DOCUMENT HISTORY LOG

STATUS[1]	DOCUMENT REVISION[2]	EFFECTIVE DATE	DESCRIPTION[3]
Baseline	2.0	September 15, 2014	Initial version Uniform Managed Care Manual Chapter 3.28, "Process for Resolution of HHSC-Referred Complaints." Version 2.0 applies to contracts issued as a result of HHSC RFP numbers 529-06-0293, 529-08-0001, 529-10-0020, 529-12-0002, 529-12-0003, and 529-13-0042.
Revision	2.1	October 15, 2014	Version 2.1 applies to contracts issued as a result of HHSC RFP numbers 529-06-0293, 529-08-0001, 529-10-0020, 529-12-0002, 529-12-0003, and 529-13-0042; and to Medicare-Medicaid Plans (MMPs) in the Dual Demonstration. Section I "Applicability of Chapter 3.28" is modified to add the Medicare-Medicaid Dual Demonstration.
Revision	2.2	November 15, 2015	Version 2.2 applies to contracts issued as a result of HHSC RFP numbers 529-08-0001, 529-10-0020, 529-12-0002, 529-12-0003, 529-13-0042, 529-13-0071, and 529-15-0001; and to Medicare-Medicaid Plans (MMPs) in the Dual Demonstration. Section I "Applicability of Chapter 3.28" is modified to add the STAR Kids Program.
Revision	2.3	September 1, 2019	Administrative changes made as follows: Section II "Requirements and Expectations for Complaint Responses" and Section A "Time frames for Responding to HHSC-Referred Complaints" are modified to delete the reference to Health Plan Management.
Revision	2.3.1	October 1, 2019	Accessibility approved version.

1 Status should be represented as "Baseline" for initial issuances, "Revision" for changes to the Baseline version, and "Cancellation" for withdrawn versions.

2 Revisions should be numbered according to the version of the issuance and sequential numbering of the revision—e.g., "1.2" refers to the first version of the document and the second revision.

3 Brief description of the changes to the document made in the revision.

I. Applicability of Chapter 3.28

This chapter applies to Managed Care Organizations (MCOs) participating in the following Programs: STAR, STAR+PLUS (including the Medicare-Medicaid Dual

Demonstration), CHIP, STAR Kids, STAR Health, or Children's Medicaid or CHIP Dental Services. The term "MCO" includes health maintenance organizations (HMOs), exclusive provider organizations (EPOs), insurers, Medicare-Medicaid Plans (MMPs), and any other entities licensed or approved by the Texas Department of Insurance.

The requirements in this chapter apply to all Programs, except where noted.

II. Requirements and Expectations for Complaint Responses

This chapter establishes the timelines and requirements for handling Member, provider, Legislative, and other Complaints received by HHSC that are referred to the MCO.

Please also see the applicable contract section on Member Complaint and Appeal Process.

A. Time frames for Responding to HHSC-Referred Complaints

Upon receiving a referred Complaint, the MCO must provide a response to HHSC within the following time frames.

Type of Complaint[1]	Maximum Response Time Allowed
Legislative or Access to Care Issue Any Complaint initiated by a legislative office or any Complaint that affects a Member's immediate care or could potentially cause Member harm (e.g., POS prescription issues, reduction in attendant hours).	Within 1 Business Day
HHSC-Expedited Issue Complaint initiated by HHSC or CMS that must be expedited (such as a request from HHSC's executive management or External Relations Division).	Within 1-5 Business Days[2]
Routine Issue Any Complaint that is not designated as Legislative or Access to Care Issue or an HHSC-Expedited Issue (e.g., appeal issues, delays in claims handling after services have been rendered).	Within 10 Business Days
Large Volume Complaint Any Routine Complaint that includes a large volume of paperwork (e.g., denied and appealed Provider claims) and requires extra time to review.	Within 14 Business Days

1 HHSC will generally identify the type of complaint when it refers the Complaint to the MCO. However, if the MCO needs clarification, the MCO should contact HHSC staff immediately upon receipt of the complaint.

2 For an HHSC-Expedited Issue, HHSC will determine the appropriate time frame for a response between one and five business days and tell the MCO in the chosen communication method.

