CONTRACT AND ENROLLMENT REVIEW – NORTH I SECTION
AUDITS AND INVESTIGATIONS
DEPARTMENT OF HEALTH CARE SERVICES

REPORT ON THE MEDICAL AUDIT OF

KP Cal, LLC
Kaiser Permanente GMC

2022

Contract Number:	07-65849 Sacramento 09-86159 San Diego
Audit Period:	November 1, 2021 Through October 31, 2022
Dates of Audit:	October 31, 2022 Through November 10, 2022
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I. INTRODUCTION

Kaiser Foundation Health Plan, Inc. (KFHP) obtained its Knox-Keene license in November 1977 and contracted with the Department of Health Care Services (DHCS) in 1994 as a Geographic Managed Care (GMC) plan to provide health care services to Medi-Cal members in the GMC counties of Sacramento and San Diego.

In 2005, KP Cal, LLC (Plan) was created and licensed as a Knox-Keene plan to hold Kaiser's GMC Contracts. DHCS then transferred the GMC Contracts to the Plan. At that time, the Plan and KFHP entered into a management and administrative services agreement to delegate administrative and operational functions such as quality improvement, grievances, and appeals to KFHP. These two entities also entered into a health services agreement to provide health care services to Plan members through KFHP's network of providers and medical centers. KFHP offers a comprehensive health care delivery system including physicians, medical centers, hospitals, laboratories, and pharmacies.

KFHP divides its operations into Northern California and Southern California regions with corresponding responsibilities for the Sacramento and San Diego GMC Contracts. The Sacramento GMC service area includes Sacramento County and members in Amador, El Dorado, and Placer Counties who were either previously enrolled or family-linked with Kaiser. The San Diego GMC service area includes San Diego County.

The scope of this audit includes the review of Seniors and Persons with Disabilities (SPD) population in the areas of Utilization Management (UM), Access and Availability of Care, Member's Rights, and Quality Management.

As of October 31, 2022, KFHP's total direct GMC Contract membership was approximately 198,253. Medi-Cal membership composition was 132,073, including 6,007 SPD members, for Sacramento GMC and 66,180, including 1,463 SPD members, for San Diego GMC.

II. EXECUTIVE SUMMARY

This report presents the audit findings of the DHCS medical audit for the period of November 1, 2021 through October 31, 2022. The audit was conducted from October 31, 2022 through November 10, 2022. The audit consisted of document reviews, verification studies, and interviews with Plan representatives.

An Exit Conference with the Plan was held on February 23, 2023. The Plan was allowed to provide supplemental information addressing the draft audit report findings. 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 audit evaluated six categories of performance: UM, Case Management and Coordination of Care, Access and Availability of Care, Member's Rights, Quality Management, and Administrative and Organizational Capacity.

The prior DHCS medical audit (for the period of September 1, 2019 through October 31, 2021) was issued on March 3, 2022. This audit examined documentation for contractual compliance and to determine to what extent the Plan has implemented their Corrective Action Plan (CAP).

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

This is a combined report for both the Sacramento GMC Contract and San Diego GMC Contract. Common findings and recommendations are reported under Sacramento and San Diego GMC. Unique findings and recommendations are specified as either Sacramento GMC or San Diego GMC.

The summary of the findings by category follows:

Category 1 – Utilization Management

Category 1 covers procedures and requirements for the Plan's UM program, including prior authorization review and the appeal process.

Sacramento GMC

The Plan is required to approve prior authorization requests for health care services for a member within the shortest applicable timeframe that is appropriate for the member's condition, but no longer than five business days from the Plan's receipt of information reasonably necessary and requested by the Plan to make a determination; and not to exceed 14 calendar days following the Plan's receipt. The Plan did not render decisions for routine prior authorization approvals within the required 14-calendar day timeframe.

