

TEXAS HEALTH AND HUMAN SERVICES COMMISSION
OFFICE OF INSPECTOR GENERAL

**MEMBER COMPLAINTS RECEIVED
BY TEXAS MEDICAID
MANAGED CARE ORGANIZATIONS**

Series II - Inspection of Complaint Resolution



August 30, 2019
OIG Report No. INS-19-002



HHSC OIG

TEXAS HEALTH AND HUMAN
SERVICES COMMISSION

OFFICE OF
INSPECTOR GENERAL

August 30, 2019 | Highlights of OIG Inspections Division Report INS-18-006

MEMBER COMPLAINTS RECEIVED BY TEXAS MEDICAID MANAGED CARE ORGANIZATIONS: *Series II - Inspection of Complaint Resolution*

WHY THE OIG CONDUCTED THIS INSPECTION

The OIG conducted an inspection to determine if Managed Care Organizations (MCOs) complaint intake and resolution processes are consistent with the Uniform Managed Care Manual (UMCM) and Uniform Managed Care Contract (UMCC) requirements. The inspection focused on determining the effectiveness of the MCO's complaint resolution process.

42 C.F.R. §438.408 states MCOs must resolve each grievance and provide notice as expeditiously as the member's health condition requires. Timeframes for resolution of grievances and notice are to be established by the state and are not to exceed 90 calendar days from the day the MCO receives the grievance. Per the UMCC, MCOs are required to maintain complaint records and provide minimum complaint details.

This inspection is the second in a series of three inspections. Series I and III focus on the following objectives:

- Series I Objective: Review MCO process on how complaints and inquiries are discerned, logged, and reported to HHSC. Published March 7, 2019.

View the report online at:
<https://oig.hhsc.texas.gov/>

- Series III Objective: Review MCO complaint appeal processes for all MCOs serving the STAR+PLUS population.

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WHAT THE OIG FOUND

The Inspections and Investigations Division found MCOs' complaint resolution processes are generally consistent with UMCC and UMCM requirements. However, UMCC complaint resolution criteria is limited to MCOs providing members a resolution letter and not requiring any specific action to resolve complaints. Also, based on inspection testing MCOs did not always complete the UMCC complaint report form consistent with their complaint records.

The population selected for review included all Texas STAR+PLUS member complaints received from all sources during the first two quarters of fiscal year 2018 from the three selected MCOs. The inspection team reviewed 709 complaints to evaluate the effectiveness of the MCOs' complaint resolution processes including:

- Subject of complaints
- Categorization of complaints
- Substantiated and unsubstantiated complaints
- Resolution of complaints

As part of its review of MCO complaint resolution and appeals procedures Managed Care Compliance & Operations (MCCO) provides the MCOs with a form specifically for reporting complaints on a quarterly basis. The MCCO Complaint Report provides instruction on how to complete the form and defines substantiated and unsubstantiated. Substantiated is defined as a complaint resolved in the member's favor and unsubstantiated as a complaint resolved in the MCO's favor.

MCCO relies on information in the complaint reporting forms to identify concerns from the MCO member population, analyze complaint trends, and provide MCO oversight. Inaccurate complaint information hinders MCCO's effectiveness to analyze member complaint data, identify trends, and provide oversight. Complaint information accuracy could be improved by increased oversight and training for MCOs.

The inspection resulted in the following observations:

- The UMCC MCO Internal Member Complaint Process contract provisions require limited investigation documentation and resolution reporting.
- The MCOs did not always accurately complete information in the complaint report form.

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I. PURPOSE AND OBJECTIVES

The Texas Health and Human Services Commission (HHSC) Office of Inspector General (OIG) Inspections and Investigations Division conducted an inspection to determine if Managed Care Organizations (MCOs) complaint intake and resolution processes are consistent with Uniform Managed Care Manual (UMCM) and Uniform Managed Care Contract (UMCC) requirements. The inspection focused on the following objective:

- Determine the effectiveness of the MCO's complaint resolution process.

This inspection is the second in a series of three inspections. Series I and III focus on the following objectives:

- Series I Objective: Review MCO process on how complaints and inquiries are discerned, logged, and reported to HHSC.
- Series III Objective: Review MCO complaint appeal processes for all MCOs serving the STAR+PLUS population.

II. BACKGROUND

Texas Medicaid provides medical care to over 3.9 million members annually through managed care organizations (MCOs).¹ HHSC monitors MCO complaints, grievances, and appeal processes to identify potential systemic problems, determine the need for policy clarifications, or identify larger operational issues for Texas Medicaid members.² This inspection focused on the complaint resolution process for the STAR+PLUS program, for fiscal year 2018 quarters 1 and 2.³ Texas Medicaid 1115 Quarterly Report shows that STAR+PLUS members have a higher number of complaints than those participating in other Medicaid programs.⁴ The STAR+PLUS program serves Medicaid members over the age of 21 with disabilities.

