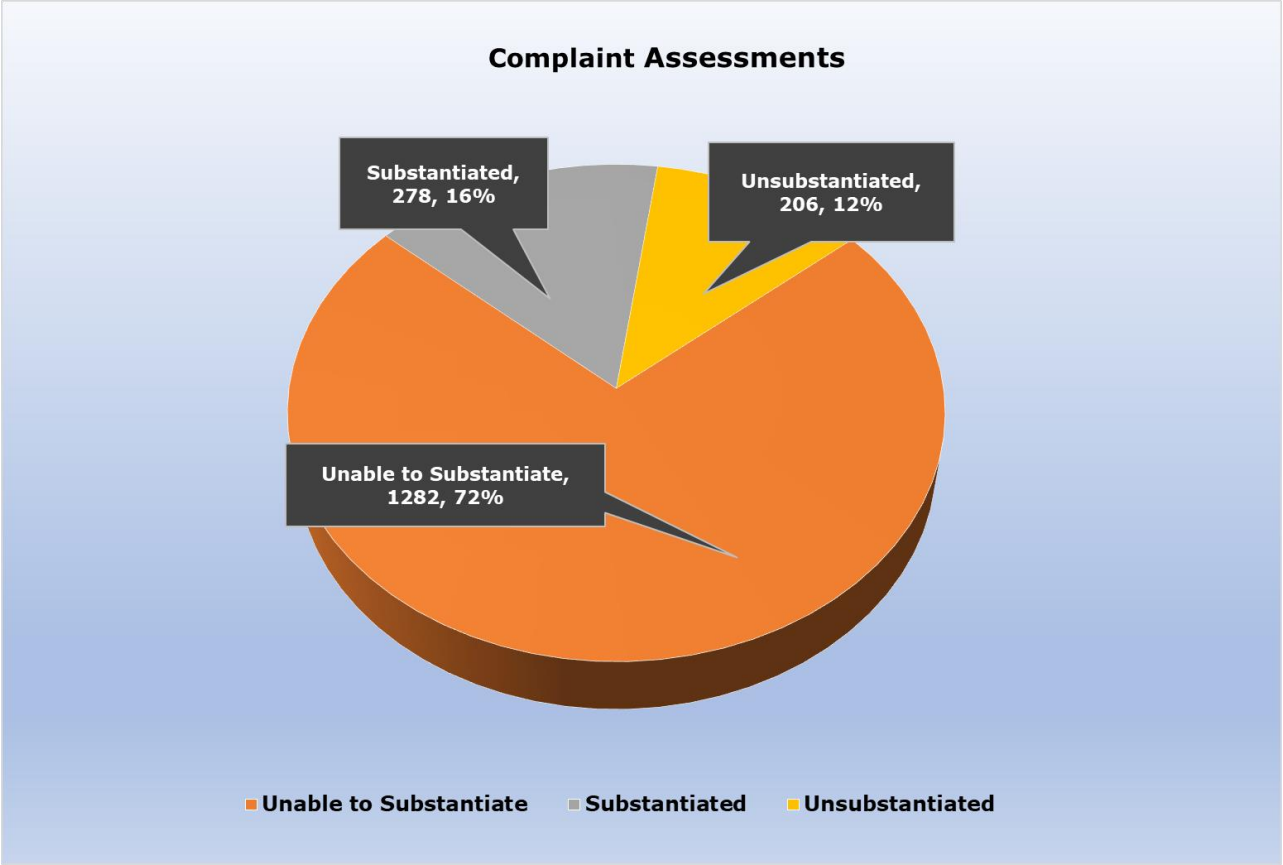
Complaints received may be categorized as: substantiated, unsubstantiated, and unable to substantiate. (For a definition and example of each of these categories, please see the glossary.) Complaints include those received by consumers on fee-for-service Medicaid, Medicaid managed care, and by consumers applying for or whose Medicaid has lapsed.

In the third quarter of fiscal year 2020, OMCAT substantiated 16 percent of complaints received. This is an increase of one percent compared to the second quarter of fiscal year 2020.

Figure 2 below shows how many complaints resolved during the third quarter were substantiated, unsubstantiated, or were unable to be substantiated.

[1] Three complaints received during the third quarter were still being worked by staff and therefore not resolved at the time the data was compiled. Those three complaints are not represented in the pie chart on the next page in Figure 2.

Figure 2 Complaints Assessments



In accordance with the statute that created OMCAT (Sec. 531.0213), OMCAT team members are required to educate consumers so that they can advocate for themselves. When consumers are educated on how to file their complaint with the appropriate area, this results in an initial referral to the health plan or appropriate HHS program. In these cases, OMCAT will not have the final resolution to the complaints and therefore cannot determine if the complaints were substantiated or not.

This statutory requirement may in part explain the number of "unable to be substantiate" cases.

Top Ten Substantiated Complaints

As identified in Figure 2: Complaints Assessments above, OMCAT received and substantiated a total of 279 complaints in the third quarter of fiscal year 2020. The 10 most common substantiated complaints are the following:

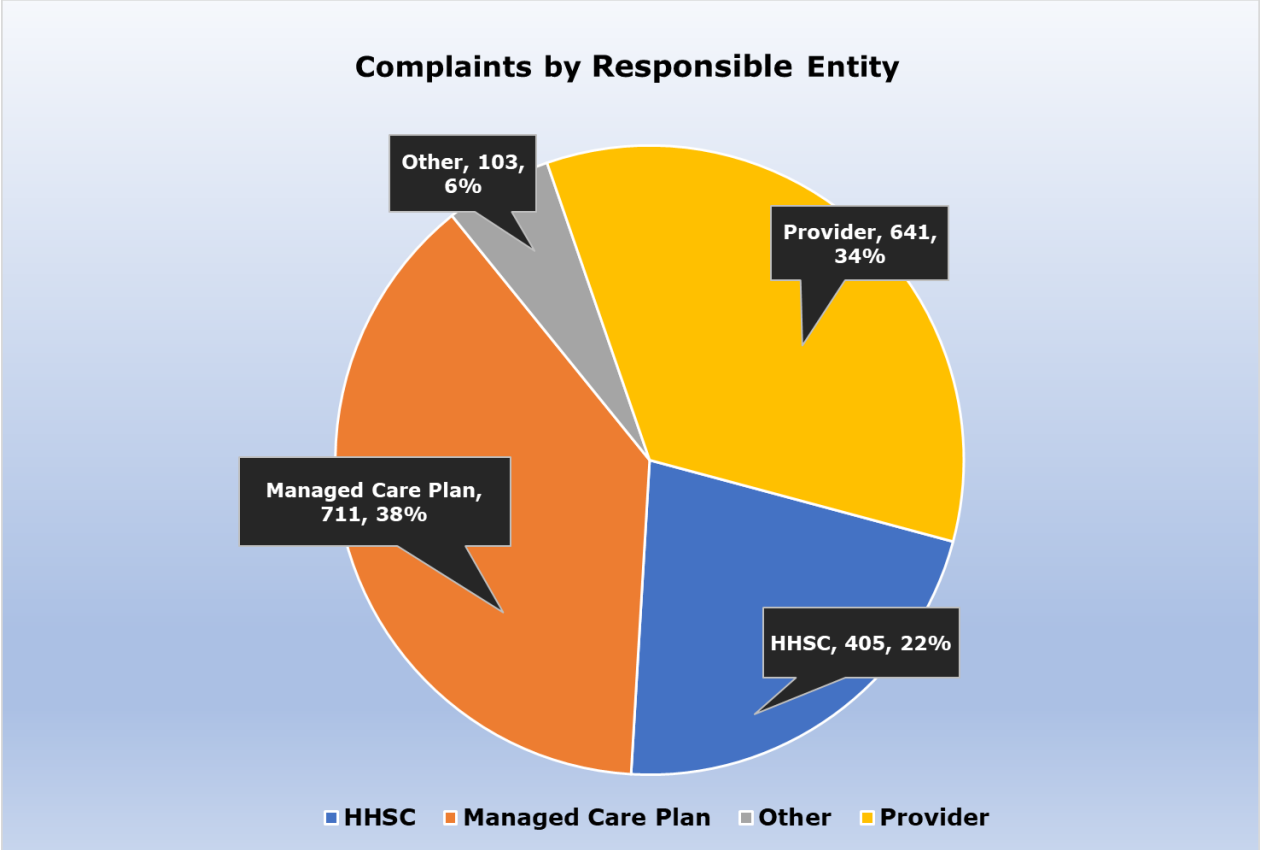
- Inability to access prescriptions due to the consumer not showing as having active Medicaid in the MCO's system or in the pharmacy's system (40);
- Inability to access prescriptions due to erroneous insurance showing on the consumer's file with the MCO's or HHSC's systems (31);
- Errors on the Medicaid case (24);
- Inability to access home health provider services (19);
- Consumers being billed for services received (17);
- Inability to access an in-network provider (non-PCP) (13);

