DHCS AUDITS AND INVESTIGATIONS

CONTRACT AND ENROLLMENT REVIEW DIVISION

SPECIALTY MENTAL HEALTH REVIEW SECTION

REPORT ON THE SPECIALTY MENTAL HEALTH SERVICES (SMHS) AUDIT OF LOS ANGELES COUNTY FISCAL YEAR 2025-26

Contract Number: 22-20110

Contract Type: Specialty Mental Health Services

Audit Period: July 1, 2024 — June 30, 2025

Dates of Audit: October 7, 2025 — October 17, 2025

Report Issued: May 4, 2026

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I. INTRODUCTION

Los Angeles County Behavioral Health (Plan) is governed by a Board of Supervisors and contracts with the Department of Health Care Services (DHCS) for the purpose of providing mental health services to county residents.

Los Angeles is located in Southern California. The Plan provides services within the unincorporated county and in 88 cities.

In Fiscal Year 24/25, the Plan served 226,655 members. In June 2025, the Plan served 103,852 members, and had 742 Medi-Cal organizational provider sites, 108 individual providers, and 2 group providers

II. EXECUTIVE SUMMARY

This report presents the audit findings of the DHCS audit for the period of July 1, 2024, through June 30, 2025. The audit was conducted from October 7, 2025, through October 17, 2025. The audit consisted of documentation review, verification studies, and interviews with the Plan's representatives.

An Exit Conference with the Plan was held on April 13, 2026. The Plan was allowed 15 calendar days from the date of the Exit Conference to provide supplemental information addressing the draft audit findings. On April 29, 2026, the Plan submitted a response after the Exit Conference. The evaluation results of the Plan's response are reflected in this report.

The audit evaluated six categories of performance: Network Adequacy and Availability of Services, Care Coordination and Continuity of Care, Access and Information Requirements, Coverage and Authorization of Services, Beneficiary Rights and Protection, and Program Integrity.

The prior DHCS compliance report, covering the review period from July 1, 2019, through June 30, 2022, identified deficiencies incorporated in the Corrective Action Plan (CAP). The prior year CAP was closed at the time of the audit. Therefore, this audit included a review of documents to determine the implementation and effectiveness of the Plan's corrective actions.

Findings denoted as repeat findings are uncorrected deficiencies substantially similar to those identified in the previous audit.

The summary of the findings by category follows:

Category 1 – Network Adequacy and Availability of Services

There were no findings noted for this category during the audit period.

Category 2 – Care Coordination and Continuity of Care

There were no findings noted for this category during the audit period.

Category 4 – Access and Information Requirements

The Plan is required to ensure that all providers explain and document all required elements listed in BHIN 23-018 when collecting telehealth consent prior to the delivery

of telehealth services. Finding 4.4.1: The Plan did not ensure that all providers explained and documented all the required elements listed in BHIN 23-018 when collecting telehealth consents prior to the delivery of telehealth services.

Category 5 – Coverage and Authorization of Services

The Plan is required to establish and implement written policies and procedures for the authorization of psychiatric inpatient hospital services and required to have a mechanism in effect to ensure the consistent application of review criteria for authorization decisions in accordance with BHIN No. 22-017. Finding 5.2.1: The Plan did not ensure concurrent authorization review procedures for continued stay of psychiatric inpatient hospital services to its members.

The Plan is required to respond to such requests within 24 hours of receipt and necessary information, as stipulated in the Concurrent Review Standards for Psychiatric Inpatient Hospital and Psychiatric Health Facility (PHF) Services, in accordance to BHIN No. 22-017. Finding 5.2.2: The Plan did not issue a decision on a hospital's continued-stay authorization request within 24 hours of receipt of the request.

In accordance with BHIN 22-017 guidelines, the Plan must ensure the consistent application of review criteria for authorization decisions and consult with the requesting provider when appropriate. Finding 5.2.3: The Plan lacked mechanisms to ensure consistent application of review criteria for authorization decisions, both when conducting concurrent reviews directly and when delegating authorization functions to an administrative entity.

Category 6 – Beneficiary Rights and Protection

The Plan is required to provide a member with a written acknowledgment of the grievance receipt, which must be postmarked within five calendar days of receiving the grievance, as specified in MHSUDS IN No. 18-010E. Finding 6.1.1: The Plan failed to guarantee that written acknowledgment letters were dispatched to members within five calendar days after receiving a grievance.