The complaint intake process was the focus of the Member Complaints Received by

¹ [Medicaid and CHIP Monthly Enrollment by Risk Group](https://hhs.texas.gov/about-hhs/records-statistics/data-statistics/healthcare-statistics) (March 2019), retrieved from: <https://hhs.texas.gov/about-hhs/records-statistics/data-statistics/healthcare-statistics>.

² States administering Medicaid are federally required by 42 Code of Federal Regulations (C. F. R.) § 438.416 to ensure MCOs maintain records of all grievances and appeals.

³ UMCC version 2.24 referenced for scope of inspection which was effective through February 28, 2018. See Appendix B.

⁴ HHSC Texas Healthcare Transformation and Quality Improvement Program Section 1115 Report (December 12, 2011 - December 31, 2017), retrieved from: <https://hhs.texas.gov/sites/default/files/documents/laws-regulations/policies-rules/1115-waiver/waiver-renewal/2017-q4-1115-report-final.pdf>

Texas Medicaid Managed Care Organizations Series I - Inspection of Intake of Member Complaints (Series I Inspection Report).⁵ The Series I Inspection Report determined MCO complaint reports differ due to utilizing multiple definitions of complaint and complaint terms than those defined in the UMCC. The findings also indicated MCOs under-reported member complaints by an estimated 5.9 percent which equated to an estimated 4,489 additional complaints not reported in fiscal year 2018 quarters 1 and 2.⁶ The OIG Inspections and Investigations Division conducted the MCO Complaints Series II inspection to assess the effectiveness of MCO's complaint resolution process.

42 C.F.R. §438.408(a) states MCOs must resolve each grievance as expeditiously as the member's health condition requires. Subsection (b) sets specific timeframes for resolution of standard grievances and notice to be established by the state are not to exceed 90 calendar days from the day the MCO receives the grievance. If an extension of the timeframe is requested, subsection (c) allows for up to 14 calendar days if requirements are met. See Appendix B.

Per the UMCC, Version 2.24, Section 8.2.6.1, MCO Member Complaint Process, The MCO's process must require every Complaint received in person, by telephone, or in writing must be acknowledged and recorded in a written record and logged with the following details:

1. a description of the reason for the internal MCO appeal or complaint;
2. the date received;
3. the date of each reviewer, if applicable, review meeting;
4. resolution at each level of the internal MCO appeal or complaint, if applicable;
5. date of resolution at each level, if applicable); and
6. name of the covered person for whom the internal MCO appeal or complaint was filed.

The records must be accurately maintained in a manner accessible to the state and available upon request to CMS.

According to Title 1 Texas Administrative Code §353.415(d) HHSC will review the MCO's complaint and appeals procedures to determine if they comply with HHSC's standards before HHSC approves use of the procedures. Reports containing complaint summaries must be submitted to HHSC in compliance with HHSC policy. As HHSC's designee, Managed Care Compliance and Operations (MCCO)

⁵ Member Complaints Received By Texas Medicaid Managed Care Organizations Series I - Inspection Of Intake Of Member Complaints (March 2019), retrieved from:

<https://oig.hhsc.texas.gov/sites/oig/files/documents/IG-Inspections-Report-MCO-Series-I-3-7-19.pdf>

⁶ The estimated number of underreported complaints is the result of testing from the inspection "Member Complaints Received by Texas Manage Care Organizations: Series I - Inspection of Intake of Member Complaints." See report for additional detail.

is responsible for oversight of the MCOs serving all Medicaid populations to include approximately 500,000 STAR+PLUS members. Their responsibilities include: (a) review and approval of MCO policies and procedures, and (b) analyzing the quarterly MCO member complaint reports to evaluate Medicaid programmatic concerns for improvement or policy changes. For complaint resolution, MCCO provides a standardized reporting form for MCOs to report the number and nature of member complaints.

The MCCO Complaint Report form provides instruction on how to complete the form, defines categories, and defines the terms substantiated and unsubstantiated. The form defines “substantiated” as a complaint resolved in the member’s favor and “unsubstantiated” as a complaint resolved in the MCO’s favor. MCOs can also identify the service category related to the complaint such as medical, dental, behavioral health, nursing facilities or pharmacy benefits. MCOs report the total number of the complaints received, category assigned, and resolutions. This form also provides areas to report if the complaint was against the MCO or subcontracted provider (provider).

According to UMCC, Version 2.24 Section 8.2.6.1, the MCO must resolve Complaints within 30 days from the date the Complaint is received. The MCO is subject to remedies, including liquidated damages, if at least 98 percent of Member Complaints are not resolved within 30 days of receipt of the Complaint by the MCO. The MCO must also inform Members how to file a Complaint directly with HHSC once the Member has exhausted the MCO’s Complaint process. Additionally, members have an option to seek assistance through MCCO or the HHSC Ombudsman Office (Ombudsman) if they are unsatisfied with the MCO’s resolution. Should MCOs fail to comply with the contract, they are subject to contractual remedies including liquidated damages.

