Policy:	GG.1834
Title:	**Multipurpose Senior Services Program (MSSP) Appeals, Grievances and Complaints Process**
Department:	Medical Management
Section:	Long Term Services and Supports
CEO Approval:	*/s/ Michael Hunn 10/31/2024*
Effective Date:	09/01/2016
Revised Date:	10/01/2024
Applicable to:	☒ Medi-Cal ☒ OneCare ☐ PACE ☐ Administrative

I. PURPOSE

This policy defines the process by which the CalOptima Health Multipurpose Senior Services Program (MSSP) Provider shall track and report a CalOptima Health Member's Appeals, Grievances and Complaints to Long Term Services and Supports (LTSS) and Grievance and Appeal Resolution Services (GARS) Departments.

II. POLICY

A. CalOptima Health MSSP Provider shall issue a Notice of Action (NOA) for any adverse decisions regarding MSSP enrollment, or when a Waiver Service is denied, reduced, suspended, or terminated by the MSSP Provider. The NOA is mailed to a Member informing of his or her rights to file an Appeal, Grievance or Complaint with the California Department of Social Services, State Hearing Division.

B. If a Member disagrees with the CalOptima Health MSSP Provider's decision, he or she must complete and submit the Request for a State Hearing Form within ninety (90) calendar days to the Office of the Chief Referee at the California Department of Social Services (CDSS).

C. CalOptima Health MSSP Provider shall retain the responsibility to receive, acknowledge, respond and track MSSP Appeals, Grievances and Complaints, and manage the State Hearing process for MSSP Waiver Participants and CalOptima Health Members receiving MSSP services.

D. CalOptima Health GARS shall manage Appeals, Grievances, and Complaints for non-MSSP related services for MSSP Waiver Participants, in accordance with CalOptima Health Policies HH.1102: Member Grievance, and MA.9002: Enrollee Grievance Process.

E. CalOptima Health LTSS Department shall be responsible for reporting MSSP Appeals, Grievances and Complaints statistics and analysis to LTSS Quality Improvement (QI) Subcommittee on a quarterly basis.

F. When a Member files a timely Appeal of CalOptima Health MSSP Provider's decision to terminate the Member from the MSSP Program or services, the MSSP Member shall be entitled to continue receiving Aid Paid Pending for Waiver services (including care management) until the State Hearing Administrative Law Judge (ALJ) has rendered a final decision.

III. PROCEDURE

A. Grievance Process

1. A MSSP Member may file a Grievance:

   a. With CalOptima Health's Customer Service Department, by telephone, or in person; or

   b. With CalOptima Health GARS, by facsimile, in writing, or through the CalOptima Health website at www.caloptima.org; or

   c. With MSSP staff, MSSP Supervisor, or MSSP Site Director by telephone, in person, or in writing.

2. Upon receipt of the MSSP Member's Grievance, MSSP shall:

   a. Send the Member an Acknowledgement Letter within five (5) calendar days after receipt of a Grievance, indicating receipt of the Grievance and identifying a MSSP staff member whom the Member may contact regarding the Grievance, and provide the Member with an estimated completion date of Resolution.

   b. Investigate the Grievance, as necessary.

   c. Send the Member a Grievance Resolution Letter within thirty (30) calendar days after receipt of the Grievance.

   d. In the event the Resolution is not reached in thirty (30) calendar days, notify the Member in writing of the status of the Grievance and provide an estimated completion date of Resolution.

3. The Grievance Resolution Letter shall describe the Grievance, and provide a clear and concise explanation of the reasons for the decision, including but not limited to:

   a. Summary of the Member's Grievance;

   b. The investigation made in the review process

   c. When possible, the outcome of the review;

   d. Alternative resources or references, when applicable; and

   e. The Member's right to Appeal, as appropriate.

B. Appeals Process

1. A MSSP Member whose services have been denied, reduced, suspended, or terminated from MSSP has the right to initiate a request for a State Hearing within ninety (90) calendar days. At

any time during this process, a Member may submit a Withdrawal of Request for State Hearing Form.

2. In the event a CalOptima Health Member does not meet California Department of Aging (CDA) MSSP eligibility criteria after telephonic screening, a home evaluation or initial face-to-face assessment is completed; the Member has the right to initiate a request for a State Hearing within ninety (90) calendar days. At any time during this process, a Member may submit a Withdrawal of Request for State Hearing Form.

3. To request a State Hearing, a CalOptima Health Member may write to:

   Mail: California Department of Social Services
   State Hearing Division
   744 P Street Mail Station 9-17-37
   Sacramento CA 95814

   Fax: (916) 651-5210 or (916) 651-1789

   A Member may also request a hearing by calling the Public Inquiry and Response Unit at 1-800-952-5253 or use TDD for the Deaf: 1-800-952-8349

4. Upon receipt of a Member's Appeal, CDSS shall complete the following:

   a. Review the Request for a State Hearing Form;

   b. Make a determination if the Appeal is granted or denied:

      i. If denied, CDSS shall notify the Member of the denial; or

      ii. If granted, CDSS shall assign the Appeal to an Administrative Law Judge (ALJ) who will precede the State Hearing.

   c. Notify CalOptima Health GARS Department that an Appeal was filed.

      i. CalOptima Health GARS shall provide the CalOptima Health MSSP Provider with the date, place, and time of the hearing.

