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

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DATE: July 8, 2022

Behavioral Health Information Notice No: 22-036

TO: California Alliance of Child and Family Services
California Association for Alcohol/Drug Educators
California Association of Alcohol & Drug Program Executives, Inc.
California Association of DUI Treatment Programs
California Association of Social Rehabilitation Agencies
California Consortium of Addiction Programs and Professionals
California Council of Community Behavioral Health Agencies
California Hospital Association
California Opioid Maintenance Providers
California State Association of Counties
Coalition of Alcohol and Drug Associations
County Behavioral Health Directors
County Behavioral Health Directors Association of California
County Drug & Alcohol Administrators

SUBJECT: Managed Care Program Annual Report (MCPAR) for Mental Health Plans (MHP) and Drug Medi-Cal Organized Delivery System (DMC-ODS) Counties.

PURPOSE: To inform and provide direction to MHPs and DMC-ODS counties about existing and additional grievance and appeal data requirements for completing the MCPAR due annually to the Centers for Medicare and Medicaid Services (CMS).

REFERENCE: Code of Federal Regulations (C.F.R.) Title 42, section 438.66(e)[1]

BACKGROUND:
On May 6, 2016, CMS published the Medicaid and Children's Health Insurance Program (CHIP) Managed Care Final Rule,[2] aimed at aligning the Medicaid managed care regulations with requirements for other major sources of coverage. This included requirements for the handling of grievances and appeals. On June 28, 2021, CMS issued further guidance on the monitoring and oversight of managed care in Medicaid

[1] The Department of Health Care Services is publishing this Behavioral Health Information Notice pursuant to Welfare & Institutions Code sections 14184.102(d), 14184.400, and 14184.401.
[2] 81 FR 27497

and CHIP, including the reporting requirements under MCPAR.[3] Pursuant to 42 CFR § 438.66(e), as part of the reporting requirements, each State Medicaid Agency is required to submit specific data to CMS no later than 180 days after each contract year for each managed care program administered by that state, including MHPs and DMC-ODS counties (herein referred to as "Plans"), which are Prepaid Inpatient Health Plans. This BHIN only addresses the grievance and appeals data required by 42 CFR § 438.66(e)(2)(v).

POLICY:

Effective immediately, the MCPAR grievance and appeal reporting indicators listed in this section supersede previous grievance and appeal reporting for Plans as follows.

- For MHPs, this BHIN supersedes reporting requirements in the Annual Beneficiary Grievance and Appeal Report specified in California Code of Regulations Title 9, Section 1810.375(a), MHP Contract, Exhibit A, Attachment 12, section 11 (July 1, 2017 – June 30, 2022), and reporting of "Exempt Grievances" in MHSUDS Information Notice 18-010E, pg. 4.
- For DMC-ODS Counties, this BHIN supersedes "Quarterly data" reporting requirements on beneficiary grievance and appeals specified in MHSUDS Information Notice 19-022, pg. 2.

Grievance, appeal, and adverse benefit determination definitions, handling, and record keeping requirements specified in 42 C.F.R. Part 438, Subpart F, and MHSUDS Information Notice 18-010E remain in effect, with the exception of the items listed above.

In accordance with 42 C.F.R. § 438.66(e) and MCPAR requirements pursuant to the June 28, 2021, CMCS CIB[4], the Department of Health Care Services (DHCS) requires each Plan to report annually on the first business day of September the following grievances and appeals data (in numerical count):

a. Grievances
    i. Resolved

[3] Center for Medicaid and CHIP Services (CMCS) Informational Bulletin – June 28, 2021 at https://www.medicaid.gov/federal-policy-guidance/downloads/cib06282021.pdf
[4] Ibid

Grievances resolved by the Plan during the reporting year (herein referred to as "Reporting Period")[5]. A grievance is "resolved" when it has reached completion and been closed by the Plan.

ii. Active
Grievances still pending or in process (not yet resolved) as of June 1st.

iii. Timely Resolution
Grievances for which timely resolution was provided by the Plan during the reporting period. (See MHSUDS Information Notice 18-010E, pg. 3, for requirements related to the timely resolution of grievances.)