When the Plan does not render decisions for routine prior authorization approvals within the required 14-calendar day timeframe, it must either deny the authorization request or immediately notify the requesting provider to submit all specific information the Plan still needs to make its authorization decision. The written notice requesting additional medical information must specify the information the Plan requested but did not receive, the expert reviewer to be consulted, or the additional examinations or tests required before the service can be approved or denied. The Plan must also include the anticipated date when its decision will be made, make a decision on the request as expeditiously as the member's health condition requires, and advise the member that they have a right to file a grievance to dispute the delay. The Plan did not notify both its requesting providers and its members of their intent to extend the processing time for routine prior authorization cases beyond the initial 14 calendar timeframe.

The Language Assistance Taglines (LAT) must be included in all member informational notices, including written notices to an individual such as those pertaining to rights and benefits. The Plan did not include updated LAT information in prior authorization and appeal notices sent to members in accordance with All Plan letter (APL) 21-004.

The Plan is required to resolve standard appeals within 30 calendar days and expedited appeals within 72 hours from the date the Plan receives an appeal request. The Plan did not resolve standard and expedited appeals cases within the required timeframes.

The Plan is required to provide members with a written notice of an adverse benefit determination using the appropriate DHCS standardized Notice of Action (NOA) "Your Rights" template. The Plan is accountable for all functions and responsibilities that are delegated. The Plan did not ensure a delegate sent the updated NOA "Your Rights" attachment from APL 21-011 for adverse benefit determinations.

San Diego GMC

The Plan must provide prior authorization for intravenous sedation and general anesthesia for dental services according to criteria in APL 15-012. The Plan denied general anesthesia for dental services using UM criteria that were more restrictive than Medi-Cal guidelines described in APL 15-012.

The Plan is required to ensure decisions regarding prior authorization are explained in the NOA letters, and that for medical necessity denials, include the clinical reason for the denial and explicitly state how the member's condition did not meet the criteria or guidelines. The Plan did not explicitly state how the members' conditions did not meet criteria and did not provide clinical reasons for decisions within NOA letters for adverse benefit determinations based on medical necessity.

The Plan is required to have a set of written criteria or guidelines for utilization review that is based on sound medical evidence, is consistently applied, regularly reviewed, and updated. The Plan did not ensure that written criteria or guidelines used for utilization review were consistently applied.

The Plan is required to provide fully translated written member information to members who speak an identified threshold language. The Plan did not provide translated written member information for prior authorization approval notices to members whose primary language was an identified threshold language.

The Plan must provide an immediate, full translation of the entire NOA, including the clinical rationale for the Plan's decision. The Plan is accountable for all functions and responsibilities that are delegated. The Plan did not ensure a delegate provided immediate, full translation of written member information in the NOA letter packet, including translation of the clinical rationale, for threshold languages.

The Plan is required to provide members with a Non-Discrimination Notice (NDN) and LAT, including all required information in APL 21-004, for written informational notices. The Plan is accountable for all functions and responsibilities that are delegated. The Plan did not ensure a delegate sent updated NDN and LAT information to members with all written notices for UM decisions.

The Plan is required to provide members with a written notice of an adverse benefit determination using the DHCS standardized NOA "Your Rights" template from APL 21-011. The Plan is accountable for all functions and responsibilities that are delegated. The Plan did not ensure a delegate sent the updated NOA "Your Rights" attachment from APL 21-011 for adverse benefit determinations.

Category 2 – Case Management and Coordination of Care

Category 2 includes requirements to provide Health Risk Assessments (HRA) and mental health and substance use disorder.

San Diego GMC

The Plan must use the HRA survey to comprehensively assess each newly enrolled SPD member's current health risk. The HRA must include specific Long-Term Services and Support (LTSS) referral questions, which are intended to assist the Plan in identifying members who may qualify for, and benefit from LTSS services. The Plan did not use LTSS referral questions to assess SPD members under 21 years of age when conducting HRA surveys.

The Plan is required to provide coverage, coordination, case management and division of financial responsibility for eating disorder treatment according to APL 22-003. The Plan did not implement all requirements for eating disorder coverage.

