MEDICAL REVIEW – SOUTHERN SECTION II
AUDITS AND INVESTIGATIONS
DEPARTMENT OF HEALTH CARE SERVICES

REPORT ON THE FOCUSED COMPLIANCE AUDIT OF

L.A. Care Health Plan

2021

Contract Number: 04-36069

Audit Period: January 1, 2019
Through
December 31, 2020

Report Issued: September 14, 2021

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I. INTRODUCTION

L.A. Care Health Plan (Plan) was established in 1997 as the local initiative Medi-Cal Managed Care health plan in Los Angeles County under the Two-Plan Medi-Cal Managed Care model. The Plan obtained its Knox-Keene License in April 1997.

The Plan provides managed care health services to Medi-Cal beneficiaries under the provision of the Welfare and Institutions Code, section 14087.3. The Plan is a separately constituted health authority governed by the Los Angeles County Board of Supervisors. The Plan utilizes a "Plan Partner" model, under which it contracts with three health plans through capitated agreements. The Plan Partners are Anthem Blue Cross, Blue Shield of California Promise Health Plan, and Kaiser Permanente. In addition to the Plan Partners model, the Plan began providing coverage directly to Medi-Cal members under its own line of business, Medi-Cal Care Los Angeles, in 2006, which includes seniors and persons with disabilities. The Plan Contracts with 32 participating physician groups who receive a capitated amount for each enrollee in its direct business line.

The Plan entered into a delegation agreement with Los Angeles County, Department of Health Services (LA DHS or the Subcontractor) on May 1, 2011.

As of March 1, 2021, the total number of Plan members assigned to LA DHS was 236,407. As of March 1, 2021, LA DHS had the following numbers of providers: 294 Primary Care Physicians, 629 Specialists, and four Hospitals.

The Los Angeles Times published an article specifically alleging that LA DHS's Quality Of Care (QOC) deficiencies resulted in patient harm. Starting September 30, 2020, the Los Angeles Times' investigation reported an average wait time of three months for LA DHS patients who needed to see a specialist. The reporters analyzed LA County data from 2016 to 2019, tracking when specialty care was requested to when an appointment occurred. Subsequently, reporters found cases from where patients died of diseases that should have been treated earlier.

On November 12, 2020, the Department of Health Care Services (DHCS) Managed Care Quality and Monitoring Division (MCQMD) requested a special focused review of Health Net's oversight process of LA DHS. MCQMD's review of submitted Corrective Action Plans (CAP) and improvement plans indicated the Plan's oversight was insufficient and the delegates' documentation did not reflect the needed remediation.

This report presents the findings from DHCS' focused audit of the Plan’s delegation and oversight of LA DHS and their collective compliance with applicable federal and state laws, Medi-Cal regulations and guidelines, and the state contract related to Utilization Management (UM), Access and Availability to Care, Members Rights, and Quality Management.

Following the completion of these audit activities identifying areas of non-compliance related to grievances and appeals and delays in treatment, on May 28, 2021, LA Care disclosed that their grievance and appeals system closed cases with no issuance of resolution letters, affecting approximately 10,230 Medi-Cal and Cal MediConnect members. The Plan also disclosed that changes to its UM system resulted in delays sending authorization requests to subcontracting plans as well as delays of pre-service requests, affecting approximately 8,517 Medi-Cal and Cal MediConnect members. These disclosures, as well as any related matters, will be addressed separately during The Plan’s annual medical audit for the fiscal year 2021 - 2022.

II. EXECUTIVE SUMMARY

This report presents the audit findings of the DHCS focused audit for the period of January 1, 2019 through December 31, 2020. The audit was conducted from January 25, 2021 through January 29, 2021. The audit consisted of document review, verification studies, and interviews with Plan personnel.

An Exit Conference with the Plan was held on August 10, 2021. The Plan was allowed 15 calendar days from the date of the Exit Conference to provide supplemental information addressing the preliminary audit findings. On August 24, 2021, the Plan submitted a response after the Exit Conference. The results of our evaluation of the Plan's response are reflected in this report.

The focused review evaluated four categories of performance: UM, Access and Availability to Care, Members' Rights, and Quality Management.

The summary of the findings follows:

Quality Improvement

The Plan is required to monitor, evaluate, and take effective action to address any needed improvements in the Quality Of Care (QOC) delivered by all providers rendering services on its behalf. The Plan did not take effective action on LA DHS to ensure QOC improvements when Potential Quality of Care Issues (PQI) case files demonstrated quality problems. The Plan failed to determine appropriate PQI severity level, refer cases to the Medical Director and Peer Review Committee (PRC) for additional review, and develop appropriate CAP when there were delays in specialty care, affecting members' health outcomes.

