

Grievance and Appeal Reporting

Introduction

In August 2015, the Centers for Medicare & Medicaid Services (CMS) approved the Department of Health Care Services (DHCS) request to amend California's section 1115 demonstration project, entitled California Bridge to Reform Demonstration. This demonstration approval authorizes DHCS to test a new pilot program of organized delivery services for Medi-Cal eligible beneficiaries with substance use disorders, known as the Drug Medi-Cal Organized Delivery System (DMC-ODS) Waiver. The Special Terms and Conditions for the waiver requires DHCS to report grievances and appeals on a quarterly and annual basis to CMS for the duration of the demonstration. Counties who choose to participate in the DMC-ODS Waiver are required to fill out the attached Grievance and Appeal Log and submit the log to DHCS 15 calendar days after the end of each quarter, unless otherwise stipulated by DHCS. Below are the instructions for filling out and submitting the Grievance and Appeal Log to DHCS.

Instructions

1. Use the same Excel workbook throughout the entire fiscal year.
2. Open and fill-out the corresponding month's Grievance and Appeal Log workbook (i.e. for the month of July, open the sheet entitled "7-July"; for the month of August, open the sheet entitled "8-August"; etc.)
3. Enter the current information for your County:
 - a. **County**
 - b. **Coordinator:** Enter the name of the individual DHCS should reach out to should there be questions regarding the County's Grievance and Appeal Log
 - c. **Phone:** Enter the Coordinator's telephone number
 - d. **E-mail:** Enter the Coordinator's e-mail address
 - e. **State Fiscal Year:** Enter the current state fiscal year
4. Do not fill-out the boxed section labeled "State Use Only"
5. Enter the following information for each of the corresponding weeks in the month (i.e. for the first week within July, fill-out the section of the table labeled "Week 1"; for the second week within July, fill-out the section of the table labeled "Week 2"; etc.):
 - a. **# of Member Grievances:** Enter the total number of member grievances the County received that week.
 - b. **# of Appeals Received:** Enter the total number of appeals received for the week from beneficiaries who have received an adverse benefit determination from the County.
 - c. **# of Grievance Resolutions:** Enter the total number of grievances the County has resolved for the week.
 - d. **# of Appeal Resolutions:** Enter the total number of appeals that County has resolved for the week.
 - e. **# of Appeals Resolved in Favor of Plan:** Enter the total number of appeals that were resolved in favor of the plan.
 - f. **# of Appeals Resolved in Favor of Beneficiary:** Enter the total number of appeals that were resolved in favor of the beneficiary.
6. Do not fill-out greyed-out section of the table labeled "Totals"

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7. Within the section labeled **# of Member Grievances Regarding**,* enter the total number of member grievances relating to the following areas received during the week:**
 - a. **Access to Care**
 - b. **Quality of Care**
 - c. **Program Requirements**
 - d. **Failure to Respect a Beneficiary's Rights**
 - e. **Interpersonal Relationship Issues**
 - f. **Other**: Indicate the number of grievances that do not pertain to the list provided above
 - g. **Description Week 1, 2, 3, 4, or 5**: If **"Other"** grievances are identified, provide a brief description of the grievance in the section labeled "Description" with the corresponding week (i.e. Description Week 1). For example, for *other* grievances identified in the first week of July, enter the description of the grievance in "Description Week 1"; for *other* grievances identified in the second week of July, enter the description of the grievance in "Description Week 2", etc.)
 - i. Do not include beneficiary specific information within the Grievance and Appeal Log, such as PHI, PII, or PI
 - ii. If there are multiple *other* grievances identified within the week, please separate the grievance descriptions within the space provided by adding a new row within the cell. This can be done by hitting **Alt+Enter**

*The total number of grievance types identified must match the total number of member grievances reported. Do not report types of grievances resolved, or types of appeals received.

**Service Denials will no longer be tracked as a grievance sub-type. Service Denials should be included in the total number of appeals received.

8. Within the section labeled **Transition of Care Requests**, enter the following information for each of the corresponding weeks in the month:
 - a. **# of Transition of Care Requests Received**: enter the total number of member requests for a Transition of Care received that week.
 - b. **# of Transition of Care Requests Approved**: enter the total number of Transition of Care requests that were approved.
 - c. **# of Transition of Care Requests Denied**: enter the total number of Transition of Care requests that were denied.

DHCS' transition of care policy requires that a DMC-ODS county allow the beneficiary to continue receiving covered DMC-ODS service(s) with an out-of-network provider when their assessment determines that, in the absence of continued services, the beneficiary would suffer serious detriment to their health or be at risk of hospitalization or institutionalization. Beneficiaries, their authorized representatives, or their current provider, may submit a request to the DMC-ODS county to retain their current provider for a period of time. Upon receipt of the request, the DMC-ODS county shall send the beneficiary written acknowledgement of receipt of the request and begin to process the request within three (3) working days. (IN 18-051)

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Definitions (42 CRF 438)

“Appeal” is the request for review of an “action.”

“Adverse Benefit Determination” Adverse benefit determination means:

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.

“Grievance” is defined as 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, program requirements (i.e. provider imposed rules for program participation), 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. A Grievance also includes an enrollee's right to dispute an extension of time proposed by the MCO, PIHP or PAHP to make an authorization decision.

Submitting Grievance and Appeal Log to DHCS

The county’s Grievance and Appeal Log must be completed and submitted to DHCS within 15 calendar days of the end of each quarter, unless otherwise stipulated by DHCS. Grievance and Appeal Logs must be submitted to DHCS via e-mail to ODSSubmissions@dhcs.ca.gov. The logs must be completed and submitted by the close of business on the provided due date. The following table indicates the due dates of the Grievance and Appeal Log for each quarter.

Quarter	Reporting Period	Due Date
FY 20-21: Q1	07/01/20 – 09/30/20	10/15/20
FY 20-21: Q2	10/01/20 – 12/31/20	01/15/21
FY 20-21: Q3	01/01/21 – 03/31/21	04/15/21
FY 20-21: Q4	04/01/21 – 06/30/21	07/15/21