

DHCS



California Department of
HealthCareServices

**Technical
Assistance
Guide**

For Medical Audits

Category 4 –
Member's Rights

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Introduction

In accordance with California Welfare and Institutions Code Section 14456, the Department of Health Care Services (DHCS) conducts medical audits of Medi-Cal managed care plans (MCPs) on an annual basis. Medical audits evaluate MCPs’ compliance with the DHCS contractual requirements and applicable laws and regulations. DHCS’ Managed Care Quality and Monitoring Division (MCQMD) is responsible for ensuring overall monitoring and oversight of MCPs. MCQMD designates the Medical Review Branch (MRB) of DHCS’ Audits and Investigations Division (A&I) to perform the mandated audits. The audit scope encompasses the following six categories of review:

- Category 1 – Utilization Management
- Category 2 – Case Management and Coordination of Care
- Category 3 – Access and Availability
- Category 4 – Member’s Rights
- Category 5 – Quality Improvement
- Category 6 – Administrative and Organizational Capacity

Guidance on Using the Technical Assistance Guide (TAG)

MCQMD and A&I have collaborated to create Technical Assistance Guides (TAG) for each category of review. The TAGs are designed to identify key elements that will be commonly evaluated to inform MCPs of the audit process and increase transparency. To this end, each TAG is broken down by subcategories and includes the following components, as applicable:

- **Contract Language:** This section identifies “key” contract provisions¹ that are the focus of review for each subcategory. While references to specific provisions may assist the MCP with narrowing the scope of review in preparation for the audit, it does not preclude the audit team from investigating the MCP’s compliance with other contract requirements not explicitly named. MCPs are ultimately responsible for ensuring compliance with *all* provisions of the DHCS contract as well as any applicable All Plan Letters (APLs) and Plan Letters (PLs). The contract provisions included in the TAG are intended to serve as guidance only as well as a quick point of reference.
- **Documentation Reviewed:** The items listed in this section reflect common *initial* documentation requests and not subsequent follow-up requests that may be warranted after initial review and interviews with the MCP. The initial documentation request includes, but is not limited to policies and procedures, organizational charts, committee meeting minutes, monitoring reports, data logs, etc. While the documentation provides the audit team with a general overview of the operational structure and the team may glean insight regarding compliance with some contractual requirements, it is not all encompassing. Therefore, to ease the burden of further document requests made onsite, the MCP is advised to submit additional pre-onsite documentation for review (even if not explicitly requested) if the MCP believes that review of such information would assist the audit team with assessing compliance in any of the subcategories.
- **Verification Study (if applicable):** This section appears within a designated subcategory when a verification study (i.e., review of specific files such as grievances, prior authorizations, claims, etc.) may be used to assist with measuring compliance. The MCP is instructed to provide data in a prescribed format (i.e., spreadsheet containing all files for the audit review period). The log will assist the audit team with selection of specific files for onsite review. The audit team is neither precluded from conducting additional verification studies as needed nor expected to consistently conduct all verification studies listed in this TAG.

¹ The TAGs cite language from the general Two-Plan Boilerplate Contract. Each MCP should reference its own Plan-specific contract to confirm requirements.

- **Examples of Best Practices:** This section details examples of best practices. The examples listed include strategies that some MCPs have implemented to either demonstrate compliance with a given standard or successfully remediate an identified deficiency. Every MCP and every audit is unique and best practices do not always transfer seamlessly. While the audit team does not audit to best practices, the burden is on the MCP to demonstrate that it is meeting its contractual obligations. To this end, examples of best practices emphasize the MCP's ability to produce *documented evidence* to substantiate that the MCP complies with the contract requirements. When monitoring efforts reveal patterns of non-compliance, the MCP should similarly be able to produce documented evidence of barrier analysis and remedial actions enacted to substantiate efforts to bring the MCP into compliance.

