DHCS AUDITS AND INVESTIGATIONS

CONTRACT AND ENROLLMENT REVIEW DIVISION

[SANTA ANA SECTION]

REPORT ON THE MEDICAL AUDIT OF SENIOR CARE ACTION NETWORK HEALTH PLAN FISCAL YEAR 2024-25

Contract Number(s): 07-65712

Audit Period: March 1, 2024 — February 28, 2025

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I. INTRODUCTION

Senior Care Action Network Health Plan (Plan) commenced operations in Long Beach, California, in 1977 as a non-profit Multipurpose Senior Services Program. The Plan received a full-service Knox Keene license in 1984. The Plan contracted with the California Department of Health Care Services (DHCS) to provide health care services as a Dual Eligible Special Needs Plan in 1985.

The Plan has the only Fully Integrated Dual Eligible Special Needs Plan (FIDE-SNP) Contract in California and provides this product line to seniors in Riverside, San Bernardino, Los Angeles, and San Diego Counties. The Plan administers the FIDE-SNP Contract to dually eligible seniors and integrates care by providing a full range of Medicare and Medi-Cal services under a single managed care organization.

As of March 2025, the Plan served 12,188 members in Los Angeles, 4,048 members in Riverside, 2,885 members in San Bernardino, and 1,636 members in San Diego through the FIDE-SNP line of business.

II. EXECUTIVE SUMMARY

This report presents the audit findings of the DHCS medical audit for the period of March 1, 2024, through February 28, 2025. The audit was conducted from April 1, 2025, through April 11, 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 August 27, 2025. The Plan was allowed 15 calendar days from the date of the Exit Conference to provide supplemental information addressing the draft audit findings. On September 12, 2025, 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 five categories of performance: Utilization Management, Case Management and Coordination of Care, Access and Availability of Care, Member's Rights, and Quality Management.

The prior DHCS medical audit for the period of March 1, 2023, through February 29, 2024, was issued on September 20, 2024. This audit examined the Plan's compliance with the DHCS Contract and assessed the implementation and effectiveness of the Plan's prior year 2024 Corrective Action Plan.

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 – Utilization Management

The Plan is required to render decisions for routine prior authorization requests as expeditiously as the member's condition requires but within five working days from receipt of the information reasonably necessary to render a decision but no longer than 14 calendar days from the receipt of the request. Finding 1.2.1: The Plan did not render decisions for integrated organization determinations within 14 calendar days from the receipt of the request by its delegated entities.

The Plan is required to notify the requesting provider of any decision to deny, approve, modify, or delay a service authorization request, or to authorize a service in an amount, duration, or scope that is less than requested. Finding 1.2.2: The Plan did not notify requesting providers of its prior authorization decisions.

The Plan is required to have written Notice of Action (NOA) letters that contain the name and direct telephone number or extension of the decision maker for written notification to the provider. Finding 1.2.3: The Plan did not include the name and direct telephone number of the decision maker in written notifications to providers for adverse benefit determination.

The Plan is required to ensure the written NOA letters contains a clear and concise explanation of the reasons for the decision and a description of the criteria or guidelines used. Finding 1.2.4: The Plan did not ensure that a clear explanation of the reasons for its prior authorization decisions was included in its NOA letters.

The Plan is required to ensure there is a set of written criteria or guidelines for Utilization Review that is based on sound medical evidence which is consistently applied in its prior authorization reviews. Finding 1.2.5: The Plan did not consistently consider Medi-Cal coverage criteria as outlined in applicable provisions of the Medi-Cal Provider Manual when making Integrated Organization Determinations.

The Plan is required to provide members with written notice of an adverse benefit determination using the appropriate DHCS-developed, standardized NOA template and the NOA "Your Rights" template. Finding 1.2.6: The Plan did not provide members with the standardized NOA letter "Your Rights" template with its written notices of adverse benefit determinations.

The Plan is required to send the member both the Notice of Appeal Resolution (NAR) "Uphold" and NAR "Your Rights" template to comply with all requirements of the NAR. Finding 1.3.1: The Plan did not include the correct NAR "Your Rights" template with its member Notices of Appeal Resolution for appeals not wholly resolved in the member's favor.

Category 2 – Case Management and Coordination of Care

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

Category 3 – Access and Availability of Care

The Plan is required to develop, implement, and maintain a procedure to monitor waiting times for telephone calls (answer and return). Finding 3.1.1: The Plan did not monitor the providers' calls (answer and return) to members.

The Plan is required to develop, implement, and maintain a procedure to monitor waiting times in network providers' offices. Finding 3.1.2: The Plan did not monitor waiting times in network providers' offices.

Category 4 – Member's Rights

The Plan is required to ensure that the person making the final decision for the proposed resolution of grievances has clinical expertise in treating a member's condition or disease if deciding any grievance or appeal involving clinical issues. Finding 4.1.1: The Plan did not ensure that the person making the final decision for the resolution of quality of care grievances is a person with clinical expertise in treating disease.

The Plan's written grievance resolution letter is required to contain a clear and concise explanation of the Plan's decision. Finding 4.1.2: The Plan's written quality of care grievance resolution letters did not contain a clear explanation of the Plan's resolution. The resolution letters were sent to the member prior to the grievance reaching a final conclusion.

