TECHNICAL ASSISTANCE GUIDE FOR MEDICAL AUDITS

Category 4: Grievances, Appeals, and Member's Rights

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DHCS
CALIFORNIA DEPARTMENT OF
HEALTH CARE SERVICES

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INTRODUCTION

In accordance with California Welfare and Institutions Code Section 14456, the Department of Health Care Services (DHCS) conducts medical audits of Medi-Cal Managed Care Plans (MCPs) on an annual basis. Medical audits evaluate MCPs' compliance with the DHCS contractual requirements and applicable laws and regulations. The Contract and Enrollment Review Division (CERD) of DHCS' Audits and Investigations (A&I) is responsible for performing the mandated audits. The audit scope encompasses the following six categories of review:

- Category 1 – Utilization Management
- Category 2 – Population Health Management and Coordination of Care
- Category 3 – Network and Access to Care
- Category 4 – Grievances, Appeals, and Member's Rights
- Category 5 – Quality Improvement and Health Equity Transformation Program
- Category 6 – Plan Organization and Administration

USING THE TECHNICAL ASSISTANCE GUIDE (TAG)

The TAGs are designed to identify key elements commonly evaluated by A&I's audit process to promote transparency. The TAG is grouped by subcategories and includes the following components, as applicable:

Requirement: This column identifies "key" statutory, regulatory, and contractual requirements related to core managed care organization systems and processes that may be included in scope and additional areas identified based on risk. While this narrows the audit scope, the audit team may investigate the MCP's compliance with other requirements.

- MCPs are ultimately responsible for ensuring compliance with all provisions of the DHCS contract as well as any applicable All Plan Letters (APLs), Plan Letters (PLs) and Dual Policy Letters.
- The contract requirements can be supplemented with applicable laws, regulations, APLs, etc.
- This TAG cites language from the DHCS Boilerplate Contract and related Federal and State laws and regulations.
- "Contractor" means "MCP" or "Plan" in this document.

Documentation Reviewed: The items in this column reflect a hierarchy of documents.

- Initially listed items (√) indicated will most likely confirm contractual compliance or not.
- Lower listed alternate/optional documents (△) may contain information that will help determine the status of the MCP's compliance with a particular requirement.
- Documents are not only reviewed for individual compliance, but as reference in the review of all other evidence and interviews to determine actual implementation in practice, effectiveness and MCP actions taken.
- The Documents include, but are not limited to:
  - Policies and Procedures
  - Organizational Charts
  - Committee Meeting Minutes
  - Monitoring Reports
  - Data Logs
- Verification Studies (▲) are listed in this section where applicable.

Examples of Best Practices: This column details strategies implemented by some MCPs to either demonstrate compliance with a contract requirement or correct an identified deficiency. MCPs and individual audits can present distinct characteristics, and best practices may not transfer seamlessly. The audit team does not audit to best practices but may use them to evaluate compliance. It remains the responsibility of the MCP to demonstrate that it is meeting its contractual obligations.

CATEGORY 4: GRIEVANCES, APPEALS, AND MEMBER'S RIGHTS OVERVIEW

Introduction/Overview

The Grievances, Appeals, and Member's Rights Audit Program includes evaluation of the MCP's overall grievance and appeal systems and its ability to resolve grievances and appeals timely. As part of this evaluation, the audit assesses the MCP's ability and compliance for providing written notification to the Member regarding the status and outcome of their grievance or appeal, including a detailed rationale for the MCP's final grievance or appeal determination. The MCP must also ensure that the linguistic and cultural needs of its Members are appropriately addressed, including those with disabilities and those with limited English proficiency or with a visual or other communicative impairment. The MCP must also adhere to notification requirements if a Member's protected health information or personally identifiable information has been compromised.

The Category 4 Audit Program includes the following subcategories:

- 4.1: Grievance and Appeal Program Requirements
- 4.2: Grievance Process
- 4.3: Discrimination Grievances
- 4.4: Notice of Action
- 4.5: Appeal Process
- 4.6: Responsibilities in Expedited Appeals
- 4.7: State Hearings and Independent Medical Reviews
- 4.8: Continuation of Services Until Appeal and State Hearing Rights Are Exhausted
- 4.9: Grievance and Appeal Reporting Data
- 4.10: Access Rights (from Contract Section 5.2.10)
- 4.11: Cultural and Linguistic Programs and Committees (from Contract Section 5.2.11)
- 4.12: Member Rights and Responsibilities (from Contract Section 5.1.1)
- 4.13: Member Information (from Contract Section 5.1.3)

CATEGORY 4.1: GRIEVANCE AND APPEAL PROGRAM REQUIREMENTS

Requirement	Documentation to Review	Examples of Best Practices
Contract Exhibit A, Attachment III: 4.6.1 **General Overview and Right to File a Grievance and Request an Appeal** Contractor must have in place a Member Grievance and Appeal system that complies with 42 CFR sections 438.228 and 438.400 – 424, 28 CCR sections 1300.68 and 1300.68.01, and 22 CCR section 53858 for Covered Services including Contractor's selected Community Supports under 42 CFR section 438.3(e)(2). Contractor must follow Grievance and Appeal requirements set forth in, and use all notice templates included in, All Plan Letter (APL) 21-011. **42 CFR 438.420(a)(b) and (c)** **Continuation of Benefits Pending Appeal and State Hearing** Includes 10 calendar day-timeline from the date on the NOA or before the effective date of the intended action of filing appeal and requirements for continuation of benefits pending the outcome of the State fair hearing.	✓ Policies and Procedures: Grievance/Appeal Processes ✓ Member Handbook ✓ Provider Manual ✓ Grievance Questionnaire Response from MCP ✓ MCP's Website ✓ MCP Templates and Member Notices (denials, resolution, appeal outcome) ✓ Committee Minutes ✓ Grievance Track and Trend Reports ✓ Verification Study ▲ (specifics contained throughout the audit guide)	The MCP's policies and procedures define grievances, complaints, inquiries, complainant, and resolved as in the contract. MCP communication informs Members and Providers of the right to file a grievance and request an appeal. The MCP ensures all expressions of dissatisfaction, whether formally identified as grievances or not, are logged, tracked, and trended, and resolved per grievance timelines. Member-facing staff are trained to recognize when an inquiry may be a grievance and escalate appropriately. The MCP does not discriminate against complainants and investigates complaints not formally filed as grievances by members.

Requirement	Documentation to Review	Examples of Best Practices
Contract Exhibit A, Attachment III: 4.6.1 **Right to Request a Grievance or Appeal Orally or in Writing** Contractor must ensure that its Grievance and Appeal system meets the following requirements: A. Allows the Member, or a Provider or Authorized Representative (AR) with the Member's written consent, to file a Grievance, or request an Appeal with Contractor either orally or in writing.	✓ Policies and Procedures ✓ Grievance Logs ✓ Inquiry Logs ✓ Verification Study ▲	The MCP provides multiple ways to file a grievance, phone, member portal, email, mail, in person. Members are educated on this process. Oral grievances are accepted without requiring written follow-up from the member. Member's written consent is obtained when grievance or appeal is submitted by a Provider or Authorized Representative. Staff are trained to recognize grievances, even when members do not use the term grievance. Members receive acknowledgments and resolutions within required timeframes.

Requirement	Documentation to Review	Examples of Best Practices
Contract Exhibit A, Attachment III: 4.6.1 **Written Acknowledgement of Grievance/Appeal and Resolution Timelines** Contractor must ensure that its Grievance and Appeal system meets the following requirements: B. Ensures timely written acknowledgement of each Grievance or Appeal, and provides a notice of resolution to the Member as quickly as the Member's health condition requires, not to exceed 30 calendar days from the date the Member makes an oral or written request to Contractor for a standard Grievance or Appeal or 72 hours for an expedited Grievance or Appeal. Contractor must notify the Member, Provider, or AR with a written resolution of the Grievance or Appeal in the Member's preferred language as required by 42 CFR sections 438.10 and 438.404, W&I section 14029.91, and 22 CCR section 53876.	✓ Policies and Procedures for Grievance/Appeal Processes ✓ Member Handbook ✓ Provider Manual ✓ Grievance Questionnaire ✓ Logs/Reports Showing Time to Resolution ✓ Committee Minutes and Packets ✓ Staff Training Materials ✓ MCP's Website ✓ Verification Study ▲	The MCP's policies and procedures define standard and expedited grievances or appeals, complaints, and inquiries, and are compliant and resolved in alignment with regulatory and contractual written acknowledgment and resolution timeline requirements. The MCP's policies and procedures define the situations that qualify for expedited review. The MCP's grievance system ensures all Members can fully participate by assisting those with Limited English Proficiency (LEP).
CCR Title 28, Section 1300.68: **Grievance System Timelines/Definitions** Every health care service MCP shall establish a grievance system pursuant to the requirements of Section 1368 of the Act. a) The grievance system shall be established in writing and provide for procedures that will receive, review, and resolve grievances within 30 calendar days of receipt by the MCP, or any provider or entity with delegated	See Above	In addition to above: MCPs provide acknowledgement and resolution letters in the Member's preferred language and within required timeframes. MCPs should develop mechanisms to ensure translated letters are sent timely. The MCP uses its Quality Improvement Committee to review Member

Requirement	Documentation to Review	Examples of Best Practices
authority to administer and resolve the MCP's grievance system. The following definitions shall apply with respect to the regulations relating to grievance systems: 1) "Grievance" means a written or oral expression of dissatisfaction regarding the MCP and/or provider, including quality of care concerns, and shall include a complaint, dispute, request for reconsideration or appeal made by an enrollee or the enrollee's representative. Where the MCP is unable to distinguish between a grievance and an inquiry, it shall be considered a grievance. 2) "Complaint" is the same as "grievance." 3) "Complainant" is the same as "grievant," and means the person who filed the grievance including the enrollee, a representative designated by the enrollee, or other individual with authority to act on behalf of the enrollee. 4) "Resolved" means that the grievance has reached a final conclusion with respect to the enrollee's submitted grievance, and there are no pending enrollee appeals within the MCP's grievance system, including entities with delegated authority.		grievances, identify trends or systemic issues, and implement policy or process changes to improve quality of care and ensure regulatory and contractual compliance. Staff receive regular training on grievance definitions and procedures, including how to identify and elevate potential grievances from inquiries. The MCP does not discriminate against complainants and investigates complaints not formally filed as grievances by Members. Verification Study shows the MCP sends timely written acknowledgement, notice of resolution to the Member as quickly as the Member's health condition requires, in the Member's preferred language.

Requirement	Documentation to Review	Examples of Best Practices
Contract Exhibit A, Attachment III: 4.6.1 **Member Assistance for Completing Grievances and Appeals** Contractor must ensure that its Grievance and Appeal system meets the following requirements: C. Ensures that Members are given assistance when completing Grievance and Appeal forms and all other procedural steps. Required assistance includes, but is not limited to, providing Members with all documents Contractor relied on for its decision, and providing Auxiliary Aid and services upon request, such as translation and interpreter services, use of alternative formats for all documents Contractor relied upon for its decision, and a toll-free number with TTY/TDD and interpreter capability. **CCR Title 28, Section 1300.68:** 3. The grievance system shall address the linguistic and cultural needs of its enrollees and the needs of enrollees with disabilities. The system shall ensure all enrollees have access to and can fully participate in the grievance system by providing assistance for those with limited English proficiency or with a visual or other communicative impairment. 6. The MCP's grievance system shall ensure that assistance in filing grievances shall be provided at each location where grievances may be submitted. A "patient advocate" or ombudsman may be used.	✓ Policies and Procedures for Grievance/Appeal Processes * ✓ Member Services Guide, including grievance forms, assistance, non-discrimination clause ✓ MCP Website * Ensures coverage of grievance filing at all locations, access to a patient advocate or ombudsman, non-discrimination clause.	The MCP produces documentation to show provider involvement in assisting members in completing forms and other procedural steps via policies and procedures, Member Services Guide, MCP Website. The MCP also ensures member assistance is provided at each location where grievances and appeals are submitted, which may include translation, interpretation and other devices. The MCP provides assistance for filing grievances, including access to a patient advocate or ombudsman. The MCP ensures grievance forms and procedures are readily accessible in person and online, with clear instructions. The MCP ensures inclusion of a non-discrimination policy. MCP regularly monitors to ensure the system is accessible to all members, including those with language or disability needs.

Requirement	Documentation to Review	Examples of Best Practices
Contract Exhibit A, Attachment III: 4.6.1 **Final Decision Maker for Resolution of Grievance or Appeal** Contractor must ensure that its Grievance and Appeal system meets the following requirements: D. Ensures that the person making the final decision for the proposed resolution of a Grievance or Appeal has neither participated in any prior decisions related to the Grievance or Appeal, nor is a subordinate of someone who has participated in the prior decision. Contractor must ensure that all Grievance or Appeals related to medical Quality of Care issues be immediately submitted to Contractor's medical director for action. Contractor must ensure that the person making the decision on the Grievance or Appeal has clinical expertise in treating a Member's condition or disease when deciding: 1. An Appeal of a denial based on lack of Medical Necessity or that the service is experimental or investigational; 2. A Grievance regarding denial of a request for expedited resolution of an Appeal; and 3. Any Grievance or Appeal involving clinical issues.	✓ Policies and Procedures for Grievance/Appeal Processes * ✓ Verification Study ▲ * Includes guidance that the person making the final decision on a grievance or appeal has not been involved in any prior decisions regarding the case. * Should also specify that the decision maker has the necessary clinical expertise.	Policies and procedures and Verification Study show that only a CA licensed physician or other treating healthcare provider (e.g., Medical Director, podiatrist, psychologist, etc.) resolve appeals involving lack of medical necessity or clinical issues. The physician conducting the review has clinical expertise in treating the Member's condition or disease. Documentation confirms the decision maker was not previously involved in the case, and that clinical grievances were reviewed by professionals, Members were informed of their right to submit additional information, and that the treating provider's notes are reviewed as part of the appeal.

Requirement	Documentation to Review	Examples of Best Practices
Contract Exhibit A, Attachment III: 4.6.1 **Consideration of Information and Member Opportunity to Present Evidence and Testimony** Contractor must ensure that its Grievance and Appeal system meets the following requirements: E. Considers all comments, documents, records, and other information submitted by the Member, Provider, or AR, regardless of whether Contractor had the Member's additional information during the initial review. F. Ensures that Members are given a reasonable opportunity to present evidence and testimony, and make legal or factual arguments, in person, by telephone, or in writing, in support of their Grievance or Appeal. Contactor must inform Members that they must submit additional evidence for Contractor to consider within the 30-calendar-day review timeframe for an Appeal and within the 72-hour timeframe for resolving an expedited Appeal.	✓ Policies and Procedures for Grievance/Appeal Processes ✓ Verification Study ▲	Verification Study shows the MCP sends acknowledgement letters timely with required information and informs Members how to submit additional evidence and testimony.

Requirement	Documentation to Review	Examples of Best Practices
Contract Exhibit A, Attachment III: 4.6.1 **Notice of Appeal Resolution and Oral Notice for Expedited Appeals** Contractor must ensure that its Grievance and Appeal system meets the following requirements: G. Ensures that Notices of Appeal Resolution (NAR) be in a format and a language that, at a minimum, meets the standards set forth in 42 CFR section 438.10, W&I section 14029.91, 22 CCR section 53876, and Exhibit A, Attachment III, Subsection 5.1.3 (Member Information). Contractor must ensure that language assistance taglines and a nondiscrimination notice meeting the minimum requirements in APL 21-004 accompanies each Member notification, and that the nondiscrimination notice is made available, upon request or as otherwise required by law, in all of the Threshold Languages / Threshold or Concentration Standard Languages and Americans with Disabilities Act of 1990 (ADA)-compliant, accessible formats as needed by Members to effectively understand Contractor's notices. H. Provides oral notice of the resolution of an expedited Appeal to the Member, Provider, or AR within 72 hours. *Note: requirements for expedited appeals are covered more extensively in sub-category 4.6 of this Audit Program.*	✓ Policies and Procedures for Grievance/Appeal Processes * ✓ Verification Study ▲ * Includes guidelines for translating NARs into threshold and concentration standard languages * Includes information for providing ADA-compliant formats	MCP has an effective process for translations and submitting NDN/LAT attachments and conducts regular training and quality assurance to ensure the process is compliant. Clear and simple language: The MCP must ensure all Member information, including the Member Handbook, Provider Directory, all mailings and notices critical to obtaining services, including Notices of Action (NOAs), Notice of Appeal Resolutions (NARs), Grievances or Appeals are provided to members at a sixth grade reading level to ensure Members can easily understand their rights and the resolution process. Taglines should explain the availability of written Member information translated in the member's preferred language or oral interpretation and inform Members of the availability of no cost language assistance services, including assistance in non-English languages and the provision of free auxiliary services. The Language Assistance Tagline should also indicate "Aids and services for people with disabilities, like documents in braille and large print, are also available."