CATEGORY 4 – MEMBER’S RIGHTS

4.1 GRIEVANCES			
CONTRACT REQUIREMENT	DOCUMENTATION REVIEWED	VERIFICATION STUDY	EXAMPLES OF BEST PRACTICES
<p>Member Grievance System 1. Member Grievance System Contractor shall implement and maintain a Member Grievance System in accordance with Title 28, CCR Section 1300.68 and 1300.68.01, Title 22 CCR Section 53858, Exhibit A, Attachment 13, Provision 4, Paragraph D.13, and 42 CFR 438.420 (a)-(c). Contractor shall resolve each Grievance and provide notice to the Member as quickly as the Member’s health condition requires, within 30 calendar days from the date the Contractor received the grievance. Contractor shall notify the member of the grievance resolution in a written member notice.</p>	<ul style="list-style-type: none"> -Grievance System Program Description -Policies and Procedures -Grievance/Complaint Logs -Grievance/Complaint Files for verification study -Grievance Committee meeting minutes -Provider Manual -Member Service Guide (EOC) 	<p>-Verification study of grievance case files may be conducted to confirm timeliness of decision-making and member notification.</p>	<ul style="list-style-type: none"> -The MCP’s Member Grievance System program description and/or policies and procedures are consistent with all contractual requirements and commit the MCP toward tracking grievances to final resolution. -The MCP provides documented evidence that providers and members are aware of the grievance process (e.g., Provider Manual, Member Services Guide, newsletters, etc.) -The Member Service Guide (EOC) clearly displays the member grievance process. -Policies and procedures are aligned with contractual requirements.
<p>2. Grievance System Oversight Contractor shall implement and maintain procedures to monitor the Member’s Grievance system and the expedited review of Grievances required under Title 28, CCR Section 1300.68 and</p>	<ul style="list-style-type: none"> -Policies and Procedures -Grievance and Appeals Committee meeting minutes 		<ul style="list-style-type: none"> -The MCP shall designate an officer that has primary responsibility for overseeing the Grievance and Appeals System. -The MCP shall continuously review the operation of the Grievance and Appeals System to identify any emergent patterns of Grievances and Appeals.

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1300.68.01 and Title 22, CCR Section 53858.			<p>-The Grievance and Appeals System shall include reporting procedures in order to improve MCP policies and procedures.</p> <p>-MCP shall notify beneficiaries are their Grievance and Appeals System, including information on MCP procedures for filing and resolving Grievances and Appeals, a toll-free telephone number or a local telephone number in each service area, the address for mailing Grievances and Appeals. MCP Grievance and Appeals System should include processes to consistently collect, aggregate and analyze grievance data for Quality Improvement. Control mechanisms should be in place for addressing Grievance related PQI information for follow up and integration within the network for process improvement.</p> <p>-MCP policies and procedures should include oversight, monitoring and controls utilized in ensuring PQI is identified in the investigation and resolution of Grievances. Data should be collected and analyzed for systematic QI, feedback and follow up with delegated entities and contracted providers.</p>

4.1 GRIEVANCES			
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<p>Timeframe for filing Grievances are delineated in both federal and state regulations. Existing state regulations establish a time frame of at least 180 calendar days from the incident subject to a beneficiary’s dissatisfaction. New federal regulations all Grievances to be filed at any time per (APL-17-006 and Title 42, CFR Section 438.402</p>	<ul style="list-style-type: none"> - Policies and procedures - Exempt Grievances Log - Grievance Log - Grievance log of any subcontracting entity delegated the responsibility to resolve grievances. 	<p>-Verification study of grievance files may be conducted to confirm that the MCP complies with grievance requirements.</p>	<ul style="list-style-type: none"> -MCPs shall adopt the standard that is least restrictive and allow Grievances to be filed at any time in accordance with new federal regulations. -MCP policies and procedures and Member Handbook/EOC shall clearly reflect this requirement. -MCP staff who process Grievances receive initial and ongoing training that address Grievance filing timeframes. The MCP is able to provide documented evidence of training (e.g., sign-in sheets, dates of training, training schedule, etc.) as well as training materials (e.g., desktop procedures, PowerPoint slides, etc.).

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<p>Method of filing. In accordance with both existing federal and state regulations, a Grievance may be filed by a beneficiary, a provider acting on behalf of a beneficiary, or an authorized representative either orally or in writing per (APL 17-006, Title 42, CFR Section 438.402 and Title 28, CCR Section 1300.68.</p>	<ul style="list-style-type: none"> - Policies and procedures - Exempt Grievances Log - Grievance Log - Grievance log of any subcontracting entity delegated the responsibility to resolve grievances. 	<p>-Verification study of grievance files may be conducted to confirm that the MCP complies with grievance requirements.</p>	<ul style="list-style-type: none"> -MCP policies and procedures shall reflect this requirement. -MCP staff who process Grievances receive initial and ongoing training that address Grievance filing timeframes. The MCP is able to provide documented evidence of training (e.g., sign-in sheets, dates of training, training schedule, etc.) as well as training materials (e.g., desktop procedures, PowerPoint slides, etc.).
<p>Standard Grievances 1. Acknowledgement In accordance with existing state laws and regulations, MCPs shall provide written acknowledgement to a beneficiary that is dated and postmarked within five calendar days of receipt of the Grievance.</p>	<ul style="list-style-type: none"> - Policies and procedures - Grievance Log -Member Handbook/EOC 	<p>-Verification study of Grievance case files may be conducted to confirm timeliness of acknowledgement and whether the acknowledgement letter complies with all contractual requirements.</p>	<p>–MCP’s Member Handbook/EOC and policies and procedures clearly indicate the Grievance processing timeframes are aligned with the contractual requirement to provide member acknowledgement within five calendar days of receipt of a Grievance.</p>

