INSTRUCTIONS FOR LOGGING HMO GRIEVANCES

The HMO quarterly grievance log, F-03112A, is the standard format health maintenance organizations (HMOs) must use to submit member grievance information to the Department of Health Services (DHS). Refer to the Contract for BadgerCare Plus and/or Medicaid SSI HMO Services for the report requirements, reporting periods, due dates, and submission email address.

Personal Information

Under Wis. Stat. § 49.45(4), personally identifiable information is kept confidential and is only used for the direct administration of the BadgerCare Plus and Medicaid SSI programs.

General Instructions

1. This is an annual grievance log divided by quarters. The HMO is to enter each quarterly report on the corresponding quarter tab. **Only enter information on the 1st Quarter, 2nd Quarter, 3rd Quarter and 4th Quarter tabs.** The spreadsheet will automatically tabulate the data on the corresponding quarterly analysis and graphs tabs.

2. **Do not make any changes to the spreadsheet layout or formulas except to enter grievance information**. Do not reorder the columns, change column labels, or dropdown options. Please submit any suggestions for categories or corrections to the report format to the Bureau of Quality Oversight (BQO).

3. There are several drop-down menus included in the spreadsheet. Some of these menus contain "other" as an available selection. If the HMO needs to select "other," add additional detail in the *Comments* column. **Note**: The narrative sections are limited to a maximum of 350 characters.

4. **Log every grievance the HMO becomes aware of, including:**
   - Internal HMO grievances that go to the HMO Grievance and Appeal Committee
   - Informal complaints – log as internal HMO grievance
   - Grievances that were not brought to the HMO Grievance and Appeal Committee – log as internal HMO grievance
   - Grievances to Third Party Administrator or Subcontractors (e.g. Dental Benefit Administrator) – log as Internal HMO Grievance
   - DHS grievance review

   Select **"Pending/In Process"** if a member filed an internal HMO grievance but a decision has not been issued by the end of the quarter being reported. The pending status should be removed, and updated information should be entered in subsequent quarterly reports. If there is a resolution within the 30 day period for the submission of the report, update the Grievance Log to reflect this.

Instructions for Header:

1. **HMO Name (cell B3)**
   Enter the name of the HMO.

2. **Program (cell B4)**
   Enter the program (BadgerCare Plus or Medicaid SSI). For HMOs serving both BadgerCare Plus and Medicaid SSI members, complete a separate Grievance Log for each program.

3. **HMO Census on Last Date of Quarter (cell G2)**
   Enter the total number of members enrolled on the last day of the previous quarter.

Instructions for Columns:

1. **Grievance # (column A):**
   Number individual grievances consecutively for ease of reference starting with number 1 for the first grievance of the calendar year.

2. **Member Name (column B):**
   Enter member's name using the following format: **Last name, First name, Middle initial**. If needed to distinguish members, you may need to add a full middle name.

3. **HMO ID (column C):**
   Enter the HMO's unique identifier. This column is optional for HMOs.

4. **Medicaid ID (column D):**
   Enter member's Medicaid ID.

5. **Grievance Type (column E):**
   Select an entry from drop-down menu. **If the member files more than one type of grievance regarding same issue, enter information about subsequent grievance or grievances on separate lines** and select appropriate grievance type on each line.
   - **HMO**: Internal HMO grievance (or informal complaint) or Third Party Administrator or Subcontractor grievance
   - **DHS:** DHS grievance review

6. **Date Grievance Filed (column F):**
   Enter the date using the following format: MM/DD/YYYY. Record the date according to grievance type:
   - **DHS Review:** Enter the date the HMO receives the document request from DHS regarding the member's grievance.
   - **Internal HMO Grievance:** Enter the date the member requests an internal HMO grievance. If a member requests an internal HMO grievance both orally and in writing, enter the earlier of those two dates. If the grievance is an informal complaint, enter the date the HMO became aware of the issue.

7. **Date Grievance Acknowledged by HMO or DHS (column G):**

Enter the date using the following format: MM/DD/YYYY. Record the date according to grievance type:

- **DHS Review**: Enter the date the HMO **receives a copy of DHS's written acknowledgement** to the member of the request for review of a grievance.
- **Internal HMO Grievance**: Enter the date the HMO **sent the Acknowledgement of Grievance Received letter** for an internal HMO grievance. (Each HMO must send a written acknowledgement of every request for internal HMO grievance to the member and/or member's representative within 10 business days of receiving the grievance.)