Requirement	Documentation to Review	Examples of Best Practices
		Nondiscrimination Notices should include the following protected classes religion, ancestry, ethnic group identification, mental disability, physical disability, medical condition, genetic information, marital status, gender, gender identity, or sexual orientation. ADA Compliance: The MCP ensures all notices are available in accessible formats for Members with disabilities, such as large print, Braile, or audio formats.
Contract Exhibit A, Attachment III: 4.6.1 **Dissemination and Training of Grievance and Appeal Policies and Procedures to Providers and Subcontractors** Contractor must ensure that its Grievance and Appeal system meets the following requirements: I. Provides Contractor's Grievance and Appeal policies and procedures to Network Providers, Subcontractors, and Downstream Subcontractors at the time that they enter into a Network Provider Agreement, Subcontractor Agreement, or Downstream Subcontractor Agreement. Contractor must ensure that Network Providers, Subcontractors, and Downstream Subcontractors are trained on and immediately notified of any changes to	✓ Policies and Procedures for Grievance/ Appeal Processes ✓ Contract Agreements with Subcontractors ✓ Provider Manual ✓ Provider Newsletters ✓ Joint Committee Minutes ✓ Internal Audit or Monitoring Reports	The MCP has a process to ensure updated Grievance and Appeal information are communicated to Network Providers and Downstream Subcontractors. The MCP has a process to ensure Network Providers, Subcontractors, and Downstream Subcontractors are trained on and adhere to the MCP's Grievance and Appeal policies and procedures. Changes to the MCP's policies and procedures are immediately communicated to Network Providers,

Requirement	Documentation to Review	Examples of Best Practices
Contractor's Grievance and Appeal policies and procedures.	✓ Network Providers, Subcontractors, and Downstream Subcontractors Training Materials ✓ Immediate notifications of any changes to P&P to Network Providers, Subcontractors, and Downstream Subcontractors, e.g. fax blast, web portal notices	Subcontractors, and Downstream Subcontractors.
Contract Exhibit A, Attachment III: 4.6.1 **P&Ps: Compilation of Data for Quality Improvement System** Contractor must ensure that its Grievance and Appeal system meets the following requirements: J. Maintains policies and procedures for compiling, aggregating, and reviewing Grievance and Appeal data for use in Contractor's Quality Improvement Strategy (QIS). Contractor must regularly analyze Grievance and Appeal data to identify, investigate, report, and act upon systemic patterns of improper service denials and other trends impacting health care access and delivery to	✓ Policies and Procedures for Grievance/Appeal Processes * ✓ Org Chart ✓ QI and UM Grievance and Appeal Committee Minutes ✓ Grievance and Appeal Tracking	The MCP has a process for aggregating appeals data and takes necessary action for trends impacting access to and delivery of health care. MCP policies and procedures must provide for the review and analysis, on a quarterly basis, of all recorded grievances related to access to care, QOC, and denial of services, and take appropriate action to remedy any problems identified. A written record of each grievance (Grievance Log) received by the MCP

Requirement	Documentation to Review	Examples of Best Practices
Members. Contractor must impose necessary Corrective Action to remedy all identified deficiencies. **Contract Exhibit A, Attachment III: 4.6.1** **Records Retention: Accessibility to DHCS and CMS and Using Data for Ongoing Monitoring and Improvement** Contractor must ensure that its Grievance and Appeal system meets the following requirements: K. Maintains records of Grievances and Appeals in a manner accessible to DHCS and to the Centers for Medicare & Medicaid Services (CMS), upon request. Contractor must review Grievance and Appeal data and information as part of its ongoing monitoring procedures as well as for updates and revisions to its QIS. The record of each Grievance or Appeal must contain, at a minimum, all information set forth in 42 CFR section 438.416(b). Contractor must ensure that all documents and records, whether in written or electronic format, generated or obtained by Contractor in the course of responding to Adverse Benefit Determinations (ABD), Grievances, Appeals, and Independent Medical Reviews (IMRs) are retained for at least 10 years pursuant to 42 CFR section 438.3(u).	and Trending Analysis ✓ Quality Improvement, Governing Board, Member Advisory Committee Minutes and Packets ✓ Grievance Logs ✓ Grievance Reports ✓ Verification Study ▲ * P&Ps describe the grievance escalation process, clinical review, Member rights, and data aggregation. * Should outline the process for filing and resolving grievances and specify timelines, responsibilities, and grievance resolution.	should include the date received, the MCP representative recording the grievance, a summary or other documents describing the grievance, and the disposition. The Grievance Log should be reviewed periodically by the governing body, the public policy body, and an officer or their designee. The review must be thoroughly documented. MCP documentation shows monitoring for appropriate grievance classification.

Requirement	Documentation to Review	Examples of Best Practices
Title 28, CCR, Section 1300.68: **Grievance System** The MCP's grievance system shall include the following: (1) An officer of the MCP shall be designated as having primary responsibility for the MCP's grievance system whether administered directly by the MCP or delegated to another entity. The officer shall continuously review the operation of the grievance system to identify any emergent patterns of grievances.	✓ Policies and Procedures for Grievance/Appeal Processes * ✓ Org Chart ✓ Grievance Review Committee or QI Committee Minutes * Should outline the process for filing and resolving grievances and specify timelines, responsibilities, notification, and grievance resolution.	Grievance or QI review committee minutes demonstrate designated MCP officer heads grievance/ grievance report review. MCP demonstrates continuous improvement of the grievance system and efforts to resolve systematic issues identified through grievance trends.

CATEGORY 4.2: GRIEVANCE PROCESS

Requirement	Documentation to Review	Examples of Best Practices
Contract Exhibit A, Attachment III: 4.6.2 **Policies and Procedures** Contractor's policies and procedures must include all required information set forth below for Grievances and the expedited review of Grievances as required under 42 CFR sections 438.402, 438.406, and 438.408; 28 CCR sections 1300.68 and 1300.68.01; and 22 CCR section 53858: A. A policy and procedure for Members to file a Grievance with Contractor at any time to express dissatisfaction about any matter other than a notice of ABD. B. A policy and procedure to allow Members to file a Grievance to contest Contractor's unilateral decision to extend the timeframe for resolution of an Appeal or expedited Appeal. C. A policy and procedure to ensure that every Grievance involving clinical issues that is submitted is reported to qualified medical professionals with appropriate clinical expertise and is escalated to Contractor's medical director as needed, to ensure the Grievance is properly handled. D. A policy and procedure to ensure that Contractor's staff monitor Grievances to identify issues that require Corrective Action. Grievances related to medical Quality of Care issues must be referred to qualified medical professionals with appropriate clinical expertise and be escalated to Contractor's medical director as needed.	✓ Policies and Procedures for Grievance Processes ✓ Member Handbook ✓ Member Services Guide ✓ Provider Manual ✓ Grievance Questionnaire ✓ MCP's Website ✓ Sample Acknowledgement Letter ✓ Case Files or Tracking Tool ✓ Grievance Logs ✓ Inquiry Logs ✓ Staff Training Materials ✓ Verification Study ▲	The MCP's policies and procedures define grievances, complaints, inquiries, complaints, complainant, and resolved as in the contract, APL 21-011, and subsequent or revised guidance issued by DHCS. The MCP provides multiple ways to file a grievance (phone, Member portal, email, mail, in person) and educates Members on this process. Oral grievances do not require written follow-up from the Member. Staff are trained to recognize grievances, even when Members do not use the term grievance. Verification Study shows MCP provides notification to the Member as stipulated in 28 CCR 1300.68.01 (a) (1). Members receive acknowledgment and resolutions within required timeframes.

Requirement	Documentation to Review	Examples of Best Practices
E. A policy and procedure for Contractor to provide written acknowledgement to the Member within five calendar days of receipt of the Grievance. The acknowledgement letter must advise the Member that the Grievance has been received; provide the date of receipt; and provide the name, telephone number, and address of the representative who the Member, their Provider, or their AR may contact about the Grievance.		

Requirement	Documentation to Review	Examples of Best Practices
Title 28, CCR, Section 1300.68(d) **Grievance System: Written Acknowledgement and Timeline Requirements** (1) A grievance system shall provide for written acknowledgment with five calendar days of receipt, except as noted in subsection (d)(8). The acknowledgment will advise the complainant that the grievance has been received, the date of receipt, and provide the name of the MCP representative, telephone number and address of the MCP representative who may be contacted about the grievance. **(7)** The Department's telephone number, the California Relay Service's telephone numbers, the MCP's telephone number and the Department's Internet address shall be displayed in all of the MCP's acknowledgments and responses to grievances in 12-point boldface type with the statement contained in subsection (b) of Section 1368.02 of the Act. (8) Grievances received over the telephone that are not coverage disputes, disputed health care services involving medical necessity or experimental or investigational treatment, and that are resolved by the close of the next business day, are exempt from the requirement to send a written acknowledgment and response. **All Plan Letter 21-011** **Grievance and Appeal Requirements, Notice and "Your Rights" Templates** 3. Timeframes for resolving grievances and sending written resolution to the member are delineated in both federal	✓ Policies and Procedures * ✓ Member Handbook ✓ Provider Manual ✓ Grievance Questionnaire ✓ MCP's Website ✓ MCP Templates and Member Notices (denials, resolution, appeal outcome) ✓ Tracking Tools and Grievance Logs ✓ Verification Study ▲ * Ensure grievance acknowledgment within 5 calendar days and 30-day resolution timeframe, with written updates if delayed. Written resolution should be clear and concise.	The MCP ensures that all required information for filing and resolving grievances is included within the notices. Each issue presented by the Member in the grievance should be addressed and resolved. Resolution letters are clear and concise and written at a sixth grade reading level. Quality of Care Grievances are resolved timely, regardless of requirements to review with QI committee. MCPs obtain and evaluate all relevant information on grievance investigations to ensure adequate consideration is given and that each issue is addressed/resolved.

Requirement	Documentation to Review	Examples of Best Practices
and state law. The state's established timeframe is 30 calendar days. MCPs must comply with the state's established timeframe of 30 calendar days for grievance resolution. a. "Resolved" means that the grievance has reached final conclusion with respect to the member's submitted grievance as delineated in state regulations. b. The MCP's written resolution must contain a clear and concise explanation of the decision. c. Even though federal regulations allow for a 14-calendar day extension for standard and expedited appeals, this allowance does not apply to grievances. In the event that resolution of a standard grievance is not reached within 30 calendar days as required, the MCP must notify the member in writing of the status of the grievance and the estimated date of resolution.		

CATEGORY 4.3: DISCRIMINATION GRIEVANCES

Requirement	Documentation to Review	Examples of Best Practices
Contract Exhibit A, Attachment III: 4.6.3 **General Requirements** Contractor must process Discrimination Grievances as required by federal and State nondiscrimination law and DHCS policy, as stated in 45 CFR section 84.7, 34 CFR section 106.8, 28 CFR section 35.107, W&I section 14029.91(e)(4), and APL 21-004. A. Contractor must designate a Discrimination Grievance coordinator responsible for ensuring compliance with federal and State nondiscrimination requirements and investigating Discrimination Grievances related to any action that would be prohibited by, or out of compliance with, federal or State nondiscrimination law. B. Contractor must adopt and implement written policies and procedures to ensure the prompt and equitable resolution of Discrimination Grievances. Contractor must not require a Member or Potential Member to file a Discrimination Grievance with Contractor before filing with the DHCS Office of Civil Rights or the U.S. Department of Health and Human Services Office for Civil Rights. C. Within ten calendar days of mailing a Discrimination Grievance resolution letter, Contractor must submit information regarding the Discrimination Grievance to the DHCS Office of Civil Rights, as specified in APL 21-004.	✓ Policies and Procedures (P&Ps) ✓ MCP's Cultural & Linguistic (C&L) Services Program ✓ Provider Manual ✓ Provider Newsletters ✓ Provider Education ✓ Documentation of Initial & Ongoing Training ✓ Member Handbook ✓ Member Newsletters ✓ MCP Website ✓ Reports and Committee Meeting Minutes: ○ Governing Body ○ Utilization Mngt. ○ QI ○ Comm. Advisory	The MCP informs Members of availability of high-quality interpreter and linguistic services and its non-discrimination policy (Provider Manual & Newsletters, initial and ongoing provider education/training, Member Handbook & Newsletters, MCP website). Grievance logs/files and Member surveys show no complaints of MCP discriminating against persons based on race, color, religion, or national origin. If there is any issue, MCP shows documentation that grievances / complaints resolved appropriately.

D. Contractor must inform Members on its website that Discrimination Grievances may be filed directly with the DHCS Office of Civil Rights and must include contact information for the DHCS Office of Civil Rights, as required by Exhibit A, Attachment III, Subsection 5.1.3 (Member Information).	✓ Grievance Logs/Files ✓ Member Satisfaction Surveys ✓ Verification Study ▲	
12. Civil Rights Act of 1964 **Prohibition Against Discrimination** The MCP shall ensure compliance with Title VI of the Civil Rights Act of 1964 and any implementing regulations (42 USC 2000d, 45 CFR 80) that prohibit recipients of federal financial assistance from discriminating against persons based on race, color, religion, or national origin. The MCP shall ensure equal access to health care services for limited English proficient Medi-Cal Members or Potential Enrollees through provision of high-quality interpreter and linguistic services. **Title 28, CCR, Section 1300.68** **Grievance System** (b)(8) The MCP shall assure that there is no discrimination against an enrollee because they filed grievance.	See Above	MCPs forward all grievances alleging discrimination to DHCS within ten calendar days of mailing a Discrimination Grievance resolution letter. MCPs must submit the following detailed information to DHCS: the original grievance; the accused party's response; Member correspondence; investigation results; corrective action; and contact information for the Member, accused party, and the staff who investigated the grievance, and any other relevant information. MCP policies and procedures are aligned with the Civil Rights Act of 1964 that prohibits discrimination for Limited English Proficient (LEP) Members through the provision of high-quality interpreter and linguistic services.

CATEGORY 4.4: NOTICE OF ACTION

Requirement	Documentation to Review	Examples of Best Practices
Contract Exhibit A, Attachment III: 4.6.4 **Overview** When Contractor makes an authorization decision, it must send a Notice of Action (NOA). A NOA is a notice of any action that impacts a Member's ability to obtain Covered Services or other benefits Contractor is required to provide under this Contract. A NOA includes, but is not limited to, a notice of ABD for a requested health care service under 42 CFR sections 438.210(d) and 438.404, including requested Community Supports that Contractor has elected to cover under 42 CFR section 438.3(e)(2). Contractor's failure to render a decision and send a written NOA to the Member within the required timeframes below is considered a denial of the requested service and therefore constitutes an ABD on the date that Contractor's timeframe for approval expires, in accordance with 42 CFR section 438.404(c)(5). In cases where Contractor fails to meet the required notice timeframes, the Member may immediately request an Appeal with Contractor and Contractor must send the Member written notice of all Appeal rights.	✓ Policies and Procedures that include provisions and requirements for NOAs and Prior Authorization Processes ✓ Logs on timeliness of notices ✓ Verification Study ▲	The MCP's policies and procedures clearly delineate the NOA requirements as further outlined below. Verification Studies and test work should sample appeals data (additional details on following pages).

Requirement	Documentation to Review	Examples of Best Practices
Contract Exhibit A, Attachment III: 4.6.4 **A. Standard Authorization Requests** 1. Contractor must ensure a NOA is sent when approving, denying or modifying a Provider's Prior Authorization or concurrent request for health care services excluding pharmacy services, but including Community Supports, for a Member within the shortest applicable timeframe that is appropriate for the nature of the Member's condition, but no longer than five Working Days from Contractor's receipt of information reasonably necessary and requested by Contractor to make a determination, not to exceed 14 calendar days following Contractor's receipt of the request for service, in accordance with 42 CFR sections 438.210(d)(1) and 438.404(c)(3) and 2. Contractor must notify the requesting Provider of its authorization decision within 24 hours of the decision and send the written NOA to the Member within two Working Days in accordance with H&S section 1367.01(h)(1) and (3). 3. Contractor must send the written NOA approving, denying, or modifying the authorization request. Contractor must approve, deny, or modify the request and send the written NOA within the shortest applicable timeframe that is appropriate for the nature of the Member's condition, but no longer than five Working Days from Contractor's receipt of information reasonably necessary and requested by Contractor to make a determination, not to exceed 14 calendar days in accordance with 42 CFR sections 438.210(d)(1) and 438.404(c)(3); and	✓ Policies & Procedures ✓ Referral Tracking Reports (timeliness) ✓ Inter-Rater Reliability Reports ✓ UM Committee Meeting Minutes for above report review ✓ Notice templates are approved by DHCS: ○ For denials or modification of services, templates include both a clear and concise explanation of the reasons for the decision and the clinical reasons for the decision regarding	Verification Study shows providers and Members receive written notification of any decision to deny, approve, modify, or delay a service authorization request, as contractually specified. Study shows the MCP initially calls/faxes providers within 24 hours of decision. Verification Study and policies/procedures confirm compliance, and the MCP conducts ongoing monitoring (e.g., audits, quality checks) at a set frequency to ensure compliance with the contractual requirement for routine prior auth and concurrent review decision timeframes and extensions.

