

TEXAS HEALTH AND HUMAN SERVICES COMMISSION
OFFICE OF INSPECTOR GENERAL

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

Series I - Inspection of Intake of Member Complaints



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OIG Report No. INS-18-004



HHSC OIG

TEXAS HEALTH AND HUMAN
SERVICES COMMISSION

OFFICE OF
INSPECTOR GENERAL

MEMBER COMPLAINTS RECEIVED BY TEXAS MEDICAID MANAGED CARE ORGANIZATIONS: *Series I - Inspection of Intake of Member Complaints*

WHY THE OIG CONDUCTED THIS INSPECTION

The OIG conducted an inspection to determine if managed care organization (MCO) member complaint intake processes are consistent with the Uniform Managed Care Contract (UMCC) and Uniform Managed Care Manual (UMCM) requirements. The inspection also assessed the validity, accuracy, and reliability of data contained in quarterly MCO member complaint reports. The inspection focused on the following objective:

- Review MCO process on how complaints and inquiries are discerned, logged, and reported to HHSC.

Inspectors collaborated with HHSC Managed Care Compliance & Operations (MCCO) Division and the HHSC Office of the Ombudsman (OO) to create 25 call scenarios and reviewed 1,156 calls.

The OIG focused on the UMCC definition of complaint, which states: “Complaint means an expression of dissatisfaction expressed by a Complainant, orally or in writing to the MCO, about any matter related to the MCO other than an Action. Complaint has the same meaning as grievance, as stated by 42 C.F.R. § 438.400(b).”

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

- Series II Objective: Determine the effectiveness of the MCOs' complaint resolution process.
- Series III Objective: Review MCO complaint appeal processes.

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

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WHAT THE OIG FOUND

The OIG Inspections and Investigations Division found that complaint reporting amongst the MCOs differs due to:

- Multiple complaint definitions and lack of clarity on contract terms allows for inconsistent reporting by MCOs.
- MCOs do not report member complaints consistently with UMCC definition of the term complaints.

There is no specific written guidance on how MCOs should interpret and apply the UMCC definition of complaint. On-site interviews with MCO staff indicate there has been inconsistent direction, which leads to variances in the quarterly MCO member complaint report. Two MCOs interviewed indicated there has been direction from MCCO to not report complaints resolved the same day as received. In addition, UMCC language does not provide clear and consistent guidance.

When assessing 25 member call scenarios, the entities did not consistently agree on if the scenarios were complaints or not a complaint. MCCO and OO disagreed on 52 percent and most MCO staff disagreed with MCCO on 40 percent of the scenarios and with OO on 20 percent.

Upon reviewing 1,156 calls, the percentage of calls identified as complaints by inspection testing is statistically higher than MCO reporting. The OIG identified an estimated average of 7.4 percent of the calls as complaints, while MCOs reported an approximate average of 1.5 percent of the calls as complaints. The estimation indicates MCOs under-reported member complaints by an estimated 5.9 percent, or an estimated 4,489 additional complaints, in fiscal year 2018 first and second quarters.

The inspection identified several potential causes for the variances in the complaint rate for MCOs. Two MCOs have a policy to not report member concerns as complaints if they were resolved in 24 hours. The UMCC does not grant an exception based on the timeframe of the resolution. In addition, there are several definitions of complaint and no definitive guidance as to which to use. Also, the UMCC does not define specific terminology within the definition of complaint.

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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 organization (MCO) member complaint intake processes are consistent with the Uniform Managed Care Contract (UMCC) and Uniform Managed Care Manual (UMCM) requirements. The inspection also assessed the validity, accuracy, and reliability of data contained in quarterly MCO member complaint reports. The inspection focused on the following objective:

- Review MCO process on how complaints and inquiries are discerned, logged, and reported to HHSC.

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

- **Series II Objective:** Determine the effectiveness of the MCOs' complaint resolution process.
- **Series III Objective:** Review MCO complaint appeal processes.

II. BACKGROUND

Texas Medicaid provides medical care to over 3.5 million members annually through MCOs. States administering Medicaid are federally required, by 42 Code of Federal Regulations (C.F.R.) § 438.16, to ensure MCOs maintain records of all grievances and appeals. C.F.R. also requires states to review the information as part of the state quality strategy. The Texas Administrative Code (TAC) § 353.415 and UMCC provide MCOs specific requirements regarding member complaint and appeal procedures and reporting requirements. The OIG Inspections and Investigations Division conducted this inspection to assess the accuracy and reliability of the MCO self-reported member complaint information.