The Plan is required to post a nondiscrimination notice that informs members about nondiscrimination, protected characteristics, and accessibility requirements, and conveys the Plan's compliance with the requirements. Finding 4.1.3: The Plan did not post correct versions of the required nondiscrimination notice and language assistance taglines in its member notices.

Category 5 – Quality Management

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 medical services provided to Plan members comply with federal and state laws, Medi-Cal regulations and guidelines, and the State Contract.

PROCEDURE

DHCS conducted an audit of the Plan from April 1, 2025, through April 11, 2025, for the audit period of March 1, 2024, through February 28, 2025. The audit included a review of the Plan's Contract with DHCS, policies and procedures for providing services, procedures used to implement the policies, and verification studies of the implementation and effectiveness of the policies. Documents were reviewed and interviews were conducted with Plan administrators and staff.

The following verification studies were conducted:

Category 1 – Utilization Management

Integrated Organization Determination: Twenty-five medical Integrated Organization Determination records were reviewed for compliance with contract requirements.

Appeal Procedures: Eighteen appeal records were reviewed for appropriate and timely adjudication.

Category 2 – Case Management and Coordination of Care

Case Management – Health Risk Assessment/HRA: Twenty medical records were reviewed to evaluate the timeliness and appropriateness of continuity of care request determination.

Category 3 – Access and Availability of Care

Non-Emergency Medical Transportation (NEMT) and Non-Medical Transportation (NMT): Fifteen records (Four NEMT and 11 NMT) were reviewed to confirm compliance with for timeliness and contract requirements.

Category 4 – Member's Rights

Quality of Care Grievances: Twenty-five quality of care grievance cases were reviewed for processing, clear and timely response, and appropriate level of review.

Quality of Service Grievances: Ten quality of service grievance cases were reviewed for timeliness, investigation process, and appropriate resolution.

Category 5 – Quality Management

Potential Quality Issue: Ten cases were reviewed for timely evaluation and effective action taken to address needed improvements.

COMPLIANCE AUDIT FINDINGS

Category 1 – Utilization Management

1.2 Prior Authorization Review

1.2.1 Integrated Organization Determination Timeframes

The Plan is required to render decisions for routine prior authorization requests as expeditiously as the Member's condition requires but within five working days from receipt of the information reasonably necessary to render a decision in accordance with Health & Safety Code, Section 1367.215, or any future amendments thereto, but no longer than 14 calendar days from the receipt of the request. *(Contract 07-65712, Amendment A16, Exhibit A, Attachment 5, 3 (G))*

The Plan is required to consider both Medicare and Medi-Cal coverage criteria when making an Integrated Organization Determination (IOD) and provide timely notice of a standard IOD as expeditiously as the Member's health condition requires, and no later than 14 calendar days from when it receives the request, in accordance with 42 CFR section 422.631(d)(2)(i)(B). *(Contract 07-65712, Amendment A31, Exhibit A, Attachment 14, 5 (C-D))*

The Plan policy, *UM-0013 Organization Determination Process* (revised 12/16/2024) states that for standard requests, the processing timeframe begins when the Plan, any unit in the Plan, or a delegated entity (including a delegated entity that is not responsible for processing) receives a request.

Finding: The Plan did not render decisions for IOD within 14 calendar days from the receipt of the request by its delegated entities.

A verification study of 25 IOD samples identified eight samples where the Plan decided on requests for IOD more than 14 calendar days (ranging from 19 to 99 calendar days) from the date the request was received by the delegated entity.

The Plan generates a report once a month of service requests denied under the Medicare benefit by delegated medical groups so that the Plan may review them under the Medi-Cal benefit. The Plan's Desk Top Procedure for Intake Process and Authorization Entry does not specify which date is to be entered into its prior

authorization system as the date received for requests that are received through this monthly report to begin the processing timeframe. Based on the verification study samples, the Plan was in practice entering the date that it received the requests from the monthly report, and not the date that the request was received by the delegate. This resulted in the Plan not following its policy UM-0013 to begin the processing timeframe from when the delegate received the request. While the Plan processed the samples within 14 calendar days of when the Plan received them, it did not account for the days that had already elapsed since the delegate received them.

During the interview, the Plan confirmed that this was the procedure it was following. The Plan's procedures do not align with the new integrated Medicare and Medi-Cal decision timeframe in Contract Amendment A31 effective 12/31/2023.

When the Plan does not ensure that IODs submitted to its delegates are processed considering both Medicare and Medi-Cal criteria within the required timeframe, members may experience undue delays in receiving medically necessary health services.

Recommendation: Revise and implement policy and procedure to ensure that IOD decisions are rendered within 14 calendar days of receipt by delegated entities.

1.2.2 Provider Notification of Prior Authorization Decisions

The Plan is required to notify the requesting provider of any decision to deny, approve, modify, or delay a service authorization request, or to authorize a service in an amount, duration, or scope that is less than requested. (*Contract 07-65712, Amendment A16, Exhibit A, Attachment 5, 2 (H))*

The decisions to approve, modify, or deny prior authorization requests must be communicated by the Plan to the provider within 24 hours of the decision. *(APL 21-011: Grievance and Appeal Requirements, Notice And "Your Rights" Templates (August 31, 2022))*

The Plan policy, *UM-0013 Organization Determination Process* (revised12/16/2024) states that provider notification of an unfavorable decision will provide a specific and detailed explanation of why the medical services were denied.