Requirement	Documentation to Review	Examples of Best Practices
4. Contractor must send the written NOA to the Member with sufficient time to allow for continuation of benefits pursuant to 42 CFR section 438.420. *Note: Prior Authorization timeframes are covered more extensively in the Category 1 Audit Program (Utilization Management)* *See Note Below Regarding Updated Requirement Effective 1/1/26* **<u>Updated Requirements Effective January 1, 2026</u>** Effective January 1, 2026, the Contractor's requirement to send a NOA is reduced from 14 calendar days to seven calendar days. The Contractor must notify the requesting Provider of its authorization decision within the seven calendar day timeframe in accordance with CMS 9-1156-F, and send a written notice to the Provider within 24 hours of the decision and send the written NOA to the Member within two working days in accordance with HA&S section 3167.01(h)(1) and (3). Additionally, the seven calendar days will be from the date the MCP receives the request (as opposed to the prior APL, which was when the MCP receives the necessary information reasonable to make determination). For auditing purposes, the Contractor may still be held to the 14-calendar day requirement, depending on the audit review period.	medical necessity ✓ Verification Study ▲	

Requirement	Documentation to Review	Examples of Best Practices
Contract Exhibit A, Attachment III: 4.6.4 **B. Expedited Authorization Requests** 1. In instances where a Provider indicates, or Contractor determines, that the standard request timeframe may seriously jeopardize the Member's life; health; or ability to attain, maintain, or regain maximum function, Contractor must approve, modify, or deny a Prior Authorization or concurrent request for health care services, and send the written NOA, in a timeframe which is appropriate for the nature of the Member's condition, but no longer than 72 hours from receipt of the authorization request in accordance with 42 CFR section 438.210(d)(2) and (d)(2)(i). 2. Contractor must send the written NOA approving, denying, or modifying the authorization request. Contractor must send the written NOA to the Member with sufficient time to allow for continuation of benefits pursuant to 42 CFR section 438.420. 3. Contractor must approve, modify, or deny the request within the shortest applicable timeframe that is appropriate for the nature of the Member's condition, but no longer than 72 hours from Contractor's receipt of additional information requested by Contractor to make a determination. Contractor's written notice to the Member must be sent with sufficient time to allow the Member (to request) Aid Paid Pending if applicable. *Note: See APL 21-011 and subsequent guidelines issued by DHCS related to item 2 above. Prior Authorization timeframes*	✓ Policies and Procedures* ✓ Member Handbook ✓ (Includes information about urgent grievances, DMHC contact rights, and no participation requirement before contracting the Department) ✓ Verification Study, including expedited grievance requests ▲ *Verifies procedures for urgent grievances, including immediate DMHC notification and response within 72 hours. P&Ps should include that the system supports	Verification Study shows MCP provides written notification as stipulated. Documentation demonstrates a qualified clinician evaluates the request for expedited status and a physician resolves grievance. Member informing materials show the Member is not required to participate in MCP's grievance process in case of an urgent grievance. Verification Study shows MCP responds to Department's document requests as outlined in CCR Title 28 1300.68.01 and shows appropriate processing of expedited grievances.

Requirement	Documentation to Review	Examples of Best Practices
are also covered in Category 1 Audit Program (Utilization Management) **Title 28, CCR 1300.68.01:** **Expedited Review of Grievances** a. Every MCP shall include in its grievance system, procedures for the expedited review of grievance involving an imminent and serious threat to the health of the enrollee, including, but not limited to, severe pain, potential loss of life, limb or major bodily function ('urgent grievance"). At a minimum, MCP procedures for urgent grievances shall include: Immediate notification to the complainant of the right to contact the: 1. Department (DMHC) regarding the grievance. The MCP shall expedite its review of the grievance when the complainant, an authorized representative, or treating physician provides notice to the MCP. Notice need not be in writing but may be accomplished by a documented telephone call. 2. A written statement to the Department and the complainant on the disposition or pending status of the urgent grievance within 72 hours of receipt of the grievance by the MCP. 3. Consideration by the MCP of the enrollee's medical condition when determining the response time. 4. No requirement that the enrollee participate in the MCP's grievance process prior to applying to the Department for review of the urgent grievance.	24/7 contact for urgent requests.	

Requirement	Documentation to Review	Examples of Best Practices
Contract Exhibit A, Attachment III: 4.6.4 **C. Retrospective Review** Contractor must approve, modify, or deny a Provider's request for Retrospective Review authorization for health care services provided to a Member, and send the written NOA to the Member, within 30 calendar days from receipt of information that is reasonably necessary to make a determination. *Note: Retrospective authorization timeframes are covered more extensively in the Category 1 Audit Program (Utilization Management).*	✓ Policies and Procedures ✓ UM Committee Meeting Minutes ✓ Verification Study of post-stabilization and retrospective requests ▲	The MCP's Policies and Procedures and Verification Studies comply with post-stabilization and retrospective review request decision timeframes and documentation requirements.
Contract Exhibit A, Attachment III: 4.6.4 **D. Terminations, Suspensions, or Reductions** **1.** For terminations, suspensions, or reductions of previously authorized services, Contractor must notify Members at least ten calendar days before the date of the action pursuant to 42 CFR section 431.211, with the exception of circumstances permitted under 42 CFR sections 431.213 and 431.214. **2.** For purposes of auditing, the postmark on Contractor's notice to the Member will be used to confirm compliance with all authorization request timeframes and notice requirements set forth in Exhibit A, Attachment III, Section 4.6 (Member Grievance and Appeal System).	✓ Policies and Procedures ✓ Verification Study ▲	The MCP's Policies and Procedures and Verification Studies comply with the Member notification postmark at least 10 calendar days prior to the date of action.

Requirement	Documentation to Review	Examples of Best Practices
Contract Exhibit A, Attachment III: 4.6.4 **E. Required Information in Contractor's NOA Informing Member of Notice of ABDs** Contractor must ensure all NOAs informing a Member of an ABD are in writing in a format and language that, at a minimum, meets the standards set forth 42 CFR sections 438.10, 438.404, and 438.408; W&I section 14029.91; 22 CCR section 53876; and Exhibit A, Attachment III, Subsection 5.1.3 (Member Information), and APL 21-004 Standards for Determining Threshold Languages, Nondiscrimination Requirements, and Language Assistance Services. Contractor's NOA informing of an ABD must include all of the following: 1. **A clear and concise explanation** of the action that Contractor or its Network Provider has taken or intends to take, including a fully translated written notice with a fully translated clinical rationale for Contractor's decision at the point of each determination. 2. **The reason for the action**, including notification to the Member of the right to be provided, upon request and free of charge, reasonable access to, and copies of, all documents, records, and any other information Contractor relied on for the decision, including clinical criteria; Medical Necessity criteria; and any processes, strategies, or evidentiary standards relied on for the decision. 3. The Member's right to request an Appeal with Contractor no later than 60 calendar days from the date on the NOA, and information on exhausting Contractor's one-level Appeal system;	✓ Policies and Procedures ✓ Member Handbook ✓ MCP's Website ✓ Evidence of Coverage (EOC) ✓ Verification Study ▲	The MCP's Policies and Procedures comply with the requirements stipulated in the Contract and APLs. Notice of Action (NOA) is written in a clear and concise format with all the required components including a fully translated version to the Member's threshold language. NOA contains DHCS approved NDN/LAT attachments and may be posted on the MCP's website and included in the Member handbook and EOC. Members are informed of their rights and instructions on how to request an appeal, an expedited appeal, State Fair Hearing, IMR with DMHC. Verification Study shows Member continues to receive covered services while their appeal is pending resolution.

Requirement	Documentation to Review	Examples of Best Practices
4. The Member's right to an expedited Appeal if the Member's health condition requires resolution in less than 72 hours and information on how to request an expedited Appeal; *Note: See updated APL 21-005 published 2/12/2025, which may supersede APL 21-004 depending on audit review period. Additional requirements found in 42 CFR section 438.404(b)(1) and APL 21-011.* *For item 1 above, MCP must also cite reasons for the decision and action taken – see H&S section 1367.01(h)(4); 22 CCR sections 51014.1(c)(2) and 53894(d)(2).* 5. **The Member's rights and information on the process to request a State Hearing** after having exhausted Contractor's internal Appeal process and having received notice that Contractor is upholding its action. The NOA must also advise that the Member may request a State Hearing in cases where Contractor fails to send a NAR or notice of extension in response to the Appeal within 30 calendar days of the Member's request for an Appeal. This is known as Deemed Exhaustion pursuant to 42 CFR section 438.402(c)(1)(i)(A). 6. **Aid Paid Pending:** The Member's right to continue receiving Covered Services pending the resolution of the Appeal, and Contractor's obligation to continue benefits as required by 42 CFR section 438.420 and Exhibit A, Attachment III, Subsection 4.6.8 (Continuation of Services Until Appeal and State Hearing Rights Are Exhausted). *Note: Continuation of Services (Aid Paid Pending) is covered more extensively in Section 4.8 of this Audit Program.*		

Requirement	Documentation to Review	Examples of Best Practices
7. **IMR:** If applicable, the Member's right to request a clinical review of Contractor's action, called an IMR, from DMHC and that the Member must request an IMR before there is a final decision on their State Hearing. *Note: IMR is covered more extensively in Sections 4.5 and 4.7 of this Audit Program.*		
Contract Exhibit A, Attachment III: 4.6.4 **F. Visually Impaired Members** For visually impaired Members, Contractor must provide the NOA in the Member's selected alternative format in order to be considered adequate notice. Contractor must not deny, delay, modify, limit, or terminate services or treatments without providing adequate notice within the timeframes stated in this Exhibit A, Attachment III, Subsection 4.6.4 (Notice of Action). In accordance with APL 22-002, Contractor must calculate the appropriate timeframe(s) for a visually impaired Member to take action from the date of receiving adequate notice in their selected alternative format, including all deadlines for Appeals.	✓ Policies and Procedures ✓ Verification Study ▲	The MCP's Policies and Procedures include auxiliary aids and services to Members with disabilities, their family member, friends, or associate of a Member if required by the ADA. The MCP provides written materials in alternative formats with adequate notice.
Contract Exhibit A, Attachment III: 4.6.4 **G. Changes to NOA Templates** Contractors are not permitted to make any changes to DHCS' NOA templates or the NOA "Your Rights" Attachment without prior review and approval from DHCS, except to	✓ Policies and Procedures ✓ Verification Study ▲	The MCP uses DHCS approved NOA templates or the NOA "Your Rights" Attachment. Of note, as of the 25-26 SFY, MCPs regularly send notices to DHCS for review and approval. There may be times in which the audit will test

Requirement	Documentation to Review	Examples of Best Practices
insert the specific reasons for Contractor's action to the Member, as required.		whether the MCP has put into practice their approved templates.

CATEGORY 4.5: APPEAL PROCESS

Requirement	Documentation to Review	Examples of Best Practices
Contract Exhibit A, Attachment III: 4.6.5 **Overview / Member Assistance** Pursuant to 42 CFR sections 438.228 and 438.400 - 424, Contractor must have an Appeal process as required below to attempt to resolve Member Appeals before the Member requests a State Hearing or an IMR. Contractor must have only one level of Appeal for Members. Upon a Member's request, Contractor must assist any Member in preparing their Appeal, which includes assisting the Member with navigating Contractor's website, providing all documents that Contractor relied on for its decision, and providing the Appeal form to the Member. **APL 21-011** **Grievance and Appeal Requirements, Notice and "Your Rights" Templates** D. An "Appeal" is a review by the MCP of an Adverse Benefit Determination.	✓ Provider Manual ✓ Member Handbook/EOC ✓ MCP Website	The Provider Manual, Member Handbook / EOC and MCP website include a clear and complete description of the Member appeals procedure. Prior Auth Verification Study confirms MCP sends NOA Your Rights attachment to Members timely explaining appeals procedure.
Contract Exhibit A, Attachment III: 4.6.5 **A. Timelines and Methods to File an Appeal / Provider Consent to File Appeal** Following the receipt of a NOA, a Member has 60 calendar days from the date on the NOA to file a request for an Appeal either orally or in writing. The Member, or a Provider or AR acting on behalf of the Member and with the Member's written consent, may request an Appeal. Unless the Member is requesting an expedited Appeal, the date of	✓ Policies and Procedures for Member Appeals* ✓ Provider Manual ✓ Member Handbook/EOC ✓ MCP Website	MCPs assist Members in filing appeals. The method, timeframe and person filing an appeal complies with contract requirements. MCPs follow deemed exhaustion requirements. MCPs do not delay processing oral appeal if a written appeal is not filed.

Requirement	Documentation to Review	Examples of Best Practices
the Member's oral or written request for an Appeal establishes the filing date for the Appeal. Contractor must resolve the Appeal within 30 calendar days of the Member's oral or written request for an Appeal. **Contract Exhibit A, Attachment III: 4.6.5** **B. Failure to Send NOA / Right to File State Hearing** If Contractor fails to send a written NOA within 30 calendar days or fails to comply with notice and language translation requirements in 42 CFR sections 438.10, 438.404, and 438.408; W&I section 14029.91; 22 CCR section 53876; and Exhibit A, Attachment III, Subsection 5.1.3 (Member Information), the Member is deemed to have exhausted Contractor's internal Appeal process and may request a State Hearing pursuant to 42 CFR section 438.402(c)(1)(i)(A). **APL 21-011** **Grievance and Appeal Requirements, Notice and "Your Rights" Templates** IV B. MCPs must accept the Member's oral request for a standard appeal. Failure to submit a written appeal is not a basis for the MCP to disregard the oral appeal. MCPs are required to assist any member wishing to file an appeal.	✓ Verification Study ▲ *Includes clear outline of process for filing an appeal, with guidelines that members have 60 calendar days to file an appeal after receiving the NOA and that appeals can be filed orally or in writing, and that a Member's written consent must be obtained if a Provider or AR files on behalf of the member.	

Requirement	Documentation to Review	Examples of Best Practices
APL 21-011 **Grievance and Appeal Requirements, Notice and "Your Rights" Templates: Written Acknowledgement within 5 Days** In accordance with state law, MCPs must provide the member with written acknowledgement within five calendar days of receipt of the appeal (for standard review). The acknowledgement letter must advise the member that the appeal has been received and the date of receipt, and it must provide the name, telephone number, and address of the representative who may be contacted about the appeal.	✓ Policies and Procedures ✓ Verification Study ▲	Verification Study shows the MCP sends acknowledgement letters timely with required information and informs Members how to submit additional evidence/testimony
Contract Exhibit A, Attachment III: 4.6.5 **C. NOA – Required Elements** Contractor's NOA informing the Member of its NAR must, at a minimum, indicate whether Contractor upheld its decision on the Appeal and the date of Contractor's decision on the Appeal. For decisions not wholly in the Member's favor, Contractor's NAR must, at a minimum, include: 1. Member's right to request a State Hearing; 2. How to request a State Hearing; 3. That the Member has a right to continuation of benefits during the State Hearing, and that Contractor is obligated to continue benefits as long as the requirements of 42 CFR section 438.420 are met; 4. If applicable, the right to request an IMR or a review of Contractor's decision by DMHC, and that the IMR must be requested before there is a final State Hearing decision; and 5. The DHCS-approved "Your Rights" Attachment.	✓ Policies and Procedures* ✓ Member Handbook/EOC ✓ Provider Manual ✓ UM Program Description ✓ Verification Study of Member Appeals for Medical Requests ▲ * P&Ps, UM Program Description, Member Handbook/EOC, and Provider Manual should outline that standard appeals	The MCP routinely monitors appeal files to ensure compliance with resolution timeframes for standard appeals and NAR "Your Rights" attachments describing Member rights. The MCP should routinely audit appeal files to confirm timely resolution of standard appeals and proper inclusion of the "Your Rights" attachment in all NARs. Staff should be trained to recognize and escalate any delays and ensure all appeal resolution communications consistently meet federal and state content requirements.

Requirement	Documentation to Review	Examples of Best Practices
APL 21-011 **Upheld Decisions and Required Elements on NAR** IV. E. For upheld decisions, the NAR must also include the NAR "Your Rights" attachment. MCPs are not permitted to make any changes to NAR templates or "Your Rights" templates without prior review and approval from DHCS, except to insert information specific to the member as required. IV. F. 1. The written NAR must contain the following: a. The results of the resolution and the date it was completed. b. For decisions to uphold a denial determination that is based in whole or in part on medical necessity: the reasons for its determination and clearly stated criteria, clinical guidelines, or medical policies used in reaching the determination.	must be resolved and noticed within 30 calendar days, and that NARs include required elements such as State Hearing rights, continuation of benefits, and the "Your Rights" attachment. The Verification Study should confirm adherence to these timeframes and inclusion of all required notice content.	