- Inability to access durable medical equipment (DME) (12);
- Inability to access prescriptions for other reasons (11);
- Inability to access prescriptions due to pharmacy billing the wrong health care coverage (11); and,
- Inability to access an out-of-network provider (10).

All Complaints by Responsible Entity

Figure 3 below shows the major entities responsible for complaints made to OMCAT by consumers as well as the percentage of complaints attributed to these entities.

Figure 3 Complaints by Responsible Entity



The Responsible Entity refers to the area found or presumed responsible for the program or service about which the consumer in contacting OMCAT. Complaints in this section of the report include those that were substantiated, unsubstantiated and those that OMCAT was unable to substantiate.

Complaints received in the third quarter were found to be associated with three main responsible entities: HHSC, managed care plans, and providers.

Managed care plans were the Responsible Entity in 38 percent of complaints (or 711). Providers were the Responsible Entity in 34 percent of complaints (or 641). HHSC was the Responsible Entity in 22 percent of complaints (or 405). The remainder of complaints were against various entities not already mentioned and comprised six percent (or 103) of all complaints received in the third quarter.

Top 5 Complaints by Responsible Entity

The tables below show the top five complaints by Responsible Entity. Complaints include those that are substantiated, unsubstantiated, and unable to substantiate.

Table 2 highlights the top 5 complaints by number of complaints received.

Table 3 highlights the top 5 complaints that were substantiated.

HHSC As the Responsible Entity

Table 2 HHSC Top 5 Complaints

Complaints	Count	Substantiated	% of Substantiated[2]
Medicaid Eligibility/Recertification	178	5	13%
Case Information Error	85	17	43%
Access to Prescriptions - Other Insurance	19	3	8%
Home Health	16	3	8%
Access to Prescriptions – Member Not Showing Active	14	1	3%

Table 3 HHSC Top 5 Substantiated Complaints

Substantiated Complaints	Count	Substantiated	% of Substantiated[3]
Case Information Error	85	17	43%
Medicaid Eligibility/Recertification	178	5	13%
Home Health	16	3	8%

[2] This represents the percent of the total substantiated complaints.
[3] This represents the percent of the total substantiated complaints.

Substantiated Complaints	Count	Substantiated	% of Substantiated[3]
Access to Prescriptions – Other Insurance	19	3	8%
Access to Out-of-Network Provider	4	2	5%

There were 466 complaints received where the entity responsible for the complaint was HHSC. Of those complaints, 40 (9 percent) were substantiated. The third quarter of fiscal year 2020 had a decrease of 40 percent (or 316 fewer) in complaints compared to the second quarter of fiscal year 2020 (which had a total of 782). The third quarter substantiated complaints remained the same as the second quarter substantiated complaints.

Substantiated complaints of incorrect information on consumer cases are related to: incorrect spelling of consumer's name; incorrect residential information; consumer showing as having Medicare but is not eligible for Medicare; or Medicaid not terminated when consumer moved out of state.

Substantiated complaints of Medicaid eligibility include: cases terminated in error and a consumer whose type of Medicaid did not transition to the correct type upon recertification.

Substantiated complaints of access to home health include: consumers whose home health services were interrupted by an erroneous termination in Medicaid coverage; and a consumer that still showed to be in a nursing facility in HHS systems but was in the community in need of home health services.

Substantiated complaints of inability to access prescriptions due to erroneous insurance showing on the Medicaid case are due to other insurance showing in HHS systems although the consumers no longer had coverage with those insurance companies.

Managed Care Plans

Table 4 Managed Care Plans Top 5 Complaints

Complaints	Count	Substantiated	% of Substantiated[4]
Home Health (formerly called Access to LTSS)	82	15	12%

[4] This represents the percent of the total substantiated complaints.

Complaints	Count	Substantiated	% of Substantiated[4]
Access to In-Network Provider (non-PCP)	75	10	8%
Access to DME	68	10	8%
Access to PCP	54	4	3%
Access to Out-of-Network Provider	54	8	6%

Table 5 Managed Care Plans Top 5 Substantiated Complaints

Substantiated Complaints	Count	Substantiated	% Substantiated[5]
Home Health (formerly called Access to LTSS)	82	15	12%
Access to Prescriptions - Other Insurance	32	14	11%
Access to Prescriptions - Member Not Showing Active	23	12	10%
Access to DME	68	10	8%
Access to In-Network Provider (non-PCP)	75	10	8%

There were 871 complaints received where the entity responsible for the complaint was an MCO. Of those complaints, 124 (or 14 percent) were substantiated. The third quarter of fiscal year 2020 had a decrease of 24 percent (or 280 fewer) in complaints compared to the second quarter of fiscal year 2020 (which had a total of 1,151). The third quarter had a decrease of eight percent in substantiated complaints compared to the second quarter.

Substantiated complaints of accessing home health services include:

- Obtaining assessment for home health service;

[5] This represents the percent of the total substantiated complaints.

- Transitioning from a facility back into the community;
- Needing an increase in home health nursing hours; and,
- Denied authorizations for home health services.

Substantiated complaints of inability to access prescriptions due to other insurance on Medicaid cases are related to: MCO consumer files showing private insurance that the consumer either no longer had or never had and consumers that showed as having Medicare in the MCO's system but were not active with that coverage.

Substantiated complaints of inability to access prescriptions due to consumer not showing as having active coverage in the MCO's pharmacy system are due to the consumers' enrollment information being sent to the MCO; however, the MCO had not uploaded the files.