Finding: The Plan did not notify requesting providers of its prior authorization decisions.

A verification study of 25 medical prior authorization samples identified five samples where the Plan did not notify the requesting provider of its prior authorization decision.

During the interview, the Plan stated that prior authorization requests that originate from its monthly Medi-Cal Benefit Review report of requests denied by its delegated medical groups do not always include the name of the requesting provider because the report does not include this information. The Plan attempts to identify the requesting provider in these cases, but if it is unable to identify the requesting provider, it notifies the member only of its decision, and it would not send any provider notification, thereby not following its policy to notify providers of its decisions. The Plan did not explain why the provider information was sometimes missing from its monthly report, nor whether it took any actions to remedy the report missing this information.

When the Plan does not notify requesting providers of its prior authorization decisions, providers are not kept informed of the status of requests that they make on members' behalf, which may result in delays in making decisions with members for alternative treatments or for appeal filing.

Recommendation: Revise and implement policy and procedure to ensure that requesting providers are notified of the Plan's prior authorization decisions.

1.2.3 Plan Decision Maker in Provider Notification of Prior Authorization Decisions

The Plan is required to carry out its Utilization Management program activities in accordance with Health and Safety Code (HSC) Section 1367.01. *(Contract 07-65712, Amendment A16, Exhibit A, Attachment 5, (1))*

Any written communication to a physician or other health care provider of a denial, delay, or modification of a request shall include the name and telephone number of the health care professional responsible for the denial, delay, or modification. The telephone number provided shall be a direct number or an extension, to allow the physician or health care provider easily to contact the professional responsible for the denial, delay, or modification. (*HSC Section 1367.01 (h) (4))*

The written Notice of Action (NOA) must contain the name and direct telephone number or extension of the decision maker for written notification to the provider. *(APL*

21-011: Grievance and Appeal Requirements, Notice And "Your Rights" Templates (August 31, 2022))

The Plan policy, *UM-0013 Organization Determination Process* (revised 12/16/2024) outlines the process for the receipt, decision, and notification of a decision to the member and requesting provider of requests for organization determinations.

Finding: The Plan did not include the name and direct telephone number of the decision maker in written notifications to providers of adverse prior authorization decisions.

A verification study of 25 medical prior authorization samples identified five samples where the name and phone number of the decision maker was not provided in the notice of the Plan's decision to the requesting provider. In four of the samples, the name of a non-physician staff member was entered as the decision maker in the provider notification instead of the physician making the decision. In the fifth sample, SCAN was named as the decision maker without any further detail. The same general phone number was listed in all five provider notifications.

In a written statement, the Plan stated that the nurse reviewer manually entered the incorrect decision maker's name and phone number in all five samples.

The Plan policy, *UM-0013 Organization Determination Process* (revised12/16/2024) does not specify that provider notifications of unfavorable prior authorization decisions must include the name and contact information of the decision maker.

The Plan's Desk Top Procedures Organization Determinations states that notification letters to providers must identify how the provider can request a peer-to-peer discussion with the reviewer. Monthly chart audits are conducted by a Medical Management Clinical Supervisor for adherence to the Letter Review process. The letter review criteria listed in the procedure does not explicitly include verifying whether the name and phone number of the decision maker were included in provider notifications.

When the Plan does not include the name and telephone number of decision makers for notices of adverse prior authorization decisions to providers, providers are not given the opportunity to request a peer-to-peer discussion of the adverse decision, which could delay the provision of services that may ultimately be found to be medically necessary.

Recommendation: Revise policy and procedure to ensure that the name and telephone number of decision makers for adverse prior authorization decisions based on medical necessity is included in written notifications to providers.

1.2.4 Reasons for Decision in Member Notices of Action (NOA)

The Plan is required to notify members of a decision to deny, defer, or modify requests for prior authorization as specified in Title 42 Code of Federal Regulations (CFR) 438.404 and HSC 1367.01. *(Contract 07-65712, Amendment A16, Exhibit A, Attachment 13 (8) (A))*

The Plan is required to include in its notice of adverse benefit determination the reasons for the adverse benefit determination. *(Title 42, CFR, Section 438.404)*

The Plan is required to include in its notices regarding decisions to deny, delay, or modify health care services a clear and concise explanation of the reasons for the Plan's decision, a description of the criteria or guidelines used, and the clinical reasons for the decisions regarding medical necessity. *(HSC Section 1367.01 (h) (4))*

The Plan is required to ensure the written NOA contains a clear and concise explanation of the reasons for the decision and a description of the criteria or guidelines used. This includes a reference to the specific regulation or authorization procedure(s) that supports the decision, as well as an explanation of the criteria or guideline. The Plan is required to provide the clinical reasons for the decision. The Plan must explicitly state how the member's condition does not meet the criteria or guidelines. For all other adverse benefit determinations that are not based on medical necessity (e.g., denials based on a lack of information, or benefit denials, etc.), the Plan is required to still ensure that the NOA provides a clear and concise explanation of the reasons for the decision. *(APL 21-011: Grievance and Appeal Requirements, Notice And "Your Rights" Template (August 31, 2022))*

The Plan policy, *UM-0013 Organization Determination Process* (revised 12/16/2024) states that member and provider notification of an unfavorable prior authorization decision will provide a specific and detailed explanation of why the medical services, items or Part B drugs were denied, including a description of the applicable coverage rule or applicable Plan policy (e.g., Evidence of Coverage provision) upon which the action was based. In addition, the notification will include a specific explanation about what information is needed to approve coverage.