42 C.F.R. § 438.400(b), 1 TAC § 353.415, Texas Department of Insurance (TDI), and the UMCC each define “complaint” differently.¹ The UMCC states:

¹ See Appendix C for relevant definitions of “complaint.” The UMCC in effect during the scope of this inspection indicated the TDI definition is applicable to CHIP only. For Medicaid, the UMCC definition of complaint refers to the C.F.R.

Complaint means an expression of dissatisfaction expressed by a Complainant, orally or in writing to the MCO, about any matter related to the MCO other than an Action. Complaint has the same meaning as grievance, as stated by 42 C.F.R. § 438.400(b).²

The OIG focused on this UMCC definition and collaborated with HHSC Managed Care Compliance & Operations (MCCO) Division and the HHSC Office of the Ombudsman (OO), who also assists Medicaid members with complaints.

The complaint process begins with MCO customer service representatives (CSRs) handling member calls, written letters, faxes, and online submissions. Customer calls are the primary avenue for member complaints. To aid in customer service and for quality assurance, MCOs record all incoming calls. The MCO calls are categorized and subcategorized to indicate the primary content of the call, and MCO provides quarterly member complaint reports to MCCO.

MCCO is responsible for receiving and analyzing data, including the quarterly MCO member complaint report, as well as aggregating member complaints to trend Medicaid programmatic concerns in areas that may require improvement or policy changes. MCCO is also responsible for reviewing and approving MCO policies and procedures for handling member complaints as indicated in the UMCC. The UMCC requires MCOs to send complainants a letter upon resolution of the complaint, and resolve 98 percent of complaints within 30 days. Should an MCO fail to comply with the contract, they are subject to contractual remedies including liquidated damages.

The OO, through authority provided by the Texas Government Code § 531.0171, provides assistance with dispute resolution and performs consumer protection and advocacy. The OO requests information and records regarding Medicaid member complaints and assists members with resolution when they have difficulty finding resolution through the MCO complaint process. The OO also contributes member complaint data quarterly for inclusion in the 1115 Waiver Quarterly Report to Centers for Medicare & Medicaid Services (CMS).³ The information in the 1115 Waiver Quarterly Report includes: program population averages; service delivery

² The C.F.R. goes on to state, "An Action is defined as: (i) the denial or limited authorization of a requested Medicaid service, including the type or level of service; (ii) the reduction, suspension, or termination of a previously authorized service; (iii) the failure to provide services in a timely manner; (iv) the denial in whole or in part of payment for a service; or (v) the failure of a managed care organization to act within the timeframes set forth by the Health and Human Services Commission and state and federal law. (B) "Action" does not include expiration of a time-limited service."

³ Complaint information is supplied in the 1115 waiver quarterly reports provided to CMS to document HHSC's progress in meeting goals. <https://hhs.texas.gov/laws-regulations/policies-rules/waivers/medicaid-1115-waiver/waiver-overview-background-resources>

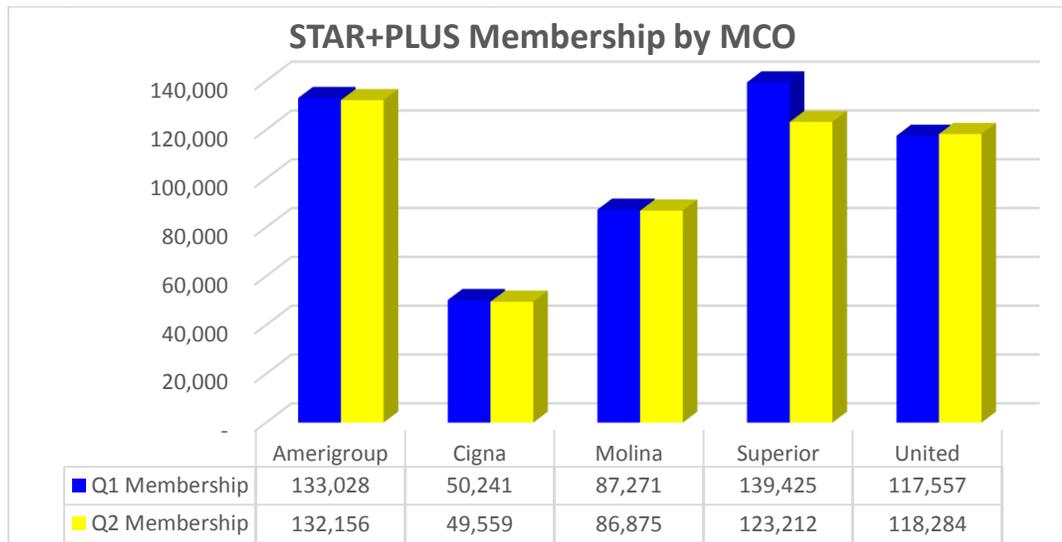
areas; number of complaints by category (for example dental/medical); and complaint resolution. In the report, HHSC is required to include MCO complaint information to document progress in meeting quality monitoring efforts.