HHSC developed a cross divisional workgroup in July 2018 whose primary goals include improving data collection, and standardizing complaint categories to provide more accurate trending data and analyze managed care member complaints. Initial accomplishments identified by the workgroup include identifying entry points and opportunities to streamline the complaint process by promoting consistency in recording, tracking, and resolution of complaints. The HHSC complaint workgroup stated they plan on implementing the following additional improvements to the complaint monitoring process:

- Implement complaint category standardization across HHSC and MCOs. HHSC will begin utilization of new categories in September 2019 and MCOs will collect complaints data using the categories in December 2019.
 - Provide MCOs training on how to implement new categories (September 2019).

- Execute contract changes related to complaints definitions (September 2019).
 - This includes clarifications that complaints resolved within one business day of contact must be reported as complaints.
 - Revises reporting requirements from quarterly to monthly to aid in early issue detection.
- Deploy client-facing changes to the new complaints process including a communications plan (September 2019). The plan includes:
 - How to submit a complaint.
 - Where to seek follow up information on a complaint.
 - The resolution process and associated timelines.
- Aggregate and verify Member and Provider complaints data as required by HB 4533 (February 2020).⁷

Inspection Methodology:

The population selected for review included all Texas STAR+PLUS member complaints received from all sources during the first two quarters of fiscal year 2018 from the three selected MCOs. A review of the complaint data for each MCO allowed the inspection team to compare the numbers of total complaints received, complaints reported, and substantiation rates. Complaint categories were also compared to complaint reports submitted to MCCO for the same periods. The three MCOs were selected for testing based on STAR+PLUS membership, number of complaints, complaints per capita, and the ratio of substantiated versus unsubstantiated complaints.

Table 1: Complaint Population and SVRS

MCO	Complaint Population	SVRS
MCO A	639	245
MCO B	811	266
MCO C	404	198
Total	1,854	709

**Sample data provided by OIG DAT division*

The OIG Data and Technology Division (DAT) provided the inspection team with a statistical valid random sample (SVRS) of complaints from each of the selected MCO's. Sample sizes were determined using a 95 percent confidence level and 10 percent precision range with an assumed error rate of 50 percent. This resulted in an overall sample of 709 complaints for review. Table 1 below details the total

⁷ Information provided by HHSC Cross-Divisional Complaint Workgroup, August 29, 2019.

complaints received for quarters 1 and 2 of fiscal year 2018, and complaint sample totals from the SVRS. For the purposes of consistency, the inspection team utilized the same naming convention to address each MCO as was used in the Series I Inspection Report.

III. INSPECTION RESULTS

The Inspections and Investigations Division found MCOs’ complaint resolution processes are generally consistent with UMCC and UMCM requirements. However, UMCC complaint resolution criteria is limited to MCOs providing members a resolution letter and not requiring any specific action to resolve complaints. Also, based on inspection testing MCOs did not always complete the UMCC complaint report form consistent with their complaint records.

The inspection team reviewed 709 complaints to evaluate the effectiveness of the MCOs’ complaint resolution processes including:

- Subject of complaints
- Categorization of complaints
- Substantiated and unsubstantiated complaints
- Resolution of complaints

Statistical Valid Random Sample (SVRS) - Subject of Complaints:

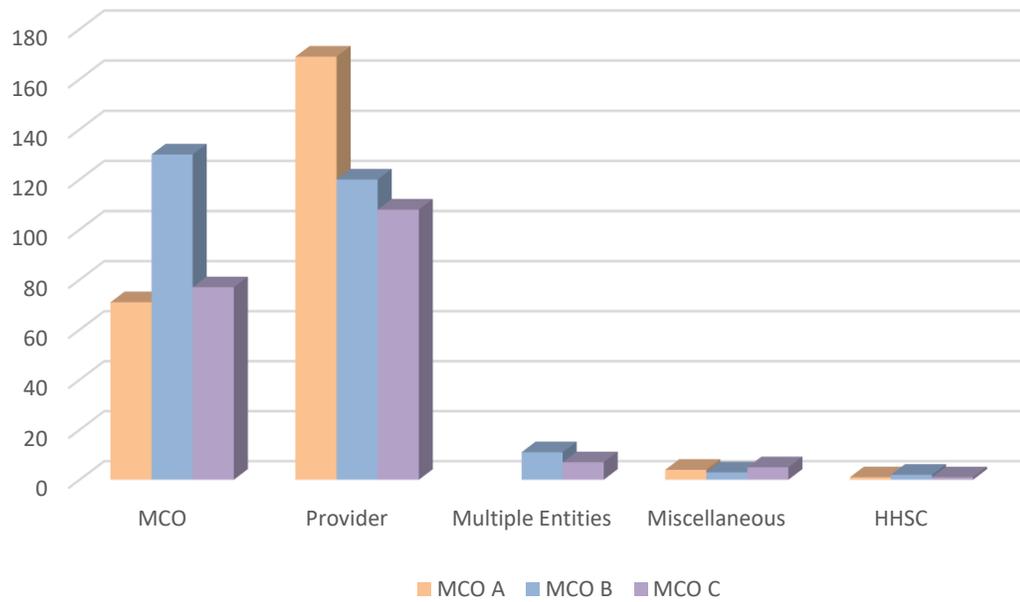
The inspection team tested a SVRS of the 709 complaint records to identify the subject or to whom the complaint was against. The following chart summarizes inspection testing results for identifying the subject for the inspection period:

MCO	Number Tested	Subject MCO	Subject Provider	Other *
MCO A	245	71	169	5
MCO B	266	130	120	16
MCO C	198	77	108	13
Total	709	278	397	34

**Additionally, for the 34 tested complaints in the other category, there were 4 complaints against HHSC, 18 complaints against multiple entities, and 12 complaints that fell under miscellaneous.*

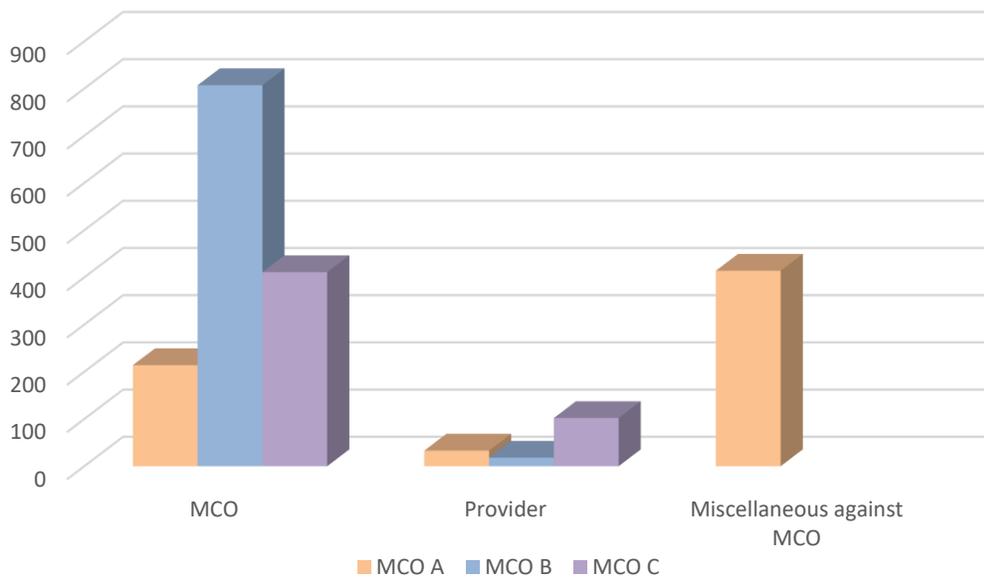
Based on testing MCO investigator records and complaint recordings of members, 39 percent (278/709) of complaints were against the MCOs. However, MCOs reported in their complaint forms a total of 92 percent (1,848/2001) of complaints were against the MCOs during the inspection period. Also, inspection testing of complaint records showed 56 percent were against the provider compared to a reported 8 percent. As a result, MCOs are over reporting complaints against themselves and underreporting complaints against their providers. See Graphs 1 and 2 below.

Graph 1: Inspection SVRS Testing Results – Subject of Complaint



Source: Analysis performed by Inspection Team

Graph 2: MCO Reported Complaints to MCCO – Subject of Complaints

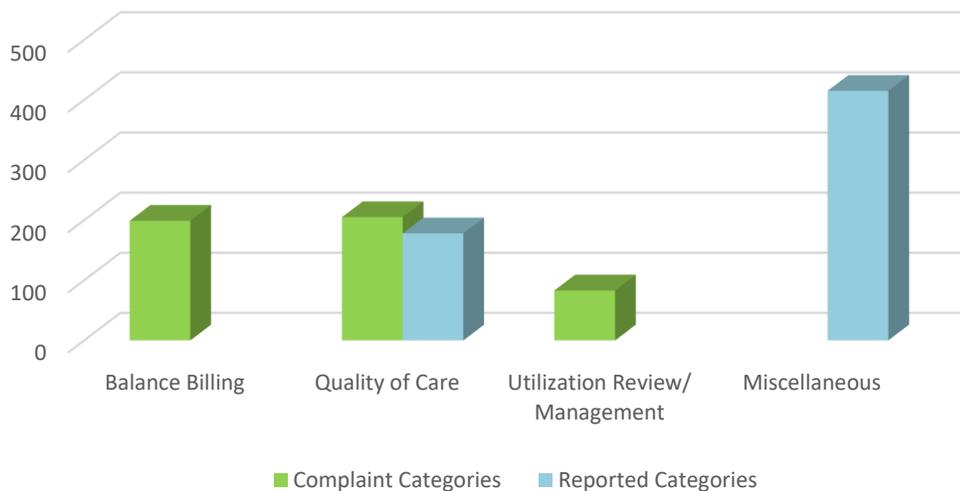


Source: Analysis performed by Inspection Team

MCO Reported to MCCO - Categories of Complaints:

Based on inspection testing for MCO A, complaint categories identified in their records did not match categories reported on their forms. MCO A’s forms reported zero complaints for balanced billing and utilization review categories, but complaint records identified 144 and 83 respectively. MCO A also reported 415 complaints for the miscellaneous category, but their complaint records identified zero complaints for this category. MCO A reported approximately the same number of complaints as identified in their complaint records for the quality of care category. See Graph 3 below for the complaint category comparison.