Finding: The Plan did not ensure that a clear explanation of the reasons for its prior authorization decisions was included in its NOA letters.

A verification study of 25 medical prior authorization samples revealed four samples where the member NOA letter did not provide a clear explanation of reasons for the Plan's adverse benefit determination. The notices only stated "Medi-Cal rules" as the reason for the decision, and the Plan did not follow its policy to describe the applicable coverage rule or applicable plan policy (e.g., Evidence of Coverage provision) upon which the action was based.

During the interview, the Plan stated that the cited samples bypassed supervisor review because the nurse reviewer incorrectly thought that denials based on a service not being a covered benefit did not require supervisor review. Usually, these types of errors would have been caught by the supervisor had it gone through that process. The same nurse reviewer processed all of the cited samples, and they did not follow the Plan procedure to submit the NOA letter for supervisor review.

The Plan's Desk Top Procedures Organization Determinations states that all NOA letters are reviewed by a Medical Management Supervisor or Manager prior to issuance for proposed denial language with appropriate criteria used. Monthly chart audits are to be carried out by a Medical Management Clinical Supervisor for adherence to the Letter Review process. The Plan's monitoring process of supervisor review and monthly chart audit did not detect the deficiency in these four samples because the nurse reviewer did not follow procedure and bypassed the supervisor review.

When the Plan does not include clear explanations for its decisions in its NOA letters, members and providers are not given sufficient information to allow them to understand the rationale for the Plan's decision and to make informed health decisions regarding any further actions they may wish to take such as pursuing alternative treatment or filing an appeal.

Recommendation: Implement policy and procedure to ensure that a clear explanation of the reasons for prior authorization decisions is included in the Plan's NOA letters.

1.2.5 Criteria for Integrated Organization Determinations

The Plan is required to ensure there is a set of written criteria or guidelines for Utilization Review that is based on sound medical evidence which is consistently applied

in its prior authorization reviews. *(Contract 07-65712, Amendment A16, Exhibit A, Attachment 5, 2 (B))*

The Plan is required to consider both Medicare and Medi-Cal coverage criteria when making an Integrated Organization Determination (IOD). *(Contract 07-65712, Amendment A31, Exhibit A, Attachment 14, 5 (C))*

The Plan is required to comply with all current and applicable provisions of the Medi-Cal Provider Manual, unless the Medi-Cal Provider Manual conflicts with this Contract, APLs, and/or any applicable federal or state laws, regulations, in which case the specific terms of this Contract, the APL, or the applicable law will apply. *(Contract 07-65712, Amendment A16, Exhibit E, Attachment 2, 1 (E))*

The Plan policy, *UM-0013 Organization Determination Process* (revised 12/16/2024) states that clinical review using evidence-based criteria shall be completed for requests for Organization Determinations. Medi-Cal ONLY services for dually enrolled members are administered by the Plan's Utilization Management department according to eligibility, benefit structure and Medi-Cal coverage criteria. Coverage criteria conform to Department of Health Care Services requirements.

Finding: The Plan did not consistently consider Medi-Cal coverage criteria as outlined in applicable provisions of the Medi-Cal Provider Manual when making Integrated Organization Determinations.

A verification study including 25 medical IOD samples identified five samples where Medi-Cal Provider Manual coverage criteria were not consistently applied when the Plan made its decision.

- In three samples, the nurse reviewer inappropriately referred to the Medi-Cal fee schedule as the source for determining Medi-Cal benefit coverage. As a result, the nurse reviewer incorrectly denied the requests based on the services being non-covered since they did not appear on the Medi-Cal fee schedule, even though the requested services have coverage criteria in the Medi-Cal Provider Manual. The administratively denied requests never underwent a physician review for medical necessity. The Plan's Desk Top Procedures Outpatient Authorizations incorrectly cites the Medi-Cal fee schedule as the source for determining Medi-Cal coverage, instead of citing the Medi-Cal Provider Manual.
- In two samples, requests for a Transcutaneous Electrical Nerve Stimulation device and a Continuous Positive Airway Pressure breathing machine were approved

without the review of any medical records and without applying prior authorization criteria in the Medi-Cal Provider Manual.