Inspection Methodology: MCO Selection

There are several programs under Texas Medicaid, including STAR+PLUS, which serves adults age 21 and older who have disabilities as well as individuals age 65 and older. There are five MCOs contracted by the state to provide health services to the STAR+PLUS population.

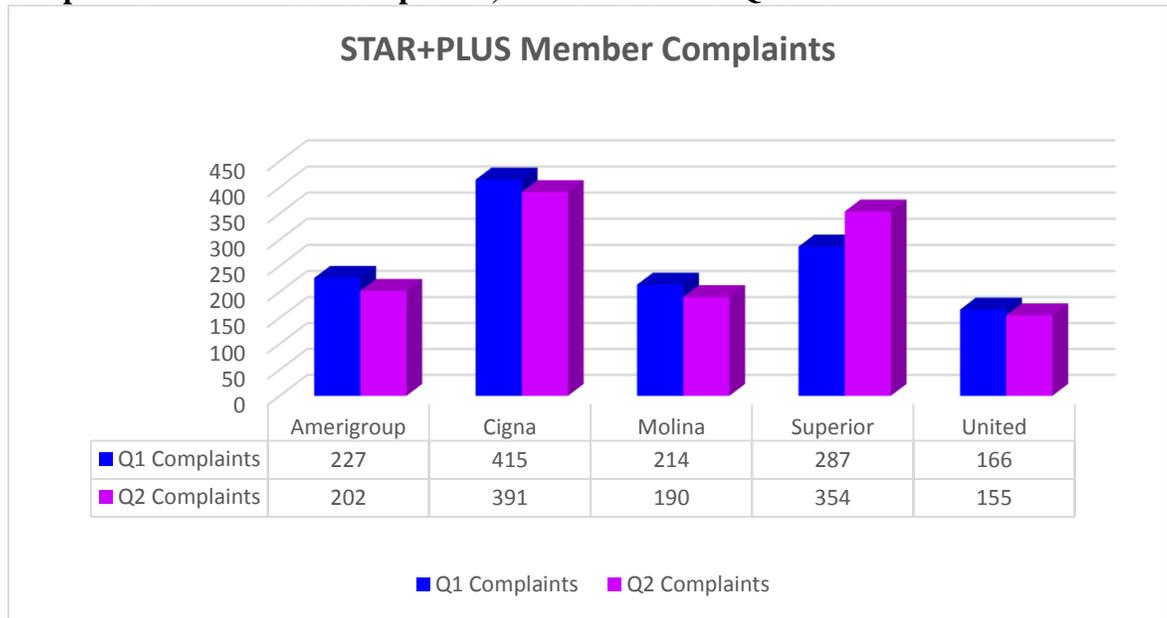
As shown in Graphs 1 through 4 and in Table 1, the OIG received and tabulated: membership, complaints, complaints per capita, adverse benefit determination appeals, and substantiated versus unsubstantiated rates for STAR+PLUS member complaint data submitted for fiscal year 2018 first and second quarters. All data reports were received from MCCO and are federally-required reportable metrics. These graphs were only used for initial review. There are several contributing factors for the self-reported variations amongst the MCOs, which are detailed within the Inspection Results. Any variations noted are not reflective of MCO performance.