Graph 3: MCO A - Inspection Population Results Compared to MCO Complaints Reported to MCCO - Categories

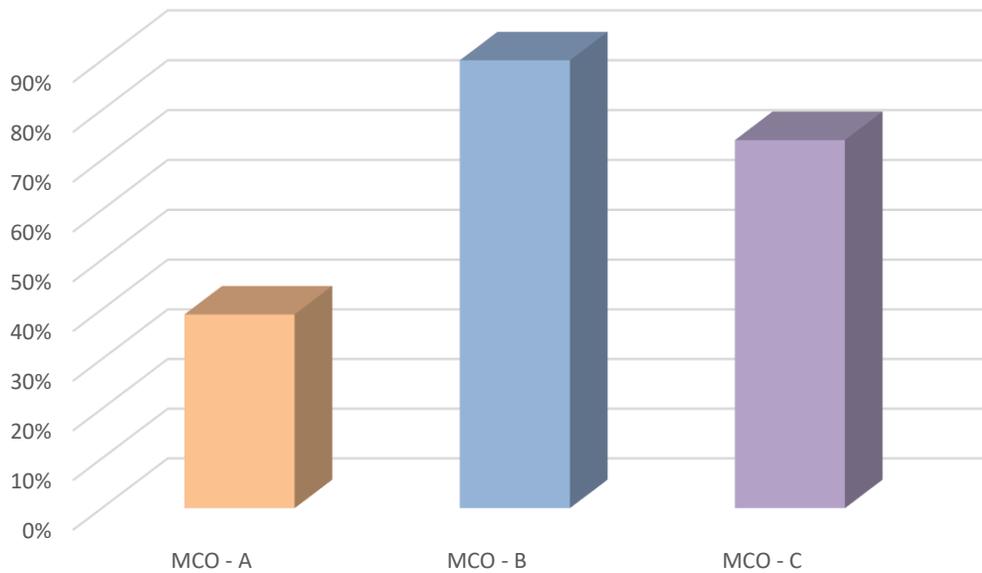


Source: Analysis performed by Inspection Team

For MCOs B and C there was no significant difference in categories reported in their complaint report forms compared to their complaint records.

Inspection testing identified quality of care services (QOCS) as the most reoccurring member complaint. MCO B had the highest percentage of QOCS complaints at 90 percent, while MCO C had the second highest at 74 percent, and MCO A had the lowest at 39 percent. Based on these reports, members’ top concern is QOCS. See Graph 4 below.

Graph 4: Inspection SVRS Testing Results – Quality of Care or Service Category



Source: Analysis performed by Inspection Team

Substantiated and Unsubstantiated Complaints

For MCOs B and C, inspection testing of complaint records identified a significant greater percentage, 10 and 27 percent respectively, of substantiated complaints than reported in the complaint form. The complaint form defines substantiated complaints as resolved in the member’s favor and unsubstantiated as resolved in the MCOs favor. Inspectors used the reporting form definition to assess if complaints were properly substantiated by the MCOs. See Table 2 below.

Table 2: Comparison of MCO Substantiated Percentages

MCO	Total Complaint Sample	Percent Substantiated by MCO	Percent Substantiated by Inspection Testing	Percent Difference between MCO and Inspection Testing
MCO A	245	64%	64%	None
MCO B	266	49%	59%	10%
MCO C	198	10%	37%	27%

Source: Analysis performed by Inspection Team

Complaint Resolution

To evaluate the effectiveness of the MCOs' complaint resolution process inspectors reviewed complaint records and investigative notes. The UMCC, Version 2.24, Section 8.2.6.1, MCO Internal Member Complaint Process requires MCOs to record and log complaint information but does not require MCOs document all investigative actions. MCOs A and C provided the minimum required information from their complaint records and logs, and as a result, inspectors could not always identify actions taken by the MCO to resolve member complaints. MCO B provided detailed investigative notes enabling inspectors to identify specific actions taken to resolve complaints.

Observation 1: The UMCC MCO Internal Member Complaint Process contract provisions require limited investigation documentation and resolution reporting.

UMCC Version 2.24, Section 8.2.6.1, MCO Internal Member Complaint Process requires MCOs to record, log and provide members written notice of resolution within 30 days when resolving complaints received in person or by phone that cannot be resolved within one working day of receipt. MCOs generally complied with the documentation and 30 days written notice requirements, however improvements can be made.