Number of grievances resolved by the Plan during the reporting period related to the following services (a single grievance may be related to multiple service types and may therefore be counted in multiple categories below):

iv. Inpatient
Grievances resolved by the Plan during the reporting period that were related to inpatient[6] mental health or substance use services.

v. Outpatient
Grievances resolved by the Plan during the reporting period that were related to outpatient mental health or substance use services.

Number of grievances resolved by the Plan during the reporting period related to the following reasons (a single grievance may be related to multiple reasons and may therefore be counted in multiple categories below):

vi. Related to Customer Service
Grievances resolved by the Plan during the reporting period that were related to Plan or provider customer service. Customer service grievances include complaints about interactions with the Plan's Member Services department, provider offices or facilities,

[5] Reporting Period of report: July 1st to June 30th of each year.
[6] Specialty Mental Health Services (SMHS) inpatient includes all psychiatric inpatient level of care services in general acute care hospitals with psychiatric units, psychiatric hospitals and psychiatric health facilities certified by DHCS as Medi-Cal providers of inpatient hospital services (pg. 5, BHIN 22-017). DMC-ODS Inpatient Services ASAM Levels 3.7 and 4.0 delivered in general acute care hospitals, Freestanding Acute Psychiatric Hospitals, or Chemical Dependency Recovery Hospitals (pg. 13, BHIN 21-075).

Plan marketing agents, or any other Plan or provider representatives.

vii. Related to Case Management
Grievances resolved by the Plan during the reporting period that were related to Plan or provider care management/case management. Care management/case management grievances include complaints about the timeliness of an assessment or complaints about the Plan or provider care or case management process.[7]

viii. Access to Care
Grievances resolved by the Plan during the reporting period that were related to access to care. Access to care grievances include complaints about difficulties finding qualified in-network providers, excessive travel or wait times, or other access issues.

ix. Quality of Care
Grievances resolved by the Plan during the reporting period that were related to quality of care. Quality of care grievances include complaints about the effectiveness, efficiency, equity, patient-centeredness, safety, and/or acceptability of care provided by a provider or the Plan.

x. County (Plan) Communication
Grievances resolved by the Plan during the reporting period that were related to Plan communications. Plan communication grievances include grievances related to the clarity or accuracy of enrollee materials or other Plan communications or to an enrollee's access to or the accessibility of enrollee materials or Plan communications.

xi. Payment/Billing issues
Grievances resolved during the reporting period that were filed for a reason related to payment or billing issues.

xii. Suspected Fraud
Grievances resolved during the reporting period that were related to suspected fraud. Suspected fraud grievances include suspected cases of financial/payment fraud perpetuated by a provider, payer, or other entity. Note: grievances reported in this row should only include grievances submitted to the Plan, not grievances submitted

[7] For purposes of MCPAR reporting, DMC-ODS Plans will include grievances related to Care Coordination in the Case Management category.

to another entity, such as a state Ombudsman or Office of the Inspector General.

xiii. Abuse, Neglect or Exploitation
Grievances resolved during the reporting period that were related to abuse, neglect, or exploitation. Abuse, neglect, and exploitation grievances include cases involving potential or actual patient harm.

xiv. Lack of Timely Response
Grievances resolved during the reporting period that were filed due to a lack of timely Plan response to a service authorization or appeal request (including requests to expedite or extend appeals).

xv. Denial of Expedited Appeal
Grievances resolved during the reporting period that were related to the Plan's denial of a beneficiary request for an expedited appeal. (Per MHSUDS Information Notice 18-010E, pg. 12, the Plan must resolve the expedited appeal within 72 hours from receipt of the appeal. If a Plan denies a request for an expedited appeal, the beneficiary or their representative have the right to file a grievance.)

xvi. Filed for other reasons
Grievances resolved during the reporting period that were filed for a reason other than the reasons listed above.

b. Appeals

i. Resolved
Report appeals resolved as of June 1st each reporting year. An appeal is "resolved" at the plan level when the Plan has issued a decision, regardless of whether the decision was wholly or partially favorable or adverse to the beneficiary, and regardless of whether the beneficiary (or the beneficiary's representative) chooses to file a request for a State Hearing.

ii. Active
Appeals still pending or in process (not yet resolved) as of June 1st.