Immediately upon receipt of the referred Complaint, the MCO must provide confirmation of receipt to HHSC. Further, on or before the response due date, the MCO must provide a response to HHSC indicating how the MCO resolved the Complaint. If a Complaint cannot be completely resolved by the due date, the MCO must provide an initial response that includes a plan of action for resolution with time frames by which the Complaint will be resolved. Once the Complaint is resolved, the MCO should provide a final response describing the resolution.

If the MCO cannot provide even an initial response by the deadline because it needs to gather more information, the MCO is responsible for asking HHSC for an extension by fax or e-mail with a specific requested due date.

- MCO must provide a valid reason for the extension request **prior to the due date**.
- HHSC will review and grant an extension, as it determines reasonable and appropriate.
- HHSC reserves the right to set or modify the timeline for responses, on a case-by-case basis.

B. General Requirements for All HHSC-Referred Complaint Responses

When providing either an initial or final response to HHSC, the MCO must:

- Restate and address all issues identified in HHSC's notification, and any other pertinent issues in the response letter.
- Include details of any communications with the complainant in chronological order, including date of calls, name, title, and phone number of MCO representative (Service Coordinator, Member Advocate, etc.) working on the case, and details of conversations. The MCO may provide HHSC with the phone number to the MCO's complaint unit rather than a direct line to the MCO representative handling the Complaint.
- If resolved, describe how the MCO resolved the Complaint and the date it was resolved. The MCO should provide a detailed explanation of how the MCO intends to prevent repeated occurrences, if requested by HHSC. If the Complaint is not completely resolved, provide an initial plan of action to resolve the Complaint and include the expected resolution date.
- Include, in both Member and provider inquiry responses, whether the issue being researched is a global issue that affects multiple Members or providers. If the issue impacts multiple Members or providers, include the number of Members or providers affected; a timeline for resolving the issue; and the steps the MCO will take to ensure that the issue will not occur again.

- The MCO must deliver the initial and final response to HHSC in appropriate business letter format by fax or secure e-mail.
- If the response necessitates that the MCO include a list of providers, it must include, as applicable, the name and DBA of each provider or provider agency, National Provider Identifier (NPI), Texas Provider Identifier (TPI), Atypical Provider Identification (API), and contact information.

C. Specific Requirements for Responses to HHSC-Referred Member Complaints

- Unless otherwise directed, upon receipt of the HHSC-referred Complaint, the MCO must contact the Member to discuss the case and ensure the Complaint is resolved. Additionally, once a resolution is determined, the MCO should notify the Member.
- If the MCO cannot reach the Member before the assigned due date, the MCO should request an extension from HHSC.
- For Members that the MCO is not able to locate even after an extension is granted, the MCO must prepare a response to HHSC that demonstrates it:
    - Attempted to contact the Member on at least three different times on three different days.
    - Sent an “unable to contact/locate” letter. The MCO must include a copy of the letter, the date it was sent, and the HHSC case ID number.
- Member Initiated Disenrollment Requests
    - The MCO should treat disenrollment requests as an opportunity to retain the Member. The MCO should make a reasonable effort to work with the Member toward a suitable resolution of his or her Complaints. However, if suitable resolution cannot be reached, the MCO must refer the Member to the HHSC Administrative Services Contractor in accordance with Attachment A of the Contract.
    - Attachment A of the Contract, including

D. Specific Requirements for Responses to HHSC-Referred Provider Complaints

- Responses regarding claim payment issues should reflect that the MCO used due diligence to resolve the issue with the provider, and that the MCO provided complete and thorough information to the provider to prevent repeated denials.
- For Complaints involving payment issues, the MCO must provide: service date, the claim number(s), check number, check date (or electronic fund transfer information), interest amount paid (if applicable), and spreadsheet with full claims

detail (upon request) to include denial reason codes and definitions for each denied payment.

- Unless otherwise directed, the MCO must contact the provider to discuss the case and ensure the Complaint is resolved.

E. Specific Requirements for Complaints Related to Balance Billing

- If the provider has billed a Medicaid Member for a Covered Service, part of the MCO's Complaint resolution process should include provider education about the prohibition of billing Medicaid Members for Covered Services. If the provider has billed a CHIP Member for anything other than an authorized copayment on a Covered Service, then the MCO should educate the provider about the prohibition on billing CHIP Members for Covered Services.
- The MCO should send the provider written notice to discontinue billing the Member and refund, within ten business days from the notice, any unauthorized amounts collected from the Member.