Adding investigation documentation requirements would allow for improved oversight. For example, MCO B provided more detailed documentation than required by the UMCC, such as who the investigator spoke with, evidence collected, and conclusions reached. This allowed inspectors to review and assess the work of the MCO investigator. Based on the inspectors' review, documentation existed to support MCO B has an effective process to investigate and resolve member complaints. Even though MCO A and C met minimum documentation requirements, inspectors generally could not determine who the MCO investigator spoke with, identify evidence collected and determine conclusions reached. As a result, documentation was not sufficient to evaluate the effectiveness of MCO A and C's investigation process.

The MCO complaint resolution process could be improved by adding a contract provision to the UMCC, or other ways HHSC deems appropriate, to require MCOs document and retain all investigative actions, notes, evidence, and conclusions from complaint investigations.

According to HHSC, complaint reporting requirements are being revised to require MCOs select a disposition and outcome for each reported complaint. Reported information will include what occurred resulting in the complaint being resolved.

Observation 2: The MCOs did not always accurately complete information in the complaint report form.

The inspection identified differences between information reported on the complaint forms, MCO supporting complaint records, and investigative notes. The inspection evaluated the following three types of information reported on the complaint form for quarters 1 and 2 of fiscal year 2018:

- Subject: To whom the complaint was against; MCO, provider or multiple entities.
- Complaint categories: Area the complaint is about; quality of care, balance billing, utilization review/management, miscellaneous, etc.
- Substantiated: Complaint found in the member's favor; or Unsubstantiated: Complaint found in the MCOs' favor.

Subject Reporting

The MCOs reported themselves as the subject of complaints for 92 percent of the complaints and 8 percent for their providers. A review of the testing sample of complaint records indicated a total of 39 percent of the complaints were against the MCOs and 56 percent were against the provider. As a result, the MCOs were over reporting the number of complaints against themselves and under reporting the complaints against their providers.

Complaint Categories Reporting

MCOs B and C accurately reported complaint categories except for small differences. MCO A did not accurately report complaint categories based on reviewing their complaint records and internal category determinations. MCO A categorized 144 complaints as balanced billing and 83 complaints as utilization review/management but reported zero complaints for these categories in their complaint forms. Also, MCO A reported 415 miscellaneous complaints but they did not categorize any as miscellaneous in their records.

Substantiated Complaints Reported

MCOs B and C underreported the number of substantiated complaints based on a review of their records. MCO B reported 49 percent substantiated, but a review of their complaint records supported 59 percent should have been substantiated. MCO C reported 10 percent substantiated, but records supported 37 percent of complaints should have been substantiated. Both MCO B and C did not use the UMCC complaint form definition, "found in the member's favor" to determine if a complaint should be substantiated. MCO B substantiated if they determined the

complaint pertained to medical necessity. MCO C substantiated complaints if they could not resolve the complaint within 30 days.

MCCO relies on information in the complaint reporting forms to identify concerns from the MCO member population, analyze complaint trends, and provide MCO oversight. Inaccurate complaint information hinders MCCO's effectiveness to analyze member complaint data, identify trends, and provide oversight. Complaint information accuracy could be improved by increased oversight and training for MCOs.

IV. CONCLUSION

The OIG Inspections Division completed an inspection to determine if Managed Care Organizations (MCOs) complaint intake and resolution processes are consistent with the Uniform Managed Care Manual (UMCM) and Uniform Managed Care Contract (UMCC) requirements.

The Inspections and Investigations Division found MCOs complaint resolution processes are generally consistent with UMCC and UMCM requirements. However, UMCC complaint resolution criteria is limited to MCOs providing members a resolution letter, but not requiring any specific action to resolve complaints. Also, based on inspection testing, MCOs did not always complete the UMCC complaint report form with accurate complaint information.

The OIG Inspections Division made the following observations:

- The UMCC MCO Internal Member Complaint Process contract provisions contain limited investigation documentation and resolution reporting requirements.
- The MCOs did not always accurately complete information in the complaint report form.

The OIG Inspections Division thanks the MCOs reviewed, HHSC MCCO and HHSC Ombudsman for their assistance and cooperation during this inspection.

V. APPENDICES

Appendix A: Detailed Methodology

The population selected for review consisted of all Texas STAR+PLUS member complaints received from all sources during the first two quarters of fiscal year 2018 from the three selected MCOs.

A review of the population data for each MCO allowed the inspection team to compare the numbers of total complaints received, substantiation rates, and time taken to resolve with the data submitted in the quarterly reports for the same periods.

The OIG Data and Technology division (DAT) provided the inspection team with a statistical random sample of complaints from each of the selected MCO’s. Sample sizes were determined using a 95 percent confidence level and 10 percent precision range with an assumed error rate of 50 percent.

MCO	Complaint Sample
MCO Plan A	245
MCO Plan B	266
MCO Plan C	198
Total	709

*Sample data provided by OIG DAT division

DAT was able to estimate the number of complaints back to the population from the sample testing for each MCO, to show the following:

- Sufficient documentation to assess the finding.
- Sufficient documentation to assess corrective actions taken.
- Non-compliances alleged and found.
- Poor service alleged and found.
- Member harm alleged and found.
- Directed against the MCO, a provider, HHSC, or other entity.
- Category and sub-category.