8. Assisting Representation (column H):

Select an entry from the drop-down menu. You do not need to indicate when a family member, friend, neighbor, or provider is present with the member in this column. **This column is optional for HMOs.**

- If the HMO would like to keep track of grievance in which a provider and/or the member's legal decision maker is present, select **"Other"** and add the information in the *Comments* column.
- Acronyms:
  DBS= Disability Benefit Specialist
  DRW= Disability Rights Wisconsin
  EBS= Elder Benefit Specialist (ages 60+)

9. Issue Type (column I):

Select an entry from the drop-down menu. If the HMO believes there is more than one issue, select what the HMO perceives as the primary issue in this column and enter additional issues in the *Comments* column. Definitions of each Issue Type can be found in the table below:

Issue Type	Definition
Abuse, neglect, or exploitation	Grievances involving physical, emotional, or sexual abuse, treatment without consent, unreasonable confinement or restraint, neglect, or financial exploitation. Abuse/neglect/exploitation grievances include cases involving potential or actual harm to members.
Access to care	Grievances involving access to care or medically necessary services, including difficulties finding qualified in-network providers, excessive travel or wait times, or other access issues.
Denial of request for expedited appeal	Grievances related to the HMO's denial of a member's request for an expedited appeal.
Lack of timely plan response to service authorization or appeal request	Grievances related to lack of timely HMO response to a service authorization or appeal request (including requests to expedite or extend appeals).
Payment/billing issue	Grievances filed for a reason related to payment or billing issues.
Plan communications	Grievances related to HMO communications, including the clarity or accuracy of member materials or other plan communications or to a member's access to or the accessibility of member materials or plan communications.
Plan or provider care management	Grievances related to plan or provider care management/case management, including complaints about the timeliness of an

	assessment or complaints about the member-centered plan, IDT provider care, or case management process.
Plan or provider customer service	Grievances related to HMO or provider customer services, including complaints about interactions with the HMO's Member Services department, provider offices or facilities, marketing agents, or any other HMO or provider representatives.
Provider quality of care	Grievances related to the HMO or provider quality of care, including complaints about the effectiveness, efficiency, equity, patient-centeredness, safety, and/or acceptability of care provided by a network provider or the HMO.
Suspected fraud	Grievances related to suspected cases of financial/payment fraud perpetuated by a provider, payer, or other entity.
Other	Any issue that does not fit into a category above.

10. Service Category, if applicable (column J)

Select an entry from the drop-down menu. Enter "N/A" if:

- The grievance does not involve a service; or
- The grievance involves a service, but the service is not a general inpatient service, general outpatient service, inpatient behavioral health service or outpatient behavioral health service.

11. Service Type, if applicable (column K):

Select an entry from the drop-down menu.

- Select the option that best describes the service type requested.
- If the service type is not listed in the drop-down, select **"Other"** and enter the service type into the *Summary of Issue* column. Service types of **"Other"** without a service type entered into the *Summary of Issue* column will result in a resubmission.
- If the HMO believes there is more than one service type involved in the grievance, select what the HMO perceives as the primary issue and enter additional services in the *Summary of Issue* column.
- Enter N/A if the grievance does not involve a service.

12. Summary of Issue (column L):

Briefly describe the nature of the member's grievance. Include the service type (if not already selected in column K) and a narrative description of the issue. Entries are limited to 350 words. Entries are limited to 350 words.

13. Date of Resolution/Decision (column M):

Enter the date using the following format: MM/DD/YYYY. Record the date according to grievance type:

- **DHS Review**: Use the date of the DHS decision.
- **Internal HMO Grievance**: Use the date of the internal HMO **decision**. Do not use the date of the HMO Grievance and Appeal Committee **meeting** unless that happens to be the same as the date of the written decision. For an informal complaint or if the grievance did not go to the HMO Grievance and Appeal committee, enter the date the HMO believes the grievance to be resolved.

Note: Leave this column blank for grievances that are Pending/In Process.

14. Timely Resolution Provided by HMO (column N)

Select an entry from the drop-down menu:

- Select **"yes - standard"** if written resolution of the member's grievance was provided to the member within the standard resolution timeframe.
- Select **"yes - standard-extended"** if written resolution of the member's grievance was provided to the member within the standard-extended resolution timeframe and the HMO followed all applicable extension requirements.

- Select **"no - standard"** if written resolution of the member's grievance was not provided to the member within the standard resolution timeframe.
- Select **"no - standard-extended"** if written resolution of the member's grievance was not provided to the member within the standard-extended resolution timeframe and the HMO followed all applicable extension requirements.

For all "no" responses, provide a brief explanation of the reason for failing to meet the applicable deadline in the *Comments* column.

Note: Select **"Pending/In Process"** if a member filed an internal HMO grievance but a decision has not been issued by the end of the quarter being reported. The pending status should be removed, and updated information should be entered in subsequent quarterly reports. If there is a resolution within the 30 day period for the submission of the report, update the Grievance Log to reflect this.

