DATE: April 10, 2014

DUALS PLAN LETTER 14-001

TO: ALL MEDI-CAL MANAGED CARE PLANS PARTICIPATING IN CAL MEDICONNECT

SUBJECT: COMPLAINT AND RESOLUTION TRACKING

PURPOSE:
The purpose of this Duals Plan Letter (DPL) is to clarify existing requirements and provide additional guidance on how Medicare-Medicaid Plans (MMPs) participating in the Duals Demonstration Project, referred to herein as Cal MediConnect, track, report, and resolve complaints.

BACKGROUND:
In January 2012, Governor Brown announced his intent to enhance health outcomes and beneficiary satisfaction for low-income Seniors and Persons with Disabilities by shifting service delivery away from institutional care to home and community-based settings. To implement that goal, Governor Brown enacted the Coordinated Care Initiative (CCI) by signing Senate Bill (SB) 1008 (Chapter 33, Statutes of 2012), SB 1036 (Chapter 45, Statutes of 2012) and SB 94 (Chapter 37, Statutes of 2013).

Cal MediConnect is one component of the CCI and will begin no sooner than April 1, 2014. Cal MediConnect will commence in the eight counties of Alameda, Los Angeles, Orange, Riverside, San Bernardino, Santa Clara, San Diego, and San Mateo according to the schedule contained in the chart titled, “CCI Enrollment Timeline By Population and County,” which can be found at: http://www.calduals.org/implementation/cci-documents/enrollment-charts-timelines/ under the heading Enrollment Chart. Cal MediConnect will serve beneficiaries eligible for both Medi-Cal and Medicare (dual-eligibles), and will combine the full continuum of acute, primary, institutional, and home and community-based Medicare and Medi-Cal services into a single benefit package delivered through an organized service delivery system administered by MMPs.

The Department of Health Care Services (DHCS) will notify dual-eligibles 90 days prior to their enrollment effective date into Cal MediConnect. DHCS will notify dual-eligibles of their right to select a participating MMP or to opt-out of Cal MediConnect participation no less than 60 days prior to the effective date of their enrollment into an MMP. When a
dual-eligible does not actively choose a participating MMP, DHCS will enroll the
beneficiary into an MMP using a seamless, passive enrollment process. This process
provides the opportunity for each dual-eligible to voluntarily choose to enroll or disenroll
from the participating MMP at any time. A dual-eligible who chooses to disenroll will
receive his or her Medi-Cal services from a Medi-Cal managed care health plan.

POLICY AND REQUIREMENTS:
In accordance with Welfare and Institutions Code, Section 14182.17(e)(4)(E)(vii), DHCS
is required to establish a tracking mechanism for Cal MediConnect consumer
complaints and resolutions for quality assessment purposes. The tracking mechanism
will monitor external and internal complaints.

External Complaints:
MMPs are required to respond to all Cal MediConnect complaints assigned through the
Complaints Tracking Module (CTM) in the Health Plan Management System
administered by the Centers for Medicare and Medicaid Services (CMS). CMS requires
all entities that operate a Medicare Advantage Product to receive, respond to, and track
complaints through the CTM. The MMP process for responding to a complaint assigned
through the CTM will be identical for Cal MediConnect.

Several other entities will also assign external complaints to MMPs, including the
Contract Management Team, Independent Duals Office of the Ombudsman, Health
Insurance Counseling and Advocacy Program, and through the Medicare toll-free help
line, 1-800-MEDICARE. MMPs are required to respond to each external complaint
through the CTM and report on how the MMP resolved the complaint.

Internal Complaints:
MMPs will directly receive internal complaints from Cal MediConnect beneficiaries,
either orally or in writing. MMPs are required to track and report all internal complaints
in accordance with the reporting template and instructions, which are included in
Attachments A and B. Internal complaint reporting requirements are aligned with the
grievance reporting requirements identified in the Medicare-Medicaid Capitated
Financial Alignment Model Reporting Requirements under Part C, Section V, which can
be located at:
http://www.cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-
Coordination/Medicare-Medicaid-Coordination-Office/FinancialAlignmentInitiative/InformationandGuidanceforPlans.html.

MMPs are only required to track internal complaints for Cal MediConnect beneficiaries.
MMPs are not required to report complaints identified through external grievance and
appeal processes, such as a State Fair Hearing or Independent Medical Review. Internal complaints do not include complaints received through the CTM. External complaints should not duplicate internal complaints.

MMPs must submit the completed reporting template to pmmp.monitoring@dhcs.ca.gov in accordance with the timeframes outlined in the reporting instructions.

