Timely Access and Network Adequacy Grievance Reporting Instructions

Each plan is to report all timely access and network adequacy grievances (exempt and standard) on the template provided.

Column Title	Description	Format
Date Received	The date the health plan received the complaint	mm/dd/yyyy
Date Resolved	The date the health plan resolved the compliant	Mm/dd/yyyy
Complaint ID	Unique identifier for the complaint. Do not include PHI or Enrollee Name	Health Plan to define Numeric/Text field
County	County in which the complainant resides or works based on health plan records	*(Please reference the Lookup Code Setup tab for "County" in the Timely Access Report network spreadsheet.)*
Medical Group/IPA	Medical Group or IPA to which enrollee is assigned at time of complaint, if assigned to a Medical Group or IPA	Text field 1-100 characters. *(Please reference the Lookup Code Setup tab for "Medical Group/IPA" in the Timely Access Report network spreadsheet.)*
Line of Business	The line-of-business (HMO, PPO, Medi-Cal, Covered California, etc.) to which the complaint was related.	*(Please reference the Lookup Code Setup tab for "Line of Business" in the Timely Access Report network spreadsheet.)*
Name of Network	The name of the network to which the complaint was related. Often more than one line of business is associated with one network.	*(Please reference the Lookup Code Setup tab for "Name of Network" in the Timely Access Report network spreadsheet.)*
Health Plan Complaint Category	The type of timely access or network adequacy complaint expressed by the enrollee, as classified by the health plan.	*For 2015 complaint data, health plans may report their own complaint category values, in addition to mapping the health plan's value to the most applicable DMHC value in the row below. For 2016 complaints, health plans will be required to map their values to the DMHC values for reporting purposes.*
DMHC Complaint Category	The type of timely access or network adequacy complaint expressed by the enrollee, as	*See DMHC complaint category values and descriptions below.*

	classified by DMHC.	
Provider Type	The type of provider the enrollee is trying to access or for whom the complaint is lodged against.	*(If for a **physician**, please reference the Lookup Code Setup tab for "Specialty" in the Timely Access Report Specialist and PCP network spreadsheet; for **mental health providers**, please reference the Lookup Code Setup tab for "Type of Licensure" in the Timely Access Report Mental Health network spreadsheet; for **ancillary providers**, please reference the Lookup Code Setup tab for "Contracted Provider Category," in the Timely Access Report Other Contracted Providers network spreadsheet; if for a clinic or hospital, please indicate "clinic" or "hospital" in this category)*
Health Plan Resolution	What the plan has done to resolve the enrollee's complaint, as classified by the health plan.	*For 2015 complaint data, health plans may report their own resolution values, in addition to mapping the health plan's value to the most applicable DMHC value in the row below. For 2016 complaints, health plans will be required to map their values to the DMHC values for reporting purposes.*
DMHC Resolution	What the plan has done to resolve the enrollee's complaint, as classified by the DMHC.	*See DMHC resolution values and descriptions below*

DMHC Complaint Category Values and Definitions:

- Timely Access PCP: Enrollee complaint regarding difficulty obtaining an appointment with a Primary Care Provider (PCP) in a timely manner, not due to delay in referral from another physician or delay in authorization by the plan or medical group. Reflects only a delay between date of request and appointment.
- Timely Access Specialist: Enrollee complaint regarding difficulty obtaining an appointment with a Specialist (non-PCP) in a timely manner, not due to delay in referral from another physician or delay in authorization by the plan or medical group. Reflects only a delay between date of request and appointment.
- Timely Access Other: Enrollee complaint regarding difficulty obtaining an appointment with another type of provider (for example laboratory, imaging) in a timely manner, not due to delay in referral from another physician or delay in authorization by the plan or medical group. Reflects only a delay between date of request and appointment.

- Geographic/Distance Access PCP: Enrollee complaint regarding distance or travel time to PCPs (e.g. travel distance is too far from home or work, travel time takes too long from home or work).
- Geographic/Distance Access Specialist: Enrollee complaint regarding distance or travel time to Specialists (e.g. travel distance is too far from home or work, travel time takes too long from home or work).
- Geographic/Distance Access Hospital: Enrollee complaint regarding distance or travel time to hospital (e.g. travel distance is too far from home or work, travel time takes too long from home or work).
- Geographic/Distance Access Other: Enrollee complaint regarding distance or travel time to other provider types (e.g. travel distance to laboratory, imaging, etc. is too far from home or work; travel time to laboratory, imaging, etc. takes too long from home or work)
- Office Wait Time: Enrollee complaint about length of time waiting for the provider during a scheduled appointment
- Telephone Access Provider: Enrollee complaint regarding difficulty reaching a live person to talk to at the provider office during or after office hours
- Telephone Access Plan: Enrollee complaint regarding difficulty reaching a live person to talk to at the health plan during or after office hours
- Language Assistance Provider: Enrollee complaint regarding difficulty obtaining interpreter or translation services from provider
- Language Assistance Plan: Enrollee complaint regarding difficulty obtaining interpreter or translation services from health plan
- Provider Not Taking New Patients: Enrollee complaint that provider is not accepting new patients
- Provider Directory Error: enrollee complaint that information listed in provider directory is inaccurate (address, phone, accepting enrollee's plan, etc.)
- Other (plan enters an applicable resolution)

DMHC Resolution Values and Definitions:

- Change PCP: The plan assigns the enrollee to a different PCP
- Change Specialist: The plan identifies a different specialist for the enrollee
- Change Medical Group: The plan assists the enrollee with assignment to a different Medical Group or IPA
- Secured Timely Appointment: The plan secures a timely appointment for the enrollee
- Out of Network Referral: the plan authorizes an out-of-network referral to meet the enrollee's needs
- Re-adjudicated claim: The plan re-processes a claim for services previously received to reflect in-network benefits
- Single Case Agreement: The plan negotiates a single case agreement for a specific non-network provider
- Provider Educated: The plan educates/informs provider of access responsibilities
- Enrollee Educated: The plan educates enrollee regarding access rules, network rules, etc.
- Other (plan enters an applicable resolution).