Corrective Action Process

The Plan is required to maintain a system that evaluates the subcontractor's ability to perform the delegated activities, including continuous monitoring, evaluation, and approval of delegated functions. The Plan did not perform continuous monitoring, evaluation, or conduct follow-up procedures to review or confirm LA DHS's progress or completion of the CAP.

Access and Availability of Care

The Plan is required to implement prompt investigation and corrective action when compliance monitoring discloses that the LA DHS provider network has failed to provide timely access to care, including taking all necessary and appropriate action to identify the causes underlying the timely access deficiencies to bring its network into compliance. The Plan does not have policies and procedures to impose prompt corrective actions to bring the noncompliant subcontracting entities into compliance with access standards.

Grievance Notifications

The Plan is required to resolve grievances and send written resolutions to the beneficiary within 30 calendar days. The Plan failed to monitor the grievance resolution and notification process and ensure timely grievance resolution and notifications were sent to LA DHS members.

In the event that the resolution of a standard grievance is not reached within 30 calendar days as required, the Plan is required to notify the member in writing of the status of the grievance and the estimated date of resolution, which shall not exceed 14 calendar days. The Plan failed to monitor the grievance resolution and notification process and ensure timely resolution and notifications were sent to LA DHS members.

III. SCOPE/AUDIT PROCEDURES

SCOPE

The DHCS Medical Review Branch conducted this focused 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 related to appointment access requirements.

PROCEDURE

DHCS conducted a focused audit of the Plan from January 25, 2021 through January 29, 2021. The audit included a review of the Plan's Medi-Cal Contract, its policies for providing services, the 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 the Plan administrators and staff.

Samples selected were exclusively from the LA DHS network. The following verification studies were conducted:

PQI: Ten cases were reviewed for an appropriate level of review and decision-making.

Provider Directory: 15 providers from the Plan's directory were surveyed. The survey consisted of five Primary Care Providers (PCPs), five specialty providers, and five obstetrics and gynecology providers.

Grievance Procedures: 26 grievances (11 access to care, six quality of service, six QOC, and three standard) were reviewed for a timely resolution, response to the complainant, and submission to the appropriate level for review and medical decision-making.

The results of the review are outlined in this report.

QUALITY IMPROVEMENT

1. Potential Quality of Care Issues

The Plan is required to monitor, evaluate, and take effective action to address any needed improvements in the QOC delivered by all providers rendering services on its behalf in any setting. (*Contract, Exhibit A, Attachment 4 (1)*)

Plan Policy No. QI-001: PQI (review date 12/1/20) describes that the Plan refers all identified medical QOC issues meeting PQI Referral Criteria and may affect the member's health outcome to the Quality Improvement (QI) department for evaluation, investigation, resolution, and tracking in a secure electronic database. The policy also stated that individual occurrences or occurrences with a potential or suspected deviation from accepted standards of care, including diagnostic or therapeutic actions or behaviors that are considered the most likely in affecting the member's health outcome, would need additional review.

In addition, the PQI policy states the provider quality nurses will screen, triage PQI cases, and determine if any QOC issues exist. If there are no QOC issues, the nurse will assign the PQI severity level zero (zero-No QOC issue) and one (one-Appropriate QOC). If there is a QOC issue, the Medical Director will assign the PQI severity level. According to the policy, the Plan has four QOC Issue Severity Levels:

- C0 - No QOC issue
- C1 - Appropriate QOC; may include recognized medical or surgical complication in the absence of negligence
- C2 - Borderline QOC with potential for adverse effect or adverse health outcome
- C3 - Moderate QOC issue with actual adverse effect and potential for adverse health outcome
- C4 - Serious and/or significant QOC issue with significant adverse effect and/or adverse health outcome.

Upon the conclusion of a PQI investigation, the findings, which include any recommended CAPs or quality improvement plans, are presented for review at the PRC. The PRC will review the PQI findings for either agreement and/or recommended correction as appropriate.

Finding: The Plan failed to take effective corrective action on LA DHS to ensure QOC improvements were implemented when PQI case files demonstrated quality problems. The Plan failed to determine the appropriate PQI severity level, refer cases to a QI Medical Director and PRC for additional review, as well as develop appropriate CAPs

when there were delays in specialty care, affecting members' health outcomes.