4.1 GRIEVANCES			
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Acknowledgement letters shall advise beneficiaries that a Grievance has been received, the date of receipt, provide the name, telephone number, and address of the representative who may be contacted about the Grievance.			
2. Resolution Timeframes for resolving Grievances and sending written resolution to the member are delineated in both federal and state regulations. Federal regulations allow the State to establish a timeframe for Grievance resolution that does not exceed 90 calendar days. The State’s established timeframe is 30 calendar days.	-Policies and procedures -Grievance logs -Member Handbook/EOC	-Verification study of Grievance case files may be conducted to confirm timeliness of resolution complies with all contractual requirements.	-MCP Member Handbook/EOC and policies and procedures clearly indicate the Grievance processing timeframes are aligned with the contractual requirement to provide member resolution within 30 calendar days of receipt of a Grievance.
“Resolved” means that the Grievance has reached a conclusion with respect to a member’s submitted Grievance.	-Policies and procedures -Grievance Program description	-Verification study of Grievance case files may be conducted to confirm if all known complaints and/or statements of	-TheMCP’s policies and procedures are aligned with the contractual requirements. -MCP staff who process Grievances receive initial and ongoing training that address identification of all complaints and/or statements of dissatisfaction. The

4.1 GRIEVANCES			
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		dissatisfaction have been addressed in the resolution letter.	MCP is able to provide documented evidence of training (e.g., sign-in sheets, dates of training, training schedule, etc.) as well as training materials (e.g., desktop procedures, PowerPoint slides, etc.).
Written resolution shall contain a clear and concise explanation of the MCP’s decision per H&S Code 1368(a)(5); Title 28, CCR Section 1300.68(d)(3).	-Policies and Procedures -NOA templates -NOAs clearly outline reasons for decision	-Verification study of Grievance case files may be conducted to confirm that Grievance resolution letters consistently contain clear and concise explanations of the MCP’s decision. Resolution letters are checked for complicated medical terminology, confusing and unnecessarily lengthy sentences, incorrect grammar, etc.	-MCP staff who process Grievances receive initial and ongoing training that addresses Grievance resolution letter requirements, including clear and concise explanations of the MCP’s decision. The MCP is able to provide documented evidence of training (e.g., sign-in sheets, dates of training, training schedule, etc.) as well as, training materials (e.g., desktop procedures, PowerPoint slides, etc.) -The MCP conducts ongoing monitoring (e.g., internal audits, etc.) at a set frequency to ensure compliance with contractual requirements. Audit tools clearly measure whether decisions are clearly documented and audit results can be produced at the frequencies indicated per MCP policies and procedures. When audit results demonstrate instances of non-compliance, the MCP takes necessary follow up action and can substantiate this through documentation (e.g., re-training, increased staffing, discussion in Committee meeting minutes,

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CONTRACT REQUIREMENT	DOCUMENTATION REVIEWED	VERIFICATION STUDY	EXAMPLES OF BEST PRACTICES
			<p>etc.). The MCP conducts re-measurements activities as necessary to monitor progress.</p> <p>-Examples of clear and concise explanations are:</p> <ul style="list-style-type: none"> - Identify the criteria in sufficient detail - Inform the member of any actions the member should take to meet the criteria - If the decision was not based on criteria, the letter must state professional medical judgement - The rationale must be provided, it is not sufficient to merely state the requested service is “not medically necessary” - If there is more than one request or concern, consider listing each item separately if it will improve the letter’s readability. - Construct sentences succinctly in a way that the audience can easily understand, using straightforward words (e.g.-make-up vs constitute, or end vs. terminate, and begin vs. commence).
<p>Federal regulations allow for a 14-calendar day extension for standard and expedited Appeals. This allowance does not apply to Grievances.</p>	<ul style="list-style-type: none"> -Policies and Procedures -Member Handbook/EOC -G&A Program description 	<p>-Verification study of Grievance case files may be conducted to confirm that Member Grievances are resolved within 30 calendar days.</p>	<p>-The MCP conducts ongoing monitoring (e.g., internal audits, tracking logs, turnaround time reports, etc.) at a set frequency to ensure compliance with contractual requirements. Auditing tools/tracking logs should specifically measure whether resolution of Grievances</p>