During the interview, the Plan confirmed that for the two samples where Durable Medical Equipment was approved, no medical records were reviewed to determine medical necessity, even though the Plan's Desk Top Procedures Extension of Authority for Organization Determinations – Non-Clinical Staff states that criteria for coverage and authorization must be met in order to approve DME. The Plan stated that the non-clinical reviewer approves a requested service if they determine that it is payable by Medi-Cal based on the Medi-Cal fee schedule. The Plan's procedure inappropriately instructs non-licensed staff to make authorization determinations where medical necessity criteria exist in the Medi-Cal Provider Manual, and the Plan's staff in practice are incorrectly using the Medi-Cal fee schedule for determining Medi-Cal coverage of medically necessary services.

While the Plan's policy, *UM-0013* states that its Medi-Cal coverage criteria conform to DHCS requirements, the policy does not specify the Medi-Cal Provider Manual as a source for Medi-Cal coverage criteria. The Plan's Desk Top Procedure: Clinical Review Request for Organization Determinations and Concurrent Review describes its criteria hierarchy for prior authorization decision making, which includes Medicare National Coverage Determinations, Medicare Manuals, and an internal Medi-Medi Manual, but it does not specifically include the Medi-Cal Provider Manual.

When the Plan does not consistently apply Medi-Cal coverage criteria in the Medi-Cal Provider Manual when making integrated organization determinations, members may be inappropriately denied medically necessary services or may be approved for services which may not be medically necessary and could potentially be harmful.

Recommendation: Revise and implement policy and procedures to ensure that Medi-Cal coverage criteria as outlined in applicable provisions of the Medi-Cal Provider Manual are consistently applied when making Integrated Organization Determinations.

1.2.6 "Your Rights" Template in Member Notices of Action

The Plan is required to inform the member of their right to an Independent Medical Review (IMR) when an adverse decision on an Integrated Organization Determination (IOD) is issued in accordance with the Knox-Keene Act, including but not limited to Health and Safety Code (HSC) sections 1368.03, 1370.4, and 1374.30, and 28 California

Code of Regulations (CCR) sections 1300.70.4 and 1300.74.30, and include verbatim language required by HSC section 1368.02(b). *(Contract 07-65712, Amendment A31, Exhibit A, Attachment 14, (5) (H))*

The Plan is required to display on its letters of denial information concerning the right of members to request an IMR through the Department of Managed Health Care (DMHC) in cases where the member believes that health care services have been improperly denied, modified, or delayed by the Plan. *(Health and Safety Code Section 1374.30 (i))*

The Plan is required to provide members with written notice of an adverse benefit determination using the appropriate DHCS-developed, standardized NOA template and the NOA "Your Rights" template. Plans are not permitted to make any other changes to the NOA templates or NOA "Your Rights" templates without prior review and approval from DHCS, except to insert information specific to the member as required.

The NOA "Your Rights" template for Knox-Keene licensed Plans provides information for members about how to request an IMR. Knox-Keene licensed plans are subject to additional state laws, including the requirement that certain written notices to members contain prescribed language advising members of additional rights and directing them to contact the DMHC to request an IMR. *(APL 21-011: Grievance and Appeal Requirements, Notice And "Your Rights" Templates (August 31, 2022))*

The Plan policy, *UM-0013 Organization Determination Process* (revised 12/16/2024) states that member notification of an unfavorable benefit determination will include information regarding the member's right to appeal and the right to appoint a representative to file an appeal on the member's behalf.

Finding: The Plan did not provide members with the standardized NOA "Your Rights" template including information on their right to an IMR with its written notices of adverse benefit determinations.

A verification study of 25 medical IOD samples identified 15 samples where the NOA letters did not include the standardized "Your Rights" template. The templates used in these 15 samples did not include information regarding Medi-Cal members' right to an IMR through the DMHC which is present in the standardized template included in *APL 21-011*.

In a written narrative, the Plan confirmed that the language in its "Your Rights" template needs to be updated to align with the DHCS requirement.

When the Plan does not inform members of all their appeal rights, members are not able to make fully informed decisions regarding their health care.

Recommendation: Revise and implement policy and procedures to ensure that the standardized NOA letter "Your Rights" template including information on member rights to an IMR is provided to members with written notices of adverse benefit determinations.

1.3 Appeals Process

1.3.1 Notice of Appeal Resolution "Your Rights" Template

The Plan is required to inform members of their rights to a State Hearing and include the most current State Hearing form when the Plan decides to deny an appeal. *(Contract 07-65712, Amendment 31, Exhibit A, Attachment 14 (6) (C))*

For appeals not resolved wholly in favor of the member, the Plan is required to provide a Notice of Appeal Resolution (NAR) which is comprised of two components: 1) the NAR "Uphold" template and 2) the NAR "Your Rights" template. The Plan is required to send the member both documents to comply with all requirements of the NAR. The NAR "Your Rights" template informs members of their rights following an adverse benefit determination that has been upheld on appeal. It does not contain information on how to file a request for an appeal, as the member will have already exhausted the plan's appeal process. *(APL 21-011 Grievance and Appeal Requirements, Notice And "Your Rights" Templates (August 31, 2022))*

The Plan policy, *GA-0034: Member Appeal Process for Medi-Cal only Benefits (Standard/Expedited)* (revised 1/2/2025) states that member notification of an appeal resolution must contain the result and date of decision, and when not decided in a member's favor, information on State Hearing rights and right to continue benefits pending a State Hearing.