5. The CalOptima Health MSSP Provider participates in a State Hearing by:

   a. Developing a written position statement in response to the Appeal request;

   b. Attending the hearing by telephone; and

   c. Responding to questions and presenting additional information to the ALJ.

6. Upon the ALJ's rendering the final decision:

   a. CDSS shall notify the Member and CalOptima Health GARS Department;

   b. CalOptima Health GARS Department shall notify the CalOptima Health MSSP Provider of the ALJ's decision within three (3) business days; and

c. The CalOptima Health MSSP Provider shall send a Letter of Notification to CalOptima Health Member within three (3) business days after notification from CalOptima Health GARS Department.

7. CalOptima Health's GARS Department shall coordinate all State Hearing actions with the CalOptima Health MSSP Provider in accordance with CalOptima Health Policy HH.1108: State Hearing Process & Procedures.

   a. MSSP Provider shall be responsible for reviewing position statement and all health records related to MSSP services; and

   b. CalOptima Health GARS Department shall review the position statement and all health records for all other non- MSSP related services.

8. On a quarterly basis, the CalOptima Health MSSP Provider shall submit a report of Member's Appeals, Grievances and Complaints, to CalOptima Health LTSS and GARS Departments during the nineteen (19) month transition period in which the MSSP benefit is being integrated into CalOptima Health, as described in All Plan Letter (APL) 15-002: Multipurpose Senior Services Program, Complaint, Grievance, and State Hearing Responsibilities in CCI Counties.

9. The MSSP Provider shall communicate any non-MSSP related Appeals, Grievances and Complaints to GARS.

10. The CalOptima Health GARS Department shall communicate any MSSP related Appeals, Grievances and Complaints that are received internally to MSSP Provider.

11. Upon receipt of Member's Appeal, Grievances and Complaints, CalOptima Health GARS Department shall keep records using an internal tracking system such as: decisions, dates and resolutions.

IV. ATTACHMENT(S)

A. Request for State Hearing Form
B. Withdrawal for Request for State Hearing Form
C. Notice of Action (NOA)-Change
D. Notice of Action (NOA)-Denial
E. Notice of Action (NOA)-Termination

V. REFERENCE(S)

A. CalOptima Health Contract with the Department of Health Care Services (DHCS) for Medi-Cal
B. CalOptima Health Contract with the Centers for Medicare & Medicaid Services (CMS) for Medicare Advantage
C. CalOptima Health Policy GG.1507: Notification Requirements for Covered Services Requiring Prior Authorization
D. CalOptima Health Policy HH.1102: Member Grievance
E. CalOptima Health Policy HH.1108: State Hearing Process and Procedures
F. CalOptima Health Policy MA.9002: Enrollee Grievance Process
G. Department of Health Care Services (DHCS) All Plan Letter (APL) 15-002: Multipurpose Senior Services Program Complaint, Grievance, Appeal, and State Hearing Responsibilities in Coordinated Care Initiative Counties

VI. REGULATORY AGENCY APPROVAL(S)

None to Date

VII. BOARD ACTION(S)

None to Date

VIII. REVISION HISTORY

Action	Date	Policy	Policy Title	Program(s)
Effective	09/01/2016	GG.1834	Multipurpose Senior Services Program (MSSP) Appeals, Grievances and Complaints Process	Medi-Cal OneCare Connect
Revised	12/01/2017	GG.1834	Multipurpose Senior Services Program (MSSP) Appeals, Grievances and Complaints Process	Medi-Cal OneCare Connect
Revised	09/01/2018	GG.1834	Multipurpose Senior Services Program (MSSP) Appeals, Grievances and Complaints Process	Medi-Cal OneCare Connect
Revised	06/01/2019	GG.1834	Multipurpose Senior Services Program (MSSP) Appeals, Grievances and Complaints Process	Medi-Cal OneCare Connect
Revised	04/01/2020	GG.1834	Multipurpose Senior Services Program (MSSP) Appeals, Grievances and Complaints Process	Medi-Cal OneCare Connect
Revised	08/01/2021	GG.1834	Multipurpose Senior Services Program (MSSP) Appeals, Grievances and Complaints Process	Medi-Cal OneCare Connect
Revised	12/31/2022	GG.1834	Multipurpose Senior Services Program (MSSP) Appeals, Grievances and Complaints Process	Medi-Cal
Revised	07/01/2023	GG.1834	Multipurpose Senior Services Program (MSSP) Appeals, Grievances and Complaints Process	Medi-Cal OneCare
Revised	10/01/2024	GG.1834	Multipurpose Senior Services Program (MSSP) Appeals, Grievances and Complaints Process	Medi-Cal OneCare