4.1 GRIEVANCES			
CONTRACT REQUIREMENT	DOCUMENTATION REVIEWED	VERIFICATION STUDY	EXAMPLES OF BEST PRACTICES
<p>If a resolution to a standard Grievance is not reached within 30 calendar days, the MCP shall notify the member in writing of the status of the Grievance and provide an estimated date of resolution.</p>			<p>are timely and if not, that members have been properly notified and provided an estimated resolution date.</p> <p>-MCP staff who process Grievances receive initial and ongoing training that address timely resolution and compliance with contractual requirements when a resolution is not reached within 30 calendar days. The MCP is able to provide documented evidence of training (e.g., sign-in sheets, dates of training, training schedule, etc.) as well as training materials (e.g., desktop procedures, PowerPoint slides, etc.)</p>
<p>Exempt Grievances</p> <p>Grievances received over the telephone that are not coverage disputes, disputed health care services involving medical necessity, or experimental or investigational treatment and that are resolved by the close of the next business day are exempt from the requirement to send a written acknowledgment and response.</p> <p>The MCP shall maintain a log of all such Grievances containing</p>	<p>-Policies and procedures</p> <p>-Exempt Grievances Log</p> <p>-Grievance Log</p> <p>- Grievance log of any subcontracting entity delegated the responsibility to resolve grievances.</p>	<p>-Verification study of Grievance case files may be conducted to confirm do not contain coverage disputes or present with quality of care issues.</p>	<p>-Ensure that exempt Grievances not fully resolved within 24 hours or by close of the next business day are processed as standard Grievances.</p> <p>-MCP conducts ongoing monitoring (internal audits, tracking logs, etc.) at a set frequency to ensure compliance with contractual requirements. MCP shall ensure exempt Grievances are incorporated into the quarterly Grievance and Appeal report that is submitted to DHCS. Grievances that include coverage disputes, disputed health care services involving medical necessity, or experimental or investigational treatment quality as Appeals and not Grievances.</p>

4.1 GRIEVANCES			
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<p>the date of the call, the name of the complainant, beneficiary identification number, nature of the Grievance, nature of the resolution, and the representative's name who took the call and resolved the Grievance.</p> <p>The MCP shall ensure exempt Grievances are incorporated into the quarterly Grievance and Appeal report that is submitted to DHCS.</p>			<p>Therefore, Appeals cannot be exempt from written acknowledgement and resolution.</p> <p>-MCP Customer Service staff receive initial and ongoing training that address proper classification of Grievances and ensure Grievances that present with quality of care issues are elevated to appropriate clinical staff for review and resolution. The MCP is able to provide documented evidence of training (e.g., sign-in sheets, dates of training, training schedule, etc.) as well as training materials (e.g., desktop procedures, PowerPoint slides, etc.).</p>
<p>Expedited Grievances</p> <p>DHCS acknowledges there are instances that may involve an imminent and serious threat to the health of a beneficiary, including but not limited to, severe pain or potential loss of life, limb or major bodily function that do not involve the Appeal of an Adverse Benefit Determination, yet are urgent or expedited in nature. Therefore, MCPs shall apply the revised</p>	<p>-Policies and Procedures -Member Handbook/EOC</p>	<p>-Verification study of expedited grievance cases to ensure contractual requirements are met.</p>	<p>-The MCP conducts ongoing monitoring e.g., audits, tracking logs, etc.) at a set frequency to ensure compliance with contractual requirements. Tracking requires MCPs to additionally record the time of Grievance receipt, and not just the date, as the specific time of receipt would drive the timeframe for resolution.</p>

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<p>federal timeframe (72 hours) for resolving expedited Grievances.</p> <p>MCPs are required to make reasonable efforts to provide oral notice to the beneficiary of the resolution. The MCP shall apply this requirement of oral notice for expedited Appeals to expedited Grievances.</p>			