The *2019 LA Care & LA DHS QI Collaborative Meeting Minutes* showed the Plan acknowledged LA DHS had a significant decline in points from the previous year in adult timely care and services based on the *2018 Clinician and Group - Customer Assessment of Healthcare Provider and System (CAHPS) reports*. However, the meeting minutes did not document any necessary corrective actions or interventions to improve LA DHS's performance.

The *2020 LA Care & LA DHS QI Collaborative Meeting Minutes* indicated LA DHS had lower performance in timely care and services and getting needed care based on the *2019 CG-CAHPS reports*. Again, the Plan did not have any necessary corrective actions or interventions to address the recurring issue. The QI section of the meeting minutes inappropriately stated that the status for CAHPS was closed.

The Plan failed to develop the necessary corrective actions or interventions to improve the CAHPS score when there was a significant decline in points of timely care and service from LA DHS.

A verification study was conducted from a sample of ten PQI files. The Plan assigned a PQI severity level to each PQI case. Five files revealed LA DHS providers failed to follow up on members' specialty referrals, pathology test results, and specialty device orders, which caused delays in specialty care and affected the members' health outcomes.

During the PQI review, it was determined that the Plan failed to apply the appropriate severity level to the cases, indicating a failure to have the correct clinician properly oversee each respective review. Three out of five cases were assigned severity level one (Appropriate QOC), despite the case files showing substandard care, affecting members' health outcomes. Due to inappropriate severity level assignment, only the Provider Quality Nurse reviewed the cases. The QI Medical Director and PRC did not review the cases or conduct CAPs for improvement.

- In one case, the member was in a car accident and received multiple pelvic fractures and a posterior urethral complete disruption. The member was hospitalized on [Day 1] for a cystourethroscopy procedure, the placement of a suprapubic catheter, and a cystogram. The [Day 1] operative report indicated the member would need to wait approximately three to six months for the urethra to heal before having an evaluation by the urethral reconstruction specialist. On [Day 95], an e-consultation was submitted for a urethral reconstruction specialist. The member filed a grievance on [Day 445] and complained that the assigned

reconstruction specialist had not once tried to reach out to discuss the member's plan of care for urethral reconstruction for more than a year. The one-year delay of reconstructive surgery adversely affected the member's health outcome. The member had multiple emergency department visits due to bladder infections secondary to prolonged suprapubic catheter use. The Plan assigned the low severity level C1 (Appropriate QOC) for this PQI case, which was not appropriate. Severity level C3 should have been given and the Plan should have conducted an additional review and developed a CAP as described in the Plan PQI policy.

- In a second case, the member had a large brain tumor (chondrosarcoma sellar/ suprasellar mass) and had a right-side orbitozygomatic craniotomy for tumor resection on [Day 1] at [Provider]. The initial surgical team said the member's tumor was too firm and scarred. Therefore, the team recommended radiation because an additional surgery was not amenable. On [Day 82], the radiology oncologist stated the member had been referred to radiation oncology in [Month 2]. Still, the radiology oncologist was not aware and could not find any data on radiation referral.

  The member's mother filed a grievance on [Day 217] and complained that the delay of specialty referral caused the member's double vision; the right eye was moving towards the left, as well as chronic headaches. The Plan assigned the low severity level C1 (Appropriate QOC) for this PQI case, which was not appropriate. Severity level C3 should have been given and the Plan should have conducted an additional review and developed a CAP as described in the Plan PQI policy.

- In a third case, the member had a cyst removed from their left eyelid on [Day 1]. The cyst was sent to the pathology department for biopsy. On [Day 59] the member returned to the clinic for a biopsy result and was told the specimen was lost.

  The member filed a grievance on [Day 95] and complained that they had to go through life without knowing if their cyst was cancerous. The provider failed to follow-up on the pathology test results. The Plan assigned the severity level C2 (Borderline QOC with a potential adverse outcome). The QI Medical Director reviewed the case and a CAP was developed. However, no action was taken to address the provider's substandard care.

- In a fourth case, the member visited their PCP on [Day 1] and complained of skin issues and diarrhea for one and a half months. The referral to gastroenterology was placed on [Day 21] due to the lack of effectiveness of the anti-diarrheal medications. On [Day 22], the gastroenterologist requested additional lab work and asked the PCP to treat for a specific bacterial infection if one of the lab tests was positive. The PCP told the member to return on [Day 90] to discuss the gastroenterologist recommendation.