Substantiated complaints of DME include: access to mobility devices (such as wheelchairs, scooters, walkers and lifts), diabetic supplies, incontinent supplies, hospital beds, nebulizer, and hearing aids. Problems with accessing medical equipment and supplies were due to: delays in receiving supplies, MCO not assisting consumer with initial attempts to obtain DME, or denial of equipment or supplies.

Substantiated complaints of inability to access an in-network provider include: access to OBGYNs, surgeons, a hematologist, a dental provider, a pediatric neurologist, and a pain management provider. The issues related to accessing in-network providers were related to:

- MCO not showing their member as active;
- MCO not able to find specialists willing to see patients during the PHE;
- Specialists not accepting consumer's MCO;
- In-network specialists having too many restrictions regarding accepting new patients;
- In-network OBGYNs not willing to accept a pregnant consumer in their third trimester as a new patient;
- Specialists listed in the MCO provider directory were no longer taking the MCO;
- DMO did not show the parent as the authorized representative in their system so will not assist the parent in changing the dental provider; and,
- A specialist did not have appointments for new patients in the near future.

Provider

Table 6 Provider Top 5 Complaints

Complaints	Count	Substantiated	% of Substantiated[6]
Balance Billing	134	9	9%

[6] This represents the percent of the total substantiated complaints.

Complaints	Count	Substantiated	% of Substantiated[6]
Access to Prescriptions – Member Not Showing Active	65	27	26%
Access to Prescriptions - Other	52	8	8%
Access to Prescriptions – Other Insurance	49	12	11%
Home Health	42	1	1%

Table 7 Provider Top 5 Substantiated Complaints

Substantiated Complaints	Count	Substantiated	% of Substantiated[7]
Access to Prescriptions - Member Not Showing Active	65	27	26%
Access to Prescriptions – Other Insurance	49	12	11%
Access to Prescriptions – Billed Incorrect Health Plan	28	10	10%
Balance Billing	134	9	9%
Access to Prescriptions - Other	52	8	8%

There were 714 complaints received where the entity that the complaint was against was a provider. Of those complaints, 105 (or 15 percent) were substantiated. The third quarter of fiscal year 2020 had a decrease of 27 percent (or 263 fewer) in complaints compared to the second quarter of fiscal year 2020 (which had a total of 977). The third quarter substantiated complaints remained the same as the second quarter substantiated complaints.

Substantiated complaints of inability to access prescriptions due to provider not showing the consumer as having active coverage are related to pharmacies whose systems do

[7] This represents the percent of the total substantiated complaints.

not show consumer has having active Medicaid coverage, but the consumer was eligible for Medicaid at the time of service.

Substantiated complaints of inability to access prescriptions related to other insurance are due to erroneous insurance showing in the pharmacies' systems. Pharmacies are required to bill private insurance before billing Medicaid; therefore, if there is incorrect/outdated private insurance showing in the system, the pharmacy is not able bill correctly for the medication. Medications are the only Medicaid service that are point of sale and cannot be billed after the service is provided. Substantiated complaints of inability to access prescriptions due to claims submitted to incorrect health plan include: pharmacies submitting claims to a consumer's previous MCO instead of to traditional Medicaid; and pharmacies that have the incorrect billing information in their systems.

Substantiated complaints of inability to access prescriptions due to billing the incorrect health plan include: pharmacies billing the consumer's previous health plan instead of their current plan; and pharmacies billing the consumer's previous health plan when the consumer was on traditional Medicaid at time of service.

Top 5 Complaints by Medicaid Managed Care Program

In this section of the report, complaints are analyzed by the Medicaid program that consumers had at the time of the complaint.

The following tables show the top five reasons for complaints for each managed care program. Complaints include those that are substantiated, unsubstantiated and unable to substantiate.

OMCAT receives many different types of complaints; therefore, the top five complaints may not always comprise a majority of total complaints for each service area.

STAR+PLUS (530,594[8])
Complaints -- (745 Total/89 Substantiated)

Table 8 STAR+PLUS Top 5 Complaints

Complaint Reasons	Count	Substantiated	% of Substantiated[9]
Home Health (formerly called Access to LTSS)	89	17	19%
Access to DME	57	6	7%

[8] The average monthly enrollment for STAR+PLUS program in the third quarter of fiscal year 2020.
[9] Represents the percent of the total substantiated complaints.

Complaint Reasons	Count	Substantiated	% of Substantiated[9]
Balance Billing	40	5	6%
COVID-19	35	0	0%
Medicaid Eligibility/Recertification	35	1	1%

OMCAT received 745 complaints from consumers in the STAR+PLUS program in the third quarter of fiscal year 2020, and of those 89 (12 percent) complaints were substantiated.

Complaints decreased by 22 percent (or215 fewer) and substantiated complaints decreased by five percent compared to the second quarter of fiscal year 2020. The top five complaints noted in the table above comprise 34 percent of the total complaints received by consumers on STAR+PLUS.

Substantiated complaints of accessing home health services include:

- Assessments not being conducted for home health services;
- Denial of services; services terminated;
- Interruption in services; and,
- Authorization of services not transferred to current plan from previous health plan.

Substantiated complaints related to COVID-19 include:

- Consumers not able to get assessments for waiver services due to MCOs not accommodating requests with telehealth assessments; and,
- A consumer who was not able to access dental services through their waiver due to the dental office being closed due to COVID-19.

STAR (2,970,260[10])
Complaints -- (563 Total/98 Substantiated)

Table 9 STAR Top 5 Complaints

Complaint Reasons	Count	Substantiated	% of Substantiated[11]
Balance Billing	59	9	9%

[10] The average monthly enrollment for STAR program in the third quarter of fiscal year 2020.
[11] Represents the percent of the total substantiated complaints.

Complaint Reasons	Count	Substantiated	% of Substantiated[11]
Access to In-Network-Provider (non-PCP)	44	8	8%
Access to Prescriptions – Other Insurance	42	15	15%
Access to Prescriptions – Member Not Showing Active	41	17	17%
Access to PCP	41	4	4%

OMCAT received 563 complaints from consumers in the STAR program in the third quarter of fiscal year 2020, and of those 98 (17 percent) complaints were substantiated. Complaints decreased by 35 percent (or309 fewer) and substantiated complaints decreased by four percent compared to the second quarter of fiscal year 2020. The top five complaints noted in the table above make up 40 percent of the total complaints received by consumers on STAR.

Substantiated complaints of inability to access prescriptions due to other insurance is due to pharmacy, HHSC or MCO systems showing consumers as having insurance other than Medicaid although the consumers were not active with any other insurance.

Substantiated complaints of inability to access prescriptions due to consumer not showing as having active coverage are due to:

- MCOs not having the updated file for the consumer in their system;
- Recently recertified consumers files that did not cross over to all HHS systems yet; and,
- Pharmacy systems that did not show active coverage for the consumer although the consumer was active with Medicaid at the time of service.