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CONTRACT REQUIREMENT	DOCUMENTATION REVIEWED	VERIFICATION STUDY	EXAMPLES OF BEST PRACTICES
<p>Timeframes for filing Appeals are delineated in the Contract, as well as, in both state and federal regulations. New federal regulations requires beneficiaries are file an Appeal within 60-calendar days from the date of the NOA. Beneficiaries must also exhaust the MCP’s Appeal process prior to requesting a State Hearing.</p>	<ul style="list-style-type: none"> - Policies and procedures - Member Handbook/EOC -Provider Manual -Committee meeting minutes (UM and G&A) 	<p>- Verification study of case files may be conducted to confirm that the MCP complying with Appeal timeframes.</p>	<ul style="list-style-type: none"> - MCP policies and procedures are aligned with the contractual requirements and the Member Handbook/EOC clearly indicate timeframes or filing Appeals are aligned with contractual requirements. -MCP staff who process appeals receive initial and ongoing training that addresses timeliness of processing. The MCP is able to provide evidence of training (e.g., sign-in sheets, dates of training, training schedules, etc.) as well as training

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CONTRACT REQUIREMENT	DOCUMENTATION REVIEWED	VERIFICATION STUDY	EXAMPLES OF BEST PRACTICES
			materials (e.g., desktop procedures, PowerPoint slides, etc.).
<p>Method of filing. In accordance with existing federal and state regulations, Appeals may be filed by the beneficiary, a provider acting on behalf of the beneficiary, or an authorized representative either orally or in writing. Appeals filed by a provider on behalf of the beneficiary require written consent from the beneficiary.</p> <p>Oral Appeals shall be following by a written, signed Appeal per federal regulations. The date of the oral Appeal establishes the filing date for the Appeal. In the event the MCP does not receive a written, signed Appeal from the beneficiary, the MCP shall neither dismiss or delay resolution of the Appeal.</p>	<ul style="list-style-type: none"> - Policies and procedures - Member Handbook/EOC -Provider Manual -Committee meeting minutes (UM and G&A) 	<p>- Verification study of case files may be conducted to confirm that the MCP complying with Appeal timeframes.</p>	<ul style="list-style-type: none"> -MCP policies and procedures and the Member Handbook/EOC are aligned with contractual requirements and clearly indicate the member Appeals process including language that indicates that a member or a provider on behalf of a member with the member’s written consent may file an Appeal. -MCP staff who process Appeals receive initial and ongoing training that address timeliness and filing requirements. The MCP is able to provide documented evidence of training (e.g., sign-in sheets, training schedule, etc.) as well as training material (e.g., desktop procedures, PowerPoint slides, etc.).
<p>Standard Appeals 1. Acknowledgement</p>	<ul style="list-style-type: none"> - Policies and procedures - Grievance/Appeals Log -Member Handbook/EOC 	<p>-Verification study of Appeal case files may be</p>	<p>–MCP’s Member Handbook/EOC and policies and procedures clearly indicate the Appeal processing timeframes are</p>

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In accordance with existing state laws and regulations, MCPS shall provide written acknowledgement to the beneficiary that is dated and postmarked within five calendar days of receipt of the Appeal. The acknowledgement letter shall advise the beneficiary that the Appeal has been received, the date of receipt, and provide the name, telephone number, and address of the representative who may be contacted about the Appeal.		conducted to confirm timeliness of acknowledgement and whether the acknowledgement letter complies with all contractual requirements.	aligned with the contractual requirement to provide member acknowledgement within five calendar days of receipt of an Appeal. -MCP staff who process Member Appeals receive initial and ongoing training that specifically addresses Appeal processing requirements. The MCP is able to provide documented evidence of training (e.g., sign-in sheets, dates of training, training schedules, etc.) as well as training materials (e.g., desktop procedures, PowerPoint slides, etc.).
2. Resolution Federal regulations for resolving Appeals has been revised from 45 to 30 calendar days.	- Policies and procedures - Grievance/Appeals Log -Member Handbook/EOC	-Verification study of Appeal case files may be conducted to confirm timeliness of resolution complies with all contractual requirements.	-MCP’s Member Handbook/EOC and policies and procedures clearly indicate the Appeal processing timeframes are aligned with the contractual requirement to provide member acknowledgement within five calendar days of receipt of an Appeal.
Expedited Appeals State laws and regulations do not distinguish Grievances from Appeals; require expedited resolution of Grievances within			-The MCP conducts ongoing monitoring (e.g., audits, tracking logs, etc.) at a set frequency to ensure compliance with contractual requirements. Tracking requires MCPs to additionally record the time of Appeal receipt, and not just the

