State of California—Health and Human Services Agency
Department of Health Care Services

TOBY DOUGLAS
Director

EDMUND G. BROWN JR.
Governor

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:

Calendar Date	Reporting Period	Due Date
April 1, 2014	April 1 – April 30, 2014	May 30, 2014
May 1, 2014	May 1 – May 31, 2014	June 30, 2014
June 1, 2014	June 1 – June 30, 2014	July 30, 2014
July 1, 2014	July 1 – July 31, 2014	August 30, 2014
August 1, 2014	August 1 – August 30, 2014	September 30, 2014
September 1, 2014	September 1 – September 30, 2014	October 30, 2014
October 1, 2014	October 1 – October 31, 2014	November 30, 2014
November 1, 2014	November 1 – November 30, 2014	December 30, 2014
December 1, 2014	December 1 – December 31, 2014	January 30, 2015
January 15, 2015	January 1 – January 31, 2015	February 30, 2015
February 1, 2015	February 1 – February 28, 2015	April 2, 2015
March 1, 2015	March 1 – March 31, 2015	April 30, 2015

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:

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

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 of 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:

  http://www.cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination-Office/FinancialAlignmentInitiative/California.html.

- 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:

  http://www.cms.gov/Medicare/Appeals-and-Grievances/MMCAG/ORGDetermin.html.

  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:

  http://www.cms.gov/Medicare/Appeals-and-Grievances/MMCAG/PartCRecon.html

- 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.

Current Reporting Period

Reporting Month or Quarter	

1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17
County	Plan Code	Total	# of Fully Resolved	# of Partially Resolved	# Not Resolved	# of Resolution Status Unknown	# Referred	Enrollment or Disenrollment	Benefit Package	Access	Marketing	Customer Service	Organization Determination and Reconsideration Process	Quality of Care	CMS or DHCS Issues	Other

Previous Reporting Period

Reporting Month or Quarter	

1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17
County	Plan Code	Total	# of Fully Resolved	# of Partially Resolved	# Not Resolved	# of Resolution Status Unknown	# Referred	Enrollment or Disenrollment	Benefit Package	Access	Marketing	Customer Service	Organization Determination and Reconsideration Process	Quality of Care	CMS or DHCS Issues	Other