Medicaid Managed Care Quarterly Complaints Data Report

HB 4533, 86th Regular Legislative Session, 2019 requires the Texas Health and Human Services Commission (HHSC) to post Medicaid managed care complaints data publicly. The linked data report satisfies that requirement.

HHSC monitors trends in Medicaid managed care complaints data to identify and address issues within Medicaid programs in a timely manner. In summer 2018, HHSC began a cross-divisional effort to revise and improve the tracking and trending of managed care complaints data. This effort resulted in the following:

- New HHSC complaint routing and resolution processes to improve consistency,
- New reporting requirements for managed care organization (MCO) and dental maintenance organization (DMO) self-reported data, including changes to definitions and categories, and
- A more complete picture of emerging trends by compiling the complaints received through multiple divisions within HHSC and through the MCOs and DMOs into one report.

A complaint is defined as an expression of dissatisfaction per the Uniform Managed Care Contract, Article 2. Definitions. Individuals seeking to submit a managed care complaint should contact their MCO/DMO.

Initial Contact Complaint: Often, MCOs/DMOs are able to resolve complaints within one business day. This is referred to as an Initial Contact Complaint (ICC). For example, a client may call to express dissatisfaction over difficulties finding a PCP, and if the MCO is able to contact that client with a PCP it is categorized as an ICC. Often times the MCO is able to resolve the issue while the client is on the initial call.

Complaints are recorded based on categories such as Access to Care, Claims/Payment, Customer Service, Quality of Care, and others. An example includes Access to In-Network Provider which may include providers who do not accept Medicaid, and providers who are out of network.

COMPLAINT PROCESS

Other than initial contact complaints which are complaints that are resolved in one business day, MCOs/DMOs are contractually required to resolve complaints within 30 days. If after working with the MCO/DMO the individual believes the issue has not been resolved, the individual may submit a complaint to HHSC. Each complaint received is logged and reported. HHSC will also accept complaints if the individual indicates they are not willing to submit a complaint with the MCO/DMO first.

As individuals have the opportunity to submit a complaint to either the MCO/DMO or HHSC, Medicaid managed care complaints data is obtained through both of these sources. Generally, member complaints are resolved by the HHSC Office of the Ombudsman and provider complaints are resolved by the HHSC division of Medicaid and CHIP Services. MCOs/DMOs are required to submit complaints data to HHSC. Complaints are grouped into categories such as Access to Care, Customer Service, and Claims Payment.

HHSC uses complaints data in managed care oversight and improvement activities. Through the process of receiving and researching provider complaints, HHSC staff identify trends. HHSC staff review to determine if there is a known reason for the trend (e.g., recent systems changes). Data is reviewed to ensure MCOs/DMOs have a consistent understanding and application of complaint reporting requirements and identified issues are addressed to provide data integrity across the MCOs/DMOs and the agency. It is anticipated that understanding and compliance with reporting requirements will continue to improve through these efforts. HHSC staff also work closely with Office of the Ombudsman staff when trends with member complaints are identified through the Ombudsman complaint resolution process.

As MCOs submit complaints data monthly, HHSC conducts quality assurance activities on the data and seeks follow up information from MCOs/DMOs when identifying potential trends that should be addressed through contract oversight activities. Staff work with internal areas where appropriate (Policy, Legal, etc.) as well as the MCO(s) to research and address identified trends.

COMPLAINTS DATA

Data is presented in two separate reports, one report for ICCs (complaints resolved in 1 business day or at the time of the call) and one report for regular complaints (a complaint that does not fall under the definition of an ICC).

The periods of data collection and data elements collected are the same for both ICCs and regular complaints. Differences in an MCO/DMO's rate of complaints between the two reports may indicate a difference in MCO/DMO process that impact how often complaints are resolved within one business day versus a longer period of time.

The reports include complaints data compiled from both MCOs/DMOs and HHSC for members and providers. The reports are published for State Fiscal Year (SFY) 2021 Quarter (Q) 1 and 2 and each subsequent quarter going forward. Complaints data is displayed by the following:

- Top five most frequent types of complaints overall, separately for members and providers, by program, and by MCO/DMO.
- Outcome status by program and by MCO/DMO.

- Distribution of complaints and enrollment by MCO/DMO.
- Overall quarterly rate of complaints by MCO/DMO, including previous six quarters (as the data becomes available).

Generally, the total number of complaints submitted is small relative to the total number of individuals enrolled in Medicaid per month. This is why the data is expressed in number of complaints per 10,000 clients (otherwise referred to as rate). Complaint volumes may vary based on MCO/DMO size, program (e.g., STAR versus STAR+PLUS) and complexity of population served.

If there are any questions about the content of the data contained in the report, please contact HPM_Complaints@hhsc.state.tx.us.