Graph 1: STAR+PLUS Membership, FY 18 1st & 2nd Quarter



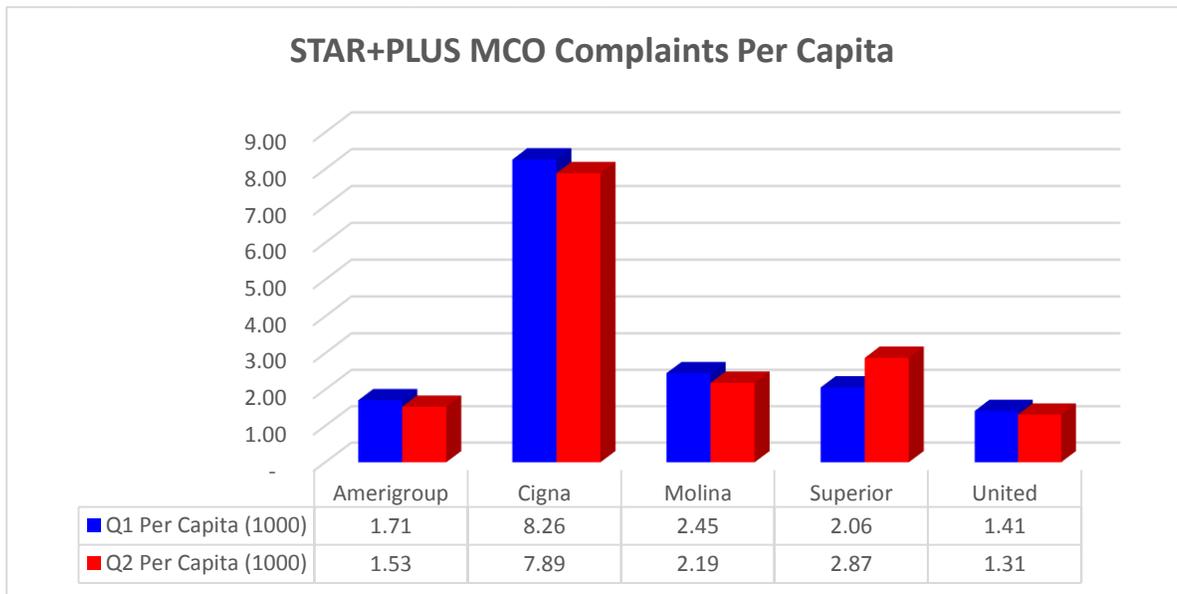
Source: MCO Complaints and Appeals reports submitted to MCCO

Graph 2: STAR+PLUS Complaints, FY 18 1st & 2nd Quarter



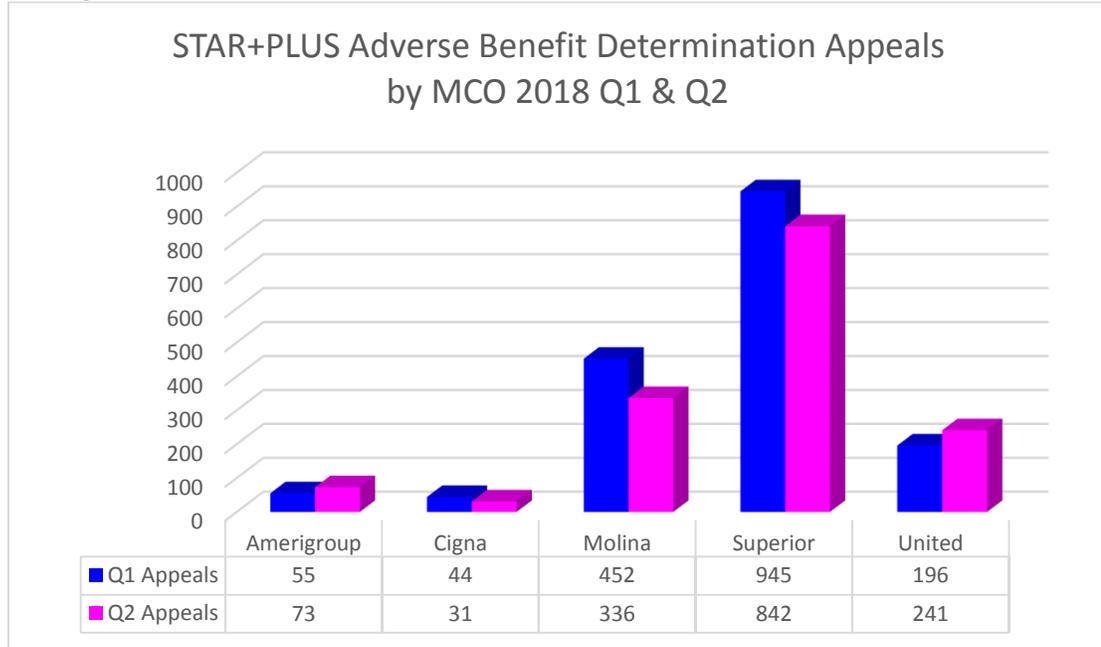
Source: MCO Complaints and Appeals reports submitted to MCCO

Graph 3: STAR+PLUS Complaints per Capita, FY 18 1st & 2nd Quarter



Source: MCO Complaints and Appeals reports submitted to MCCO

Graph 4: STAR+PLUS Adverse Benefit Determination Appeals, FY 18 1st & 2nd Quarter



Source: MCO Complaints and Adverse Benefit Determination Appeal reports submitted to MCCO

Table 1: Substantiated Versus Unsubstantiated, FY 18 1st & 2nd Quarter

MCO	Average Substantiated Rate*	Average Unsubstantiated Rate**
Amerigroup	76%	24%
Cigna-HealthSpring	47%	53%
Molina	11%	89%
Superior	54%	46%
United	46%	54%

*Substantiated as defined by the quarterly MCO member complaint report means complaints were resolved in the member’s favor.