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<p>three calendar days. Federal regulations revise the timeframe for resolving Appeals from three calendar days to 72 hours. The 72-hour timeframe requires MCPs to additionally record the time of Appeal receipt, and not just the date, as the specific time of receipt would drive the timeframe for resolution.</p> <p>Additionally, MCPs are required to make reasonable efforts to provide oral notice to the beneficiary of the resolution.</p>			<p>date, as the specific time of receipt would drive the timeframe for resolution.</p>
<p>Notice of Appeal Resolution (NAR)</p> <p>MCPs are required to comply with federal and state regulations in sending written response to Appeals as follows:</p> <p>The results of the resolution and the date it was completed.</p> <p>If the MCP’s denial determination is based in whole or in part on medical necessity, the MCP shall</p>			<p>-MCP staff who process Member Appeals receive initial and ongoing training that specifically addresses NAR letter requirements (e.g., clear and concise reason, description of criteria/guideline, clinical reason, information on how to request a State Fair Hearing, etc.)</p> <p>-Examples of clear and concise explanation are:</p> <ul style="list-style-type: none"> - Identify the criteria in sufficient detail - Inform the member of any actions the member should take to meet the criteria

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<p>include in its written response the reasons for its determination and clearly state the criteria, clinical guidelines or medical policies used in reaching the determination.</p> <p>If the MCP’s determination specifies the requested service is not a covered benefit, the MCP shall include in its written response the provision in the Contract, Evidence of Coverage, or Member Handbook that excluded the service.</p>			<ul style="list-style-type: none"> - If the decision was not based on criteria, the letter must state professional medical judgement - The rationale must be provided, it is not sufficient to merely state the requested service is “not medically necessary” - If there is more than one request or concern, consider listing each item separately if it will improve the letter’s readability. - Construct sentences succinctly in a way that the audience can easily understand, using straightforward words (e.g.-make-up vs constitute, or end vs. terminate, and begin vs. commence). -MCP conducts ongoing monitoring (e.g., audits, etc.) at a set frequency to ensure compliance with the requirements. Audit tools specifically measure each of the required components of a NAR. Audit results can be produced at the frequencies indicated per the MCP’s policies and procedures. When audit results demonstrate instances of non-compliance, the MCP takes follow up action as necessary and can substantiate this through documentation (e.g., re-training, discussion in committee meeting minutes, etc.). The MCP conducts re-measurement activities as necessary to monitor progress.

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<p>“Your Rights” Attachment. In accordance with federal and state regulations, written NARs shall, at a minimum include the following requirements:</p> <p>The member’s right to request a State Hearing no later than 120 calendar days from the date of the MCP’s written appeal resolution and instructions on how to request a State Hearing.</p> <p>The member’s right to request and receive continuation of benefits while the State Hearing is pending and instructions on how to request continuations of benefits, including the timeframe in which the request shall be made.</p> <p>For Knox-Keene licensed plans, the member’s right to request an IMR from DMHC if the MCP’ decision is based in whole or in part on a determination that the</p>	<ul style="list-style-type: none"> -Member Handbook/EOC -Policies and Procedures -NOA templates 	<p>-Verification study of appeals case files to ensure applicable Your Rights attachment is enclosed.</p>	<ul style="list-style-type: none"> -The MCP’s policies and procedures and the Member Handbook/EOC clearly indicate the State Hearing timeframes that align with contractual requirements. -MCP staff who process appeals receive initial and ongoing training that address timeliness and notification requirements. The MCP is able to provide documented evidence of training (e.g., sign-in sheets, dates of training, training schedule, etc.) as well as training materials (e.g., desktop procedures, PowerPoint slides, etc.). -The MCP conducts ongoing monitoring (e.g., audits, etc.) at a set frequency to ensure compliance with contractual requirements. When monitoring efforts demonstrate instances of non-compliance, the MCP takes follow up action as necessary and can substantiate this through documentation (e.g., retraining, increased staffing, discussion in appropriate committee meeting minutes, etc.)