Requirement	Documentation to Review	Examples of Best Practices
APL 21-011 **Grievance and Appeal Requirements, Notice and "Your Rights" Templates: Upheld Decisions and Required Elements on NAR** IV. F. 1. The written NAR must contain the following: c. For decisions to uphold a denial on a determination that the requested service is not a covered benefit: the provision in the DHCS Contract, Evidence of Coverage/Member Handbook that excludes the service. The response must either identify the document and page where provision can be found, provide a copy of the provision and explain in clear and concise language how the exclusion applied to the specific service requested. IV. F 2. For appeals not resolved wholly in favor of the member, the NAR is comprised of the NAR "Uphold" template and the NAR "Your Rights" attachment. The NAR "Your Rights" Attachment includes all of the following required elements: a. The member's right to request a State Hearing no later than 120 calendar days from the date of the MCP's written NAR and instructions on how to request a State Hearing. b. The member's right to Aid Paid Pending and instructions on how to timely file for a State Haring (i.e. within 10 days of the NAR) regarding a decision to terminate, suspend, or reduce services. MCPs must provide Aid Paid Pending regardless of whether the member makes a	Review of Documents Confirms that: * NARs for upheld appeals include "Your Rights" attachment and "Uphold" template. * The NAR communicates resolution outcome and completion date. * If denial is based on medical necessity, NAR cites specific clinical guidelines or policies. * If denial is based on benefit exclusion, The NAR references contract/EOC provision and page or includes copy and plain language explanation.	The MCP routinely monitors appeal files to ensure compliance with resolution timeframes for standard appeals and NAR "Your Rights" attachments describing Member rights. The MCP uses the required DHCS templates and ensures the "Your Rights" attachment contains: * Instructions for requesting a State Hearing within 120 days * Instructions and eligibility criteria for Aid Paid Pending, including automatic provision when a timely State Hearing is requested (within 10 days) * For Knox-Keene MCPs: Member's right to an IMR with required enclosures (IMR form, instructions, DMHC phone number, and pre-addressed envelope).

Requirement	Documentation to Review	Examples of Best Practices
separate request to the MCP when the member timely files for a State Hearing. c. For Knox-Keene licensed MCPs, the member's right to request an IMR from DMHC if the MCP's decision is based in whole or in part on a determination that the service is not medically necessary, is experimental/investigational, or is a disputed emergency service. The MCP must include the IMR form, application instructions, DMHC's toll-free telephone number, and an envelope addressed to DMHC.	* The MCP does not alter DHCS approved NAR or "Your Rights" templates except to insert member-specific information.	

Requirement	Documentation to Review	Examples of Best Practices
Contract Exhibit A, Attachment III: 4.6.5 **D. Reversal of Decision / Authorization of Disputed Services** If Contractor reverses its decision during the Appeal, it must authorize or provide the disputed services promptly, and as expeditiously as the Member's health condition requires, but no later than 72 hours from the date it reverses the action if the disputed services were not provided during the Appeal. **Contract Exhibit A, Attachment III: 4.6.5** **E. Payment of Disputed Services** Contractor must pay for disputed services if the Member received the disputed services while the Appeal was pending. **APL 21-011** **Decisions in Favor of Member and NAR Requirements** IV F. d. For appeals resolved in favor of the member: the written NAR must contain a clear and concise explanation of why the decision was overturned. IV G. For appeals resolved in favor of the member, the NAR only consists of the NAR "Overturned" template; the "Your Rights" attachment is not included. MCPs must authorize or provide services no later than 72 hours from the date the determination is reversed.	✓ Policies and Procedures ✓ UM Program Description Provider Manual Member Handbook/EOC Verification Study ▲ * For appeals resolved in favor of the Member, MCP uses the NAR "Overturned" template only and does not include the "Your Rights" template * NAR includes a clear and concise explanation of why the decision was overturned * Timely Authorization: Services that were denied must be authorized or provided within 72	The MCP's policies, procedures, and the Member Handbook/EOC indicate that the MCP will pay for disputed services if the Member received the disputed services while the appeal was pending. The MCP monitors the quality of notice of appeal resolution letters and includes a statement that it will provide the now-approved service within 72 hours of the decision.

Requirement	Documentation to Review	Examples of Best Practices
	hours of the date the appeal was resolved in the member's favor.	
Contract Exhibit A, Attachment III: 4.6.5 **F. Right to Examine Case File** Contractor must provide the Member or AR the opportunity before and during their Appeal process to examine their case file. Contractor must provide, sufficiently in advance of the resolution timeframe and free of charge, the Member's case file, including Medical Records, clinical criteria, guidelines, and all documents and records Contractor relied on during the Appeal process for its decision. Contractor must assist any Member who requires assistance preparing their Appeal.	✓ Policies and Procedures	The MCP assists Members to prepare for the Appeal and provides all documents and records before the resolution timeframe to Members or AR and during the appeal process.
Contract Exhibit A, Attachment III: 4.6.5 **G. Withdraw of Grievance or Appeal** Contractor may withdraw a Grievance or Appeal upon Member request if performed in compliance with the established Grievance and Appeals processes required in this Contract and federal and State laws and regulations. Where a Grievance or Appeal was filed by a Provider or AR of a Member, written Member consent is required for a Provider or AR to withdraw the Grievance or Appeal.	✓ Policies and Procedures	The MCP's Policies and Procedures include the process for Grievance or Appeal withdrawal. Records of written Member consent obtained when withdrawal is requested by a Provider or AR.

CATEGORY 4.6: RESPONSIBILITIES IN EXPEDITED APPEALS

Requirement	Documentation to Review	Examples of Best Practices
Contract Exhibit A, Attachment III: 4.6.6 **Policies and Procedures** Contractor must implement and maintain policies and procedures as described below to resolve expedited Appeals. Contractor must follow the expedited Appeal process when it determines or the requesting Provider indicates that taking the time for a standard resolution could seriously jeopardize the Member's life; physical or mental health; or ability to attain, maintain, or regain maximum function. A. A Member, or a Provider or an AR with the Member's written consent, may file an expedited Appeal either orally or in writing. No additional follow-up from the Member is required. Contractor must ensure that punitive action is not taken against a Provider who requests an expedited resolution or supports a Member's Appeal. B. Contractor must inform the Member of the limited time available for the Member to present evidence and allegations of fact or law, in person, by phone, or in writing, sufficiently in advance of the resolution timeframe. C. Contractor must resolve an expedited Appeal as quickly as the Member's health condition requires, but no later than 72 hours from the day Contractor receives the request for an expedited Appeal.	✓ Policies and Procedures* ✓ Verification Study ▲ * Includes guidelines for resolution timeframe (72 hours max, or sooner if needed); reasonable effort to give oral notice; written notice (NAR) required with appropriate templates and rights attachment (if upheld). * Required notices include guidelines for use of NAR "Overturned" or "Uphold" templates. * The "Your Rights" attachment is included if appeal is not fully in favor of Member.	The MCP routinely monitors appeal files to ensure compliance with expedited appeal procedures and resolution timeframes. The MCP only downgrades expedited appeals to standard timeframe if they don't meet the definition of expedited as required by the contract (i.e., after a clinical review determines the request does not meet expedited criteria). MCP includes documentation of the downgrade rationale and timely notice to the Member. MCP maintains a 24/7 on-call clinical reviewer process to support timely triage and decision-making, especially during weekends and holidays. The MCP processes denied expedited Appeals in accordance with the standard Appeal process timeframes for resolutions.

Requirement	Documentation to Review	Examples of Best Practices
D. Contractor must make a reasonable effort to provide oral notice of an expedited Appeal decision. E. If Contractor denies a request for an expedited resolution of an Appeal, it must process the request for an Appeal in accordance with the standard Appeal process timeframes for resolutions and extensions as required in Exhibit A, Attachment III, Subsection 4.6.5 (Appeal Process).	* Member, provider (with written consent) or authorized rep (with written consent) can file the appeal; oral or written request accepted and no follow-up required for oral request.	

CATEGORY 4.7: STATE HEARINGS AND INDEPENDENT MEDICAL REVIEWS

Requirement	Documentation to Review	Examples of Best Practices
Contract Exhibit A, Attachment III: 4.6.7 **A. State Hearings (Requests)** 1. The Member, or a Provider or AR with the Member's written consent, may request a State Hearing: a. After receiving a NAR confirming that Contractor has upheld its ABD, and the request is made within 120 calendar days from the date on the NAR; b. In cases of Deemed Exhaustion, due to Contractor's failure to comply with Appeal notice and timing requirements as required by 42 CFR sections 438.10, 438.402, 438.404, 438.406, 438.408, and 438.410; W&I sections 10951 and 10951.5; and as stated in this Contract, the Member may immediately request a State Hearing. In cases of Deemed Exhaustion, Contractor must not request a dismissal of the State Hearing based on a failure to exhaust Contractor's internal Appeal process; or c. If Contractor fails to provide Appeal notices required in 42 CFR section 438.408 to a Member with a visual impairment, in the Member's selected alternative format and within the applicable federal or State timeframes, the Member is deemed to have exhausted Contractor's internal Appeal process and may immediately request a State Hearing. In such cases, Contractor is prohibited from requesting dismissal of a State Hearing on the basis of failure to exhaust Contractor's internal Appeal process.	✓ Policies and Procedures ✓ Member Handbook/EOC ✓ Provider Manual ✓ Verification Study ▲	The MCP's Policies and procedures, and Member facing materials include information on filing a State Hearings. For visually impaired members, MCPs must provide NOA letters in the member's selected alternative format in order to be considered adequate notice. Of note, the Verification Study includes appeal samples that are reviewed for multiple requirements.

Requirement	Documentation to Review	Examples of Best Practices
Contract Exhibit A, Attachment III: 4.6.7 **A. State Hearings (Member Assistance)** 2. Upon request from the Member, Contractor must assist the Member with preparing for the State Hearing by providing the Member or their AR with the Member's case file, including Medical Records, other documents and records, guidelines, clinical criteria, and any new or additional evidence that Contractor relied on for its initial denial and anything Contractor considered during its internal Appeal process. This information must be provided free of charge and sufficiently in advance of the resolution timeframe.	✓ Policies and Procedures ✓ Member Handbook/EOC	The MCP assists Members to prepare for the appeal and provides all documents and records before the resolution timeframe to Members or AR and during the appeal process.
Contract Exhibit A, Attachment III: 4.6.7 **A. State Hearings (Statement of Position / Participation)** 3. Contractor must provide its statement of position for the State Hearing to the Member and to the California Department of Social Services at least two Working Days before the State Hearing. 4. Contractor must ensure that an employee familiar with the facts of the case and Contractor's basis for upholding its ABD is available to actively participate in the State Hearing by ensuring that the employee is available and prepared to present Contractor's position and be subject to cross examination at the State Hearing as required by 42 CFR sections 431.205 and 431.242 and Goldberg v. Kelly (1970) 397 US 254. Contractor must ensure that it provides accurate contact information for its State Hearing representative to ensure an appearance at the State Hearing via telephone or in person. Additionally, to	✓ Policies and Procedures	The MCP provides its statement of position to the Member and DSS at least 2 working days prior to the State Hearing. The MCP's employees who are familiar with the case must be made available to participate in the State Hearing. Accurate contact information must be provided to its State Hearing representative.

Requirement	Documentation to Review	Examples of Best Practices
ensure Member's right to due process during the State Hearing process, Contractor must ensure that a statement of position is timely filed with the California Department of Social Services and provided to the Member not less than two Working Days before the hearing as required by W&I section 10952.5.		
Contract Exhibit A, Attachment III: 4.6.7 **A. State Hearings (Overturned Decisions / Authorization)** 5. In cases where the State Hearing decision overturns Contractor's decision, Contractor must authorize or provide the disputed services promptly, and as expeditiously as the Member's health condition requires, but no later than 72 hours from the date Contractor receives notice that the State Hearing decision reversed Contractor's decision.	✓ Policies and Procedures ✓ Verification Study ▲	The MCP's Policies and Procedures include processes for overturned decisions by State Hearings. Verification Study shows the MCP authorized or provided the disputed services for overturned decisions no later than 72 hours.
Contract Exhibit A, Attachment III: 4.6.7 **A. State Hearings (Payment of Disputed Services)** 6. Contractor must pay for disputed services if the Member received the disputed services while the State Hearing was pending.	✓ Policies and Procedures ✓ Verification Study ▲	Verification Study shows payments for disputed services received while the State Hearing was pending.
Contract Exhibit A, Attachment III: 4.6.7 **A. State Hearings (Represented Parties)** 7. The parties to a State Hearing must include Contractor as well as the Member, their AR, or the representative of a deceased Member's estate.	✓ Policies and Procedures ✓ Verification Study ▲	See Above. In addition, the parties to a State Hearing must include the Contractor as well as the Member, their AR, or the representative of a deceased Member's estate.

Requirement	Documentation to Review	Examples of Best Practices
Contract Exhibit A, Attachment III: 4.6.7 **A. State Hearings (Member Notification of Decision)** **8.** Contractor must notify Members that the State must make a decision for a State Hearing within 90 calendar days of the date of the State Hearing request. For an expedited State Hearing, DHCS will take final administrative action as expeditiously as the individual's health condition requires, but no later than three Working Days after Contractor provides DHCS with the case file and information supporting its Appeal of an ABD pursuant to W&I section 10951.5. Contractor must also comply with all other requirements as required by 42 CFR sections 438.410 and 438.404(a), W&I section 14029.91(e), 22 CCR sections 53876 and 53895, and APL 21-011.	✓ Policies and Procedures ✓ Verification Study ▲	The MCP notifies Members that the State must make a decision within 90 calendar days of the State Hearing request, and no later than 3 working days for expedited State Hearing after the MCP submits case documents to DHCS. As part of the Verification Study, appeals samples and member-facing materials are reviewed.
Contract Exhibit A, Attachment III: 4.6.7 **B. Contractor's Obligations for Expedited State Hearings** 1. Within two Working Days of being notified by DHCS or the California Department of Social Services that a Member has filed a request for State Hearing which meets the criteria for expedited resolution, Contractor must deliver directly to the designated / appropriate California Department of Social Services administrative law judge all information and documents which either support, or which Contractor considered in connection with, the action which is the subject of the expedited State Hearing. This includes, but is not limited to, copies of the relevant Treatment Authorization Request and NOA, plus any pertinent NAR and all documents	✓ Policies and Procedures ✓ Verification Study ▲	The MCP provides all information and documents subject to the Expedited State Hearing within two working days of being notified by DHCS or DSS, directly to the designated DSS law judge, including copies of the original NOAs and NARs, and fully translated versions if originals are not in English. The MCP's employees who are familiar with the case must be made available to participate in the Expedited State Hearing. Accurate contact information must be provided to its State Hearing representative.

Requirement	Documentation to Review	Examples of Best Practices
Contractor relied on for its denial, including clinical criteria and guidelines. If the NOA or NARs are not in English, Contractor must transmit fully translated copies to the California Department of Social Services along with copies of the original NOA and NARs. 2. Contractor must ensure that an employee familiar with the facts of the case and Contractor's basis for upholding its ABD is available to actively participate in the expedited State Hearing by ensuring that the employee is available and prepared to present Contractor's position during cross examination at the State Hearing as required by 42 CFR sections 431.205 and 431.242 and Goldberg v. Kelly (1970) 397 US 254. Contractor must ensure that it provides accurate contact information for its State Hearing representative to ensure an appearance at the Hearing via telephone or in person. Additionally, to ensure Member's right to due process during the State Hearing process, Contractor must ensure that its completed case file, including the statement of position, is timely filed with the California Department of Social Services as required by W&I section 10951.5(b)(1).		The MCP submits completed case file timely to DSS.

Requirement	Documentation to Review	Examples of Best Practices
Contract Exhibit A, Attachment III: 4.6.7 **C. Independent Medical Review** 1. If applicable to Contractor's MCP model, Contractor must inform Members of the right to request an IMR of an action resulting in a Member request for an Appeal, or the outcome of an Appeal. 2. An IMR must be requested by the Member, or a Provider or AR with written authorization from the Member to act on the Member's behalf. Contractor must not require a Member to request an IMR before, or use one as a deterrent to, requesting a State Hearing. 3. IMRs must be conducted by the California Department of Managed Healthcare (DMHC) independently from either the Member or Contractor, and at no cost to the Member. 4. IMRs do not extend any of the time frames stated in this Contract for Appeals, and do not disrupt the continuation of Covered Services per 42 CFR section 438.420. **APL 21-011** **Grievance and Appeal Requirements, Notice and "Your Rights" Templates: Decisions Not in Favor of Member and NAR Requirements** IV. F 2. For appeals not resolved wholly in favor of the member, the NAR is comprised of the NAR "Uphold" template and the NAR "Your Rights" attachment. The NAR "Your Rights" Attachment includes all of the following required elements:	✓ Policies and Procedures ✓ Member Handbook/EOC ✓ MCP Website ✓ Verification Study ▲	MCP policies and procedures outline the process for IMR conducted by DMHC at no cost to the Member. Members are informed of IMR, at no cost. Verification Study shows "Your Rights" attachment contains: Member's right to an IMR with required enclosures (IMR form, instructions, DMHC phone number, and pre-addressed envelope). IMR adheres to contractual timeframes.