  On [Day 55], the member stated that they had previously asked for a dermatology referral three times. On [Day 72], the member went to the clinic, and photographs were taken for dermatology referral. However, the pictures were not uploaded into the e-consult system for dermatologist review; therefore, the approval was never given.

  The provider delayed the gastroenterology requests and failed to follow-up on the dermatology referral. The Plan assigned severity level C2 (Borderline QOC with a potential adverse outcome). The QI Medical Director reviewed the case. However, the Plan did not require corrective action to improve the provider's substandard care or proper oversight of its subcontractors.

- In a fifth case, the member had asthma and requested a nebulizer on [Day 1]. The provider placed an order in electronic health records for the nebulizer. However, the order was not received by the LA DHS coordinator. The phone visit notes on [Day 218] stated that the patient qualified for a nebulizer to help control their asthma symptoms. The notes also stated that a nebulizer would be ordered that day. However, the provider was interrupted by an acute patient issue and did not place the order.

  The member filed a grievance on [Day 364] and complained that they were still waiting for the nebulizer machine for almost a year. The provider failed to follow up on the nebulizer machine order, which caused a delay in the member's specialty treatment. The Plan assigned severity level C1 (Appropriate QOC) for this PQI case, which was not appropriate. Severity level C2 should have been given and the Plan should have conducted an additional review and developed a CAP as described in the Plan PQI policy.

When addressing QOC improvement concerns such as PQI cases and for the timely provision of specialty care, the Plan's delay or ineffective action can lead to substandard medical care that increases the risk of severe complications, disability morbidity, and mortality.

❖ COMPLIANCE AUDIT FINDINGS (CAF) ❖
PLAN: LA Care Health Plan
AUDIT PERIOD: January 1, 2019 through December 31, 2020 **DATE OF AUDIT:** January 25, 2021 through January 29, 2021

Recommendation: Require the Plan to implement a CAP for LA DHS to address all needed improvements in the QOC. LA Care will also be required to implement a CAP to address its failures to properly oversee the actions of its subcontractors.

CORRECTIVE ACTION PROCESS

1. Delegate Corrective Action Process

The Plan is accountable for all QI functions and responsibilities delegated to network providers and subcontractors. The Plan shall maintain a system to ensure accountability for delegated QI activities, including evaluating the subcontractor's ability to perform the delegated activities. The Plan shall ensure the subcontractor meets standards set forth by the Plan and DHCS, including the continuous monitoring, evaluation, and approval of the delegated functions. *(Contract, Exhibit A, Attachment 4 (6)(A)(B)).*

The Plan is ultimately responsible for ensuring their network providers and subcontractors comply with all applicable federal & state laws and regulations, Contract requirements, reporting requirements, and other DHCS guidance. The Plan must also have policies and procedures for imposing corrective action on subcontractors upon discovery of non-compliance. *(Managed Care All Plan Letter 17-004, Subcontractual Relationships and Delegation)*

Plan Policy CA-001: Clinical Assurance Oversight of Delegated Functions (review date 11/26/18) states delegated activities/functions are reviewed annually according to specifications described in a mutually agreed upon Delegation Agreement. The agreement is developed using Centers for Medicare & Medicaid Services, DHCS, Department of Managed Health Care regulations, National Committee for Quality Assurance standards, and current contractual requirements. The Plan reassesses the subcontractor's performance on an annual basis through an onsite audit of its UM/Case Management program, staff capacity, referral management, and decision-making documentation and files through CAP follow-up audits.

The policy also states the special audits are used to review the network providers' and subcontractors' progress with their CAP when they require additional review before the next annual audit as determined by the Plan's Regulatory Analysis and Communications team. Critical and non-critical CAPs should have a CAP follow-up within 60-90 days to monitor the subcontractor's correction in improvement.

The Plan did not implement its policies and procedures for imposing corrective action for LA DHS.

Finding: The Plan did not perform continuous monitoring, evaluation, or conduct follow-up procedures to review or confirm LA DHS's progress or completion of their CAP. The Plan did not ensure the CAPs were operationalized.