STAR Kids (159,361[12])
Complaints -- (160 Total/30 Substantiated)

Table 10 STAR Kids Top 5 Complaints

Complaint Reasons	Count	Substantiated	% of Substantiated[13]
Medicaid Eligibility/Recertification	12	3	10%
Access to DME	11	4	13%
Access to Out-of-Network Provider	11	0	0%
Home Health	10	1	3%
COVID-19	10	1	3%

OMCAT received 160 complaints from consumers in the STAR Kids program in the third quarter of fiscal year 2020, and of those 30 (19 percent) were substantiated. Complaints decreased by 26 percent (or56 fewer) and substantiated complaints increased by three percent compared to the second quarter of fiscal year 2020. The top five complaints noted in the table above make up 34 percent of the total complaints received by consumers on STAR Kids.

Complaints related to Medicaid eligibility include:

- MDCP waiver denied;
- Erroneous processing of MDCP eligibility;
- SSI Medicaid terminated;
- YES waiver denied;
- Medicaid terminated erroneously;
- Medicaid eligibility interrupted; and,
- Medicaid not terminated although previously requested by consumer.

Complaints related to accessing DME include access to: incontinence supplies, bandages, enteral supplies, a hospital bed and a weighted blanket.

Obstacles in obtaining DME include:

- Denials of DME;

[12] The average monthly enrollment for STAR Kids program in the third quarter of fiscal year 2020.
[13] Represents the percent of the total substantiated complaints.

- Lack of coordination between the prescribing provider and MCO;
- DME provider did not know how to process an authorization; and,
- MCO not responding to requests for service coordination of DME.

Complaints related to accessing out of network providers include:

- Consumers that moved out of the service area and needed to access providers in their new area until the address on the Medicaid case updated;
- Consumers that needed authorization to see an out of network provider due to not being able to find an in-network provider that provided the needed services; and,
- A consumer that needed to access services from an out of state provider.

Complaints related to accessing home health services include:

- Decrease in home health service hours; home health providers not being paid;
- Interruption in home health services due to interruption in Medicaid eligibility; and,
- Denial of home health services.

Complaints related to Covid-19 include:

- Parents not comfortable taking children to doctor appointments due to possible exposure to Covid-19;
- Facilities not seeing patients unless they were Covid-19 positive or emergency patients; and,
- Consumers not allowing others into the home due to possible exposure to Covid-19.

STAR+PLUS Dual Demo (39,812[14])
Complaints -- (30 Total/3 Substantiated)

Table 11 STAR Plus Dual Demo Top 5 Complaints

Complaint Reasons	Count	Substantiated	% of Substantiated[15]
Balance Billing	4	1	33%
Medicaid Eligibility/Recertification	3	0	0%
Access to Dental Services (adult)	3	0	0%

[14] The average monthly enrollment for STAR+PLUS Dual Demo program in the third quarter of fiscal year 2020.
[15] Represents the percent of the total substantiated complaints.

Complaint Reasons	Count	Substantiated	% of Substantiated[15]
Case Information Error	2	1	33%
Access to DME	2	0	0%

OMCAT received 30 complaints from consumers in the STAR+PLUS Dual Demo program in the third quarter of fiscal year 2020, and of those 3 (10 percent) complaints were substantiated. Complaints decreased by 38 percent (or 18 fewer) and substantiated complaints decreased nine percent as compared to the second quarter of fiscal year 2020. The top five complaints noted in the table above make up 47 percent of the total complaints received by consumers on STAR+PLUS Dual Demo.

STAR Health (32,814[16])
Complaints -- (40 Total/1 Substantiated)

Table 12 STAR Health Top 5 Complaints

Complaint Reasons	Count	Substantiated	% of Substantiated[17]
COVID-19	9	0	0%
Appointment Availability	7	0	0%
Access to In-Network Provider (non-PCP)	6	0	0%
Access to PCP	2	0	0%
Case Information Error	2	0	0%

OMCAT received 40 complaints from consumers in the STAR Health program in the third quarter of fiscal year 2020, and of that one complaint was substantiated**.** Complaints increased by 122 percent (or 22) and substantiated complaints decreased four percent as compared to the second quarter of fiscal year 2020. The top five complaints noted in the table above make up 65 percent of the total complaints received by consumers on STAR Health.

Complaints related to Covid-19 include:

[16] The average monthly enrollment for STAR Health program in the third quarter of fiscal year 2020.
[17] Represents the percent of the total substantiated complaints.

- Parents not able to get dental appointments for consumers due to dentists only seeing emergency patients;
- Consumers not able to be seen by local providers due to closed offices or not taking patients for non-sick appointments (i.e. THSteps appointments); and
- A consumer not able to find a mental health facility that will take new patients during the PHE.

Dental Managed Care (2,868,519[18])
Complaints -- (35 Total/8 Substantiated)

Table 13 Dental Managed Care Top 5 Complaints

Top 5 Complaint Reasons	Count	Substantiated	% of Substantiated[19]
Provider Treatment Inappropriate/Ineffective	4	1	13%
Medicaid Eligibility/Recertification	4	1	13%
Authorization Issue	4	1	13%
Other Insurance	3	1	13%
Access to In-Network Provider (non-PCP)	3	1	13%

OMCAT received 35 complaints from consumers in the Dental Managed Care program in the third quarter of fiscal year 2020, and of those eight (or 23 percent) complaints were substantiated. Complaints decreased by 43 percent (or 26 fewer) and substantiated complaints increased by seven percent compared to the second quarter of fiscal year 2020. The top five complaints noted in the table above make up 51 percent of the total complaints received by consumers on Dental Managed Care.

Complaints of inappropriate or ineffective treatment by dental providers include:

- Infection that developed after dental procedure;
- Incomplete dental exam; and,
- Ineffective use of anesthesia.

Complaints of Medicaid eligibility are related to consumers who do not show as having active Medicaid coverage in the dental plan's system.

[18] The average monthly enrollment for Dental Managed Care program in the third quarter of fiscal year 2020.
[19] Represents the percent of the total substantiated complaints.

Complaints of authorization issues include:

- Anesthesia not approved for dental surgery;
- Provider not able to get authorization for procedure due to being out of network; and,
- Dental procedure requested is not a covered Medicaid benefit.

Fee-for-Service/Traditional Medicaid (252,082[20])
Complaints -- (257 Total/44 Substantiated)

Table 14 Fee-for-Service Top 5 Complaints

Complaint Reasons	Count	Substantiated	% of Substantiated[21]
Access to Prescriptions – Member Not Showing Active	29	12	27%
Access to Prescriptions – Other Insurance	26	5	11%
Medicaid Eligibility/Recertification	23	1	2%
Access to Prescriptions – Over the Limit (3)	21	4	9%
Access to Prescriptions – Non-Medicaid Provider	19	7	16%

OMCAT receives contacts from all consumers on Medicaid. This includes those that are on traditional Medicaid which means they are not enrolled with an MCO.

OMCAT received 257 complaints from consumers in the Fee-for-Service/Traditional Medicaid program in the third quarter of fiscal year 2020, and of those 44 (17 percent) were substantiated. Complaints decreased by 43 percent (or191 fewer) and substantiated complaints decreased by two percent compared to the second quarter of fiscal year 2020. The top five complaints noted in the table above make up 46 percent of the total complaints received by consumers on fee-for-service/Traditional Medicaid.