The Plan is required to maintain a log and record grievance, appeals, and expedited appeals in the log within one working day of the date of receipt. Finding 6.2.1: The Plan did not ensure that grievances were logged within one working day of their receipt.

The Plan is required to resolve each grievance expeditiously, considering the beneficiary's health condition, within 90 calendar days. Additionally, a Notice of Adverse Benefit Determination (NOABD) must be provided if the Plan fails to act within the

specified timeframes for resolving grievances and appeals, as outlined in MHSUDS IN No. 18-010E. Finding 6.3.1: The Plan did not ensure grievances were resolved within 90 calendar days from the date received and did not issue the required Notice of Adverse Benefit Determination for timely resolution to members.

Category 7 – Program Integrity

There were no findings noted for this category during the audit period.

III. SCOPE/AUDIT PROCEDURES

SCOPE

The DHCS, Contract and Enrollment Review Division conducted the audit to ascertain that medically necessary services provided to Plan members comply with federal and state laws, Medi-Cal regulations and guidelines, and the State's Specialty Mental Health Services Contract.

PROCEDURE

DHCS conducted an audit of the Plan from October 7, 2025, through October 17, 2025, for the audit period of July 1, 2024, through June 30, 2025. The audit included a review of the Plan's policies for providing services, procedures to implement these policies, and the process to determine whether these policies were effective. Documents were reviewed, and interviews were conducted with the Plan's representatives.

The following verification studies were conducted:

Category 1 – Network Adequacy and Availability of Services

Mobile Crisis Service Encounters: Ten member samples were reviewed for evidence of documentation of standardized dispatch, assessment tools, and progress notes of crisis planning.

Category 2 – Care Coordination and Continuity of Care

Coordination of Care Referrals: Twelve member referrals from the Managed Care Plan (MCP) to the Mental Health Plan (MHP) and fourteen member referrals from the MHP to MCP were reviewed for evidence of referrals, initial assessments, progress notes of treatment planning, and follow-up care between MCP and MHP.

Category 4 – Access and Information Requirements

Access Line Test Calls: Five test calls requesting information about SMHS and how to treat an urgent condition were made to the Plan's statewide 24/7 toll-free number to confirm compliance with regulatory requirements; two test calls requesting information about the beneficiary problem resolution and fair hearing processes were made to the Plan's statewide 24/7 toll-free number to confirm compliance with regulatory requirements.

Access Line Test Call Log: The Plan's call log was reviewed to ensure all required log components were documented for five test calls made to the Plan.

Member Telehealth Consent: Ten telehealth consent samples were reviewed for evidence of documentation of telehealth consent prior to the initial delivery of telehealth services.

Category 5 – Coverage and Authorization of Services

Services Authorizations: Ten member files were reviewed for evidence of appropriate services authorization requests.

Treatment Authorization: 20 member files were reviewed for evidence of appropriate treatment authorization including the concurrent review authorization process.

Category 6 – Beneficiary Rights and Protection

Grievance Procedures: Nine grievances regarding the quality of care and fourteen grievances regarding the quality of services were reviewed for timely resolution, an appropriate response to the complainant, and submission to the appropriate level for review.

Category 7 – Program Integrity

There were no verification studies conducted for the audit review.

COMPLIANCE AUDIT FINDINGS

Category 4 – Access and Information Requirements

4.4 Telehealth Member Consent

4.4.1 Telehealth Requirements

The Plan is required to comply with all state and federal statutes and regulations, the terms of the contract, with BHINs, and any other applicable authorities. *(Contract, Exhibit E, section (6)(H))*

Prior to initial delivery of covered services via telehealth, providers are required to obtain verbal or written consent for the use of telehealth as an acceptable mode of delivering services, and must explain the following to members:

- The member has a right to access covered services in person.
- Use of telehealth is voluntary and consent for the use of telehealth can be withdrawn at any time without affecting the member's ability to access Medi-Cal covered services in the future.
- Non-medical transportation benefits are available for in-person visits.
- Any potential limitations or risks related to receiving covered services through telehealth as compared to an in-person visit, if applicable.

