**Attachment A: Instructions**

The purpose for this instruction document is to explain the steps for reporting the number and types of complaints for issues related to the Coordinated Care Initiative. The following templates fulfill the requirements set forth in Senate Bill 1008 (Welfare and Institutions Code Section 14182.17(d)(10)(B)(iii)).

**Reporting Calendar:**

The plan will be required to report monthly for all opt-in months and passive enrollment months. If a plan has less than 12 passive enrollment months, the monthly reporting period will be the 12 month period beginning from the date the plan begins passive enrollment or the date the plan achieves full enrollment. After the end of the monthly reporting period, plans will continue to submit reports on a quarterly basis.

Monthly reports will be due 15 days after the end of the reporting period. 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. The reporting period will be different depending on the county:

|  |  |  |
| --- | --- | --- |
| **Calendar**  | **Reporting Period** | **Due Date** |
| April 1, 2014 | April 1 – April 30, 2014 (Cal MediConnect only) | May 15, 2014 |
| May 1, 2014 | May 1 – May 31, 2014 (Cal MediConnect only) | June 15, 2014 |
| June 1, 2014 | June 1 – June 30, 2014 (Cal MediConnect only) | July 15, 2014 |
| July 1, 2014 | July 1 – July 31, 2014 | August 15, 2014 |
| August 1, 2014 | August 1 – August 30, 2014 | September 15, 2014 |
| September 1, 2014 | September 1 – September 30, 2014 | October 15, 2014 |
| October 1, 2014 | October 1 – October 31, 2014 | November 15, 2014 |
| November 1, 2014 | November 1 – November 30, 2014 | December 15, 2014 |
| December 1, 2014 | December 1 – December 31, 2014 | January 15, 2015 |
| January 15, 2015 | January 1 – January 31, 2015 | February 15, 2015 |
| February 1, 2015 | February 1 – February 28, 2015 | March 15, 2015 |
| March 1, 2015 | March 1 – March 31, 2015 | April 15, 2015 |

The quarterly reports will be due 45 days after the end of the reporting period. The following table lists the reporting periods and due dates:

|  |  |  |
| --- | --- | --- |
| **Calendar** | **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, 2015 |
| 2nd Quarter | April 1 – June 30, 2016 | August 15, 2016 |

**Reporting Mechanism:**

Plans must submit all data reports in Excel to pmmp.monitoring@dhcs.ca.gov.

**Data Element Description:**

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

* Column 1 (Interaction Type): An interaction consists of a complaint.
* Column 2 (County): Enter the county in which the plan operates as a Cal MediConnect primary contractor.
* Column 3 (Plan Code): Enter the assigned plan code.
* Column 4 (Total): Enter the total number of complaints received. The total number of complaints must be equal to the sum of columns 5–9.
* Column 5 (# of Fully Resolved): Enter the number of complaints resolved for each member interaction at of the end of the reporting period.
* Column 6 (# of Partially Resolved): Enter the number of complaints partially resolved at the end of the reporting period. .
* Column 7 (# Not Resolved): Enter the number of complaints not resolved at of the end of the reporting period.
* Column 8 (# of Resolutions Status Unknown): Enter the number of complaints that have an unknown resolution status at the end of the reporting period.
* Column 9 (# Referred): Enter the number of complaints that the plan referred to an entity outside of the plan. If a plan uses this data element, the plan must include a text response with the data template that briefly explains the type of referrals and the referral entity. The brief explanation must include, at a minimum, the plan’s top five reasons for the referral and identification of the referral entity, if applicable.
* Column 10 (Inappropriate Treatment, Diagnosis, or Care): Enter the number of complaints related to quality of care.
* Column 11 (Cal MediConnect Enrollment / Disenrollment): Enter the number of complaints related to the enrollment disenrollment of a member for the Cal MediConnect program.
* Column 12 (Prior Authorization Denial / Delay): Enter the number of complaints related to the denial or delay of a prior authorization.
* Column 13 (LTC): Enter the number of complaints related to long-term care.
* Column 14 (Home or Community Based Access): Enter the number of complaints related to a member not being able to obtain access to a home- or community-based provider.
* Column 15 (Institutional Access Services): Enter the number of complaints related to a member not being able to obtain access to an institutional provider.
* Column 16 (Mental Health Access): Enter the number of complaints related to a member not being able to obtain access to a mental health provider. Access issues include, but are not limited to, appointment wait times, time and distance, and physical accessibility.
* Column 17 (Substance Use Treatment Access): Enter the number of complaints related to a member not being able to obtain access to a substance use and treatment providers. Access issues include, but are not limited to, appointment wait times, time and distance, and physical accessibility.
* Column 18 (Educational Question Regarding Cal MediConnect): Enter the number of general questions regarding the Cal MediConnect program or plan. Member contact could begin with a general inquiry and lead to a complaint.
* Column 19 (Other): Enter the number of all other complaint interaction types not identified in columns 10–18. If a plan uses this data element to record interaction types, the plan must include a text response with the data template that includes a brief explanation of the type of interactions. The brief explanation must be separate for inquires and complaints and include, at a minimum, the top five interaction types, if applicable.

**Definitions:**

1. **Interactions** mean any contact or inquiry from a Cal MediConnect member that leads to a complaint. Complaints received through the Complaint Tracking Module in the Health Plan Management System administered by the Centers for Medicare and Medicaid Services does not need to be included. Interactions may include, but are not limited to, contact made through the MMP Member Services Department, email, or fax.
2. **Complaint** means an oral or written expression of dissatisfaction. A complaint pertains to a specific problem encountered by a Cal MediConnect member that needs investigation and intervention.
3. **Fully Resolved Complaint** means adequate assistance was available that lead to favorable and complete resolution of the Cal MediConnect member complaint.
4. **Partially Resolved Complaint** means a Cal MediConnect member interaction lead to more than one complaint, and at least one is not fully resolved. A partially resolved complaint may also mean assistance was available to resolve some elements of the complaint, but some problem remained.
5. **Not Resolved Complaint** means the complaint was not resolved; the disposition of the initial complaint did not change.
6. **Resolved Status Unknown** means the disposition of the complaint is unknown, or the beneficiary requested to withdraw the complaint.