The Plan is required to provide coverage and coordination for non-specialty mental health services (NSMHS) according to APL 22-005. The Plan did not implement all new requirements for NSMHS coverage and coordination with the county Mental Health Plan (MHP).

The Plan is required to provide services and coverage for NSMHS according to APL 22-006. The Plan did not implement all requirements for coverage of new NSMHS, including new benefits and covered populations.

Category 3 – Access and Availability of Care

Category 3 includes requirements regarding the adjudication of claims for family planning services.

Sacramento GMC

The Plan is required to ensure covered services are provided in an amount no less than what is offered under the Medi-Cal Fee-For-Service Program as described in the DHCS Provider Manual. The Plan inappropriately applied a fifty-percent payment reduction to family planning services.

Sacramento and San Diego GMC

The Plan is required to directly pay qualified family planning providers a fixed add-on amount for specified family planning services listed in APL 20-013. The Plan did not distribute add-on payments for specified family planning claims.

Category 4 – Member's Rights

Category 4 includes requirements for the handling of grievances and Cultural and Linguistic Services (CLS).

Sacramento GMC

The Plan is required to provide oral notice of the resolution of an expedited grievance review within 72 hours. The Plan did not provide oral resolution to the member within the required 72-hour timeframe for expedited grievances.

In the event that 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 should not exceed 14 calendar days. The Plan did not notify members of resolution delays in writing for grievances not resolved within 30 calendar days.

The Plan is required to implement and maintain a written description of its CLS Program, which should include an organizational chart of its CLS Program. This organization chart is required to have specific elements. The Plan's CLS Program organizational chart did not have all required elements.

San Diego GMC

The Plan's written grievance resolution must contain a clear and concise explanation of the Plan's decision. The Plan did not ensure grievance resolution letters contained a clear and concise explanation of the Plan's decision.

The written record of grievances must be reviewed periodically by the governing body, the public policy body, and a Plan officer or their designee. The review must be thoroughly documented. The Plan's public policy body did not periodically review written grievance logs or reports and did not thoroughly document the review.

Sacramento and San Diego GMC

The NDN and LAT must be included in all member informational notices, including written notices to an individual such as those pertaining to rights and benefits. The Plan did not ensure that updated NDN and LAT information were included in all member informational notices, such as grievance letters, newsletters, and online member materials, in accordance with APL 21-004.

The Plan is required to provide written resolution to the member that is dated within 30 days of receipt of the grievance. The Plan did not provide written resolution to members within 30 calendar days from the date of receipt of a standard grievance.

The Plan must ensure that all grievances with alleged discrimination are investigated by the Plan's designated discrimination grievance coordinator and resolved within the grievance system. The Plan did not ensure that discrimination grievances were investigated by the discrimination grievance coordinator and resolved within the grievance system.

The Plan must forward all grievances with alleged discrimination to DHCS within ten calendar days of the grievance resolution for review and appropriate action. The Plan did not forward all discrimination grievances to DHCS within ten calendar days of the grievance resolution.

The Plan must submit detailed and specific information regarding the grievance to DHCS for all grievances with alleged discrimination. The Plan's emails to DHCS regarding discrimination grievances did not have all required information as specified in APL 21-004.

The grievance system must be established in writing and provide for procedures that will receive, review, and resolve grievances. If multiple issues are presented by the member, the Plan must ensure that each issue is addressed and resolved. The Plan sent resolution letters for grievances without completely resolving all member complaints.

Category 6 – Administrative and Organizational Capacity

Category 6 includes requirements to maintain a health education system and investigate fraud and abuse.

Sacramento and San Diego GMC

The Plan is required to provide educational interventions addressing all specified health education categories and associated topics. The Plan did not provide educational interventions to address two required topics within the Effective Use of Managed Health Care Services (MHCS) category: Health Education Services and Managed Health Care System.