❖ COMPLIANCE AUDIT FINDINGS (CAF) ❖

PLAN: LA Care Health Plan

AUDIT PERIOD: January 1, 2019 through December 31, 2020
DATE OF AUDIT: January 25, 2021 through January 29, 2021

The *2019 Final Annual Audit Report – LA DHS* with a review period of April 1, 2018 through March 31, 2019 was issued to LA DHS on February 3, 2020. The report confirmed that the audit areas of cultural and linguistic services, information security, privacy, provider network, and UM were found to be out of compliance. LA Care imposed a CAP on LA DHS. LA DHS responded to the CAP on November 25, 2020.

The Plan did not submit documents supporting the implementation of this process for continuous monitoring to ensure the progress and completion of CAPs.

The Plan was asked how they monitor the imposed CAP once LA DHS responded to the non-compliance issues. The Plan stated that it does not completely follow its policies and procedures for continuous monitoring of CAPs. Once a CAP was imposed in response to LA DHS's non-compliance, the Plan did not implement its procedures for continuous monitoring of subcontractors within 60-90 days of CAP initiation as specified in the *Plan Policy CA-001*. The Plan stated that the CAP would be evaluated at the next annual audit.

The Plan not monitoring timely completion of CAPs applied to noncompliant subcontractors can lead to delays in obtaining necessary medical services for LA DHS members.

Recommendation: Develop and implement effective procedures to monitor and evaluate the timely progress and completion of CAPs and ensure compliance with standards set forth by the Plan and DHCS. Require the Plan to implement a CAP for LA DHS to address all needed improvements in the cultural and linguistic services, information security, privacy, provider network, and UM. LA Care will also be required to implement aCAP to address its failures to properly oversee the actions of its network providers and subcontractors.

ACCESS AND AVAILABILITY OF CARE

1. Access and Availability of Care Monitoring

The Plan is required to establish acceptable accessibility standards in accordance with the California Code of Regulations (CCR), Title 28, section 1300.67.2.2. The Plan shall communicate, enforce, and monitor providers' compliance with access standards. *(Contract, Exhibit A, Attachment 9 (3))*

The Plan is required to implement prompt investigation and corrective action when compliance monitoring confirms deficiencies in the Plan's provider network, leading to a failure to comply with timely access requirements. The Plan must ensure corrective action is imposed and includes taking all necessary and appropriate action to identify the causes underlying identified timely access deficiencies to bring its network into compliance with network adequacy and timely access requirements. *(28 CCR section 1300.67.2.2 (d)(3))*

The Plan is ultimately responsible for ensuring their subcontractors comply with all applicable federal & state laws and regulations, Contract requirements, reporting requirements, and other DHCS guidance. The Plan must also have policies and procedures for imposing corrective action on network providers and subcontractors upon discovery of non-compliance. *(Managed Care All Plan Letter 17-004, Subcontractual Relationships and Delegation)*

Plan Policy QI-030: Assessment of Appropriate Access to Covered Services (review date 12/2/19) states where patterns of non-compliance exist, provider groups and subcontractors meet with the Plan to review and analyze performance at the provider/practitioner level to identify root causes of non-compliance, to discuss opportunities and interventions for improvement, and ongoing monitoring efforts. The effectiveness of interventions is evaluated or re-measured at least annually.

Finding: The Plan does not have procedures to impose prompt and effective corrective actions to bring noncompliant subcontractors into compliance with access standards.

The Plan conducted a *Provider Appointment Availability Survey (PAAS)* and *Provider After-Hour Access Study (PAHS)* for Measured Year 2018 on LA DHS.

Based on the *PAAS* results, LA DHS did not meet the performance goals for ten out of the 15 measures for appointment availability. The Plan did not request a root cause analysis for those underperforming measures from the LA DHS. When questioned, the Plan stated that the root cause analysis was driven by the LA DHS's overall performance

and not a particular group's performance.

LA DHS did not meet the performance goals for one of the two measures based on the PAHS results. As a result, the Plan requested a root cause analysis. However, once the responses were received, the Plan did not conduct any follow-up review to verify if the action plans were implemented or brought the LA DHS's providers into compliance.

During the interview, the Plan confirmed they have no procedures outlining how the CAP process brings noncompliant provider groups into compliance.

The Plan is required to ensure that LA DHS complies with the appointment availability and after-hour accessibility standards. Without prompt investigation regarding causes of non-compliance and lack of CAP monitoring, the Plan cannot ensure that LA DHS complies with all applicable federal and state laws, regulations, and Contract requirements. The risk of prolonged non-compliance can lead to delays in obtaining necessary medical services for LA DHS members.