Requirement	Documentation to Review	Examples of Best Practices
c. For Knox-Keene licensed MCPs, the member's right to request an IMR from DMHC if the MCP's decision is based in whole or in part on a determination that the service is not medically necessary, is experimental/investigational, or is a disputed emergency service. The MCP must include the IMR form, application instructions, DMHC's toll-free telephone number, and an envelope addressed to DMHC.		

CATEGORY 4.8: CONTINUATION OF SERVICES UNTIL APPEAL AND STATE HEARING RIGHTS ARE EXHAUSTED

Requirement	Documentation to Review	Examples of Best Practices
Contract Exhibit A, Attachment III: 4.6.8 **Providing Disputed Services Pending Appeal / State Hearing** A. Contractor must automatically continue providing the disputed services to the Member while the Appeal and State Hearing are pending if all of the following conditions are met: 1. The Member filed their Appeal within the required timeframes set forth in 42 CFR section 438.420; 2. The Appeal involves the termination, suspension, or reduction of previously authorized Covered Services; 3. The disputed services were ordered by the Member's Provider; and 4. The period covered by the original authorization has not expired. B. If Contractor, at the Member's request, continues or reinstates the provision of disputed services while an Appeal or State Hearing is pending, those services must continue until: 1. The Member withdraws their request for an Appeal or a State Hearing; 2. The Member fails to request a State Hearing and continuation of disputed services within ten calendar days of when the NOA was sent; or 3. The final State Hearing decision is adverse to the Member.	✓ Policies and Procedures ✓ Member Handbook ✓ Disputed Services Pending Appeals/State Hearing Log* ✓ Verification Study ▲ *Of note, the information for appeals and hearings may be captured on a specific dispute log or elsewhere, as long as the MCP is tracking hearings and following up accordingly.	The MCP's Policies and Procedures outline the MCP's obligations to Members when the Appeal and State Hearings are pending. Verification Study shows the MCP continued to provide the disputed services while the Appeal and State Hearing were pending when conditions were met. Verification Study shows the MCP paid for the disputed services the Member received and was not billed for the continued services.

Requirement	Documentation to Review	Examples of Best Practices
C. Contractor must pay for disputed services if the Member received the disputed services while the Appeal or State Hearing was pending. Contractor must ensure the Member is not billed for the continued services even if the State Hearing or IMR finds the disputed services were not Medically Necessary.		

CATEGORY 4.9: GRIEVANCE AND APPEAL REPORTING AND DATA

Requirement	Documentation to Review	Examples of Best Practices
Contract Exhibit A, Attachment III: 4.6.9 **General Requirements** A. Contractor must submit to DHCS a monthly Grievance and Appeal report for Medi-Cal Members only in the form that is required by and submitted to Department of Managed Health Care (DMHC), as set forth in 28 CCR section 1300.68(f), with additional information required by DHCS per 42 CFR section 438.416 and 22 CCR section 53858(e). B. Contractor must comply with the requirements set forth in Exhibit A, Attachment III, Section 2.1 (Management Information System) of this Contract for the reporting of Grievance and Appeal data. C. Contractor must maintain records of Grievances and Appeals and must have policies and procedures in place governing the review of the information as part of its ongoing QIS. Contractor must identify systemic patterns of wrongful denials and impose Corrective Action as necessary. The records must be accurately maintained in a manner accessible to the State and available to CMS upon request. Records must include all required information set forth in 42 CFR section 438.416(b). Contractor must ensure that all documents and records, whether in a written or electronic format, generated or obtained by Contractor in the course of responding to ABDs, Grievances, Appeals, and IMRs are retained for at least 10 years pursuant to 42 CFR section 438.3(u).	✓ Policies and Procedures: Grievance and Appeal Tracking, Analysis, and Corrective Action ✓ Grievance Logs, including Subcontractor Logs *Should include all required fields and demonstrate tracking/resolution of exempt grievances ✓ Quality Improvement, Governing Board, Member Advisory Committee Minutes ✓ Documentation of Data Submission to DHCS and DMHC	Grievance logs demonstrate all elements required and show the inclusion of exempt grievances. Data submitted to DHCS and DMHC is consistently accurate, timely, and aligns with internal logs. The MCP documents review of the grievance log as contractually required. The MCP ensures all grievance and appeal records are securely maintained and easily accessible for audit or CMS review, with a policy confirming a 10-year retention.

Requirement	Documentation to Review	Examples of Best Practices
	✓ Record Retention Policy (10 years)	
CCR Title 22, Section 53858 **Member Grievance Procedures** **(e)** The member grievance procedures shall at a minimum provide for: **(1)** The recording in a grievance log of each grievance received by the MCP, either verbally or in writing. The grievance log shall include the following information: **(A)** The date and time the grievance is filed with the MCP or provider. **(B)** The name of the member filing the grievance. **(C)** The name of the MCP provider or staff person receiving the grievance. **(D)** A description of the complaint or problem. **(E)** A description of the action taken by the MCP or provider to investigate and resolve the grievance. **(F)** The proposed resolution by the MCP or provider. **(G)** The name of the MCP provider or staff person responsible for resolving the grievance. **(H)** The date of notification of the member of the proposed resolution. **CCR Title 28, Section 1300.68** **Grievance System**	✓ Policies and Procedures* ✓ Grievance Logs, including Subcontractor Logs ✓ Quality Improvement, Governing Board, Member Advisory Committee Minutes * Should include date and time grievance was filed, Member's name, staff/provider receiving and resolving grievance, description of the issue, resolution, date of Member notification *Should include exempt grievances	Grievance logs demonstrate all elements required and show the inclusion of exempt grievances. The MCP documents review of the grievance log as contractually required. The MCP uses grievance log trends to identify systematic issues and integrate findings into its quality improvement strategy. Verification Study shows MCP responds to Department's document requests as outlined in CCR Title 28 1300.68.01.

Requirement	Documentation to Review	Examples of Best Practices
(b)(5) A written record shall be made for each grievance received by the MCP, including the date received, the MCP representative recording the grievance, a summary or other document describing the grievance, and its disposition. The written record of grievances shall be reviewed periodically by the governing body of the MCP, the public policy body created pursuant to CCR Title 28 section 1300.69, and by an officer of the MCP or his designee. This review shall be thoroughly documented.	Verification Study ▲	
CCR Title 28, Section 1300.68 **Grievance System** **(e)**The MCP's grievance system shall track and monitor grievances received by the MCP, or any entity with delegated authority to receive or respond to grievances. The system shall be able to indicate the total number of grievances received, pending and resolved in favor of the enrollee at all levels of grievance review and to describe the issue or issues raised in grievances as (1) coverage disputes, (2) disputes involving medical necessity, (3) complaints about the quality of care and (4) complaints about access to care (including complaints about the waiting time for appointments), and (5) complaints about the quality of service, and (6) other issues.	See Above	See Above

Requirement	Documentation to Review	Examples of Best Practices
Title 28, CCR 1300.68.01 **Urgent Grievance Tracking and Monitoring** **(f)** According to Title 28, CCR 1300.68.01 (b) (2)-(3), each MCP's grievance system shall allow the Department to contact the MCP regarding urgent grievances 24 hours a day, 7 days a week. During normal work hours, the MCP shall respond to the Department within 30 minutes after initial contact from the Department. During non-work hours, the MCP shall respond to the Department within one hour after initial contact from the Department.	✓ Policies and Procedures* ✓ Verification Study, including expedited grievance requests ▲ *Includes details that the grievance system supports 24/7 contact with the Department for urgent grievances and includes response time requirements.	MCPs are able to demonstrate how DHCS may access the MCP's grievance system and respond to DHCS' document requests as outlined in CCR Title 28 1300.68.01 and demonstrates appropriate processing of expedited grievances.

CATEGORY 4.10: ACCESS RIGHTS

Requirement	Documentation to Review	Examples of Best Practices
Contract Exhibit A, Attachment III: 5.2.10 **A. Equal Access for Linguistic Services** Contractor must ensure equal access to the provision of high quality interpreter and linguistic services for LEP Members and Potential Members, and for Members and Potential Members with disabilities, in compliance with federal and State law, and APL 21-004.	✓ Policies and Procedures (P&Ps) ✓ MCP's Cultural & Linguistic (C&L) Services Program ✓ Provider Manual ✓ Provider Newsletters ✓ Provider Education: ✓ Documentation of Initial & Ongoing Training ✓ Member Handbook ✓ Member Newsletters ✓ MCP Website ✓ Reports to- and Committee Meeting Minutes: ✓ Governing Body ✓ Utilization Mngt. ✓ Quality Improvement ✓ Community Advisory ✓ Grievance Logs/Files ✓ Member Satisfaction Surveys	MCP informs Members of availability of high- quality interpreter and linguistic services and its non-discrimination policy (Provider Manual & Newsletters, initial and ongoing provider education/training, Member Handbook & Newsletters, MCP website). Grievance logs/files and Member surveys show no complaints of MCP discriminating against persons based on race, color, religion, or national origin. If there is any issue, MCP shows documentation that grievances/complaints resolved appropriately. MCPs must ensure language assistance services are provided free of charge, be accurate and timely, and protect the privacy and independence of LEP members. MCPs must establish processes for ensuring subcontractors and network providers comply with applicable state and federal laws and regulations, contract requirements and other DHCS guidance.

Requirement	Documentation to Review	Examples of Best Practices
Contract Exhibit A, Attachment III: 5.2.10 **B. Linguistic Services: 24-Hour Interpreter Services** 1. Contractor must comply with W&I section 14029.91 and ensure that all monolingual, non-English-speaking, or LEP Members and Potential Members receive 24-hour interpreter services at all key points of contact, as defined in Paragraph B.4) of this provision, either through interpreters, telephone language services, or other legally compliant electronic options. 2. Contractor must ensure that any lack of interpreter services does not impede or delay a Member's timely access to care.	✓ Policies and Procedures (P&P) ✓ MCP's C&L Services Program ✓ Contracts: Interpretation Services ✓ MCP's List of Staff's Linguistic Capacity for Interpretation Services ✓ Provider Manual ✓ Provider Newsletters ✓ Provider Education ✓ Documentation of Initial & Ongoing Training ✓ Member Handbook ✓ Member Newsletters ✓ MCP Website ✓ Reports to- and Committee Meeting Minutes: ✓ Governing Body ✓ UM, QI, CAC ✓ Grievance Logs/Files ✓ Member Satisfaction Surveys	MCP policies and procedures delineate the MCP's responsibility to provide and inform providers and Members of its 24-hour linguistic services at all medical and non-medical key points of contact, e.g., telephone advice lines, urgent care and outpatient encounters such as pharmacy and other provider sites, Member and appointment services, orientation, etc. Grievance files have minimal to no cases related to 24-hour linguistic services; MCP is appropriate and timely in grievance resolution and takes follow-up action to correct any identified deficiencies.

Requirement	Documentation to Review	Examples of Best Practices
Contract Exhibit A, Attachment III: 5.2.10 **B. Linguistic Services: 24-Hour Interpreter Services** See Criteria Above	See Above	In addition to above: MCP is able to provide documentation of how it provides 24-hour linguistic services at all key points of Member contact, e.g., bilingual and/or multilingual staff list, contracts for telephone interpretation services, telephone interpretation hotline number, contracts for ASL interpretation services and/or telecommunication device for the deaf (TDD), etc. Committee Meeting Minutes include discussion of C&L services, issues, concerns, policy or program changes, etc.

Requirement	Documentation to Review	Examples of Best Practices
Contract Exhibit A, Attachment III: 5.2.10 **B. Linguistic Services: Minimum Services** 3. Contractor must comply with Title VI of the Civil Rights Act of 1964 and 42 CFR section 438.10(d) and have the capacity to provide, at minimum, the following linguistic services at no cost to Members or Potential Members: a. (Oral) interpreters, sign language Providers, or bilingual Network Providers, Network Provider staff, Subcontractors, and Downstream Subcontractors at all key points of contact. These services must be provided in all languages spoken by Medi-Cal Members and Potential Members and not limited to those that speak the threshold or concentration standards languages. b. Full and immediate translation of written materials pursuant to 42 CFR sections 438.10(d)(3), 438.404(a), and 438.408(d); W&I section 14029.91; and 22 CCR section 53876 for LEP Members and Potential Members who speak Threshold or Concentration Standard Languages, fully translated Member Information, including: the Member Handbook, Provider Directory, welcome packets, Marketing information, Member rights information, form letters and individual notices, including Notice of Action (NOA) letters, all notices related to Grievances and Appeals including Grievance and Appeal acknowledgement and resolution letters, and any	✓ Policies and Procedures (P&Ps) ✓ MCP's Cultural & Linguistic (C&L) Services Program ✓ PNA ✓ Provider Manual ✓ Provider Newsletters ✓ Provider Education ✓ Documentation of Initial & Ongoing Training ✓ Member Handbook ✓ Member Newsletters ✓ MCP Website ✓ Reports to Committee and Meeting Minutes ○ Governing Body ○ UM ○ QI ○ Comm. Advisory ✓ Tracking/Monitoring Reports: Referrals to C&L Community Programs ✓ Grievance Logs/Files ✓ Member Satisfaction Surveys	Using various methods (e.g., Provider Manual & Newsletters, initial and ongoing provider training, Member Handbook, Newsletters, MCP Website, Fax Blasts, etc.), the MCP informs providers, Members, and potential enrollees about the provision of linguistic services provided at no cost to them. Provision of these services is not limited to those that speak the threshold or concentration standard languages: • Interpreter Services • Sign Language Interpreter and Relay Services • Bilingual providers and staff at all key points of contact • Fully translated Member information (Member Handbook), Welcome Packets, marketing info, and form letters, NOA and Grievance and Appeal Acknowledgement and Resolution Letters) • Referrals to C&L community service programs • Auxiliary aids (TDD – Telecommunication Devices for the Deaf) The MCP's Interpreter Utilization logs and signers show that the MCP provides oral interpreters, sign language providers,

Requirement	Documentation to Review	Examples of Best Practices
other materials as required by Title VI of the Civil Rights Act of 1964 and APL 21-004. c. Referrals to culturally and linguistically appropriate community service programs. d. Auxiliary Aids such as Telephone Typewriters (TTY)/ Telecommunication Devices for the Deaf (TDD), qualified interpreters including American Sign Language interpreters, and information in alternative formats including Braille, large print text (20 point font or larger), audio, and electronic formats, in accordance with written informing materials in alternative formats, selected by the Member, as specified in APL 21-004 and APL 22-002. **CFR Section 438.10** **Information Requirements** Includes criteria for MCPs to provide all required information to enrollees in a manner and format that may be easily understood and readily accessible	✓ Translated Materials: Welcome Packets, Health Education ✓ Medical Records	Network bilingual providers, Network Provider staff, subcontractors, and downstream subcontractors at all key points of contact in all languages spoken by Medi-Cal Members. The MCP conducts ongoing monitoring to ensure that it meets Contract requirements for linguistic services, e.g., internal audits, Provider and Member surveys, grievances, Population Needs Assessment (PNA) studies, etc. MCP provides documentation to support the use of PNA data to translate written materials to threshold languages (PNA's MCP Threshold Languages Report, the Member Handbook translated in Spanish, etc.) MCP provides documents of fully translated materials: • Welcome Packets • Marketing Materials • Provider Listings or Directories • Member Handbook, • Newsletters, Surveys • Health Education Materials • Preventive Health Reminders: appts., immunization, IHA, prenatal care follow-up

Requirement	Documentation to Review	Examples of Best Practices
		• Forms: Disclosure forms, patient history/ intake forms, consent forms, complaint / grievance forms • Instructions: Accessing covered services requiring prior authorizations, filing/completing a grievance form and obtaining a fair hearing • Form Letters: NOAs, Prior Authorization Denial or Approval letters, NARs, Emergency Room Follow-up, etc. • Medical records include the Member's C&L preference. Using this data, the MCP tracks and monitors that Members are referred to C&L appropriate community service programs, e.g., referral tracking logs.

Requirement	Documentation to Review	Examples of Best Practices
Contract Exhibit A, Attachment III: 5.2.10 **B. Linguistic Services: Key Points of Contact** 4. Key points of contact include: a. Medical care settings, such as telephone, advice and Urgent Care transactions, and outpatient Encounters with Providers; and b. Non-medical care settings, such as Member services, orientations, and appointment scheduling. **W&I section 14029.91** **General Provisions** Includes requirements for managed care MCPs contracting with the Department to provide language assistance services to LEP members.	✓ Policies and Procedures (P&Ps) ✓ MCP's Cultural & Linguistic (C&L) Services Program ✓ Provider Manual ✓ Member Handbook ✓ MCP Website ✓ Reports to Committee and Meeting Minutes: ○ Governing Body ○ UM ○ QI ○ Comm. Advisory ✓ Grievance Logs and Files ✓ Member Satisfaction Surveys	MCP policies and procedures delineate the MCP's responsibility to provide and inform providers and Members of its 24-hour interpreter services at all medical and non-medical key points of contact, e.g., telephone advice lines, urgent care and outpatient encounters such as pharmacy and other provider sites, Member and appointment services, orientation, etc. At a minimum, Over-the-Phone Interpreters (OPI) services must be available in the threshold languages if requested by a LEP Member for pharmacy counseling. During the onsite interview/visit, MCP providers are able to show how they provide language services, e.g., providers, staff, and Members have easy access to the MCP's interpreter telephone hotline. Grievance logs/files have minimal or no cases related to the 24-hour language services; The MCP follows protocols for appropriate and timely grievance resolution and takes follow-up action.to correct any deficiencies identified.