Finding: The Plan did not include the correct NAR "Your Rights" template with its member NAR for appeals not wholly resolved in the member's favor.

A verification study of 18 appeal samples identified 15 samples where the Plan did not include the required NAR "Your Rights" template. In 10 of the samples, the contact information for the California Department of Social Services (CDSS) to request a State

Hearing is outdated. The website and fax number for CDSS are missing, and the State Hearing form has an outdated mailing address, phone and fax numbers, and no e-mail address. In five of the samples, instead of the NAR "Your Rights" template, the NOA "Your Rights" template was used which included the first level appeal rights which no longer apply once a NAR is issued.

The Plan's Desk Top Procedure (DTP): State Regulatory Guidance Distribution Process describes the Plan's process for distributing new APL guidance to affected business units and monitoring compliance. The DTP states that the Plan's Regulatory Affairs unit is responsible for ensuring that affected business units submit proof of compliance and ensuring that their performance is regularly monitored going forward to ensure compliance. In a written statement, the Plan confirmed that it was using the incorrect NAR "Your Rights" template with its NARs and was thus not following its procedure. The Plan's monitoring process described in its DTP was insufficient to ensure compliance.

When the Plan does not include the correct NAR "Your Rights" template with its NARs, the members are not given the correct information to fully exercise all their additional appeal rights and make informed decisions about their health care.

Recommendation: Revise and implement policy and procedure to ensure that the Plan includes the correct NAR "Your Rights" template with its NAR.

COMPLIANCE AUDIT FINDINGS

Category 3 – Access and Availability of Care

3.1 Access and Availability of Care – Appointment Wait Times

3.1.1 Telephone Wait Times

The Plan is required to establish acceptable accessibility standards in accordance with CCR, Title 28, section 1300.67.2. The Plan is required to communicate, enforce, and monitor providers' compliance with access standards. The Plan is required to develop, implement, and maintain a procedure to monitor waiting times for telephone calls (to answer and return). *(Contract 07-65712 A16, Exhibit A, Attachment 9(3)(C)*)

Finding: The Plan did not develop, implement and maintain a procedure to monitor waiting times for telephone calls (to answer and return) to members.

The Plan does not have a policy for telephone wait times. However, the Plan's 2024 UM Audit Tool, states that the provider office shall develop, implement, and maintain a documented process to monitor waiting times in the providers' offices, telephone calls (to answer and return) and time to obtain appointments; and for triaging members' calls, providing telephone medical advice (if it is made available) and accessing telephone interpreters.

The Plan did not have any documentation to substantiate how it determined the wait time for providers' return calls.

In an interview, the Plan stated that all monitoring of provider compliance with access standards is delegated to the Plan's provider groups and it does not have any mechanism to monitor providers' return calls to members. Since the provider groups are delegated with monitoring their own network providers, the Plan does not have policies or procedures for monitoring provider compliance with waiting times for telephone calls to return and answer.

If the Plan cannot monitor the providers' return calls to members, this may result in delayed access to medically necessary services.

Recommendation: Develop and implement policies and procedures to monitor wait times to return telephone calls in the providers' offices.

3.1.2 Office Wait Times

The Plan is required to establish acceptable accessibility standards in accordance with CCR, Title 28, section 1300.67.2.1. The Plan is required to communicate, enforce, and monitor providers' compliance with access standards. The Plan is required to develop, implement, and maintain a procedure to monitor waiting times in network providers' offices. *(Contract 07-65712 A16, Exhibit A, Attachment 9(3)(C))*

Finding: The Plan did not develop, implement, and maintain a procedure to monitor waiting times in network providers' offices.

The Plan does not have a policy for in-office wait times. However, the Plan's 2024 UM Audit Tool, states that the provider office shall develop, implement, and maintain a documented process to monitor waiting times in the providers' offices, telephone calls (to answer and return) and time to obtain appointments; and for triaging calls, providing telephone medical advice (if it is made available) and accessing telephone interpreters.

In the interview, the Plan stated that it conducted a member satisfaction survey and provider group oversight audits to monitor in-office wait times. The Plan acknowledged that the member satisfaction survey does not include questions related to in-office wait times and the provider group oversight audits could not identify providers who are non-compliant with office wait time requirements. In addition, the Plan stated that all monitoring of provider compliance with access standards is delegated to the Plan's provider groups and it does not have any mechanism to monitor providers' office wait times. Since the provider groups are delegated with monitoring their own network providers, the Plan does not have policies or procedures for monitoring provider compliance with office waiting times.

If the Plan is unable to identify providers who did not comply with office wait time requirements, it cannot ensure their compliance with this requirement. This may result in delayed access to medically necessary services.

Recommendation: Develop and implement policies and procedures to monitor providers comply with office wait time requirements.