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<p>service is not medically necessary, is experimental/investigational, or is an emergency service. The MCP shall include the IMR application instructions, DMHC’s toll-free telephone number and an envelope addressed to DMHC.</p>			
<p>State Hearings Timeframes for Filing. New federal regulations require members to request a State Hearing within 120 calendar days from the date of the NAR, which informs the member that the Adverse Benefit Determination was upheld.</p> <p>For standard hearings, MCPs are required to notify members the State has reached a decision within 90 calendar days of the date of the request.</p> <p>For expedited hearings, MCPs are required to notify members the State has reached a decision</p>	<ul style="list-style-type: none"> -Policies and Procedures -Member Handbook/EOC -NOA templates 	<p>-Verification study of appeals case files.</p>	<ul style="list-style-type: none"> -The MCP’s policies and procedures and the Member Handbook/EOC clearly indicate the State Hearing timeframes that align with contractual requirements. -MCP staff who process appeals receive initial and ongoing training that address timeliness and notification requirements. The MCP is able to provide documented evidence of training (e.g., sign-in sheets, dates of training, training schedule, etc.) as well as training materials (e.g., desktop procedures, PowerPoint slides, etc.). -The MCP conducts ongoing monitoring (e.g., audits, etc.) at a set frequency to ensure compliance with contractual requirements. When monitoring efforts demonstrate instances of non-compliance, the MCP takes follow up action as necessary and can substantiate this through documentation (e.g.,

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<p>within three working days of the date of the request.</p> <p>For overturned decisions, MCPs are required to authorize and provide the disputed services promptly and as expeditiously as the member’s health condition requires, but not later than 72 hours from the date, it receives notice reversing the determination.</p>			<p>retraining, increased staffing, discussion in appropriate committee meeting minutes, etc.)</p>

4.1 APPEALS			
CONTRACT REQUIREMENT	DOCUMENTATION REVIEWED	VERIFICATION STUDY	EXAMPLES OF BEST PRACTICES

4.2 CULTURAL AND LINGUISTICS SERVICES			
CONTRACT REQUIREMENT	DOCUMENTATION REVIEWED	VERIFICATION STUDY	EXAMPLES OF BEST PRACTICES
<p><u>Title 22, CCR, Section 53858(e)(6); Title 28, CCR, Section 1300.68(b)(3); APL 17-006</u></p> <p>The MCP shall address the linguistic and cultural needs of its beneficiary population as well as the needs of beneficiaries with disabilities. The MCP shall ensure all beneficiaries have access to and can fully participate in the Grievance and Appeal System by assisting those with limited English proficiency or with a visual or other communicative impairment. Such assistance shall include, but is not limited to, translations of Grievance and Appeal procedures, forms, and MCP responses to Grievances and Appeals, as well as access to interpreters, telephone relay systems and other devices that aid disabled individuals to communicate.</p>	<ul style="list-style-type: none"> - Policies and Procedures - Grievance Management/Quality Improvement/Community Advisory Committee meeting minutes - MCP’s Group Needs Assessment - Member Grievances - Provider Manual - Member Services Guide - Evidence of Coverage Booklet, and/or the Member Services Guide - Provider Directory - Disclosure Forms - Enrollment and disenrollment information - Process for filing grievance and fair hearing - Form letters (denial letters, emergency room follow-up) - MCP-generated preventive health reminders (appointments and immunization 	<p>-Verification study of fully translated informing materials, including NOA/NAR notification letters are written in the member’s preferred language.</p>	<p>Conduct a Group Needs Assessment to identify the cultural and linguistic needs of its members within 12 months of commencing operations, and at least every 5 years.</p> <p>Implement the Needs Assessment results for the continuous development and improvement of the cultural and linguistic services program.</p> <p>Incorporate the results of the Assessment in the development of Marketing materials.</p> <p>Ensure that all monolingual, non-English-speaking and limited English proficient (LEP) Medi-Cal members and potential members receive 24-hour oral interpreter services at all key points of contact, either through interpreters, telephone language services, or any electronic communication options.</p> <p>The MCP shall ensure that lack of interpreter services does not</p>