Requirement	Documentation to Review	Examples of Best Practices
Contract Exhibit A, Attachment III: 5.2.10 **C. Access for Persons with Disabilities** Contractor must comply with the requirements of Titles II and III of the Americans with Disabilities Act of 1990 (42 USC sections 12131 et seq. and 12181 et seq.), section 1557 of the Affordable Care Act of 2010 (42 USC section 18116), sections 504 and 508 of the Rehabilitation Act of 1973 (29 USC sections 794 and 794d), Government Code (GC) sections 7405 and 11135, and all applicable implementing regulations, and must ensure access for people with disabilities including, without limitation, accessible web and electronic content, ramps, elevators, accessible restrooms, designated parking spaces, and accessible drinking water.	✓ Policies and Procedures ✓ Member Handbook ✓ Grievance Log ✓ Member Satisfaction Surveys ✓ Verification Study ▲	MCP policies and procedures delineate its responsibilities to provide assessable accommodations to Members with disabilities without limitation, including Video Remote Interpreting (VRI), Video Relay Services (VRS), Telecommunication Relay Service and/or Teletypewriter (TTY) services at all medical point. MCP ensures Member-facing materials inform Members of their rights and services offered to people with disabilities. Grievance logs/files have minimal to no cases related to access for people with disabilities; The MCP follows protocols for appropriate and timely grievance resolution and takes follow-up actions to correct any deficiencies identified.

CATEGORY 4.11: CULTURAL AND LINGUISTIC PROGRAMS AND COMMITTEES

Requirement	Documentation to Review	Examples of Best Practices
Contract Exhibit A, Attachment III: 5.2.11 **A. C&L Program: Policies and Procedures** 1. Contractor must develop and implement policies and procedures for assessing the performance of its employees, contracted staff, and other individuals who provide linguistic services, addressing any identified gaps in the provision of cultural and linguistic services by Contractor's staff, and for overall monitoring and evaluation of its cultural and linguistic services programs. **A. C&L Program: Monitoring and Improving Delivery of Services** 2. Contractor must have in place and continually monitor, improve, and evaluate cultural and linguistic services that support the delivery of Covered Services to Members. Contractor must ensure it has proper policies and procedures in place to provide appropriate cultural and linguistic services for all of its Members. **A. C&L Program: Addressing Deficiencies** 3. Contractor must take immediate action to improve the delivery of culturally and linguistically appropriate services when deficiencies are noted.	✓ Policies and Procedures (P&Ps) ✓ MCP's C&L Services Program ✓ Reports to Committee and Meeting Minutes: ○ Governing Body ○ UM ○ QI ○ Comm. Advisory ✓ Grievance Logs and Files	MCP is able to provide documents to support its implementation of P&Ps for ongoing monitoring that includes assessing the performance of individuals who provide language services as well as for overall monitoring and evaluation of the C&L Services Program, e.g., internal audit, Member satisfaction surveys, grievances, etc. Committee Meeting Minutes include discussion of C&L services, issues, concerns, policy or program changes, etc. Grievance logs/files have minimal or no cases related to C&L services; MCP follows protocols for appropriate and timely grievance resolution and takes follow-up action to correct any deficiencies identified. Evidence of active recruiting and retaining of culturally and linguistically competent Providers that reflect the needs of the Medi-Cal population in the MCP's Service Area.

Requirement	Documentation to Review	Examples of Best Practices
A. C&L Program: Recruitment and Retention of Providers 4. Contractor must be active in recruiting and retaining culturally and linguistically competent Providers that reflect the needs of the Medi-Cal population in Contractor's Service Area.		
Contract Exhibit A, Attachment III: 5.2.11 **A. C&L Program: Adherence to Federal and State Requirements and Immediate Translation of Critical Member Information** 5. Contractor must have a cultural and linguistic services program, as required by 22 CCR section 53876, that incorporates all requirements of applicable federal and State law, including without limitation those requirements cited in Exhibit A, Attachment III, Subsection 5.2.10 (Access Rights), 42 CFR section 438.206(c)(2), 22 CCR sections 51202.5 and 51309.5(a), and 28 CCR sections 1300.67.04(c)(2)(A) - (B) and 1300.67.04(c)(2)(G)(v) - (c)(4). Contractor must ensure immediate translation of all critical Member Information as required by 42 CFR sections 438.10, 438.404(a), and 438.408(d), and W&I section 14029.91. **Contract Exhibit A, Attachment III: 5.2.11** **A. C&L Program: Alignment with Population Needs Assessment** 6. Contractor must review and update its cultural and linguistic services programs to align with the	✓ Policies and Procedures (P&Ps) ✓ MCP's C&L Services Program ✓ DHCS C&L Questionnaire ✓ PNA Report: Note Threshold Language ✓ Provider Manual ✓ Provider Newsletters ✓ Provider Education: ✓ Documentation of Initial & Ongoing Training ✓ Member Handbook ✓ Member Newsletters ✓ MCP Website ✓ Grievance Logs and Files ✓ Reports to Committee and Meeting Minutes: ○ Governing Body ○ UM ○ QI	MCP policies and procedures delineate how the MCP's C&L Services Program meets Contract requirements that include quality improvement measures in the delivery of C&L services. The Contract with the MCP includes CCR, Title 22, § 53876 requirements reflected in MCP policies and procedures that delineate how the MCP provides members access to interpreters, translated signage and written materials, and referrals to C&L community services programs. Policies and procedures require the MCP to maintain a CAC and meet periodically with the committee concerning the development and implementation of its C&L accessibility standards/procedures.

Requirement	Documentation to Review	Examples of Best Practices
Population Needs Assessment (PNA) implementation and subsequent findings. Contractor must ensure its Network Providers, Subcontractors, Downstream Subcontractors cultural and Health Equity linguistic services programs also align with the PNA. *Note: This section contains new 2024 MCP Contract requirements pertaining to the CAC, Chief Health Equity Officer, etc.*	○ Comm. Advisory	
Contract Exhibit A, Attachment III: 5.2.11 **A. C&L Program: Written Description / Minimum Requirements** 7. Contractor must implement and maintain a written description of its cultural and linguistic services program which must include, at a minimum, the following: a. Its organizational commitment to deliver culturally and linguistically appropriate health care services; b. Services that comply with Title VI of the Civil Rights Act of 1964 (42 USC section 2000e et seq.), section 1557 of the Affordable Care Act of 2010 (42 USC section 18116), 42 CFR section 438.10, APL 21-004, and Exhibit A, Attachment III, Subsection 5.2.10 (Access Rights). c. Use of national standards for Culturally and Linguistically Appropriate Services (CLAS) for reference; d. An organizational chart showing the key staff with overall responsibility for cultural and linguistic services programs;	✓ Policies and Procedures (P&Ps) ✓ MCP's Cultural & Linguistic (C&L) Services Program: Written Description ✓ MCP's C&L Organization Chart ✓ PNA ✓ Provider Manual ✓ Member Handbook ✓ Member Newsletters ✓ MCP Website ✓ Reports to Committee and Meeting Minutes: ○ Governing Body ○ UM ○ QI ○ Comm. Advisory	The MCP maintains a written description of its C&L Services Program that includes: An organizational commitment to deliver culturally and linguistically appropriate health care services. Goals, objectives and a timetable for implementation. accomplishment of the C&L Services Program. An organizational chart showing the key staff persons with responsibility, and their qualifications Standards and Performance requirements for the delivery of culturally and linguistically appropriate health care services.

Requirement	Documentation to Review	Examples of Best Practices
e. A narrative explaining the organizational chart and describing the oversight and direction to the Community Advisory Committee (CAC), requirements for Contractor's support staff, and reporting relationships. Qualifications of Contractor's staff, including appropriate education, experience, and training must also be included; f. The role of the PNA to inform Contractor's cultural and linguistic services program priorities in compliance with Exhibit A, Attachment III, Subsection 4.3.2 (Population Needs Assessment); g. The implementation and maintenance of annual sensitivity, diversity, communication skills, Health Equity, and cultural competency/humility training and related trainings (e.g., providing gender affirming care) for employees and contracted staff (clinical and non-clinical), as determined by Section C of this provision, Diversity, Equity, and Inclusion Training; and h. Contractor's administrative oversight and compliance monitoring of the cultural and linguistic services program and requirements for the delivery of culturally and linguistically appropriate health care services.		

Requirement	Documentation to Review	Examples of Best Practices
22 CCR section 53876 **Cultural and Linguistic Requirements** Includes requirements for the contract between the Department and MCP to include at a minimum interpreters, translated signage, translated written materials, and referrals to culturally and linguistically appropriate community service programs as well as establishment of a community advisory committee.	✓ See Above	The MCP utilizes national standards for Culturally and Linguistically Appropriate Services (CLAS) for reference.

Requirement	Documentation to Review	Examples of Best Practices
Contract Exhibit A, Attachment III: 5.2.11 **B. Linguistic Capability of Employees and Contracted Staff** Contractor must assess and track the linguistic capability of its interpreters or bilingual staff and contracted staff (clinical and non-clinical). Contractor must implement a system to provide adequate training regarding its language assistance programs to all employees and contracted staff who have routine contact with LEP Members or Potential Members and systematically address any identified gaps in Contractor's ability to address Members' cultural and linguistic needs. The training must include instruction on: 1. Contractor's policies and procedures for language assistance; 2. How to work effectively with LEP Members and Potential Members; 3. How to work effectively with interpreters in person and through video, telephone, and other media; and, 4. Understanding the cultural diversity of Members and Potential Members, and sensitivity to cultural differences relevant to delivery of health care interpretation services, in accordance with Exhibit A, Attachment III, Subsection 5.2.11 (Cultural and Linguistic Programs and Committees).	✓ Policies and Procedures (P&Ps) ✓ MCP's C&L Services Program ♦ ✓ PNA ✓ DEI Training Records/Attestations ✓ Annual DEI Training Evaluation by CHEOs ✓ Reports to Committee and Meeting Minutes: ♦ ○ Governing Body ○ UM ○ QI ○ Comm. Advisory	The MCP is able to demonstrate a compliant program and monitoring of employee linguistic capability that includes assessing, identifying, and tracking interpreters and bilingual staff as well as the development of procedures for assessing interpreters' capabilities, (attestation of linguistic capability, language proficiency results, etc.). The MCP monitors C&L service needs within the committees and ensures Network Providers and Allied Health Personnel receive pertinent information regarding the PNA findings and the identified targeted strategies.

Requirement	Documentation to Review	Examples of Best Practices
Contract Exhibit A, Attachment III: 5.2.11 **C. Diversity, Equity, and Inclusion Training** Contractor must provide annual sensitivity, diversity, cultural competency/humility and Health Equity training for its employees and contracted staff as detailed in APL 23-025. Training must consider structural and institutional racism and Health Inequities and their impact on Members, staff, Network Providers, Subcontractors, and Downstream Subcontractors. Contractor must ensure Network Providers and Allied Health Personnel receive pertinent information regarding the PNA findings and the identified targeted strategies. Contractor must use the most appropriate communication method(s) to assure the information can be accessed and understood. The training must include the following requirements: 1. Promote access and delivery of services in a culturally competent manner to all Members and Potential Members, regardless of sex, race, color, religion, ancestry, national origin, creed, ethnic group identification, age, mental disability, physical disability, medical condition, genetic information, health status, marital status, gender, gender identity, sexual orientation, or identification with any other persons or groups defined in Penal Code section 422.56; and 2. Information about the Health Inequities and identified cultural groups in Contractor's Service Area which includes but is not limited to: the groups' beliefs about illness and health; need for gender	In addition to above: ♦ MCP's C&L Services Program and Meeting Minutes: Auditor reviews individually for compliance and as a reference when reviewing all other evidence. Auditors also conduct verification studies and interviews to ensure implementation in practice at all points of contact and correspondence with members. Includes assessing the training of MCP staff and other available resources to ensure the delivery of culturally and linguistically appropriate services.	The MCP uses the most appropriate communication method(s) to assure the information can be accessed and understood to promote access and delivery of services in a culturally competent manner. Information about the Health Inequities and identified cultural groups in MCP's Service Area is addressed.

Requirement	Documentation to Review	Examples of Best Practices
affirming care; methods of interacting with Providers and the health care structure; traditional home remedies that may impact what the Provider recommends to treat the patient; and language and literacy needs. *Note: This section contains new 2024 MCP Contract requirements related to diversity and health equity training of MCP staff. Training and certification of MCP staff are included in Audit Category 6.*		
Contract Exhibit A, Attachment III: 5.2.11 **D. Community Engagement** Contractor must develop a policy and procedure for a Member and family engagement strategy that involves Members and their families as partners in the delivery of Covered Services. This includes, but is not limited to the following: 1. Maintaining an organizational leadership commitment to engaging with Members and their families in the delivery of care; 2. Routinely engaging with Members and families through focus groups, listening sessions, surveys and/or interviews and incorporating results into policies and decision-making, as described in Exhibit A, Attachment III, Subsection 2.2.7.A (Quality Improvement and Health Equity Annual Plan); 3. Developing processes and accountability for incorporating Member and family input into policies and decision-making;	✓ Policies and Procedures ✓ Focus group, Listening sessions, surveys and/or interviews from Members and families ✓ Consumer surveys ✓ QI Work Plan ✓ QI committee meeting minutes ✓ Cultural and Linguistic committee meeting minutes	The MCP's policies and procedures show the MCP has a family engagement strategy that involves Members and their families as partners in the delivery of Covered Services.

Requirement	Documentation to Review	Examples of Best Practices
4. Developing processes to measure and/or monitor the impact of Member and family input into policies and decision-making; 5. Developing processes to share with Members and families how their input impacts policies and decision-making; 6. Conducting consumer surveys and incorporating results in Quality Improvement (QI) and Health Equity activities as described in Exhibit A, Attachment III, Subsection 2.2.9.C (Consumer Satisfaction Survey); 7. Partnering with community based organizations to cultivate Member and family engagement; 8. Maintaining a CAC whose composition reflects Contractor's Member population and whose input is actively utilized in policies and decision-making by Contractor, as outlined below in Exhibit A, Attachment III, Subsection 5.2.11.E. (Cultural and Linguistic Programs and Committees).		
Contract Exhibit A, Attachment III: 5.2.11 **E. Community Advisory Committee (CAC): Diversity and Representation** 1. Contractor must have a diverse CAC pursuant to 22 CCR section 53876(c), comprised primarily of Contractor's Members, as part of Contractor's implementation and maintenance of Member and community engagement with stakeholders, community advocates, traditional and Safety-Net Providers, and Members. 2. CAC Membership	✓ Policies and Procedures ✓ CAC Charter ✓ CAC Committee Meeting Minutes ✓ Org Charts	The MCP's policies and procedures show the CAC is represented in accordance with Contract requirements and 22 CCR section 53876(c). CAC demonstrates good faith effort to select representative members of the CAC.

Requirement	Documentation to Review	Examples of Best Practices
a. Contractor must convene a CAC selection committee tasked with selecting the members of the CAC. Contractor must demonstrate a good faith effort to ensure that the CAC selection committee is comprised of a representative sample of each of the persons below to bring different perspectives, ideas, and views to the CAC: i. Persons who sit on Contractor's Governing Board, which should include representation in the following areas: Safety Net Providers including FQHCs, Behavioral Health Providers, Regional Centers (RC), Local Education Agencies (LEAs), dental Providers, IHCPs, and Home and Community-Based Service (HCBS) program Providers; and ii. Persons and community-based organizations who are representatives of each county within Contractor's Service Area adjusting for changes in membership diversity. *Note: See Contract Section 1.1.7 and APL 25-009 for further CAC requirements related to Contractor's obligation to consult with their Health Equity Officer.*		

Requirement	Documentation to Review	Examples of Best Practices
Contract Exhibit A, Attachment III: 5.2.11 **E. 2. CAC Membership: Diversity and Representation (continued)** b. The CAC selection committee must ensure the CAC membership reflects the general Medi-Cal Member population in Contractor's Service Area, including representatives from IHCPs, and adolescents and/or parents and/or caregivers of Children, including foster youth, as appropriate and be modified as the population changes to ensure that Contractor's community is represented and engaged. The CAC selection committee must make good faith efforts to include representatives from diverse and hard-to-reach populations on the CAC, with a specific emphasis on persons who are representative of or serving populations that experience Health Disparities such as individuals with diverse racial and ethnic backgrounds, genders, gender identity, and sexual orientation and physical disabilities.	✓ See Above	See Above
Contract Exhibit A, Attachment III: 5.2.11 **E. 2. CAC Membership: Timeline for Selecting and Replacing Members** c. Contractor's CAC selection committee must select all of its CAC members promptly no later than 180 calendar days from the effective date of this contract. d. Should a CAC member resign, is asked to resign, or is otherwise unable to serve on the CAC, Contractor must make its best effort to promptly replace the	✓ Policies and Procedures ✓ CAC Committee Meeting Minutes	The MCP's policies and procedures describe process to replace vacant seat for CAC members. All CAC committee members should be selected. Best efforts to replace vacant seats are made within 60 calendar days of the CAC vacancy.