COMPLIANCE AUDIT FINDINGS

Category 4 – Member's Rights

4.1 Grievance System

4.1.1 Final Decision Maker for Resolution of Quality of Care (QOC) Grievances

The Plan is required to ensure that the person making the final decision for the proposed resolution of grievances has clinical expertise in treating a member's condition or disease if deciding any grievance or appeal involving clinical issues. *(Contract 07-65712, Amendment A31, Exhibit A, Attachment 14 (1) (D))*

The Plan is required to ensure that the decision-maker for any grievance involving clinical issues must be a health care professional with clinical expertise in treating a member's condition or disease. *(APL 21-011 Grievance and Appeal Requirements, Notice And "Your Rights" Templates (August 31, 2022))*

The Plan policy, *GA-0033 Medi-Cal Grievance Resolution Process* (revised 1/2/2025) states that for grievances involving medical issues, the case is to be reviewed by a Medical Director, and this Medical Director is a health care professional with clinical expertise in treating a member's condition or disease. Upon determination of resolution of the issues, the Grievances and Appeals Department Coordinator will create and mail a grievance closure letter clearly communicating the resolution to the member.

Finding: The Plan did not ensure that the person making the final decision for the resolution of QOC grievances is a person with clinical expertise in treating disease.

A verification study of 25 QOC grievance samples identified 25 samples where the final decision maker for resolving the grievance was not a physician or other person with clinical expertise in treating a member's condition or disease. The sampled grievances were resolved by grievance coordinators. There was no physician review prior to QOC grievance resolution letters being sent to the members. The Plan did not follow its *Policy GA-0033* to have cases involving medical issues reviewed by a Medical Director to determine resolution of the issues before sending QOC grievance closure letters to members.

In an interview and a written statement, the Plan stated that it follows the process outlined in its Desk Top Procedure (DTP) Medi-Cal Integrated Grievance (Standard) Process. This DTP states that when a Grievance Coordinator (GC) identifies a QOC grievance, they are instructed to complete a Potential Quality Issue (PQI) referral note to initiate a PQI investigation that is processed separately and then close the QOC grievance and send a grievance closure letter to the member. The DTP does not instruct the GC to have the QOC grievance reviewed by a Medical Director prior to resolving and closing the grievance as required by the Plan's policy *GA-0033*.

When the Plan does not ensure that the person resolving grievances involving clinical issues has clinical expertise in treating disease, any urgent need for medical intervention to address a member's concerns may not be identified resulting in member harm, or a health care professional or facility providing substandard care may not be identified in time to prevent harm to other members.

Recommendation: Implement policy and revise procedures to ensure that the person making the final decision for the resolution of QOC grievances is a person with clinical expertise in treating disease.

4.1.2 Quality of Care (QOC) Grievance Resolution

The Plan is required to have a procedure to resolve standard integrated grievances as expeditiously as the member's health condition requires and provide a written resolution to the member for an integrated grievance when the integrated grievance is related to quality of care. *(Contract 07-65712, Amendment A31, Exhibit A, Attachment 14 (3) (F and H))*

Regarding grievance resolution, "Resolved" means that the grievance has reached a final conclusion with respect to the member's submitted grievance. The Plan's written resolution must contain a clear and concise explanation of the Plan's decision.

The Plan must ensure adequate consideration of grievances and rectification when appropriate. If multiple issues are presented by the members, the Plan must ensure that each issue is addressed and resolved.

(APL 21-011 Grievance and Appeal Requirements, Notice And "Your Rights" Templates August 31, 2022))

The Plan policy, *GA-0033 Medi-Cal Grievance Resolution Process* (revised 1/2/2025) describes the procedure for resolving grievances. The assigned Grievance Coordinator (GC) is to validate the information received and request medical records as needed. For grievances involving medical issues, the case is to be reviewed by a Plan nurse and medical director for next steps. Upon determination of resolution of the issues, the GC will create and mail a grievance closure letter clearly communicating the resolution to the member.

Finding: The Plan did not ensure that QOC grievances had reached a final conclusion prior to considering them resolved.

A verification study of 25 QOC grievance samples identified six samples where QOC grievances were closed and considered resolved prior to the case coming to a final conclusion.

- In one sample, a member complained of losing vision under the care of their eye doctors. The grievance was resolved and closed two days after the Plan received the complaint without reviewing medical records to determine the nature of the member's condition. While the member service representative (MSR) did attempt to arrange an appointment with an alternate provider, there was no clear resolution by the time the grievance was closed.
- In another sample, a member was not happy with the care they were receiving at a facility. The grievance was resolved and closed three days after the Plan received the grievance, before the member's request for assistance with changing facilities was addressed. A referral was made by the MSR to the Plan's Clinical Resource Triage Team (CRTT) on 5/17/24, but the grievance closure letter had already been sent by the GC to the member on 5/14/24. The CRTT did not close its case until 5/30/24.

The Plan's policy GA-0033 does not explicitly state that all of the issues raised by the member in a grievance must be addressed when resolving a grievance. In addition, while the Plan's policy GA-0033 states that the GC requests medical records and that a medical director reviews the case to determine resolution for QOC grievances, the Plan in practice follows a different procedure outlined in the Plan's Desk Top Procedure (DTP) Medi-Cal Integrated Grievance (Standard) Process. The DTP states that when the GC identifies grievance with a QOC component, they are instructed to initiate a Potential Quality Issue (PQI) referral. The PQI investigation is performed separately from the grievance resolution process. The GC is then instructed to close the QOC grievance case

and send a resolution letter, without any request for medical records or review by a medical director.