If you have any questions regarding this DPL, please contact Sarah Brooks, Chief, Program Monitoring and Medical Policy Branch, at sarah.brooks@dhcs.ca.gov.

Sincerely,

Original Signed by Margaret Tatar

Margaret Tatar
Assistant Deputy Director
Health Care Delivery Systems

Attachments
Attachment A: Instructions

This instruction document explains the steps for reporting the number and types of complaints and resolutions for issues related to the Coordinated Care Initiative. The following templates fulfill the requirements set forth in Welfare and Institutions Code Section 14182.17(e)(4)(E)(vii).

Reporting Calendar:

The Department of Health Care Services (DHCS) is requiring Medicare-Medicaid Plans (MMPs) to report monthly for all opt-in and passive enrollment months. If an MMP has less than 12 passive enrollment months, the monthly reporting period will be the 12-month period beginning from the date the MMP begins passive enrollment or the date the MMP achieves full enrollment. After the end of the monthly reporting period, DHCS will require MMPs to submit reports on a quarterly basis.

Monthly reports will be due to DHCS 30 days after the end of the reporting period. If a monthly or quarterly report due date falls on a Saturday, Sunday, or State holiday, the report will be due the following business day. A list of California state holidays can be found at:

http://www.calhr.ca.gov/employees/pages/state-holidays.aspx (Note: hit cancel if a security pop-up window appears).

The following sample table lists the reporting periods and due dates assuming passive enrollment begins on April 1, 2014 and continues for 12 consecutive months. Reporting periods will vary depending on the county:

<table>
<thead>
<tr>
<th>Calendar Date</th>
<th>Reporting Period</th>
<th>Due Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>April 1, 2014</td>
<td>April 1 – April 30, 2014</td>
<td>May 30, 2014</td>
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<td>May 1, 2014</td>
<td>May 1 – May 31, 2014</td>
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<td>July 1 – July 31, 2014</td>
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<td>October 1, 2014</td>
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<td>November 1, 2014</td>
<td>November 1 – November 30, 2014</td>
<td>December 30, 2014</td>
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<tr>
<td>February 1, 2015</td>
<td>February 1 – February 28, 2015</td>
<td>April 2, 2015</td>
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<tr>
<td>March 1, 2015</td>
<td>March 1 – March 31, 2015</td>
<td>April 30, 2015</td>
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</tbody>
</table>
Quarterly reports will be due to DHCS 45 days after the end of the reporting period. The following table lists the reporting periods and due dates:

<table>
<thead>
<tr>
<th>Quarter</th>
<th>Reporting Period</th>
<th>Due Date</th>
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</thead>
<tbody>
<tr>
<td>2nd Quarter</td>
<td>April 1 – June 30, 2015</td>
<td>August 15, 2015</td>
</tr>
<tr>
<td>3rd Quarter</td>
<td>July 1 – September 30, 2015</td>
<td>November 15, 2015</td>
</tr>
<tr>
<td>4th Quarter</td>
<td>October 1 – December 31, 2015</td>
<td>February 15, 2015</td>
</tr>
<tr>
<td>1st Quarter</td>
<td>January 1 – March 1, 2016</td>
<td>May 15, 2016</td>
</tr>
<tr>
<td>2nd Quarter</td>
<td>April 1 – June 30, 2016</td>
<td>August 15, 2016</td>
</tr>
</tbody>
</table>

**Reporting Mechanism:**

MMPs must submit all data reports in Excel and Word, if applicable as explained further below, to pmmp.monitoring@dhcs.ca.gov.

**Data Element Description:**

**Tab One: Current Reporting Period**

The data must be county-specific and cannot be aggregated. The MMP must expand the number of rows in the reporting template to report on each location in which the MMP operates as a Cal MediConnect primary contractor.