**Unsubstantiated as defined by the quarterly MCO member complaint report means complaints were resolved in the MCO’s favor.

The OIG compared the complaint data to the enrollment population size and analyzed complaint trending to select MCOs for this inspection. Based on various factors, such as highest number of complaints and ratio of complaints to members, three MCOs were selected for this inspection. They are: Cigna-HealthSpring, Molina, and Superior.

Inspection Methodology: Testing

The OIG relied on specific characteristics to determine whether the calls should be categorized as a complaint or inquiry.⁴ Those characteristics include:

- Situational - caller made several attempts to rectify the concern with the MCO
- Vocal Tone - caller spoke in elevated volumes, cried, or expressed anger
- Words Utilized - caller indicated they were upset or angry
- Dissatisfaction - caller expressed dissatisfaction as defined by 42 C.F.R. § 438.400(b)⁵

The OIG created 25 member call scenarios to test consistency among MCCO, OO, and the MCOs in distinguishing a complaint from an inquiry. This scenario testing sheet was vetted through MCCO and the OO to determine and document MCO expected responses. In addition, the inspection team performed on-site interviews with 24 CSRs and 9 supervisors at the 3 selected MCOs. These 33 staff were each given the same complaint and inquiry scenario testing sheet to determine if they evaluated each scenario as an inquiry or complaint.

⁴ MCOs reviewed during this inspection each rely on a combination of the same characteristics.

⁵ "Grievance means an expression of dissatisfaction about any matter other than an adverse benefit determination."

III. INSPECTION RESULTS

While the OIG Inspections and Investigations Division found MCOs have policies and procedures for complaint resolution, the inspection also found MCOs do not categorize complaints consistently with the UMCC definition for complaint.⁶ To evaluate MCO processes for categorizing member calls as a complaint or inquiry, OIG staff reviewed 1,156 recorded calls, a statistical random sample (SRS) of STAR+PLUS population of calls. The OIG analysis of each MCO’s calls shows the percentage of member calls identified by OIG as complaints is higher than what was identified by each MCO. In all cases, these differences were statistically significant, as shown in Table 2.

Table 2: Difference in Complaints between OIG and MCO

MCO	OIG % of Complaints	MCO % of Complaints
A	6.9 %	0.4 %
B	7.2 %	1.6 %
C	8.1 %	2.4 %

OIG staff requested that MCCO, OO, and staff from the 3 inspected MCOs each categorize, as complaint or inquiry, the 25 member call scenarios crafted by OIG. The results demonstrate the UMCC definition of complaint is not consistently applied. The inspection found the MCOs inconsistently determine when a call includes an expression of dissatisfaction. Inspectors listened to recorded calls where members expressed dissatisfaction with services that were not reported as complaints by the MCOs. See Table 3 for more details.

Complaint Definition

HHSC does not have specific written guidance on how MCOs should interpret and apply the UMCC definition of complaint. On-site interviews with MCO staff indicate there has been inconsistent direction from HHSC, which leads to variances in the quarterly MCO member complaint report. Two MCOs interviewed indicated there has been direction from MCCO to not report complaints resolved the same day as received. In addition, UMCC language does not provide clear and consistent guidance, including the following examples:

1. “Dissatisfaction” is not defined.
2. UMCC states, “Complaint has the same meaning as grievance, as provided by 42 C.F.R. § 438.400(b).” The UMCC goes on to provide that complaints are

⁶ “Complaint means an expression of dissatisfaction expressed by a Complainant, orally or in writing to the MCO, about any matter related to the MCO other than an Action.”

about any matter “related to the MCO other than an Action.” In addition, “related to the MCO” is not used in the C.F.R.

3. The contract provides a standard definition of complaint, but does not offer guidance on application or interpretation, thereby allowing inconsistent interpretation. One MCO uses the TDI definition of “complaint” and “misunderstanding” rather than using the UMCC. The TDI definition is more restrictive and underestimates the number of complaints by eliminating the need to report “misunderstandings.”

Multiple definitions, along with lack of clearly defined language in the UMCC, lead to variances in quarterly MCO member complaint reports. These variances make it challenging to evaluate MCO performance in providing services to Medicaid members and affect MCCO assessment of this information. In addition, MCOs categorize and subcategorize complaint calls differently, making it difficult to identify member complaint trends.

Observation 1: Multiple complaint definitions and lack of clarity on contract terms allow for inconsistent reporting by MCOs.