Substantiated complaints of inability to access prescriptions due to consumer not showing as having active coverage are due to pharmacies not showing consumers with active Medicaid in their systems.

[20] The average monthly enrollment for Fee-for-Service Medicaid in the third quarter of fiscal year 2020.
[21] Represents the percent of the total substantiated complaints.

Substantiated complaints of inability to access prescriptions due to prescribing provider not being enrolled with Medicaid include:

- Consumers who obtained prescriptions from Medicaid enrolled providers, however the providers were not yet uploaded to the Vendor Drug Program (VDP) system; and,
- Consumers that received services at a Medicaid enrolled facility but were attended to by a provider in the facility that is not individually enrolled as a Medicaid provider.

Substantiated complaints of inability to access prescriptions due to other insurance include outdated insurance information showing on the consumers' Medicaid cases in HHS systems or in the pharmacies' systems.

No Medicaid Complaints -- (258 Total/6 Substantiated)

Table 15 No Medicaid Top 5 Complaints

Complaint Reasons	Count	Substantiated	% of Substantiated[22]
Medicaid Eligibility/Recertification	119	2	33%
Balance Billing	19	0	0%
Case Information Error	15	2	33%
Access to Prescriptions – Member Not Showing Active	14	1	17%
Home Health	14	0	0%

OMCAT receives inquiries and complaints from consumers that may not be on any type of Medicaid or may have a type of Medicaid that only pays for their Medicare premium, copays and deductibles for Medicare services. Many of these contacts are related to clients applying or reapplying for Medicaid.

OMCAT received 258 complaints from consumers who were not on Medicaid third quarter of fiscal year 2020, and of those 6 (or 2 percent) were substantiated**.** Complaints decreased by 50 percent (or259 fewer) and substantiated complaints decreased by one percent as compared to the second quarter of fiscal year 2020. The top five complaints noted in the table above make up 70 percent of the total complaints received of No Medicaid.

[22] Represents the percent of the total substantiated complaints.

Complaints related to Medicaid eligibility and recertification include:

- Consumers who were not aware that the Medicaid had terminated until trying to obtain medical services;
- HHSC not showing consumers' Supplemental Security Income Medicaid (SSI) as active however, Social Security Administration (SSA) had consumers as having active coverage;
- Medicaid terminated erroneously;
- Consumers who had issues with the application process;
- Consumers who disagreed with the denial or termination of Medicaid; and,
- Applications not processed timely.

Service Area Complaints and Inquiries

The map in Figure 4 includes all complaints and substantiated complaints by program type for each service area.

Figure 4 Managed Care Service Areas and Related Complaints

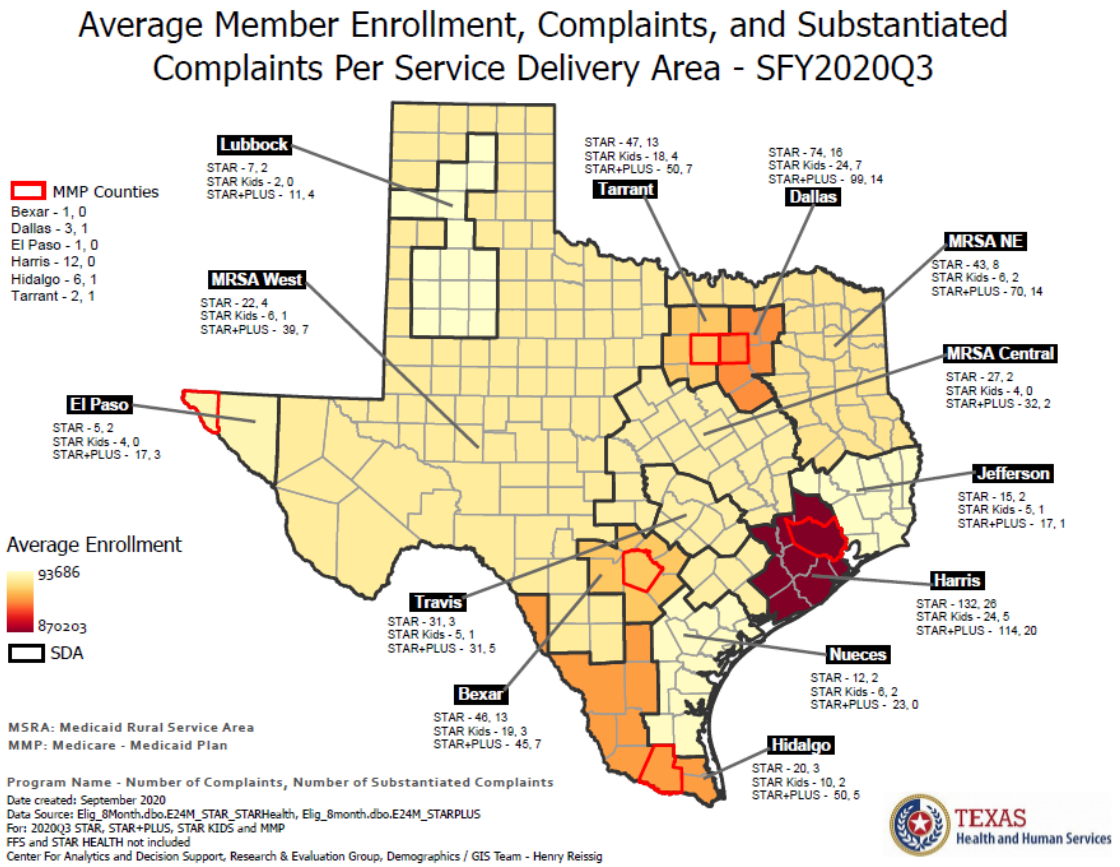


Table 16 Service Delivery Area Complaints and Substantiated Complaints by Program Type

Service Delivery Area	STAR	STAR Kids	STAR+PLUS
Bexar	46 Complaints 13 Substantiated complaints	19 Complaints 3 Substantiated complaints	45 Complaints 7 Substantiated complaints
Dallas	74 Complaints 16 Substantiated complaints	24 Complaints 7 Substantiated complaints	99 Complaints 14 Substantiated complaints
El Paso	5 Complaints 2 Substantiated complaints	4 Complaints 0 Substantiated complaints	17 Complaints 3 Substantiated complaints

Service Delivery Area	STAR	STAR Kids	STAR+PLUS
Harris	132 Complaints 26 Substantiated complaints	24 Complaints 5 Substantiated complaints	114 Complaints 20 Substantiated complaints
Hidalgo	20 Complaints 3 Substantiated complaints	10 Complaints 2 Substantiated complaints	50 Complaints 5 Substantiated complaints
Jefferson	15 Complaints 2 Substantiated complaints	5 Complaints 1 Substantiated complaints	17 Complaints 1 Substantiated complaints
Lubbock	7 Complaints 2 Substantiated complaints	2 Complaints 0 Substantiated complaints	11 Complaints 4 Substantiated complaints
Medicaid Rural Service Area Central	27 Complaints 2 Substantiated complaints	4 Complaints 0 Substantiated complaints	32 Complaints 2 Substantiated complaints
Medicaid Rural Service Area Northeast	43 Complaints 8 Substantiated complaints	6 Complaints 2 Substantiated complaints	70 Complaints 14 Substantiated complaints
Medicaid Rural Service Area West	22 Complaints 4 Substantiated complaints	6 Complaints 1 Substantiated complaints	39 Complaints 7 Substantiated complaints
Nueces	12 Complaints 2 Substantiated complaints	6 Complaints 2 Substantiated complaints	23 Complaints 0 Substantiated complaints
Tarrant	47 Complaints 13 Substantiated complaints	18 Complaints 4 Substantiated complaints	50 Complaints 7 Substantiated complaints
Travis	31 Complaints 3 Substantiated complaints	5 Complaints 1 Substantiated complaints	31 Complaints 5 Substantiated complaints