Requirement	Documentation to Review	Examples of Best Practices
vacant seat within 60 calendar days of the CAC vacancy.		
Contract Exhibit A, Attachment III: 5.2.11 **E. 2. CAC Membership: Coordinator Responsibilities** e. Contractor must designate a CAC coordinator and maintain a written job description detailing the CAC coordinator's responsibilities, which must include having responsibility for managing the operations of the CAC in compliance with all statutory, rule, and contract requirements, including, but not limited to: i. Ensuring CAC meetings are scheduled and committee agendas are developed with the input of CAC members; ii. Maintaining CAC membership, including outreach, recruitment, and onboarding of new members, that is adequate to carry out the duties of the CAC; iii. Actively facilitating communications and connections between the CAC and Contractor leadership, including ensuring CAC members are	✓ CAC Coordinator Job Description	CAC written job description describes the CAC coordinator's responsibilities to be in compliance with all statutory, rules, and contract requirements.

Requirement	Documentation to Review	Examples of Best Practices
informed of Contractor decisions relevant to the work of the CAC; iv. Ensuring that CAC meetings, including necessary facilities, materials, and other components, are accessible to all participants and that appropriate accommodations are provided to allow all attending the meeting, including, but not limited to, accessibility for individuals with a disability or LEP Members to effectively communicate and participate in CAC meetings; v. Ensuring compliance with all CAC reporting and public posting requirements; and vi. The CAC coordinator may be an employee of Contractor, Subcontractor, or Downstream Subcontractor. Contractor's CAC coordinator must not be a member of the CAC or a Member enrolled with Contractor.		
Contract Exhibit A, Attachment III: 5.2.11 **E. 3. CAC Meetings** a. Contractor must hold its first regular CAC meeting promptly after all initial CAC members have been selected by the CAC selection committee and at least quarterly thereafter. b. Contractor must make the regularly scheduled CAC meetings open to the public, posting meeting information publicly on Contractor's website in a centralized location 30 calendar days prior to the meeting, and in no event later than 72 hours prior to the meeting.	✓ Policies and Procedures ✓ CAC Meeting Minutes ✓ MCP Website	The MCP's policies and procedures describes meeting schedule and process to conduct meetings. CAC meetings are regularly scheduled, open to the public, and accessible to all. CAC meeting minutes are posted to the MCPs website with 45 calendar days after each meeting. Resources are provided to CAC members to effectively participate in meetings.

Requirement	Documentation to Review	Examples of Best Practices
c. Contractor must provide a location for CAC meetings and all necessary tools and materials to run meetings, including, but not limited to, making the meeting accessible to all participants and providing accommodations to allow all individuals to attend and participate in the meetings. d. CAC must draft written minutes of each of its meetings and the associated discussions. All minutes must be posted on Contractor's website and submitted to DHCS no later than 45 calendar days after each meeting. Contractor must retain the minutes for no less than ten years and provided to DHCS, upon request. e. Contractor must ensure that CAC members are supported in their roles on the CAC, including but not limited to providing resources to educate CAC members to ensure they are able to effectively participate in CAC meetings, providing transportation to CAC meetings, arranging childcare as necessary, and scheduling meetings at times and in formats to ensure the highest CAC member participation possible. f. Contractor must demonstrate that CAC input is considered in annual reviews and updates to relevant policies and procedures, including CAC input pursuant to Exhibit A, Attachment III, Subsection 5.2.11.E. (Cultural and Linguistic Programs and Committees) that is relevant to policies and procedures affecting quality and Health Equity. Contractor must provide a feedback loop to inform CAC members how their input has been incorporated.		

Requirement	Documentation to Review	Examples of Best Practices
Contract Exhibit A, Attachment III: 5.2.11 **E. 4. Duties of the CAC** The CAC must carry out the duties as set forth in this Contract. Such duties include, but are not limited to: a. Identifying and advocating for Preventive Care practices to be utilized by Contractor; b. Contractor must ensure that the CAC is included and involved in developing and updating cultural and linguistic policy and procedure decisions including those related to QI, education, and operational and cultural competency issues affecting groups who speak a primary language other than English. The CAC may also advise on necessary Member or Provider targeted services, programs, and trainings; c. The CAC must provide and make recommendations to Contractor regarding the cultural appropriateness of communications, partnerships, and services; d. The CAC must review PNA findings and have a process to discuss improvement opportunities with an emphasis on Health Equity and Social Drivers of Health. Contractor must allow its CAC to provide input on selecting targeted health education, cultural and linguistic, and QI strategies; e. Contractor must provide sufficient resources for the CAC to support the required CAC activities outlined above, including supporting the CAC in engagement strategies such as consumer listening sessions, focus groups, and/or surveys; and f. The CAC must provide input and advice, including, but not limited to, the following:	✓ Policies and Procedures ✓ CAC Meeting Minutes ✓ Reports and/or Recommendations from CAC	The MCP's policies and procedures describes the duties of the CAC. CAC identifies and advocates for Preventative Care practices to be used by the MCP. CAC is included in cultural and linguistic policies and procedure decisions related to QI, education, and operational and cultural competency. CAC makes recommendations regarding the cultural appropriateness of communications. In addition to above: The CAC reviews PNA findings and has a process to discuss improvement opportunities. The MCP provides resources to support the CAC activities. Contractor must engage their CAC as part of their participation in Local Health Jurisdictions' Community Health Assessments (CHA) and Community Health Improvement MCPs (CHIP) process. (contract language will most likely be updated in next iteration).

Requirement	Documentation to Review	Examples of Best Practices
i. Culturally appropriate service or program design; ii. Priorities for health education and outreach program; iii. Member satisfaction survey results; iv. Findings of the PNA; v. MCP Marketing Materials and campaigns. vi. Communication of needs for Network development and assessment; vii. Community resources and information; viii. Population Health Management; ix. Quality; x. Health Delivery Systems Reforms to improve health outcomes; xi. Carved Out Services; xii. Coordination of Care; xiii. Health Equity *xiv.* Accessibility of Services ***Note:*** *See APL 25-009 and PHM Policy Guide for updated and/or further requirements regarding Duties of the CAC.*		
Contract Exhibit A, Attachment III: 5.2.11 **E. 5. Contractor's Annual CAC Demographic Report** To ensure Contractor's CAC membership is representative of the Communities in Contractor's Service Area, Contractor must complete and submit to DHCS annually an Annual CAC Member Demographic Report by April 1 of each year. The Annual CAC Member Demographic Report must include descriptions of all of the following: a. The demographic composition of CAC membership;	✓ Annual CAC Member Demographic Report	The MCP submits a CAC Member Demographic Report by April 1 of each year to DHCS.

Requirement	Documentation to Review	Examples of Best Practices
b. How Contractor defines the demographics and diversity of its Members and Potential Members within Contractor's Service Area; c. The data sources relied upon by Contractor to validate that its CAC membership aligns with Contractor's Member demographics; d. Barriers to and challenges in meeting or increasing alignment between CAC's membership with the demographics of the Members within Contractor's Service Area; e. Ongoing, updated and new efforts and strategies undertaken in CAC membership recruitment to address the barriers and challenges to achieving alignment between CAC membership with the demographics of the Members within Contractor's Service Area; and f. A description of the CAC's ongoing role and impact in decision-making about Health Equity, health-related initiatives, cultural and linguistic services, resource allocation, and other community-based initiatives, including examples of how CAC input impacted and shaped Contractor initiatives and/or policies.		

CATEGORY 4.12: MEMBER RIGHTS AND RESPONSIBILITIES

Requirement	Documentation to Review	Examples of Best Practices
Contract Exhibit A, Attachment III: 5.1.1 **A. Member Rights and Responsibilities: Policies and Procedures** Contractor must develop, implement, and maintain written policies and procedures that set forth the Member's rights and responsibilities and must communicate its policies to its Members, Providers, and, upon request, Potential Members. 1. Contractor's written policies and procedures must include the following Member rights: a. To be treated with respect, giving due consideration to the Member's right to privacy and the need to maintain confidentiality of the Member's Protected Health Information (PHI) and private information. b. To be provided with information about Contractor's organization and all services available to Members. c. To be able to choose their Primary Care Provider (PCP) within Contractor's Network unless the PCP is unavailable or is not accepting new patients. d. To participate in decision-making regarding their health care, including the right to refuse treatment. e. To submit Grievances, either verbally or in writing, about Contractor, Providers, care received, and any other expression of dissatisfaction not related to an Adverse Benefit Determination (ABD). f. To request an Appeal of an ABD within 60 calendar days from the date on the Notice of Adverse Benefit	✓ Policies and Procedures (P&Ps) ✓ Written Information: Privacy and Security Program ✓ Grievance Logs/Files	The MCP's policies and procedures describe the Member's rights: to privacy and the need to maintain confidentiality of the Member's Protected Health Information (PHI) and private information, to all available services, to choose their PCP within Network, to participate in decision-making regarding their health care, including the right to refuse treatment, to submit grievance, to request an appeal. The MCP communicates Member Rights and Responsibilities policies to its Members, Providers, and, upon request, Potential Members. The MCP's policies and procedures describe the Member's rights: to request a State Hearing, to receive interpretation services and written translation, to have a valid Advance Directive in place, to have access to family planning services and sexually transmitted disease services, from a Provider of their choice, without referral or Prior Authorization, to have Emergency Services provided in or outside of Contractor's Network, to

Requirement	Documentation to Review	Examples of Best Practices
Determination (NABD) and request how to continue benefits during the in-MCP Appeal process through the State Hearing, when applicable. g. To request a State Hearing, including information on the circumstances under which an expedited State Hearing is available. h. To receive interpretation services and written translation of critical informing materials in their preferred Threshold Language, including oral interpretation and American Sign Language. i. To have a valid Advance Directive in place, and an explanation to Members of what an Advance Directive is. j. To have access to family planning services and sexually transmitted disease services, from a Provider of their choice, without referral or Prior Authorization, either in or outside of Contractor's Network. To have Emergency Services provided in or outside of Contractor's Network, as required pursuant to federal law. k. To have access to Federally Qualified Health Centers (FQHCs), Rural Health Centers (RHCs) and Indian Health Care Providers (IHCP) outside of Contractor's Network, pursuant to federal law. l. To have access to, and receive a copy of, their Medical Records, and request that they be amended or corrected, as specified in 45 Code of Regulations (CFR) sections 164.524 and 164.526. m. To change Medi-Cal managed care MCPs upon request, if applicable. n. To access Minor Consent Services.		have access to their Medical Records, to change managed care MCPs, to access Minor Consent Services, to receive written information in alternative formats. The MCP's policies and procedures describe the Member's rights: to be free from any form of restraint or seclusion, to receive information on available treatment options and alternatives, to freely exercise these Member rights without retaliation.

Requirement	Documentation to Review	Examples of Best Practices
o. To receive written Member informing materials in alternative formats, including Braille, large size print no smaller than 20-point font, accessible electronic format, and audio format, upon request and in accordance with 42 CFR section 438.10 and 45 CFR sections 84.52(d) and 92.102. p. To be free from any form of restraint or seclusion used as a means of coercion, discipline, convenience, or retaliation. q. To receive information on available treatment options and alternatives, presented in a manner appropriate for the Member's condition and ability to understand available treatment options and alternatives. r. To freely exercise these Member rights without retaliation or any adverse conduct by Contractor, Subcontractors, Downstream Subcontractors, Network Providers, or the State.		
Contract Exhibit A, Attachment III: 5.1.1 **A. Member Rights and Responsibilities: Distribution of Policies and Procedures** **2.** Contractor must provide its written policies and procedures regarding Member rights and responsibilities to its staff and all Network Providers, Subcontractors, and Downstream Subcontractors. Contractor must ensure that its staff, Network Providers, Subcontractors, and Downstream Subcontractors are trained and knowledgeable on Members' rights as required under Exhibit A, Attachment III, Section 3.2 (Provider Relations).	✓ Policies and Procedures ✓ Training Materials ✓ Training Acknowledgements and/or Certificates ✓ MCP Website ✓ Provider Manual	The MCP provides Member Rights and Responsibilities policies and procedures to its staff and all Network Providers, Subcontractors, and Downstream Subcontractors and ensures they are trained and knowledgeable on Members' rights.

Requirement	Documentation to Review	Examples of Best Practices
Contract Exhibit A, Attachment III: 5.1.1 **B. Member's Right to Confidentiality** Contractor must have policies and procedures in place to ensure Members' rights to confidentiality of PHI and Personal Information (PI) in accordance with 45 CFR parts 160 and 164, and in accordance with Civil Code section 1798 et seq. 1. Contractor must ensure that all Subcontractors, Downstream Subcontractors, and Network Providers have policies and procedures in place to guard against unlawful disclosure of PHI, PI, and any other Confidential Information to any unauthorized persons or entities. 2. Contractor must inform and advise Members on the right to confidentiality of their PHI and PI. Contractor must obtain the Member's prior written authorization to release Confidential Information, unless such prior written authorization is not required by 22 California Code of Regulations (CCR) section 51009. **45 CFR Parts 160 and 164** **General Provisions for Health Plans and Providers** Includes standards, requirements and definitions regarding sharing and protection of confidential health information *Note: Requirements from Contract Exhibit G regarding safeguards, security, breaches/security incidents, and related investigations and reporting included on the following pages.*	✓ Policies and Procedures (P&Ps) ✓ Written Information: Privacy and Security Program ✓ Grievance Logs/Files	MCP policies and procedures delineate that Members have the right to confidentiality of medical information. MCP policies require that Facilities implement and maintain procedures that guard against disclosure of confidential information to unauthorized persons inside and outside the network. MCP policies include the counseling of Members on their right to confidentiality and that the MCP will obtain a Member's consent prior to release of confidential information.

Requirement	Documentation to Review	Examples of Best Practices
Contract Exhibit G – Business Associate Addendum **9.2 Safeguards and Security** 1. Business Associate use safeguards that reasonably and appropriately protect the confidentiality, integrity, and availability of PHI and other confidential data and comply, where applicable, with subpart C of 45 CFR part 164 with respect to electronic protected health information, to prevent use or disclosure of the information other than as provided for by this Agreement. Such safeguards are based on applicable Federal Information Processing Standards (FIPS) Publication 199 protection levels. 2. Business Associate, at a minimum, utilize a National Institute of Standards and Technology Special Publication (NIST SP) 800-53 compliant security framework when selecting and implementing its security controls and maintain continuous compliance with NIST SP 800-53 as it may be updated from time to time.	✓ Policies and Procedures (P&Ps) ✓ Written Information: Privacy and Security Program ✓ DHCS Confidentiality Rights Questionnaire ✓ Provider Manual ✓ Provider Newsletters ✓ Provider Education: ✓ Documentation of Initial & Ongoing Training ✓ Member Handbook ✓ Member Newsletters ✓ MCP Website	MCP policies and procedures include the following: The MCP maintains a Written Information Privacy and Security Program that includes administrative, technical, and physical safeguards by which the MCP protects the privacy of the personally identifiable information it stores. MCP policies and procedures delineate how the MCP ensures the Member's right to confidentiality of medical information. MCP policies and procedures include the following: • The MCP's Written Information Privacy and Security Program, policies and procedures that include precautions listed in the Business Associate Data Security Requirements (Contract, Exhibit G, Attachment A). • The MCP has a designated Compliance Officer responsible for carrying out the requirements of this section and for communicating on security matters with DHCS. MCP maintains latest version of policies and procedures, reviewed/approved by

Requirement	Documentation to Review	Examples of Best Practices
		DHCS, that reflects information from recent Contract requirement changes and/or APLs. Using various methods (e.g., Provider Manual & Newsletters, initial and ongoing provider training, Member Handbook & Newsletters, MCP website, etc.), the MCP informs Members and providers of the Member's right to confidentiality of medical information. Notice of Privacy Practices inform Members of how their health information may be used, how to access it, and how it may be shared. NPP are provided to Members upon enrollment.
Contract Exhibit G – Business Associate Addendum **18. Breaches and Security Incidents** Business Associate implement reasonable systems for the discovery and prompt reporting of any breach or security incident, and take the following steps: **18.1 Notice to DHCS:** Business Associate notify DHCS immediately upon the discovery of a suspected breach or security incident that involves Social Security Administration (SSA) data. This notification will be provided by email upon discovery of the breach. If Business Associate is unable to provide	✓ Policies and Procedures (P&Ps) ✓ Written Information: Privacy and Security Program ✓ Privacy Incident Response Plan ✓ PHI Breach/Suspected Breach Log of Incidents	MCP's policies and procedures clearly indicate the contractor shall notify / report the discovery of any known or suspected breach of data security, intrusion, or unauthorized Use or Disclosure of PHI to DHCS. The DHCS Contract Manager, the DHCS Privacy Officer, and the DHCS Information Security Officer must be notified by electronic mail of facsimile, and by telephone.