iii. Timely Resolution (standard)
Standard appeals for which timely resolution was provided by the Plan during the reporting period. (See MHSUDS Information Notice 18-010E, pg. 10, for requirements related to timely resolution of standard appeals.)

iv. Timely Resolution (expedited)
Expedited appeals for which timely resolution was provided by the Plan during the reporting period. (See MHSUDS Information Notice

18-010E, pg. 12, for requirements related to timely resolution of expedited appeals.)

v. Denial or Limited Authorization of Service(s)
Appeals resolved by the Plan during the reporting period that were related to the Plan's denial of authorization for a service not yet rendered or limited authorization of a service. (Appeals related to denial of payment for a service already rendered should be counted in appeals of Payment Denials.)

vi. Reduction, Suspension, or Termination of a Previously Authorized Service
Appeals resolved by the Plan during the reporting period that were related to the Plan's reduction, suspension, or termination of a previously authorized service.

vii. Payment Denial
Appeals resolved by the Plan during the reporting period that were related to the Plan's denial, in whole or in part, of payment for a service that was already rendered.

viii. Service Timeliness
Appeals resolved by the Plan during the reporting period that were related to the Plan's failure to provide services in a timely manner (as defined by the state).

ix. Untimely Response to Appeal or Grievance
Appeals resolved by the Plan during the reporting period that were related to the Plan's failure to act within the timeframes provided in MHSUDS Information Notice 18-010E, pg. 3, and pg. 10, regarding the standard resolution of grievances and appeals.

x. Denial of Beneficiary Request to Dispute Financial Liability
Appeals resolved by the Plan during the reporting period that were related to the Plan's denial of an enrollee's request to dispute a financial liability.

Number of appeals resolved by Plan during the reporting period related to the following services: (A single appeal may be related to multiple service types and may therefore be counted in multiple categories below.)

xi. Inpatient
Appeals resolved by the Plan during the reporting period that were related to inpatient mental health or substance use services.

xii. Outpatient
Appeals resolved by the Plan during the reporting period that were related to outpatient mental health or substance use services.

Data Submission

DHCS will collect the MCPAR data for existing and additional grievance and appeal data requirements specified in this BHIN from Plans. DHCS will submit all MCPAR data and information collected from Plans within 180 days after each contract year to CMS.[8] All Plans are required to submit the applicable data to DHCS as follows:

Grievance and appeal data must be emailed to MCBHDmonitoring@dhcs.ca.gov using the reporting template provided by DHCS. The reporting template and instructions will be provided to Plans in an email correspondence shortly after this BHIN is released. Plans must complete separate reports for each delivery system (i.e., MHPs submit one report, and DMC-ODS counties submit a separate report). Plans should not integrate MHP and DMC-ODS data.

DHCS intends to utilize a more automated data collection system for future MCPAR submissions. However, for the first submission due to DHCS in September 2022 that will start with reporting period for Fiscal Year (FY) 2021/2022, a manual reporting template will be used.

MCPAR Submission Timeline

Contract Year of the Plan	***Reporting Period of Report***	***Plan Data Submission due to DHCS***	***DHCS MCPAR Due to CMS***
Contract start date (varies by contract through June 30)	July 1st to June 30th of each year.	Annually on the first business day of September.	Annually by December 27.

Future Coordination with DHCS and Plans

In the coming months of 2022, DHCS will be coordinating with Plans on future MCPAR data reporting processes, beginning with the MCPAR data reporting due to DHCS in September 2022. DHCS is currently assessing the impact of MCPAR on existing technological capabilities and processes for collecting requisite data on Plans. Reporting instructions and a template will be provided shortly after this BHIN is released.

[8] 42 C.F.R. § 438.66(e)

To ensure the accurate and timely completion of MCPAR, DHCS requires Plans to provide all needed MCPAR data requested above, as well as abide by all established DHCS timelines and processes for submission purposes.

If you have any questions regarding MCPAR grievance and appeals reporting, please contact the DHCS Medi-Cal Behavioral Health Division, County/Provider Operations and Monitoring Branch at MCBHDmonitoring@dhcs.ca.gov.

Sincerely,

Original signed by

Ivan Bhardwaj, Acting Chief
Medi-Cal Behavioral Health Division