Table 17 Medicare-Medicaid Plan by Counties Complaints and Substantiated Complaints

County	Complaints	Substantiated Complaints
Bexar	1 Complaint	0 Substantiated complaints
Dallas	3 Complaints	1 Substantiated complaint
El Paso	1 Complaint	0 Substantiated complaints
Harris	12 Complaints	0 Substantiated complaints
Hidalgo	6 Complaints	1 Substantiated complaint
Tarrant	2 Complaints	1 Substantiated complaint

Top 5 Reasons for Complaints and Inquiries by Service Area

The following tables contain the top five reasons of complaints and inquiries received by service area. Complaints include those that are substantiated, unsubstantiated and unable to substantiate.

Bexar Service Area (330,628[23])
Complaints -- (139 Total/23 Substantiated)

Table 18 Bexar Top 5 Complaints

Complaint Reasons	Count	Substantiated	% of Substantiated[24]
Home Health	11	1	4%
Balance Billing	10	1	4%
Case Information Error	10	0	0%
Access to PCP	9	1	4%
Access to Prescriptions – Other	8	3	13%

[23]The average monthly enrollment in Bexar in the third quarter of fiscal year 2020.
[24] Represents the percent of the total substantiated complaints.

Table 19 Bexar Top 5 Inquiries

Top 5 Inquiries	Count
Access to PCP/Change PCP	31
Verify Health Coverage	29
Reporting Change	21
Explanation of Benefits/Policy	15
Billing Inquiry	10

OMCAT received 139 complaints from consumers in the Bexar Service Area in the third quarter of fiscal year 2020, and of those 23 (or 17 percent) were substantiated. Complaints decreased by 37 percent (or 83 fewer complaints) and substantiated complaints remained the same compared to the second quarter of fiscal year 2020. The top five complaints noted in the table above comprise 35 percent of the total complaints received of Bexar Service Area.

Dallas Service Area (478,549[25])
Complaints -- (237 Total/38 Substantiated)

Table 20 Dallas Top 5 Complaints

Complaint Reasons	Count	Substantiated	% of Substantiated[26]
Balance Billing	23	4	11%
Access to In-Network Provider (non-PCP)	17	4	11%
Home Health	16	2	5%
Access to DME	12	2	5%
COVID-19	11	1	3%

[25] The average monthly enrollment in Dallas Service Area in the third quarter of fiscal year 2020.
[26] Represents the percent of the total substantiated complaints.

Table 21 Dallas Top 5 Inquiries

Top 5 Inquiries	Count
Verify Health Coverage	24
Access to PCP/Change PCP	23
Explanation of Benefits/Policy	21
Reporting Change	19
Change Plan	16

OMCAT received 237 complaints from consumers in the Dallas Service Area in the third quarter of fiscal year 2020, and of those 38 (16 percent) were substantiated. Complaints decreased by 16 percent (or45 fewer) and substantiated complaints increased by one percent as compared to the second quarter of fiscal year 2020. The top five complaints noted in the table above make up 33 percent of the total complaints received of Dallas Service Area.

El Paso Service Area (148,098[27])
Complaints -- (35 Total/5 Substantiated)

Table 22 El Paso Top 5 Complaints

Complaint Reasons	Count	Substantiated	% of Substantiated[28]
Balance Billing	3	1	20%
Access to In-Network Provider	3	0	0%
COVID-19	3	0	0%
Access to DME	3	0	0%
Home Health	3	0	0%

[27] The average monthly enrollment in El Paso Service Area in the third quarter of fiscal year 2020.
[28] Represents the percent of the total substantiated complaints.

Table 23 El Paso Top 5 Inquiries

Top 5 Inquiries	Count
Reporting Change	8
Verify Health Coverage	7
Billing Inquiry	5
Explanation of Benefits/Policy	4
Access to PCP/Change PCP	3

OMCAT received 35 complaints from consumers in the El Paso Service Area in the third quarter of fiscal year 2020, and of those 5 (or 14 percent) were substantiated. Complaints decreased by 22 percent (or 10 fewer) and substantiated complaints increased by one percent compared to the second quarter of fiscal year 2020. The top five complaints noted in the table above make up to 43 percent of the total complaints received of El Paso Service Area.

Harris Service Area (870,203[29])
Complaints -- (340 Total/51 Substantiated)

Table 24 Harris Top 5 Complaints

Complaint Reasons	Count	Substantiated	% of Substantiated[30]
Balance Billing	26	4	8%
Access to DME	22	2	4%
Access to Out-of-Network Provider	21	5	10%
Access to Prescriptions – Other Insurance	21	7	14%

[29] The average monthly enrollment in Harris Service Area in the third quarter of fiscal year 2020.
[30] Represents the percent of the total substantiated complaints.

Complaint Reasons	Count	Substantiated	% of Substantiated[30]
Access to In-Network Provider (non-PCP)	18	0	0%

Table 25 Harris Top 5 Inquiries

Top 5 Inquiries	Count
Verify Health Coverage	44
Access to PCP/Change PCP	32
Change Plan	31
Explanation of Benefits/Policy	23
Reporting Change	23

OMCAT received 340 complaints from consumers in the Harris Service Area in the third quarter of fiscal year 2020, and of those 51 (or 15 percent) were substantiated. Complaints decreased by 28 percent (or 132 fewer) and substantiated complaints decreased by six percent compared to the second quarter of fiscal year 2020. The top five complaints noted in the table above make up 32 percent of the total complaints received of Harris Service Area.

Hidalgo Service Area (436,856[31])
Complaints -- (100 Total/11 Substantiated)

Table 26 Hidalgo Top 5 Complaints

Complaint Reasons	Count	Substantiated	% of Substantiated[32]
Home Health (formerly called Access to LTSS)	11	2	18%
Staff Behavior	8	0	0%

[31] The average monthly enrollment in Hidalgo Service Area in the third quarter of fiscal year 2020.
[32] Represents the percent of the total substantiated complaints.

Complaint Reasons	Count	Substantiated	% of Substantiated[32]
Access to DME	8	1	9%
Access to Prescriptions – Member Not Showing Active	6	2	18%
Fair Hearings/Appeals	6	0	0%

Table 27 Hidalgo Top 5 Inquiries

Top 5 Inquiries	Count
Access to PCP/Change PCP	19
Verify Health Coverage	17
Explanation of Benefits/Policy	9
Change Plan	9
Reporting Change	6

OMCAT received 100 complaints from consumers in the Hidalgo Service Area in the third quarter of fiscal year 2020, and of those 11 (or 11 percent) were substantiated. Complaints decreased by 27 percent (or37 fewer) and substantiated complaints decreased by four percent compared to the second quarter of fiscal year 2020. The top five complaints noted in the table above make up 39 percent of the total complaints received of Hidalgo Service Area.