Providers must also document the members' verbal or written consent to receive covered services via telehealth prior to the initial delivery of the services. The members' consent must be documented in their medical record and made available to DHCS upon request. A provider may use a general consent agreement to meet this documentation requirement if the agreement: 1) specifically mentions the use of telehealth delivery of covered services; 2) includes the information described above, 3) is completed prior to initial delivery of services; and 4) is included in the member record. *(BHIN 23-018, Updated Telehealth Guidance for Specialty Mental Health Services and Substance Use Disorder Treatment Services in Medi-Cal)*

The Plan may delegate duties and obligations to subcontracting entities if the Plan determines that the subcontractor entities selected are able to perform the delegated duties in an adequate manner, in compliance with the requirements of this contract. The Plan shall maintain ultimate responsibility for adhering to and otherwise fully complying with all terms and conditions of its contract with the DHCS, notwithstanding any

relationship(s) that the Plan may have with any subcontractor. *(Contract, Exhibit A, Attachment 1, section 3; Title 42 of Code of Federal Regulations (CFR) section 438.230(b)(1))*

Plan policy *No. 308.01, Telehealth & Telephone Services (Effective Date: 2/10/2022),* stated that prior to the initial delivery of covered services via telehealth or telephone, providers are required to obtain verbal or written consent for the use of telehealth as an acceptable mode of delivering services and will explain all required information elements in accordance with BHIN 23-018.

Finding: The Plan did not ensure that all providers explained and documented all required elements listed in BHIN 23-018 when collecting member telehealth consents prior to the delivery of telehealth services.

A verification study revealed that seven of ten member records did not document telehealth consent for all four required elements listed in BHIN 23-018. There is no documentation of an explanation for the following elements:

- Members have the right to access covered services in person.
- Use of telehealth is voluntary and consent for the use of telehealth can be withdrawn at any time without affecting member for future Medi-Cal services.
- Non-medical transportation benefits are available for in-person visits.
- Any potential limitations or risks related to receiving covered services through telehealth as compared to an in-person visit.

In an interview, the Plan stated that during their medical chart reviews, the telehealth consent was overlooked and not part of the chart review process. Although the Plan has policies and procedures, it did not monitor the providers' consent documentation nor ensure that providers explained member benefits. Furthermore, the Plan indicated that training was provided through QA bulletins; however, when requested during the review process, the supporting documents were not received.

When the Plan does not ensure that all providers are appropriately obtaining and documenting telehealth consent before rendering telehealth services to members, it may lead to members making uninformed health decisions due to insufficient knowledge about their treatment options.

Recommendation: Implement policies and procedures to ensure all providers explain and document all required elements listed in BHIN 23-018 when collecting telehealth consents prior to the delivery of telehealth services.

COMPLIANCE AUDIT FINDINGS

Category 5 – Coverage and Authorization of Services

5.2 Concurrent Review and Prior Authorization Requirements

5.2.1 Concurrent Review of Psychiatric Services: Psychiatric Health Facility Services

The Plan is required to comply with the state and federal statutes and regulations, the terms of the contract, with Behavioral Health Information Notices (BHIN), and any other applicable authorities. *(Contract, Exhibit E, section (6)(B))*

The Plan's UM Program must evaluate medical necessity, appropriateness, and efficiency of services provided to Medi-Cal members prospectively, such as through prior or concurrent authorization review procedures. The Plan shall establish and implement written policies and procedures for the authorization of psychiatric inpatient hospital services in accordance with BHIN 22-017 and shall have a mechanism in effect to ensure that consistent application of review criteria for authorization decisions and shall consult with the requesting providers when appropriate. This process applies to all inpatient psychiatric care in acute care hospitals, psychiatric hospitals, and PHFs certified by DHCS as Medi-Cal providers. When medically necessary for the member, before the end of the initial authorization period or a subsequent authorization period, the hospital or PHF shall submit a continued stay authorization request for the specified number of days to the responsible county Plan. *(BHIN 22-017, Concurrent Review Standards for Psychiatric Inpatient Hospital and Psychiatric Health Facilities Services)*

Plan policy *400.02 Authorization of Services – Procedures (effective: 03/2024)* stated, for concurrent review and authorization of Psychiatric Inpatient Hospital and Psychiatric Health Facility services, "Providers must submit requests for concurrent review and authorization for psychiatric inpatient hospital services and psychiatric health facility services through a current approved departmental application in accordance with DMH Organizational Provider's Manual and/or other department issued bulletins, alerts, and manuals," and "Multiple days may be authorized based on the member's mental health condition for as long as the services are medically necessary."