Recommendation: Develop and implement procedures to ensure prompt investigation and effective corrective actions for non-compliance to ensure timely access throughout the Plan's provider network. Require the Plan to implement a CAP for LA DHS to address all needed improvements in access standards and network adequacy requirements. LA Care will also be required to implement a CAP to address its failures to properly oversee the actions of its network providers and subcontractors.

❖ COMPLIANCE AUDIT FINDINGS (CAF) ❖

PLAN: LA Care Health Plan

AUDIT PERIOD: January 1, 2019 through December 31, 2020
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GRIEVANCE NOTIFICATIONS

1. Notifications of Grievance Resolution

The Plan is required to implement and maintain procedures to monitor the member's grievance system and the expedited review of grievances required under Title 28, CCR, Sections 1300.68 and 1300.68.1 and Title 22 CCR Section 53858. The Contract also highlights that the Plan shall have procedures to ensure timely acknowledgment, resolution, and feedback to the complainant. *(Contract, Exhibit A, Attachment 14 (1)(2))*

The Plan is required to have timeframes for acknowledging receipt of and resolving grievance and sending written resolutions to the beneficiary that are required under federal and state law. The state's established timeframe is 30 calendar days for grievance resolution. *(All Plan Letter 17-006, Grievance and Appeal Requirements and Revised Notice Templates and "Your Rights" Attachments)*

Plan Policy No. AG-008: Complaint Process for Member (review date 11/25/19) states that "all standard grievance requests will be resolved within 30 calendar days."

Finding: The Plan failed to monitor the grievance notification process for members. Specifically, the Plan failed to provide written notifications of resolution in a timely manner and process the grievance resolutions and notifications within the required timeframes.

The Plan attributed the failure to provide members with timely notifications of written resolution to the managerial turnover in their Appeals and Grievance (A&G) unit, lack of proper training provided to staff, and failure to effectively monitor the A&G unit in properly utilizing inventory tools and resources to ensure notification letter timeliness.

A verification study was conducted from a sample of 26 grievances from LA DHS members. 26 grievance files showed the Plan failed to comply with the required time frame of 30 calendar days to notify the member with written resolution. The average age of these grievance notifications was 242 days.

The failure to adhere to the required timeframes for resolving grievances may restrict the LA DHS member's rights from receiving timely medical services.

Recommendation: Develop and implement procedures to monitor the grievance resolution and notification process and implement policy and procedures to ensure timely grievance resolution and notifications. Require the Plan to implement a CAP to correct all identified deficiencies in the Plan's grievance processing.

2. Notifications of Grievance Status and Estimated Date of Resolution

The Plan is required to implement and maintain procedures to monitor the member's grievance system and the expedited review of grievances required under Title 28, CCR, Sections 1300.68 and 1300.68.1 and Title 22 CCR Section 53858. The Plan shall have procedures to ensure timely acknowledgment, resolution, and feedback to the complainant. *(Contract, Exhibit A, Attachment 14 (1)(2))*

In the event that the resolution of a standard grievance is not reached within 30 calendar days as required, the Plan shall notify the member in writing that it needs more information to process the claim or approve it. If more time is needed, it shall not exceed 14 calendar days and the member must be notified of the exact information the plans need to make a decision on the grievance. *(All Plan Letter 17-006, Grievance and Appeal Requirements and Revised Notice Templates and "Your Rights" Attachments)*

Plan Policy No. AG-008: Complaint Process for Member (review date 11/25/19) states in the event that the resolution of a standard grievance is not reached within 30 calendar days as required, the Plan shall notify the member in writing of the status of the grievance and the estimated date of resolution, which shall not exceed 14 calendar days.

Finding: The Plan failed to monitor the grievance notification process. Subsequently, the Plan failed to send written notification of grievance status and estimated date of resolution.

The Plan attributed the failure to provide members with written notifications to managerial turnover in their A&G unit, lack of proper training provided to staff, and failure to effectively monitor the A&G unit in properly utilizing inventory tools and resources to ensure notification letter were sent.

A verification study was conducted from a sample of 26 grievances from LA DHS members. 16 grievance files showed the Plan failed to provide the member written notifications of their grievance status and the estimated resolution date.

The failure to notify LA DHS members of their grievance status and estimated resolution date may restrict their member rights from receiving timely medical services.

Recommendation: To develop and implement procedures to monitor the grievance resolution and notification process and implement policy and procedures to ensure timely grievance resolution and notifications. Require the Plan to implement a CAP to correct all identified deficiencies in the Plan's grievance processing.