15. Resolution Type (column O):

Select an entry from the drop-down menu.

- Select **"DHS - Upheld HMO decision"** when DHS issued a resolution that agreed with or upheld the HMO decision.
- Select **"DHS - Overturned HMO decision"** when DHS issued a resolution that overturned the HMO decision.
- Select **DHS - Partially upheld HMO decision"** when the DHS issues a decision that partially upholds the HMO's response to a grievance or partially agrees with the member.
- Select **"HMO Committee - Unfounded"** when the HMO Committee finds that the member's grievance is unfounded or unsubstantiated in its entirety. This is a decision that is adverse to the member in its entirety.
- Select "**HMO Committee - Founded"** when the HMO Committee finds that the member's grievance is founded or substantiated in its entirety. This is a decision that is wholly in favor of the member.
- Select **"HMO Committee - Partially founded"** when the HMO committee finds that the member's grievance is partially founded or partially substantiated. This is a decision that is partially in favor of the member.
- Select **"Member withdrew"** when a member chooses to withdraw or not participate in the internal HMO grievance or DHS grievance review, after the member has requested an HMO Grievance and Appeal committee meeting or DHS grievance review, such as in the following types of situations:
    - The member requested a withdrawal of the DHS grievance review or HMO internal grievance.
    - The HMO was unable to contact the member to process a request for internal grievance (for example, unable to reach a member to schedule a time with the HMO Grievance and Appeal Committee meeting).

- Select **"Member Did Not Pursue"** if the member did not pursue a review of the grievance by the HMO Grievance and Appeal Committee and the grievance was not otherwise resolved.. If known, include information in the *Comments* column to briefly explain why the member chose this option. Select this option when:
    - The member chooses not to bring the grievance to the HMO Grievance and Appeal Committee after dissatisfaction with mediation.
- Select **"Disenrolled"** if the member disenrolled. If known, include information in the *Reason for Disenrollment* column to briefly explain why the member disenrolled.
- Select **"Mediation - resolved"** when the grievance is resolved informally through compromise or negotiation without a formal review by the HMO Grievance and Appeal Committee.

Note: Select **"Pending/In Process"** from the drop-down menu if a member filed a grievance (i.e., internal HMO grievance or DHS review) but the grievance has not been resolved by the end of the quarter being reported. The pending status should be removed and updated information should be entered in subsequent quarterly reports. If there is a resolution within the 45-day period for the submission of the report, update the Grievance Log to reflect this.

16. Summary of Resolution / Reason for withdrawal (column P):

Briefly describe the resolution of the member's grievance. This should be brief but provide sufficient information to be meaningful.

- **When there is a written formal resolution** made by the HMO Grievance and Appeal Committee or DHS, please include a brief synopsis of the decision maker's (or reviewer's) ruling and the reasoning.
- **When the member withdraws the grievance request**, and the HMO knows the reason why, please include a brief description of how the HMO responded to the member's grievance.
- **When a grievance is resolved by informal mediation or negotiation,** describe the terms of the compromise or solution. Be specific in describing the details of how the HMO responded or compromised with the member rather than making a general statement like, "Member agreed with explanation of policy."

  Note: Select **"Pending/In Process"** if a member filed a grievance (i.e., internal HMO grievance or DHS review) but the grievance has not been resolved by the end of the quarter being reported. The pending status should be removed and updated information should be entered in subsequent quarterly reports. If there is a resolution within the 45 day period for the submission of the report, update the Grievance Log to reflect this.

17. Did Member Disenroll? (column Q)

Select an entry from the drop-down menu:

- Select **"yes"** if the member disenrolled during the course of the grievance or within fourteen calendar days of receipt of a decision from the HMO Grievance and Appeal Committee or DHS.
- Select **"no"** if the member did not disenroll during the course of the grievance or within fourteen calendar days of receipt of a decision from the HMO Grievance and Appeal Committee or DHS.
- Select **"unknown"** when the HMO does not know the member's enrollment status following the grievance.

18. Reason for Disenrollment, if known (column R):

If the answer to the previous column was "yes," briefly state, to the best of your knowledge, the reason the member disenrolled.

19. Comments (column S):

Comments are only mandatory when applicable to the situation, requested on this form, or when requested after the HMO selects "other." Examples of information to include in the *Comments* column:

- Relevant notes for a pending/in process grievance.
- Explanation of why a member's grievance was not acknowledged within 10 business days of receipt.
- Explanation of why a member's standard or expedited grievance was not timely resolved.
- The reason for a member not following through with the grievance process.
- Any other information the HMO would like to report to BQO or would like to track.