Finding: The Plan did not ensure that concurrent review for continued stay of PHF services authorization was based on the individual's medical necessity.

Plan policy *Concurrent Review: Residential Services and Psychiatric Health Facilities (PHF) (07/2022)* stated that, "authorization will be provided for one week" with a timeframe of seven days. However, it did not state that multiple days may be authorized based on an individual's medical needs.

In a verification study, all ten member samples revealed that the Plan's authorization process for PHF services was inconsistent with concurrent review. The Plan implemented its policy and auto-approved for seven days. However, the requirement states that there needs to be a medical determination based on medical necessity.

In an interview, the Plan confirmed that the concurrent review process for PHF is based on a seven-day authorization period, which is outlined in the Plan's Concurrent Review PHF Provider Manual and complies with Plan Policy *400.02 Authorization of Services*, stating that "Multiple days may be authorized based on the member's needs." However, the Plan did not ensure that the PHF services were based on each individual's medical necessity when authorizing.

When the Plan does not utilize medical necessity in the determination of concurrent review of PHF Services, there is a risk that members will be inappropriately approved for services, which could lead to over-and under-utilization, as well as poor health outcomes.

Recommendation: Revise and implement policies and procedures to ensure the Plan conducts concurrent review based on individuals' medical necessity when making authorization determinations for PHF Services.

5.2.2 Concurrent Review of Psychiatric Services: Fee-for-Service (FFS)/Medi-Cal Hospitals

The Plan is required to comply with all state and federal statutes and regulations, the terms of the contract, with Behavioral Health Information Notices (BHIN), and any other applicable authorities. *(Contract, Exhibit E, section (6)(B))*

When medically necessary for the member, before the end of the initial authorization period or a subsequent authorization period, the hospital or PHF shall submit a continued-stay-authorization request for the specified number of days to the responsible county BHP. The responsible county BHP shall issue a decision on a hospital or PHF's continued-stay-authorization request within 24 hours of receipt of the request and all information reasonably necessary to make a determination *(BHIN 22-017,*

Concurrent Review Standards for Psychiatric Inpatient Hospital and Psychiatric Health Facility Services).

Plan's *Medi-Cal Fee-For-Service Inpatient Hospital Provider Manual (4th edition, 09/2022)* stated, "the Los Angeles County Department of Mental Health (LACDMH), Intensive Care Division (ICD), Treatment Authorization Reviewer (TAR) Unit shall issue a decision on a hospital's continued-stay-authorization request within 24 hours of receipt of the request and all information reasonably necessary to make a determination."

Plan policy *400.02 Authorization of Services (effective: 03/2024)* stated, "The designated Department of Mental Health (DMH) administrative division are responsible for reviewing all requests for authorizations of SMHS in accordance with Department of Health Care Services (DHCS) mandates," and "Decisions to approve, modify, or deny provider requests shall be communicated by the designated DMH administrative division to the affected provider, including the hospital and treating practitioner if applicable, in writing, within 24 hours of the decision.

Finding: The Plan did not issue a decision on an FFS hospital's continued-stay authorization request within 24 hours of receipt of the request.

In a verification study, all ten member samples revealed inconsistencies in notification of authorization decisions within 24 hours by the Plan. Non-compliant notifications fell within a range of one to five days beyond the 24-hour timeframe. For example, a member's chart documentation and request for additional acute services were received by the Plan from a hospital on 5/23/2025 (Friday), but the Plan did not respond to the hospital with an authorization decision unit 5/28/2025. For the same member, the Plan received documentation and a request for services on 5/27/2025 and did not respond with an authorization decision until 5/30/2025.

The Plan is aware of the BHIN 22-017 requirements; however, staffing shortages with clinical reviewers and administrative support staff have been a barrier to conducting concurrent reviews consistently and in a timely manner.

Without timely concurrent review and authorization of psychiatric inpatient services for Fee-for-Service/Medi-Cal Hospitals, it may result in delays to the member's services, potentially adversely affecting the member's health and well-being.

Recommendation: Revise and implement policy and procedures to ensure the Plan authorizes concurrent review of psychiatric inpatient services for Fee-for-Service/Medi-Cal Hospitals within the required timeframe.