Jefferson Service Area (106,769[33])
Complaints -- (42Total/4 Substantiated)

Table 28 Jefferson Top 5 Complaints

Complaint Reasons	Count	Substantiated	% of Substantiated[34]
Access to Prescriptions – Other Insurance	4	1	25%
Access to Prescriptions – Other	4	1	25%
Medicaid Eligibility/Recertification	4	0	0%
Balance Billing	4	1	25%
Access to In-Network Provider (non-PCP)	3	0	0%

Table 29 Jefferson Top 5 Inquiries

Top 5 Inquiries	Count
Reporting Change	4
Other/NA	4
Access to PCP/Change PCP	4
Access to Long Term Care	3
Verify Health Coverage	3

OMCAT received 42 complaints from consumers in the Jefferson Service Area in the third quarter of fiscal year 2020, and of those 4 (or 10 percent) were substantiated. Complaints decreased by 39 percent (or27 fewer) and substantiated complaints decreased by ten percent compared to the second quarter of fiscal year 2020. The top

[33] The average monthly enrollment in Jefferson Service Area in the third quarter of fiscal year 2020.
[34] Represents the percent of the total substantiated complaints.

five complaints noted in the table above make up 45 percent of the total complaints received of Jefferson Service Area.

Lubbock Service Area (93,686[35])
Complaints -- (22 Total/6 Substantiated)

Table 30 Lubbock Top 5 Complaints

Complaint Reasons	Count	Substantiated	% of Substantiated[36]
Balance Billing	4	1	17%
Home Health	3	1	17%
Case Information Error	3	1	17%
Access to DME	2	0	0%
Access to Prescriptions – Other Insurance	2	2	33%

Table 31 Lubbock Top 5 Inquiries

Top 5 Inquiries	Count
Access to PCP/Change PCP	5
Verify Health Coverage	5
Adult Dental	2
Obtain Medicaid ID card	2
Reporting Change	2

OMCAT received 22 complaints from consumers in the Lubbock Service Area in the third quarter of fiscal year 2020, and of those 6 (or 27 percent) were substantiated. Complaints decreased by 58 percent (or31 fewer) although substantiated complaints increased by two percent compared to the second quarter of fiscal year 2020. The top

[35] The average monthly enrollment in Lubbock Service Area in the third quarter of fiscal year 2020.
[36] Represents the percent of the total substantiated complaints.

five complaints noted in the table above make up 64 percent of the total complaints received of Lubbock Service Area.

MRSA Central Service Area (182,346[37])
Complaints -- (74 Total/4 Substantiated)

Table 32 MRSA Central Top 5 Complaints

Complaint Reasons	Count	Substantiated	% of Substantiated[38]
Access to Prescriptions – Other	9	1	25%
Medicaid Eligibility/Recertification	6	0	0%
Access to Prescriptions – Other Insurance	5	1	25%
Balance Billing	4	0	0%
Access to Prescriptions – PDL Prior Authorization	4	1	25%

Table 33 MRSA Central Top 5 Inquiries

Top 5 Inquiries	Count
Verify Health Coverage	13
Access to PCP/Change PCP	13
Reporting Change	7
Billing Inquiry	7
Explanation of Benefits/Policy	5

OMCAT received 74 complaints from consumers in the MRSA Central Service Area in the third quarter of fiscal year 2020, and of those 4 (or 5 percent) were substantiated.

[37] The average monthly enrollment in MRSA Central Service Area in the third quarter of fiscal year 2020.
[38] Represents the percent of the total substantiated complaints.

Complaints decreased by 33 percent (or 37 fewer) and substantiated complaints decreased by 13 percent compared to the second quarter of fiscal year 2020. The top five complaints noted in the table above make up 38 percent of the total complaints received of MRSA Central Service Area.

MRSA Northeast Service Area (228,723[39])
Complaints -- (147 Total/24 Substantiated)

Table 34 MRSA Northeast Top 5 Complaints

Complaint Reasons	Count	Substantiated	% of Substantiated[40]
Home Health	12	3	13%
Case Information Error	11	3	13%
Balance Billing	11	2	8%
Access to Prescriptions – Other Insurance	9	4	17%
Access to DME	9	2	8%

Table 35 MRSA Northeast Top 5 Inquiries

Top 5 Inquiries	Count
Verify Health Coverage	21
Access to PCP/Change PCP	13
Reporting Change	10
Access to Long Term Care	6
Obtain Health Plan ID card	6

OMCAT received 147 complaints from consumers in the MRSA Northeast Service Area in the third quarter of fiscal year 2020, and of those 24 (or 16 percent) were

[39] The average monthly enrollment in MRSA Northeast Service Area in the third quarter of fiscal year 2020.
[40] Represents the percent of the total substantiated complaints.

substantiated. Complaints increased by two percent (or 3) and substantiated complaints decreased by two percent compared to the second quarter of fiscal year 2020. The top five complaints noted in the table above make up 35 percent of the total complaints received of MRSA Northeast Service Area.

MRSA West Service Area (197,565[41])
Complaints -- (85 Total/12 Substantiated))

Table 36 MRSA West Top 5 Complaints

Complaint Reasons	Count	Substantiated	% of Substantiated[42]
Home Health	8	2	17%
Case Information Error	5	3	25%
Access to DME	5	2	17%
Access to In-Network Provider (non-PCP)	4	0	0%
Access to Prescriptions – Other Insurance	4	2	17%

Table 37 MRSA West Top 5 Inquiries

Top 5 Inquiries	Count
Access to PCP/Change PCP	11
Verify Health Coverage	9
Reporting Change	7
Explanation of Benefits/Policy	6
Obtain Health Plan ID card	5

[41] The average monthly enrollment in MRSA West Service Area in the third quarter of fiscal year 2020.
[42] Represents the percent of the total substantiated complaints.

OMCAT received 85 complaints from consumers in the MRSA West Service Area in the third quarter of fiscal year 2020, and of those 12 (or 14 percent) were substantiated. Complaints decreased by 41 percent (or60 fewer) and substantiated complaints decreased by 11 percent compared to the second quarter of fiscal year 2020. The top five complaints noted in the table above make up 31 percent of the total complaints received of MRSA West Service Area.

Nueces Service Area (115,983[43])
Complaints -- (49 Total/4 Substantiated)

Table 38 Nueces Top 5 Complaints

Complaint Reasons	Count	Substantiated	% of Substantiated[44]
Access to Prescriptions - Other	4	1	25%
Access to Prescriptions – Other Insurance	4	1	25%
Home Health	4	0	0%
Staff Behavior	3	0	0%
Access to DME	3	0	0%

Table 39 Nueces Top 5 Inquiries

Top 5 Inquiries	Count
Explanation of Benefits/Policy	7
Verify Health Coverage	7
Access to Long Term Care	5
Access to PCP/Change PCP	4
Adult Dental	3

[43] The average monthly enrollment in Nueces Service Area in the third quarter of fiscal year 2020.
[44] Represents the percent of the total substantiated complaints.