IX. GLOSSARY

Term	Definition
Aid Paid Pending	Continuation of Covered Services for a Member who has filed a timely request for a State Hearing as a result of a notice of action of intent to terminate, suspend, or reduce an existing authorized service.
Appeal	Medi-Cal: A review by CalOptima Health of an adverse benefit determination, which includes one of the following actions: 1. A 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 Service; 2. A reduction, suspension, or termination of a previously authorized service; 3. A denial, in whole or in part, of payment for a service; 4. Failure to provide services in a timely manner; or 5. Failure to act within the timeframes provided in 42 CFR 438.408(b). OneCare: Any of the procedures that deal with the review of an adverse initial determination made by CalOptima Health on health care services or benefits under Part C or D the Member believes he or she is entitled to receive, including a delay in providing, arranging for, or approving the health care services or drug coverage (when a delay would adversely affect the health of the Member), or on any amounts the Member must pay for a service or drug as defined in 42 CFR §422.566(b) and §423.566(b). These procedures include reconsideration or redetermination, a reconsideration by an independent review entity (IRE), adjudication by an Administrative Law Judge (ALJ) or attorney adjudicator, review by the Medicare Appeals Council (MAC), and judicial review.
Complaint	Medi-Cal: A complaint is the same as a Grievance. If CalOptima Health is unable to distinguish between a Grievance and an Inquiry, it must be considered a Grievance. OneCare: Any expression of dissatisfaction to CalOptima Health, a Provider, or the Quality Improvement Organization (QIO) by a Member made orally or in writing. A Complaint may also involve CalOptima Health's refusal to provide services to which a Member believes he or she is entitled. A Complaint may be a Grievance or an Appeal, or a single Complaint could include both.
Grievance	Medi-Cal: An oral or written expression of dissatisfaction about any matter other than an action that is an adverse benefit determination, as identified within the definition of an Appeal, and may include, but is not limited to: the quality of care or services provided, interpersonal relationships with a Provider or CalOptima Health's employee, failure to respect a Member's rights regardless of whether remedial action is requested, and the right to dispute an extension of time proposed by CalOptima Health to make an authorization decision. OneCare: An expression of dissatisfaction with any aspect of the operations, activities or behavior of a plan or its delegated entity in the provision of

Term	Definition
	health care items, services, or prescription drugs, regardless of whether remedial action is requested or can be taken.
Long Term Services and Supports (LTSS)	Medi-Cal: A wide variety of services and supports that help Members meet their daily needs for assistance and improve the quality of their lives. LTSS are provided over an extended period, predominantly in homes and communities, but also in facility-based settings such as nursing facilities. As described in California WIC Section 14186.1, Medi-Cal covered LTSS includes all of the following: 1. Community-Based Adult Services (CBAS); 2. Multipurpose Senior Services Program (MSSP) services; and 3. Skilled nursing facility services and subacute care services. 4. In-Home Supportive Services (IHSS). OneCare: A wide variety of services and supports that help Members meet their daily needs for assistance and improve the quality of their lives. LTSS are provided over an extended period, predominantly in homes and communities, but also in facility-based settings such as nursing facilities. LTSS includes all of the following: 1. Community-Based Adult Services (CBAS); 2. Multipurpose Senior Services Program (MSSP) services; 3. Skilled Nursing Facility services and subacute care services; and 4. In-Home Supportive Services (IHSS).
Member	A beneficiary enrolled in a CalOptima Health program.
Multipurpose Senior Services Program (MSSP)	The Waiver program that provides social and health care management to a Member who is 65 years or older and meets a nursing facility level of care as an alternative to nursing facility placement in order to allow the Member to remain in their home, pursuant to the Medi-Cal 2020 Waiver.
Multipurpose Senior Services Program (MSSP) Provider	An entity contracted with California Department of Aging (CDA) to participate in the MSSP Waiver Program and provide MSSP Waiver Services
Multipurpose Senior Services Program (MSSP) Waiver Participant	Any Member who has met MSSP eligibility requirements and has been enrolled in the MSSP
Provider	Medi-Cal: A physician, nurse, nurse mid-wife, nurse practitioner, medical technician, physician assistant, hospital, laboratory, ancillary provider, or other person or institution that furnishes Covered Services. OneCare: Any Medicare provider (e.g., hospital, skilled nursing facility, home health agency, outpatient physical therapy, comprehensive outpatient rehabilitation facility, end-stage renal disease facility, hospice, physician, non-physician provider, laboratory, supplier, etc.) providing Covered Services under Medicare Part B. Any organization, institution, or individual that provides Covered Services to Medicare members. Physicians, ambulatory surgical centers, and outpatient clinics are some of the providers of Covered Services under Medicare Part B.

Term	Definition
State Hearing	A quasi-judicial proceeding based upon administrative law and operated by the California Department of Social Services (DSS) which allows an avenue for Medi-Cal beneficiaries to appeal eligibility determinations and specific denials of medical services under the Medi-Cal program. All testimony is submitted under oath, affirmation, or penalty of perjury. The claimant is not required to attend a hearing, but if the claimant will not be present, an Authorized Representative is required to attend on his or her behalf, unless the hearing is a rehearing or a further hearing. All documents submitted by either the claimant or the involved agency shall be made available to both parties. Documents provided to the claimant shall be free of charge.