5.2.3 Concurrent Review of Psychiatric Services: Short-Doyle/Medi-Cal Hospital

The Plan is required to comply with all state and federal statutes and regulations, the terms of the contract, with Behavioral Health Information Notices (BHIN), and any other applicable authorities. *(Contract, Exhibit E, section (6)(B))*

The Plan shall establish and implement written policies and procedures for the authorization of psychiatric inpatient hospital services in accordance with BHIN 22-017 and shall have a mechanism in effect to ensure the consistent application of review criteria for authorization decisions and shall consult with the requesting provider when appropriate. This concurrent review authorization process applies to all psychiatric inpatient level of care services in general acute care hospitals with psychiatric units, psychiatric hospitals, and psychiatric health facilities (PHF) certified by DHCS as Medi-Cal providers of inpatient hospital services *(BHIN 22-017, Concurrent Review Standards for Psychiatric Inpatient Hospitals and Psychiatric Health Facility Services)*.

Finding: The Plan did not establish a concurrent review authorization process for Short-Doyle hospitals.

During our review process, we attempted to obtain and examine the Plan's policy and procedure documents relevant to the SD/Medi-Cal Hospital. However, the Plan was unable to provide these documents for our review. As a result, we were not able to verify whether the necessary policies and procedures are in place or aligned with regulatory standards.

In an interview, the Plan stated that for Short-Doyle/Medi-Cal (SD/MC) Hospitals, there was no existing process for conducting or overseeing concurrent review and authorization for the five SD/MC Hospitals in Los Angeles County.

Without mechanisms in effect to ensure consistent application of review criteria for authorization decisions for the SD/MC Hospitals, this could cause member service delays and potentially harm members' services.

Recommendation: Develop and implement policies and procedures to ensure the Plan has a mechanism in effect to make consistent application of concurrent review criteria for authorization of psychiatric inpatient services in SD/MC Hospitals.

COMPLIANCE AUDIT FINDINGS

Category 6 – Beneficiary Rights and Protection

6.1 Grievance and Appeals System Requirements

6.1.1 Grievance Acknowledgment Letters

The contractor shall provide the member with a written acknowledgment of receipt of the grievance. The written acknowledgment to the member must be postmarked within five calendar days of receipt of the grievance. *(Contract, Exhibit A, Attachment 12, 3(B)); (Mental Health Substance Use Disorder Information Notice No. 18-010E)*

Plan's *Grievance Complaint Process Desk Reference* outlines that a written acknowledgement to the member must be postmarked within five calendar days of receipt of the grievance.

Finding: The Plan did not ensure that written letters of acknowledgment was provided to members within five calendar days of receipt.

A verification study showed that grievances initially received by the provider and then forwarded to the Plan, the Plan was unable to ensure compliance with the five-day timeframe requirement.

During an interview, the Plan confirmed that provider sites do not time-stamp grievances submitted by members. Without a time-stamping process, tracking becomes inaccurate for grievances submitted by providers since the Plan calculated the five-day response period based on the date recorded in the Plan's grievance log. The Plan's approach, based on the logged receipt date, is only accurate for initial and directly submitted grievances received by the Plan's Grievance Department. However, the five-day timeframe requirement begins with the grievance is first received, whether by the provider or the Plan's Grievance Department.

As a CAP to the prior fiscal year 2021/2022 audit Finding 6.1.5, the Plan developed and implemented a written desk reference and ongoing monitoring of grievances and the grievance log on a daily, weekly, and monthly basis to ensure accuracy and task completion. However, despite these efforts, the developed and implemented corrective actions did not work as intended, as the deficiency persisted.

Not tracking a grievance can cause delays in the grievance process, which may result in prolonged access to necessary services for the member.

This is a repeat of the 2021-2022 audit finding – Grievance and Appeal System Requirement

Recommendation: Implement procedures to collect and accurately track grievances to meet the five-day timeframe for the acknowledgment letter.

6.2 Handling Grievance and Appeals

6.2.1 Grievance Tracking

The Plan shall maintain a grievance and appeal log and record grievances, appeals, and expedited appeals in the log within one working day of the date of receipt of the grievance, appeal, or expedited appeal. *(Contract, Exhibit A, Attachment 12, section 2(A)); (CFR, Title 42, section 438.416(a); California Code Regulation, Title 9, section 1850.205 subdivision (d)(1))*

Plan's *Grievance Complaint Process Desk Reference* described all grievance forms that are collected daily from the mail room are date-stamped for the date of receipt. Afterwards, the grievance forms are reviewed and entered in the grievance log.