From the sample testing for each MCO, the inspection team was able to comment on, but not estimate back to the population, the numbers of substantiated complaints:

- In which the documentation justified the finding and supported any corrective actions taken.
- Directed against the MCO, a provider, HHSC, or other entity.

- Which documented a noncompliance.
- Documented poor service.
- Found member harm had occurred.
- In each category and subcategory.

Data Sources

Complaint numbers and information were provided by the MCOs selected for this inspection. Reports on complaints, substantiated and unsubstantiated rates were obtained from MCCO report logs supplied by the MCOs for quarters 1 and 2 of fiscal year 2018.

Standards

The OIG Inspections and Investigations Division conducts inspections of the Texas Health and Human Services programs, systems, and functions. Inspections are designed to be expeditious, targeted examinations into specific programmatic areas to identify systemic trends of fraud, waste, or abuse. Inspections typically result in observations and may result in recommendations to strengthen program effectiveness and efficiency. The OIG Inspections and Investigations Division conducted the inspection in accordance with Quality Standards for Inspection and Evaluation issued by the Council of the Inspectors General on Integrity and Efficiency.

Appendix B: Definitions, Codes and Rules Related to the Complaint Resolution Process Complaint

42 C.F.R. § 438.400(b)

Grievance means an expression of dissatisfaction about any matter other than an adverse benefit determination. Grievances may include, but are not limited to, the quality of care or services provided, and aspects of interpersonal relationships such as rudeness of a provider or employee, or failure to respect the enrollee's rights regardless of whether remedial action is requested. Grievance includes an enrollee's right to dispute an extension of time proposed by the MCO, the Prepaid Inpatient Health Plan (PIHP), or the Prepaid Ambulatory Health Plan (PAHP) to make an authorization decision. Adverse benefit determination means, in the case of an MCO, PIHP, or PAHP, any of the following:

- (1) The denial or limited authorization of a requested service, including determinations based on the type or level of service, requirements for medical necessity, appropriateness, setting, or effectiveness of a covered benefit.
- (2) The reduction, suspension, or termination of a previously authorized service.
- (3) The denial, in whole or in part, of payment for a service.
- (4) The failure to provide services in a timely manner, as defined by the state.
- (5) The failure of an MCO, PIHP, or PAHP to act within the timeframes provided in § 438.408(b)(1) and (2) regarding the standard resolution of grievances and appeals.
- (6) For a resident of a rural area with only one MCO, the denial of an enrollee's request to exercise his or her right, under § 438.52(b)(2)(ii), to obtain services outside the network.
- (7) The denial of an enrollee's request to dispute a financial liability, including cost sharing, copayments, premiums, deductibles, coinsurance, and other enrollee financial liabilities.

42 C.F.R. § 438.408 Resolution and notification: Grievances and appeals.

(a) Basic rule. Each MCO, PIHP, or PAHP must resolve each grievance and appeal, and provide notice, as expeditiously as the enrollee's health condition requires, within State-established timeframes that may not exceed the timeframes specified in this section.

(b) Specific timeframes.

- (1) Standard resolution of grievances. For standard resolution of a grievance and notice to the affected parties, the timeframe is established by the State but may not exceed 90 calendar days from the day the MCO, PIHP, or PAHP receives the grievance.

(c) Extension of timeframes.

(1) The MCO, PIHP, or PAHP may extend the timeframes from paragraph (b) of this section by up to 14 calendar days if -

(i) The enrollee requests the extension; or

(ii) The MCO, PIHP, or PAHP shows (to the satisfaction of the State agency, upon its request) that there is need for additional information and how the delay is in the enrollee's interest.

(d) Format of notice -

(1) Grievances. The State must establish the method that an MCO, PIHP, and PAHP will use to notify an enrollee of the resolution of a grievance and ensure that such methods meet, at a minimum, the standards described at §438.10.

Texas Administrative Code § 353.2(17)

Complaint--Any dissatisfaction expressed by a complainant, orally or in writing, to the MCO about any matter related to the MCO other than an action. Subjects for complaints may include:

(A) the quality of care of services provided;

(B) aspects of interpersonal relationships such as rudeness of a provider or employee; and

(C) failure to respect the member's rights.

Texas Insurance Code, § 843.002(6)

Texas Insurance Code defines complaint as:

(6)"Complaint" means any dissatisfaction expressed orally or in writing by a complainant to a health maintenance organization regarding any aspect of the health maintenance organization's operation. The term includes dissatisfaction relating to plan administration, procedures related to review or appeal of an adverse determination under § 843.261, the denial, reduction, or termination of a service for reasons not related to medical necessity, the manner in which a service is provided, and a disenrollment decision. The term does not include:

(A) a misunderstanding or a problem of misinformation that is resolved promptly by clearing up the misunderstanding or supplying the appropriate information to the satisfaction of the enrollee; or

(B) a provider's or enrollee's oral or written expression of dissatisfaction or disagreement with an adverse determination."