In a written statement, the Plan explained that when a GC processes a QOC grievance, they close the QOC grievance upon referral of the case to the Plan's clinical team for separate review as a Potential Quality Issue. The grievance closure letter explains that the Plan will review the member's concerns and take any necessary actions. The Plan is acknowledging in the grievance closure letter that the member's concerns are yet to be reviewed, and the Plan has not reached a final conclusion.

During the interview, another contributing factor to incomplete QOC grievance resolution was identified: insufficient communication between different Plan departments that are involved in taking actions to address issues raised in a member QOC grievance. The Plan explained that the MSR in the Member Services Department (MSD) is usually a member's first point of contact before a grievance reaches the Grievance and Appeals Department (GAD). The MSR follows the procedure outlined in the Plan MSD's Grievance DTP. The MSR who initially receives the QOC grievance is responsible for identifying and addressing any gaps in care or any immediate service needs of the member filing a grievance. The MSR may seek assistance from the Plan's CRTT for any clinical concerns. This activity occurs separately and is not communicated to the Plan's staff in the GAD. The GAD's procedures allow for the GC to resolve a QOC grievance without considering the status of the MSR's actions to help resolve the grievance which may still be pending. The lack of coordination between departments results in grievances getting resolved and closed by the GAD prior to the conclusion of activities in the MSD.

When the Plan prematurely resolves and closes QOC grievances prior to reaching a final conclusion, members are not provided the information they need to make informed decisions about their health care.

Recommendation: Revise policy and procedures to ensure that QOC grievances have come to a final conclusion prior to closing QOC grievance cases.

4.1.3 Nondiscrimination Notice (NDN) and Language Taglines (LAT) for Member Notices

The Plan is required to take affirmative action to ensure that members are provided covered services without regard to race, color, creed, religion, sex, national origin, ancestry, marital status, sexual orientation, gender identity, health status, physical or mental disability, or identification with any other persons or groups defined in Penal Code 422.56, except where medically indicated. *(Contract 07-65712, Amendment A16, Exhibit E, Attachment 2 (28) (A))*

The Plan is required to include in significant member notices, and any notices related to grievances and appeals, taglines, and information on how to request auxiliary aids and services, including materials in alternative formats, in large print font no smaller than 18-point, and in all State threshold languages as required. The taglines shall explain the availability of written member information translated in that language or oral interpretation to understand the information provided, and the toll-free and TTY/TDD telephone number for the Plan's member services. *(Contract 07-65712, Amendment A31, Exhibit A, Attachment 13 (4) (E) (4))*

The Plan is required to comply with the nondiscrimination and language assistance requirements as outlined in *APL 21-004*, including any subsequent updates or revisions to this APL when sending the grievance and appeals notification to members. *(APL 21-011 Grievance and Appeal Requirements, Notice And "Your Rights" Templates(August 31, 2022))*

The Plan must post in its member notices a nondiscrimination notice that informs members about nondiscrimination, protected characteristics, and accessibility requirements, and conveys the Plan's compliance with the requirements. The Plan must also post in its member notices Language Assistance Taglines which inform members of the availability of no-cost language assistance services, including assistance in non-English languages and the provision of free auxiliary aids and services for people with disabilities. DHCS-provided templates for the nondiscrimination notice and language assistance taglines are attached to this APL. *(APL 21-004 Standards for Determining Threshold Languages, Nondiscrimination Requirements, And Language Assistance Services (May 3, 2022))*

The Plan policy, *GA-0033 Medi-Cal Grievance Resolution Process* (revised 1/2/2025) states that if changes are made to any of the grievance member letters, revised letters are submitted to DHCS for review and approval prior to use.

Finding: The Plan did not post correct versions of the required nondiscrimination notice and language assistance taglines in its member notices.

A verification study of 25 QOC grievance samples identified 25 samples where the NDN and LAT included in member grievance acknowledgement and resolution letters were not the same as the templates in *APL 21-004*. The Plan's NDN does not include all of the protected classes that are listed in the APL template. The following protected classes are not included in the Plan's notice: religion, ancestry, ethnic group identification, mental disability, physical disability, medical condition, genetic information, marital status, gender, gender identity, or sexual orientation. The Plan's version of the LAT does not include the following sentence: "Aids and services for people with disabilities, like documents in braille and large print, are also available."

The Plan's policy GA-0033 discusses requirements for grievance member letter changes but does not specifically address incorporating changes required by DHCS for member notice attachments.

In a written statement, the Plan confirmed that it was not using the correct NDN and LAT in its member notices.

The Plan's Desk Top Procedure: State Regulatory Guidance Distribution Process describes the Plan's process for distributing new APL guidance to affected business units and monitoring compliance. The Plan did not effectively implement its procedure for ensuring compliance with APL 21-004. This deficiency was also observed in the verification study samples for member appeal notices as well as member notices related to organization determination requests. The Plan's monitoring process was insufficient to ensure compliance across its business units.

When the Plan does not include the correct non-discrimination notice and language assistance taglines in its member notices, members are not fully informed of their rights so that they may make informed decisions about their health care.

Recommendation: Revise and implement policy and procedure to ensure the correct versions of the required nondiscrimination notice and language assistance taglines are included in member notices.