MCOs, MCCO, and OO categorize member calls differently due to multiple complaint definitions, which results in inconsistent reporting. To determine if complaints are consistently categorized, the OIG requested that MCCO, OO, and 11 staff from each of the 3 MCOs determine whether 25 member call scenarios were complaints. The scenarios were presented to MCCO and OO with the request that they review and determine whether they would expect the MCOs to classify each scenario as a complaint. The scenarios were vetted based on feedback from MCCO and OO and were reassessed. MCO staff indicated the scenario testing sheet was useful in providing their management team with insight into CSR performance and to provide potential training focus.

The scenarios were presented to 8 customer service representatives and 3 managers from each of the 3 MCOs, for a total of 33 staff. Instructions were given to classify each as “complaint” or “not a complaint” based solely on the information in the scenario. The results were noted and compared with those from MCCO and OO. Table 3 reflects a summary of the agreement versus disagreement in identifying scenarios as complaints. Overall, the 3 MCOs, MCCO, and OO agreed on 12 percent, or 3 out of 25 scenarios. Table 2 includes the various comparisons of agreement between two of the three entities and is not intended to add up to 100 percent. See Appendix D for a full list of the scenarios and response summaries.

Table 3: Summary of Agreement for 25 Scenarios

MCCO, OO, & 33 MCO Staff	Number of Scenarios	Percentage of Scenarios
All Agreed Complaint	3 ⁷	12%
MCCO & OO Disagreed	13	52%
MCCO Disagreed with MCO staff	10	40%
OO Disagreed with MCO staff	5	20%

Source: *OIG Complaint Scenario Assessment Results*

Observation 2: MCOs do not report member complaints consistently with UMCC definition of the term “complaints.”

The inspection reviewed 1,156 calls and identified 82 complaints compared to 17 complaints reported in the sample by the 3 MCOs. The SRS was selected from a population of member calls received during the first and second quarters of fiscal year 2018 for the three MCOs.⁸ Inspectors reviewed each of the 1,156 calls to determine if the call met the UMCC definition of a complaint. Of those 1,156 calls, the MCOs could not provide 43 of the recordings, which were not evaluated or counted as complaints.

Estimating the SRS to the population shows the percentage of member calls identified as complaints by inspection testing is statistically higher than the percentage calculated based on MCO reporting. The estimated percentage of complaints identified by inspection testing ranges from 6.9 to 8.1 percent among the tested MCOs, compared to the range of 0.4 to 2.4 percent based on MCO reporting. The OIG identified an estimated average of 7.4 percent of calls as complaints across all three MCOs, while MCOs reported an approximate average of 1.5 percent of the calls as complaints. The estimation indicates MCOs under-reported member complaints by an estimated 5.9 percent. This equates to an estimation of 4,489 additional complaints in fiscal year 2018 first and second quarters, than the MCOs reported.

The inspection identified several potential causes for the variances in the complaint rate for MCOs. Two MCOs train staff to not report a member complaint if it was resolved in 24 hours. The third MCO does not have this policy. The UMCC does not provide for this type of exception. There are several definitions of complaint and no definitive guidance as to which definition to use nor the definition of terminology used as it applies to the MCOs. Also the UMCC is the only written guidance provided to MCOs regarding the definition of complaints and it does not define specific terminology.

⁷ See Appendix D, Table 5, numbers 6, 9, and 18.

⁸ See Appendix A: Detailed Methodology for how the SRS was drawn.

IV. CONCLUSION

The OIG Inspections and Investigations Division completed an inspection to determine if MCO member complaint intake processes are consistent with the UMCC requirements. The OIG reviewed 1,156 STAR+PLUS calls and asked MCCO, OO, and 33 staff at 3 MCOs to complete a test sheet with 25 member call scenarios, where they indicated if they believed each was a complaint.

The OIG found that complaint reporting amongst the MCOs differs due to:

- Multiple complaint definitions and lack of clarity on contract terms allows for inconsistent reporting by MCOs.
- MCOs do not report member complaints consistent with UMCC definition of the term “complaints.”

When assessing the 25 member call scenarios, MCCO, OO, and 33 staff from the MCOs agreed on 12 percent, or 3 out of 25 scenarios. On 88 percent, the entities did not consistently agree on if the scenario was a complaint or not.

Upon reviewing 1,156 calls, the percentage of calls identified as complaints by inspection testing is statistically higher than MCO reporting. The OIG identified an estimated average of 7.4 percent of calls as complaints, while MCOs reported an approximate average of 1.5 percent of the calls as complaints. The estimation indicates MCOs underreported member complaints by 5.9 percent conservatively. This equates to an estimation of 4,489 additional complaints in fiscal year 2018 first and second quarters, than the MCO reported.

The inspection identified several potential causes for the variances in the complaint rate for MCOs. Two MCOs have a policy to not report member concerns as complaints if they were resolved in 24 hours. The UMCC does not grant an exception based on the timeframe of the resolution. In addition, there are several definitions of complaint and no definitive guidance as to which to use. Also the UMCC does not define specific terminology within the definition of complaint.