Finding: The Plan did not ensure grievances were logged within one working day of the date of receipt of the grievance.

A verification study showed that, initially, grievances received by the provider and then forwarded to the Plan, the Plan was unable to ensure that grievances were logged within one working day of the date of receipt of the grievance.

During an interview, the Plan confirmed that provider sites do not time stamp grievances submitted by members. Without a time-stamping process, tracking becomes inaccurate for grievances submitted by providers since the Plan calculated the one working day response period based on the date recorded in the Plan's grievance log. The Plan's approach, based on the logged receipt date, is only accurate for initial and directly submitted grievances received by the Plan's Grievance Department. However, the one working day of the date of receipt of the grievance requirement begins when the grievance is first received, whether by the provider of the Plan's Grievance Department.

As a CAP to the prior fiscal year 2021/2022 audit Finding 6.2.1, the Plan developed and implemented a written desk reference and ongoing monitoring of grievances and the grievance log on a daily, weekly, and monthly basis to ensure accuracy and task

completion. However, despite these efforts, the developed and implemented corrective actions did not work as intended, as the deficiency persisted.

When the Plan does not accurately track grievances, it can cause a delay in the grievance process, which in turn can lead to a delay in member access to necessary services.

This is a repeat of the 2021-2022 audit finding – Handling Grievance and Appeals

Recommendation: Implement procedures to collect and accurately track grievances to meet the one working day timeframe for written log entries.

6.3 Grievance Process

6.3.1 Resolution Timeliness and NOABD Notifications

The Plan shall resolve each grievance as expeditiously as the beneficiary's health condition requires, not to exceed 90 calendar days from the day the Plan receives the grievance. *(Contract, Exhibit A, Attachment 12, section 3(C)); (CFR, Title 42, section 438.408(a)-(b)(1)); (Mental Health Substance Use Disorder Information Notice Number 18-010E)*

The Plan must provide a member with a Notice of Adverse Benefit Determination (NOABD) when failure to act within the timeframes provided in 42 C.F.R. section 438.408(B)(1) and (2) regarding the standard resolution of grievances and appeals. *(Contract, Exhibit A, Attachment 12, section 10(A)(1)-(6)); (CFR, Title 42, section 438.400(b)(5)); (Mental Health Substance Use Disorder Information Notice Number 18-010E)*

Plan's *Grievance Complaint Process Desk Reference* outlined the procedures for managing grievances. The desk reference specified that if its Mental Health Advocate (MH) cannot complete the grievance within the 90-day timeliness standards, a Notice of Adverse Benefit Determination letter will be mailed to the member or consumer.

Finding: The Plan did not ensure that grievances were resolved within 90 calendar days from the date received and failed to provide the members with a NOABD when failure to act within timeframes.

A verification study showed that for nine pending and five closed grievances initially received by the provider and then forwarded to the Plan, the Plan was unable to ensure

compliance with the 90-day timeliness standard, and NOABD was not issued to inform members of the delays.

In an interview, the Plan confirmed that the grievance desk reference outlined the timeliness standard and NOABD procedure; however, lack of transfer of that knowledge put in place above, staff were not consistently utilizing it. In addition, the Plan acknowledged that there is no monitoring of the grievance process or oversight of staff performance.

The Plan provided a narrative indicating that it has not been providing members with NOABD when they exceeded the 90-day timeliness standards.

A review of the grievance log and related documentation showed that multiple grievances exceeded the 90-day timeliness standard without issuance of the required NOABD. Inaccurate tracking and inconsistent application of the grievance procedure contributed to delays in case resolution. The Plan's monitoring and oversight of the grievance process were not sufficient to ensure compliance with regulatory requirements, and staff were not consistently following established timeliness protocols.

As a CAP to the prior fiscal year 2021/2022 audit Finding 6.3.2, the Plan developed and implemented new internal procedures for handling grievances and monitoring timelines, which were overseen weekly by supervisors and the grievance team. However, despite these efforts, the corrective actions did not achieve the desired outcomes, as the deficiency persisted.

When the Plan does not train on their policies and procedures and lacks a process for timeliness, members are deprived of timely and essential information about their grievance outcomes and appeal rights.

This is a repeat of the 2021-2022 audit finding – Grievance Process and NOABD Requirements

Recommendation: Implement policies and procedures to ensure grievances are resolved within 90 days, and a NOABD is issued when applicable.