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<p><u>81 FR 31375; Title 45, CFR, Section 92.8;ACA, Section 1557; APL 17-006</u></p> <p>MCPs are required to post nondiscrimination notice requirements and language assistance taglines in significant communications to beneficiaries.</p> <p>MCPs may utilize the templates provided by DHCS, make modifications to the templates, or create new templates. If modifications or new templates are created, DHCS review and approval must be obtained prior to use.</p> <p>These templates must be sent in conjunction with each of the following significant notices sent to beneficiaries: NOA, Grievance acknowledgment letter, Appeal acknowledgment letter, Grievance resolution letter, and NAR.</p>	<p>reminders, initial health examination notices, and prenatal care follow-up)</p> <ul style="list-style-type: none"> - Member surveys - Newsletters - Others, including health education materials, patient instructions, appointment forms, patient history forms (intake forms), complaint/grievance form 		<p>impede or delay timely access to care.</p> <p>Maintain effective monitoring in the delivery of interpreter services.</p> <p>Ensure that MCP training for staff, providers and subcontractors at key points of contact, includes information about the identified cultural groups in the Service Areas:</p> <ul style="list-style-type: none"> - cultural competency - cultural sensitivity - cultural diversity training <p>Assess the effectiveness of the linguistic services program with a direct link to the MCP’s quality improvement processes, including but not limited to, analysis of grievances and complaint logs regarding communication or language problems and assessment of member satisfaction with the quality and availability of interpreter services.</p>

4.3 CONFIDENTIALITY RIGHTS (HIPAA)			
CONTRACT REQUIREMENT	DOCUMENTATION REVIEWED	VERIFICATION STUDY	EXAMPLES OF BEST PRACTICES
<p><u>Exhibit G – Health Insurance Portability and Accountability Act (HIPAA)</u></p> <p>J. Breaches and Security Incidents.</p> <p>Notice to DHCS</p> <p>(1) To notify DHCS immediately by telephone call plus email or fax upon the discovery of a breach of unsecured PHI or PI...</p> <p>(2) To notify DHCS within 24 hours by email or fax of the discovery of any suspected security incident, intrusion or unauthorized access, use or disclosure of PHI or PI...</p> <p>Notice shall be provided to the DHCS Program Contract Manager, the DHCS Privacy Officer and the DHCS Information Security Officer.</p>	<ul style="list-style-type: none"> -Policies and Procedures -Reports to Governing Body -Oversight Committee Meeting Minutes -PHI Breach/Suspected Breach Log of Incidents -Provider Manual -Member Services Guide 	<p>-Verification study of case files maybe conducted to confirm whether MCP reports are compliant with the reporting timeframes and that all appropriate parties are included.</p>	<ul style="list-style-type: none"> -The MCP’s policies and procedures are consistent with contractual requirements and ensure the MCP reports suspected security incidents and breaches to the appropriate DHCS staff within the required timeframes. -MCP provides documented evidence that it is reporting timely. -MCP implements a system of controls to ensure continuity of operations and compliance. -MCP staff who process suspected breaches and security incident reports receive initial and ongoing training that address reporting and investigation requirements. The MCP is able to provide documented evidence of training (e.g., sign-in sheets, dates of training, training schedule, etc.) as well as training materials (e.g., desktop procedures, PowerPoint slides, etc.). -MCP conducts ongoing monitoring (e.g., audits, etc.) at a set frequency to ensure compliance with contractual requirements; auditing tools specifically measure

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<p>If the incident occurs after business hours or on a weekend or holiday and involves electronic PHI, notice shall be provided by calling the DHCS ITSD Service Desk.</p> <p>Notice shall be made using the DHCS Privacy Incident Report (PIR) form, including all information known at the time.</p> <p>Investigation and Report</p> <p>Within 72 hours of the discovery, the MCP shall submit an updated DHCS PIT form containing the information marked with an asterisk and all other applicable information listed on the form, to the extent known at the time.</p> <p>Notice shall be provided to the DHCS Program Contract Manager, the DHCS Privacy Officer, and the DHCS Information Security Officer.</p>			<p>whether all parties at DHCS have been reported too, whether all applicable timeframes have been met and if PIR reports are complete.</p> <p>-When audit results demonstrate incidents of non-compliance, the MCP takes appropriate follow up action as necessary and can substantiate through supporting documentation.</p>

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<p>Complete Report</p> <p>MCP to provide a complete report of the investigation within ten (10) working days of the discovery of the breach or unauthorized use or disclosure.</p> <p>The report shall be submitted on the DHCS PIR form and shall include an assessment of all known facts relevant to a determination of whether a breach occurred. The report shall also include a full, detailed corrective action plan, including information on measures that were taken to halt and/or contain the improper use or disclosure.</p> <p>Notice shall be provided to the DHCS Contract Program Manager, the DHCS Privacy Officer, and the DHCS Information Security Officer.</p>			

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CONTRACT REQUIREMENT	DOCUMENTATION REVIEWED	VERIFICATION STUDY	EXAMPLES OF BEST PRACTICES