Texas Insurance Code Sec. 843.253. Complaint Investigation and Resolution

(a) A health maintenance organization shall investigate each complaint received in accordance with the health maintenance organization's policies and in compliance with this chapter.

(b) After a health maintenance organization has investigated a complaint, the health maintenance organization shall issue a response letter to the complainant within the time prescribed by Section 843.252(c) that:

(1) explains the health maintenance organization's resolution of the complaint;

states the specific medical and contractual reasons for the resolution;

(3) states the specialization of any physician or other provider consulted; and

(4) contains a complete description of the process for appeal, including the deadlines for the appeals process and the deadlines for the final decision on the appeal.

UMCC Version 2.24 – Definitions

Action (Medicaid only) means:

(1) the denial or limited authorization of a requested Medicaid service, including the type or level of service;

(2) the reduction, suspension, or termination of a previously authorized service;

(3) the denial in whole or in part of payment for service;

(4) the failure to provide services in a timely manner;

(5) the failure of an MCO to act within the timeframes set forth in the Contract and 42 C.F.R. §438.408(b); or

(6) for a resident of a rural area with only one (1) MCO, the denial of a Medicaid Members' request to obtain services outside of the Network.

An Adverse Determination is one (1) type of Action.

Adverse Determination means a determination by an MCO or Utilization Review agent that the Health Care Services furnished, or proposed to be furnished to a patient, are not Medically Necessary or not appropriate.

Appeal (CHIP and CHIP Perinatal Program only) means the formal process by which a Utilization Review agent addresses Adverse Determinations.

Complainant means a Member or a treating provider or other individual designated to act on behalf of the Member who filed the Complaint.

Complaint (CHIP Program only) means any dissatisfaction, expressed by a Complainant, orally or in writing to the MCO, with any aspect of the MCO's operation, including, but not limited to, dissatisfaction with plan administration, procedures related to review or Appeal of an Adverse Determination, as defined in

Texas Insurance Code, Chapter 843, Subchapter G; the denial, reduction, or termination of a service for reasons not related to Medical Necessity; the way a service is provided; or disenrollment decisions. The term does not include misinformation that is resolved promptly by supplying the appropriate information or clearing up the misunderstanding to the satisfaction of the CHIP Member.

Complaint and Internal MCO Appeal System means the process the MCO or Dental Contractor implements to handle internal MCO or Dental Contractor appeals of a complaint or action, as well as the process to collect and track information about the complaint and internal MCO or Dental Contractor appeal.

Appendix D: Report Team and Report Distribution

Report Team

The OIG staff members who contributed to this report include:

- Lisa Campos Garza, CFE, CGAP, Assistance Deputy Inspector General for Inspections
- Troy Neisen, CPA, Director for Inspections
- Dora Fogle, Team Lead for Inspections
- Pat Krempin, Inspector
- Kenin Weeks, Inspector
- Jill Townsend, Editor
- Xiaoling Huang, Chief Statistician for Data and Technology

Report Distribution

Texas Health and Human Services:

- Courtney N. Phillips, PhD, Executive Commissioner
- Cecile Erwin Young, Chief Deputy Executive Commissioner
- Ruth Johnson, Chief Operating Officer
- Victoria Ford, Chief Policy and Regulatory Officer
- Karen Ray, Chief Counsel
- Stephanie Muth, Deputy Executive Commissioner, Medicaid and CHIP Services
- Nicole Guerrero, Director, Internal Audit
- Joel Schwartzman, Ombudsman
- Grace Windbigler, Director, Managed Care Compliance & Operations Division

Appendix E: OIG Mission and Contact Information

Inspector General Mission

The mission of the OIG is to prevent, detect, and deter fraud, waste, and abuse through the audit, review, investigation, and inspection of federal and state taxpayer dollars used in the provision and delivery of health and human services in Texas. The senior leadership guiding the fulfillment of OIG's mission and statutory responsibility includes:

- Sylvia Hernandez Kauffman, Inspector General
- Dirk Johnson, OIG Chief Counsel
- Susan Biles, OIG Chief of Staff
- Christine Maldonado, Chief of Operations and Workforce Leadership
- Olga Rodriguez, Chief of Strategy and Audit
- Quinton Arnold, Chief of Inspections and Investigations
- Steve Johnson, Interim Chief of Medicaid Program Integrity

To obtain copies of OIG reports

- OIG website: <https://oig.hhsc.texas.gov/>

To report fraud, waste, and abuse in Texas HHS programs

- Online: <https://oig.hhsc.texas.gov/report-fraud>
- Phone: 1-800-436-6184

To contact the Inspector General

- Email: OIGCommunications@hhsc.state.tx.us
- Mail: Texas Health and Human Services Commission
Inspector General
P.O. Box 85200
Austin, Texas 78708-5200
- Phone: (512) 491-2000

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