Inspections related to MCO member complaints review of MCO policies and procedures for complaint resolution and review of MCO complaint appeal processes are forthcoming.

The OIG Inspections and Investigations Division thanks Cigna-HealthSpring, Molina, Superior, and HHSC MCCO and OO for their assistance and cooperation during the course of this inspection.

V. APPENDICES

Appendix A: Detailed Methodology

HHSC MCCO receives and analyzes the quarterly MCO member complaint report received from each MCO covering a Medicaid program. Research revealed for fiscal year 2017, the STAR+PLUS population submitted 4,307 complaints and the STAR population filed 2,479 complaints. Therefore, the inspection focused on the STAR+PLUS program. The OIG received and analyzed complaint and appeals data submitted by MCOs for fiscal year 2018 first and second quarters.

The volume of incoming calls related to Texas STAR+PLUS members from the 3 selected MCOs for fiscal year 2018 first and second quarter was 203,565 calls from 75,825 members, with some members calling multiple times during those quarters. The OIG requested recordings of incoming member calls from all 3 selected MCOs, and drew an SRS from the 75,825 members, reviewing one call per member.

A sample of 1,181 call records were statistically randomly selected from a population of one call from unique STAR+PLUS members. The inspection team requested recordings of those calls. Among them, 25 of the calls were identified as provider calls, which fall out of the inspection scope and therefore were excluded from the assessment. The inspection team reviewed the remaining 1,156 calls to determine if MCOs correctly categorized them as inquiries or complaints based on the UMCC complaint definition. Further, 43 call recordings not received from MCOs were assumed to be categorized correctly. See Appendix B for more details.

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: Detailed Methodology for MCO Call Review

Data Collection and Analysis

The inspection team requested all call logs for fiscal year 2018 first and second quarter STAR+PLUS Texas member calls from the three selected MCOs. These call logs were to include: date, time, member identification (ID), call categorization, and sub-categorizations. The call logs contain 203,565 calls from 75,825 members. The final population contains 75,825 calls, which is one call per member. A sample size is determined for each of the MCOs with 95 percent confidence level and 10 percent precision range, and an assumed error rate of 50 percent. A total of 1,181 calls are randomly selected for the review. Among those sampled, 25 calls are not member calls and 43 recordings were missing. In relation to the missing recordings, OIG assumes the MCO categorized them correctly. The weights applied to the calls according to the original population distribution of call categories. For missing recordings, OIG used the MCO's categorization.

OIG Data and Technology (DAT) drew SRSs from each MCO set, resulting in 1,181 call recordings with 17 calls categorized as complaints to be reviewed. OIG DAT team, in their analysis, removed calls associated with providers or internal MCO calls concerning members from the evaluated data. Furthermore, missing recordings were not counted as errors.

Table 4: Files Received by OIG

MCO	Files Requested	Files Excluded	Files Reviewed
Cigna-HealthSpring	389	10 2.6%	379 97%
Molina	395	5 1.2%	390 99%
Superior	397	10 2.5%	387 97%
TOTAL	1,181	25 2.1%	1,156 98%

The analysis shows the estimated percentage of member calls identified by the OIG as complaints is larger than it is identified by each individual MCO and in all cases these differences were statistically significant. The OIG estimates suggest the percentage of complaints across the 3 MCOs is on average 7.4 percent of all member calls, comparing to the estimates for the complaints identified by the MCOs, which averages to 1.5 percent. These differences represent a 5.9 percentage difference.

Appendix C: Complaint Definitions

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.

Appeal means a review by an MCO, PIHP, or PAHP of an adverse benefit determination.

Texas Administrative Code § 353.2(16)

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.

HHS Circular C-052

The OO utilizes HHS Circular C-052, which defines complaint as:

Complaint: any expression of dissatisfaction by a consumer of an HHS program or service about HHS benefits or services. For purposes of this circular, complaints do not include:

- allegations of abuse, neglect, or exploitation;
- allegations of violations of civil rights, including discrimination;
- allegations of fraud, waste, or abuse;
- personnel and disciplinary matters;
- requests for Fair Hearings and/or other appeals; or
- concerns about regulated individuals (e.g., occupational licensees) and entities (e.g., nursing facilities).

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."

UMCC

Prior to March 1, 2018:

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 (Medicaid only) means an expression of dissatisfaction expressed by a Complainant, orally or in writing to the MCO, about any matter related to the MCO

other than an Action. As provided by 42 C.F.R. § 438.400, possible subjects for Complaints include, but are not limited to, the quality of care of services provided, and aspects of interpersonal relationships such as rudeness of a provider or employee, or failure to respect the Medicaid Member's rights.