Requirement	Documentation to Review	Examples of Best Practices
notification by email, the Business Associate provides notice by telephone to DHCS. Business Associate notify DHCS within 24 hours by email (or by telephone if Business Associate is unable to email DHCS) of the discovery of the following, unless attributable to a treatment provider that is not acting as a business associate of Business Associate: 1. Unsecured PHI if the PHI is reasonably believed to have been accessed or acquired by an unauthorized person; 2. Any suspected security incident which risks unauthorized access to PHI and/or other confidential information; 3. Any intrusion or unauthorized access, use or disclosure of PHI in violation of this Agreement; or 4. Potential loss of confidential information affecting this Agreement.	✓ Breach Emails or Faxes to the three DHCS officers with the updated "DHCS Privacy Incident Report" with the required information ✓ Reports to- and Committee Meeting Minutes: ✓ Governing Body ✓ Utilization Mngt. ✓ Quality Improvement	The MCP's breach / suspected breach log reflects timely reporting of incidents upon their discovery. The MCP has email or fax reports to support the timely reporting of each case in the breach/suspected breach log. Governing body and oversight committee meeting minutes include reports that summarize the number of breaches/suspected breaches, discussions, and follow-up actions to prevent recurrence.
Contract Exhibit G – Business Associate Addendum **18.2. Investigation** Business Associate immediately investigate such security incident or breach. Notice be provided to the DHCS Program Contract Manager (as applicable), the DHCS Privacy Office, and the DHCS Information Security Office (collectively, "DHCS Contacts") using the DHCS Contact Information at Section 18.6. below.	✓ Policies and Procedures (P&Ps) ✓ Written Information: Privacy and Security Program ✓ Privacy Incident Response Plan ✓ PHI Breach/Suspected Breach Log of Incidents ✓ Breach Emails or Faxes to the three	The MCP's Written Information Privacy and Security Program, policies and procedures, and response MCP include immediate investigation of a breach or suspected breach and timeframe for submission of the "DHCS Privacy Incident Report" with the required information to all three (3) DHCS officers. The MCP's breach / suspected breach log reflects immediate investigation of each case and timely submission of the "DHCS Privacy Incident Report" with the required information to all three (3)

Requirement	Documentation to Review	Examples of Best Practices
	DHCS officers with the updated "DHCS Privacy Incident Report" with the required information ✓ Reports to- and Committee Meeting Minutes: ✓ Governing Body ✓ Utilization Mngt. ✓ Quality Improvement	DHCS officers for each case that occurred past 72 hours. The MCP has emails or faxes to all three (3) DHCS officers with the updated "DHCS Privacy Incident Report" with the required information to support immediate investigation of each case in the breach/suspected breach log that occurred past 72 hours. Governing body and oversight committee meeting minutes include reports that summarize the status of breach/suspected breach investigations.

Requirement	Documentation to Review	Examples of Best Practices
Contract Exhibit G – Business Associate Addendum **18.3. Complete Report** To provide a complete report of the investigation to the DHCS contacts within ten (10) working days of the discovery of the security incident, breach or unauthorized use or disclosure.	✓ Policies and Procedures (P&Ps) ✓ Written Information: Privacy and Security Program ✓ Privacy Incident Response Plan ✓ PHI Breach/Suspected Breach Log of Incidents ✓ Breach Emails or Faxes to the three DHCS officers with the updated "DHCS Privacy Incident Report" with the required information ✓ Reports to- and Committee Meeting Minutes: ✓ Governing Body Utilization Mngt. ✓ Quality Improvement ✓ Verification Study▲	The MCP's Written Information Privacy and Security Program, policies and procedures, and response MCP include the timeframe for submission of a complete report of the investigation of a breach or suspected breach to all three (3) DHCS officers. The MCP's breach/suspected breach log reflects timely submission of the complete report of the investigation to all three (3) DHCS officers for each case that occurred past ten (10) working days. The MCP has emails or faxes to all three (3) DHCS officers with the complete report of the investigation for each case that occurred past ten (10) working days. Governing body and oversight committee meeting minutes include reports that summarize the number of completed breach/suspected breach investigations

Requirement	Documentation to Review	Examples of Best Practices
Contract Exhibit A, Attachment III: 5.1.1 **C. Member's Right to Advance Directives** Contractor must have written policies and procedures to ensure Members are informed of what an Advance Directive is and how to put a valid Advance Directive in place. Contractor must have policies and procedures in place to ensure all involved in the Member's care comply with the terms of a Member's valid Advance Directive in accordance with the requirements of 42 CFR sections 422.128 and 438.3(j). *See Pages 301-302 of Contract for further requirements*	✓ Policies and Procedures (P&Ps)	The MCP's policies and procedures describe Member's right to an advance directive and ensure all involved in the Member's care comply with the terms of a Member's valid Advance Directive.
Contract Exhibit A, Attachment III: 5.1.1 **D. Interoperability Requirements for Member Records** Contractor must implement and maintain a Patient Access Application Programming Interface (API) as specified in 42 CFR section 431.60 as if such requirements applied directly to Contractor, and as set forth in APL 22-026. The Patient Access API must also meet the technical standards in 45 CFR section 170.215. Data maintained on or after January 1, 2016, must be made available to facilitate the creation and maintenance of a Member's cumulative health record. *See Pages 301-302 of Contract for further requirements; includes claims data, cost data that may be Appealed, Provider remittances, and Member cost-sharing pertaining to such claims, encounter data, clinical data and drug coverage.*	✓ Policies and Procedures (P&Ps) ✓ MCP's Website ✓ Online Member Educational Resources ✓ Online Provider Directory	The MCP implements an API that is a secure, standards-based interface that allows Members to access their health information. Member educational resources are easily accessible on the MCPs' website in non-technical, simple and easy-to understand language. The Provider Directory is a publicly accessible standards-based API.

CATEGORY 4.13: MEMBER INFORMATION

Requirement	Documentation to Review	Examples of Best Practices
Contract Exhibit A, Attachment III: 5.1.3 **Member Rights and Responsibilities: Policies and Procedures** A. Contractor must provide all new Members, and Potential Members upon request, with information in compliance with 42 CFR section 438.10, Welfare and Institutions Code (W&I) section 14406, 22 CCR section 53895, and as set forth in this provision. B. Contractor must provide information as required in 42 CFR section 438.10, W&I section 14406, and 22 CCR section 53895 no later than seven calendar days after the effective date of a Member's Enrollment. C. Contractor must distribute the information required by Exhibit A, Attachment III, Subsection 5.1.3 (Member Information), Paragraphs A-B annually, and upon a Member's request. Contractor must ensure the information is current and has prior approval for distribution from DHCS. D. All Member Information must be in a format that is easily understood and in a font size no smaller than 12-point, in compliance with all requirements in 42 CFR sections 438.10, 438.404, and 438.408, W&I section 14029.91, and 22 CCR section 53876. Member Information is defined in this Contract and discussed in detail in APL 21-004. Member Information includes, but is not limited to, the Member Handbook (also called the Evidence of Coverage, or EOC), Provider Directory, and all mailings and notices critical to obtaining services, including form	✓ Policies and Procedures (P&Ps) ✓ Member Handbook/EOC ✓ Provider Directory ✓ New Member Welcome Packet	The MCP provides all new Members, by the seventh day of the first month of enrollment and annually thereafter, information including, but not limited to, the Member Handbook, Provider Directory, all mailings and notices critical to obtaining services, form letters, NOAs, NABDs, Grievances or Appeals, welcome packets, Marketing information, preventive health reminders, Member surveys, notices of the availability of free language assistance, and newsletters. Member Information must be in a format that is easily understood and in a font size no smaller than 12-point. The MCP provides Member Information in alternate formats of as requested and in all Threshold Languages. Member Information is at a sixth grade reading level and approved by DHCS before distribution. Member Information informs Members on MCP's processes and the Member's right to make informed health decisions.

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letters, Notices of Action (NOAs), NABDs, Grievances or Appeals, welcome packets, Marketing information, preventive health reminders, Member surveys, notices advising of the availability of free language assistance, and newsletters. E. If a Member or Potential Member requests Member Information in a format other than as printed materials, Contractor must provide the Member Information in the alternate formats, including Braille, large-size print font no smaller than 20-point, accessible electronic format, or audio format. F. Contractor must ensure that all Member Information is provided to Members at a sixth grade reading level and approved by DHCS before distribution. Member Information must inform Members on Contractor's processes and the Member's right to make informed health decisions. 1. Contractor must submit to DHCS for review and approval their policy and process for collecting requests and disseminating materials in an alternative format when requested by Member. 2. For Members with disabilities, including visual impairment Contractor must provide Member Information in all Threshold Languages, alternative formats as specified by DHCS and in APL 21-004 and APL 22-002 (including Braille, large-size print font no smaller than 20-point, accessible electronic format, audio compact disc (CD) format, or data CD format), and through Auxiliary Aids at no cost and upon request. Contractor must provide Member Information in a timely fashion appropriate for the format being requested and		

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taking into consideration the special needs of Members with disabilities or Limited English Proficiency (LEP) Members. a. Contractor must inform Members who exhibit or mention difficulty reading print communications of their right to receive Auxiliary Aids and services, including alternative formats. b. For Members who request an electronic alternative format to receive Member information, Contractor must inform the Member that, unless they request a password-protected format, the Member Information will be provided in an electronic format that is not password protected, which may make the information more vulnerable to loss or misuse. Contractor must clearly communicate to Members that they may request an encrypted electronic format with unencrypted instructions on how the Member can access the encrypted information. c. Contractor must accommodate the communication needs of qualified individuals with disabilities, which may include communication with the Member's Authorized Representative (AR) or someone with whom it is appropriate for Contractor to communicate, such as a Member's disabled spouse. For these qualified individuals, Contractor must facilitate alternative format requests as identified in this Paragraph, as well as requests for other Auxiliary Aids and services. 3. Contractor must establish policies and procedures to ensure Members receive all Member Information in a Threshold Language or alternative format of their choice		

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as required by 42 CFR section 438.10, W&I section 14029.91, and Exhibit A, Attachment III, Subsection 5.2.10.B (Access Rights).		
Contract Exhibit A, Attachment III: 5.1.3 **Posting of Non-Discrimination Notice** 4. Contractor must post a DHCS-approved nondiscrimination notice. Contractor must also post a notice with language taglines in a conspicuously visible font size in English, at least the top 15 non-English languages in the State, and any other languages, as determined by DHCS, explaining the availability of free	✓ Policies and Procedures (P&Ps) ✓ MCP website ✓ Member Handbook/EOC	A Non-Discrimination Notice is posted in a conspicuous place in all physical locations where the MCP interacts with the public, on the MCP's website, Member Handbook/EOC, and in all Member Information, informational notices, and materials.

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language assistance services, including written translation and oral interpretation, and information on how to request Auxiliary Aids and services, including materials in alternative formats. The nondiscrimination notice and the notice with taglines must include Contractor's toll-free and Telephone Typewriters (TTY)/Telecommunication Devices for the Deaf (TDD) telephone number for obtaining these services, and must be posted as follows: a. In a conspicuous place in all physical locations where Contractor interacts with the public; b. In a location on Contractor's website that is accessible on Contractor's home page, and in a manner that allows Members, Potential Members, and members of the public to easily locate the information; and c. In the Member Handbook/EOC, and in all Member Information, informational notices, and materials critical to obtaining services targeted to Members, Potential Members, applicants, and the public at large, in accordance with APL 21-004 and APL 22-002, 42 CFR section 438.10(d)(2)-(3), and W&I section 14029.91(a)(3) and (f).		
Contract Exhibit A, Attachment III: 5.1.3 **Required Information for Non-Discrimination Notice and How to File a Discrimination Grievance** 5. Contractor's nondiscrimination notice must include all information required by W&I section 14029.91(e), any additional information required by DHCS, and must provide information on how to file a Discrimination Grievance with:	✓ Policies and Procedures (P&Ps) ✓ Grievance and Appeal Logs ✓ Verification Study ▲	The MCP's policies and procedures follows nondiscrimination and language assistance requirements for grievance and appeals notifications sent to Members. The grievance and appeal verification study shows the MCP complies with the nondiscrimination and language

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a. Both Contractor and the DHCS Office of Civil Rights, if there is a concern of discrimination based on sex, race, color, religion, ancestry, national origin, ethnic group identification, age, mental disability, physical disability, medical condition, genetic information, health status, marital status, gender, gender identity, or sexual orientation, or identification with; any other persons or groups defined in Penal Code section 422.56; and b. The United States Department of Health and Human Services (U.S. DHHS) Office for Civil Rights if there is a concern of discrimination based on race, color, national origin, sex, age, or disability, per W&I section 14029.91(e)(5). **All Plan Letter 21-011:** **Grievance and Appeal System Oversight: (Non-Discrimination and Language Assistance)** When sending the required grievance and appeals notifications to members, MCPs must comply with the nondiscrimination and language assistance requirements as outlined in APL 21-004, including any subsequent updates or revisions to this APL.		assistance requirements notifications to Members.

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Contract Exhibit A, Attachment III: 5.1.3 **G. Member Information Noticing in Electronic Format** Contractor has the option to send Members a notice in Member welcome packets or annual informational mailings to inform Members of how to obtain their Provider Directory and Member Handbook electronically or in a paper version if preferred. The notice can be an insert, flyer, or other form of noticeable communication. *See Pages 306-307 for additional requirements*	✓ Policies and Procedures (P&Ps) ✓ Insert, flyer, or other form of noticeable communication	The MCP sends notices to Members about the option to obtain their Provider Directory and Member Handbook electronically or in a paper version if preferred.
Contract Exhibit A, Attachment III: 5.1.3 **H. Provider Directory** 1. Contractor must submit its complete Provider Directory to DHCS for review and approval prior to initial operations. 2. Contractor must make its Provider Directory available to all Members and to DHCS for distribution as required. 3. Contractor's Provider Directory must be available in both paper and electronic formats. Provider Directory information must be included with Contractor's written Member Information for new Members, and thereafter available upon request. An electronic Provider Directory must be posted on Contractor's website in a machine readable and accessible file and format. *See Pages 308-310 of Contract for Additional Requirements*	✓ Policies and Procedures (P&Ps) ✓ Provider Directory ✓ MCP Website ✓ New Member Welcome Packet	The Provider Directory is available to all Members and DHCS. The Provider Directory is available in both paper and electronic formats. New Members receive the Provider Directory. The Provider Directory is readable and accessible on the MCP's website.

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Contract Exhibit A, Attachment III: 5.1.3 **Member Handbook** I. Contractor must comply with the requirements in 22 CCR section 53895(b) by distributing a Member Handbook, also known as an Evidence of Coverage and Disclosure Form (EOC/DF) to each Member and to Potential Members, upon request. The Member Handbook must meet all requirements in 42 CFR section 438.10(g), 22 CCR section 53881, and any other requirements in State and federal law, and this Contract. In addition, the Member Handbook must meet all applicable requirements contained in 42 CFR section 438.10(d), W&I section 14029.91, 22 CCR section 53876 for Limited English Proficiency (LEP) Members and Potential Members and H&S section 1363 as to translation, print size, readability, and understandability of text. 1. Contractor must provide to each Member, or Member's family unit, a Member Handbook that constitutes a full and fair disclosure of the Member's right to obtain and Contractor's provision of all Medi-Cal services that are available and accessible to the Member. Contractor must post its most recent Member Handbook to its website. *See Pages 310 – 316 of Contract for additional requirements, including specific information that must be included in the Member Handbook*	✓ Policies and Procedures (P&Ps) ✓ Member Handbook/ EOC and Disclosure Form (EOC/DF) ✓ MCP Website ✓ New Member Welcome Packet	The Member Handbook, also known as an Evidence of Coverage and Disclosure Form (EOC/DF) discloses the availability of and restrictions of services provided by the MCP, and any exclusions from coverage. The Member Handbook is the applicable translation, print size, readability, and understandability of text for LEP Members and Potential Members. The Member Handbook is provided to each Member, or Member's family. The most recent Member Handbook is posted on the MCP's website.

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Contract Exhibit A, Attachment III: 5.1.3 **Member Identification Card** J. Contractor must provide an identification card to each Member, which identifies the Member and authorizes them to access Covered Services. The card must inform the Member that they may seek Emergency Services from out-of-Network Providers. The card must inform the Member of the Medi-Cal Rx telephone number. The Member identification card must also inform the Member that Emergency Services are covered by Contractor without Prior Authorization, and at no cost to the Member.	✓ Policies and Procedures (P&Ps) ✓ Member Identification Card ✓ New Member Welcome Packet	The MCP provides identification cards to each Member which identifies the Member and authorizes them to access Covered Services. Medi-Cal Rx telephone number is printed on the card. The identification cards inform Members that they may seek Emergency Services from out-of-Network Providers, that Emergency Services are covered without Prior Authorization, and at no cost to the Member.