- **Column 1 (County):** Enter the county in which the MMP operates as a Cal MediConnect primary contractor. The MMP must expand the number of rows in tab one to account for multiple counties of operation. Multiple tabs may not be used. The data cannot be aggregated and must be reported by county.
- **Column 2 (Plan Code):** Enter the assigned plan code.
- **Column 3 (Total):** Enter the total number of complaints received. The total number of complaints must be equal to the sum of columns 4–8.
- **Column 4 (# of Fully Resolved):** Enter the number of complaints resolved for each member interaction at the end of the reporting period.
- **Column 5 (# of Partially Resolved):** Enter the number of complaints partially resolved at the end of the reporting period.
- **Column 6 (# Not Resolved):** Enter the number of complaints not resolved at the end of the reporting period. The MMP shall enter complaints in this column that the MMP will be able to report a disposition on (column 4-8) by the end of the next reporting period.
- **Column 7 (# of Resolutions Status Unknown):** Enter the number of complaints that have an unknown resolution status at the end of the reporting period. The MMP shall enter complaints in this column that the MMP will not be able to report the disposition on (column 4-8) by the end of the next reporting period.
- **Column 8 (# Referred):** Enter the number of complaints that the MMP referred outside of the MMP. If an MMP uses the other column to record referrals, the MMP must submit a Word document that includes an analysis of the types of referrals made. The text analysis must include, at a minimum, the top five referral types, if applicable.
- **Column 9 (Enrollment or Disenrollment):** Enter the complaints related to enrollment or disenrollment.
- **Column 10 (Benefit Package):** Enter the complaints related to the MMP benefit package for Cal MediConnect.
**Column 11 (Access):** Enter the complaints related to access to covered services.

**Column 12 (Marketing):** Enter the complaints related to MMP marketing. Additional information on marketing can be found at:


**Column 13 (Customer Service):** Enter the complaints related to the MMP customer or member services departments.

**Column 14 (Organization Determination and Reconsideration Process):** An organization determination is any decision made by MMP regarding:

1. Receipt of, or payment for, a managed care item or service;
2. The amount an MMP requires a member to pay for an item or service; or
3. A limit on the quantity of items or services.

Additional information on organization determinations can be found at:


If an MMP denies a member's request for an item or service in whole or in part (issues an adverse organization determination), the member may appeal the decision to the MMP by requesting reconsideration. Additional information on reconsiderations can be found at:


**Column 15 (Quality of Care):** Enter any complaints related to MMP quality of care.

**Column 16 (CMS or DHCS Issues):** Enter the number of complaints concerning the Centers for Medicare and Medicaid Services (CMS) or DHCS policies, processes, or operations. This type of grievance is not directed against the MMP or providers and is meant to identify complaints that are due to CMS or DHCS policies and out of the MMP’s direct control.

**Column 18 (Other):** Enter the number of complaints that do not fall under a complaint type identified in Columns 9–16. If an MMP uses the other column to record complaints, the MMP must submit a Word document that includes an analysis of the types of complaints received. The text analysis must include, at a minimum, the top five interaction types, if applicable.

**Tab Two: Previous Reporting Period**

Tab two must be used to report on the results of complaints that were not resolved the previous reporting period. Column six in tab one must match column three in tab two. Column six in tab two may not be used; all other reporting instructions from tab one shall mirror tab two.

**Definitions:**

1. **Interactions:** contacts or inquiries from a Cal MediConnect member, whether orally or in writing.
2. **Complaint:** an oral or written expression of dissatisfaction. A complaint pertains to a problem encountered by a Cal MediConnect member that needs investigation and intervention.

3. **Fully Resolved Complaint:** adequate assistance was available that led to a favorable and complete resolution of the Cal MediConnect member complaint.

4. **Partially Resolved Complaint:** a Cal MediConnect member’s interaction led to more than one complaint during one interaction, and at least one is not fully resolved at the end of the reporting period. A partially resolved complaint may also mean assistance was available to resolve some elements of the complaint, but a portion of the problem remained.

5. **Not Resolved Complaint:** the complaint was not resolved; the disposition of the initial complaint did not change.

6. **Resolved Status Unknown:** the disposition of the complaint is unknown at the time of the reporting period, or the member requested to withdraw the complaint.
<table>
<thead>
<tr>
<th>Reporting Month or Quarter</th>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
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<th>6</th>
<th>7</th>
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<th>15</th>
<th>16</th>
<th>17</th>
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<tbody>
<tr>
<td>County</td>
<td>Plan Code</td>
<td>Total</td>
<td># of Fully Resolved</td>
<td># of Partially Resolved</td>
<td># of Not Resolved</td>
<td># of Resolution Status Unknown</td>
<td># Referred</td>
<td>Enrollment or disenrollment</td>
<td>Benefit Package</td>
<td>Access</td>
<td>Marketing</td>
<td>Customer Service</td>
<td>Organization Determination and Reconsideration Process</td>
<td>Quality of Care</td>
<td>CMS or DHCS Issues</td>
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<tr>
<td>County</td>
<td>Plan Code</td>
<td>Total</td>
<td># of Fully Resolved</td>
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<td># of Not Resolved</td>
<td># of Resolution Status Unknown</td>
<td># Referred</td>
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<td>CMS or DHCS Issues</td>
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## Previous Reporting Period

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<th>County</th>
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