As of March 1, 2018:

Complaint means an expression of dissatisfaction expressed by a Complainant, orally or in writing to the MCO, about any matter related to the MCO other than an Action. Complaint has the same meaning as grievance, as provided by 42 C.F.R. § 438.400(b). Possible subjects for Complaints include 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 Member's rights regardless of whether remedial action is requested. Complaint includes the Member's right to dispute an extension of time (if allowed by law) proposed by the MCO to make an authorization decision.

Appendix D: Scenario Results

Inquiry vs. Complaint Scenario Review

The inspection team developed 25 scenarios, which were vetted through MCCO and OO to determine what response, complaint or not a complaint, was expected from MCOs. The scenarios were then assessed by eight CSRs and three supervisors at MCO call centers. Inspectors found that most MCO staff disagreed with MCCO expectations in 10 scenarios (40 percent), highlighted in Table 5. In addition, most MCO staff disagreed with the OO in 5 of the 25 scenarios (20 percent), also highlighted in Table 5.

Table 5: Scenario Assessment Summary

	MCO Staff Indicated <u>Complaint</u>	MCO Staff Indicated <u>Not a Complaint</u>	MCCO Expectation	MCCO/MCO Agreement	OO Expectation	OO/MCO Agreement
1	27	6	Not a Complaint	No	Complaint	Yes
2	30	3	Not a Complaint	No	Complaint	Yes
3	18	15	Not a Complaint	No	Complaint	Yes
4	25	8	Complaint	Yes	Not a Complaint	No
5	19	14	Not a Complaint	No	Complaint	Yes
6	33	0	Complaint	Yes	Complaint	Yes
7	18	15	Complaint	Yes	Complaint	Yes
8	29	4	Complaint	Yes	Complaint	Yes
9	33	0	Complaint	Yes	Complaint	Yes
10	23	10	Complaint	Yes	Complaint	Yes
11	32	1	Complaint	Yes	Complaint	Yes
12	10	23	Not a Complaint	Yes	Not a Complaint	Yes
13	9	24	Not a Complaint	Yes	Not a Complaint	Yes
14	32	1	Complaint	Yes	Complaint	Yes
15	18	15	Complaint	Yes	Not a Complaint	No
16	24	9	Not a Complaint	No	Complaint	Yes
17	31	2	Not a Complaint	No	Complaint	Yes
18	33	0	Complaint	Yes	Complaint	Yes
19	32	1	Not a Complaint	No	Complaint	Yes
20	7	26	Not a Complaint	Yes	Not a Complaint	Yes
21	17	16	Complaint	Yes	Not a Complaint	No
22	31	2	Complaint	Yes	Not a Complaint	No
23	25	8	Not a Complaint	No	Complaint	Yes
24	32	1	Not a Complaint	No	Complaint	Yes
25	16	17	Complaint	No	Complaint	No

Appendix E: Report Team and Report Distribution

Report Team

The OIG staff members who contributed to this OIG Inspections and Investigations Division report include:

- Lisa Campos Garza, CFE, CGAP, Director for Inspections
- Troy Neisen, Manager for Inspections
- Dora Fogle, RS, MPH, Team Lead for Inspections
- Michael Greer, Inspection Co-Lead
- Pat Krempin, Inspector
- Levi Martinez, Inspector
- Kenin Weeks, Inspector
- Coleen McCarthy, MS, CHES[®], Editor

Report Distribution

Texas Health and Human Services:

- Courtney N. Phillips, PhD, Executive Commissioner
- Cecile Erwin Young, Chief Deputy Executive Commissioner
- Victoria Ford, Chief Policy Officer
- Karen Ray, Chief Counsel
- Enrique Marquez, Chief Program and Services Officer
- Stephanie Muth, Deputy Executive Commissioner, Medicaid and CHIP Services
- Karen Hill, Director, Internal Audit
- Joel Schwartz, HHS Ombudsman
- Grace Windbigler, Director, Managed Care Compliance & Operations Division

Appendix F: 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
- Anita D'Souza, OIG Chief Counsel and Chief of Staff
- Christine Maldonado, Chief of Operations and Workforce Leadership
- Olga Rodriguez, Chief Strategy Officer
- Lizet Hinojosa, Deputy IG for Benefits Program Integrity
- Brian Klozik, Deputy IG for Medicaid Program Integrity
- David Griffith, Deputy IG for Audit
- Quinton Arnold, Deputy IG for Inspections and Investigations
- Alan Scantlen, Deputy IG for Data and Technology
- Judy Knobloch, Assistant Deputy IG for Medical Services

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