OMCAT received 49 complaints from consumers in the Nueces Service Area in the third quarter of fiscal year 2020, and of those four (or 8 percent) were substantiated. Complaints decreased by 23 percent (or15 fewer) and substantiated complaints decreased by eight percent compared to the second quarter of fiscal year 2020. The top five complaints noted in the table above make up 37 percent of the total complaints received of Nueces Service Area.

Tarrant Service Area (329,389[45])
Complaints -- (135 Total/25 Substantiated)

Table 40 Tarrant Top 5 Complaints

Complaint Reasons	Count	Substantiated	% of Substantiated[46]
Access to In-Network Provider (non-PCP)	14	4	16%
Access to Out- of- Network Provider	11	2	8%
Balance Billing	11	1	4%
Access to Prescriptions – Member Not Showing Active	10	5	20%
Home Health	7	1	4%

Table 41 Tarrant Top 5 Inquiries

Top 5 Inquiries	Count
Verify Health Coverage	30
Reporting Change	24
Access to PCP/Change PCP	17
Change Plan	15

[45] The average monthly enrollment in Tarrant Service Area in the third quarter of fiscal year 2020.
[46] Represents the percent of the total substantiated complaints.

Top 5 Inquiries	Count
Explanation of Benefits/Policy	12

OMCAT received 135 complaints from consumers in the Tarrant Service Area in the third quarter of fiscal year 2020, and of those 25 (19 percent) were substantiated. Complaints decreased by 44 percent (or105 fewer) and substantiated complaints decreased by two percent compared to the second quarter of fiscal year 2020. The top five complaints noted in the table above make up 39 percent of the total complaints received of Tarrant Service Area.

Travis Service Area (181,231[47])
Complaints -- (83 Total/9 Substantiated)

Table 42 Travis Top 5 Complaints

Complaint Reasons	Count	Substantiated	% of Substantiated[48]
Access to PCP	8	0	0%
Case Information Error	7	2	22%
Home Health	7	2	22%
COVID-19	7	0	0%
Access to Out-of-Network Provider	6	1	11%

Table 43 Travis Top 5 Inquiries

Top 5 Inquiries	Count
Verify Health Coverage	17
Access to PCP/Change PCP	14
Billing Inquiry	9

[47] The average monthly enrollment in Travis Service Area in the third quarter of fiscal year 2020.
[48] Represents the percent of the total substantiated complaints.

Top 5 Inquiries	Count
Reporting Change	7
Obtain Health Plan ID card	4

OMCAT received 83 complaints from consumers in the Travis Service Area in the third quarter of fiscal year 2020, and of those 9 (or 11 percent) were substantiated. Complaints decreased by 25 percent (or28 fewer) and substantiated complaints decreased by two percent compared to the second quarter of fiscal year 2020. The top five complaints noted in the table above make up 42 percent of the total complaints received of Travis Service Area.

5. Barriers and Recommendations to Address Them

Erroneous Insurance on Medicaid Cases

Often consumers do not realize that there is other insurance listed on their Medicaid case until they try to access services. When this error occurs, the Medicaid claim is denied, and consumers are prevented from accessing needed medical care.

OMCAT has the following recommendations to mitigate incorrect insurance information on file:

Whenever private insurance is identified in the HHS TIERS system as being active for a consumer, the consumer should be notified and allowed the opportunity to either (a) confirm the additional insurance or (b) correct the misinformation. Notifications should be provided on consumer accounts in the Your Texas Benefits self-service portal as well as by mail. These notifications should also be provided again upon recertification.

Consumers Not Showing Active in MCO Systems

Consumers whose Medicaid is recertified in the middle of the month are backdated to the beginning of the month. Their enrollment into an MCO is also backdated to the beginning of the month and is sent on a daily file to the MCO. However, MCOs are not required to upload those files upon receipt. This causes a barrier to consumers newly recertified in accessing medical services through the MCO that same month.

STAR, STAR+PLUS, and STAR Kids MCOs should be contractually required to upload member enrollment daily files to their systems within 24 hours of receipt.

6. Ombudsman Collaboration and Initiatives

OMCAT collaborates with HHS programs and MCOs in identifying and resolving barriers to accessing Medicaid services.

OMCAT is responsible for facilitating collaboration through the cross coordination of HHS program areas that have a direct or indirect impact on the delivery of Medicaid services to HHS consumers. The network meets quarterly to share information regarding barriers to care that Medicaid consumers experience, discusses how to mitigate or resolve barriers to care, and provides training to ensure all HHS areas participating in the network are aware of the work and functions of their counterparts.

7. Conclusion

OMCAT is the HHS public facing contact for consumers who need to make complaints and inquiries regarding Medicaid services. As such, the HHS Office of the Ombudsman's goal in this report is to spotlight issues that Medicaid consumers face and provide recommendations to remove barriers where possible, thereby improving the experience of Texas Medicaid consumers.

8. Glossary

Contact – An attempt by HHS consumers to inquire or complain about HHS programs or services.

Complaint – A contact regarding any expression of dissatisfaction.

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

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

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

Lock-In Program – The program restricts consumers whose use of medical services is documented as being excessive. Consumers are "Locked-In" to a specific pharmacy to prevent consumers from obtaining excessive quantities of prescribed drugs through multiple visits to physicians and pharmacies.

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

Managed Care Compliance Operations - The area within HHSC that provides oversight of the managed care contracts.

Medicare Savings Program – The use of Medicaid funds to help eligible consumers pay for all or some of their out-of-pocket Medicare expenses, such as premiums, deductibles or co-insurance.

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

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

Substantiated – A complaint determination where research clearly indicates agency policy was violated or agency expectations were not met. (Example: Consumer complains that their home health attendant did not show up for duty. Research shows that the home health agency confirmed that the attendant was not able to work that day.)

Texas Medicaid Healthcare Partnership – The authorization and claims payment entity for consumers on traditional, fee-for-service, Medicaid.

Unable to Substantiate – A complaint determination where research does not clearly indicate if agency policy was violated or agency expectations were met. (Example:

Consumer has a complaint about accessing medical services and is referred to their MCO to address the complaint since they have not yet tried to work with their MCO.)

Unsubstantiated – A complaint determination where research clearly indicates agency policy was not violated or agency expectations were met. (Example: Consumer complains that that their prescription was rejected at the pharmacy. Research shows that the consumer is not yet due to refill that prescription.)

List of Acronyms

ACRONYM-FULL NAME

CHIP - Children's Health Insurance Program

DME - Durable Medical Equipment

LTSS - Long Term Services and Supports

MCO - Managed Care Organization

MCCO - Managed Care Compliance Operations

MDCP - Medically Dependent Children's Program

MRSA - Medicaid Rural Service Area

PAS - Personal Attendant Services

PCP - Primary Care Provider

PHE – Public Health Emergency

PDL - Preferred Drug List

PDN - Private Duty Nursing

TDD - Telephonic Device for the Deaf

THS – Texas Health Steps

TMHP - Texas Medicaid Healthcare Partnership

YES – Youth Empowerment Services