The Plan is required to conduct, complete, and report to DHCS, the results of a preliminary investigation of the suspected fraud and/or abuse within ten working days of the date the Plan first becomes aware of, or is on notice of, such activity. The Plan did not report suspected fraud and/or abuse to DHCS within ten working days of the date it first became aware.

III. SCOPE/AUDIT PROCEDURES

SCOPE

This audit was conducted by DHCS to ascertain that the medical services provided to Plan members comply with federal and state laws, Medi-Cal regulations and guidelines, and the state Contracts.

PROCEDURE

The audit was conducted from October 31, 2022 through November 10, 2022. The audit included a review of the Plan's 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 Plan administrators and staff.

The following verification studies were conducted:

Category 1 – Utilization Management

Prior Authorization Requests: 52 (27 Sacramento GMC and 25 San Diego GMC) medical prior authorization requests, including 26 SPD cases, were reviewed for timeliness, consistent application of criteria, and appropriate review.

Post-stabilization Requests: Ten (Five Sacramento GMC and Five San Diego GMC) post-stabilization requests, including five SPD cases, were reviewed for appropriate and timely adjudication.

Appeal Procedures: Five Sacramento GMC prior authorization appeals, including three SPD cases, were reviewed for appropriate and timely adjudication. San Diego GMC did not have prior authorization appeals during the audit period.

Delegated Authorization Requests: 34 (20 Sacramento GMC and 14 San Diego GMC) authorization requests from a delegate, including six SPD cases, were reviewed for timeliness, consistent application of criteria and appropriate adjudication.

Category 2 – Case Management and Coordination of Care

HRA: Seven (Three Sacramento GMC and four San Diego GMC) files concerning SPD members were reviewed to confirm coordination of care and fulfillment of HRA requirements.

California Children's Services (CCS): Six (Three Sacramento GMC and three San Diego GMC) medical records were reviewed to confirm coordination of care between the Plan and CCS providers.

Initial Health Assessment (IHA): Eight (Four Sacramento GMC and four San Diego GMC) medical records were reviewed for evidence of coordination of care and fulfillment of IHA requirements.

Complex Case Management: Six (Three Sacramento GMC and three San Diego GMC) medical records were reviewed to confirm coordination of care.

Behavioral Health Treatment: 13 (Seven Sacramento GMC and six San Diego GMC) medical records were reviewed to confirm coordination of care and fulfillment of behavioral health requirements.

Continuity of Care (COC): Six (Four Sacramento GMC and two San Diego GMC) medical records were reviewed to confirm COC and fulfillment of requirements.

NSMHS: 20 (Ten Sacramento GMC and ten San Diego GMC) clinical records were reviewed to confirm appropriate provision of NSMHS.

Category 3 – Access and Availability of Care

Claims: 20 (Ten Sacramento GMC and ten San Diego GMC) emergency service claims and 20 (Ten Sacramento GMC and ten San Diego GMC) family planning claims were reviewed for appropriate and timely adjudication.

Non-Medical Transportation (NMT): 40 (20 Sacramento GMC and 20 San Diego GMC) NMT records were reviewed for appropriate adjudication. Contracted NMT providers were reviewed for Medi-Cal enrollment requirements.

Non-Emergency Medical Transportation (NEMT): 40 (20 Sacramento GMC and 20 San Diego GMC) NEMT records were reviewed for appropriate adjudication. Contracted NEMT providers were reviewed for Medi-Cal enrollment requirements.

Category 4 – Member's Rights

Sacramento GMC Grievances: 73 grievances, including 43 standard grievances, 15 expedited grievances and 15 exempt grievances, were reviewed for timely resolution, response to complainant, and submission to the appropriate level for review. The 43 standard grievance cases included 16 quality of service (non-clinical) and 27 quality of care (clinical) grievances. 33 grievances involved SPD members.

San Diego GMC Grievances: 78 grievances, including 48 standard grievances, 15 expedited grievances and 15 exempt grievances, were reviewed for timely resolution, response to complainant, and submission to the appropriate level for review. The 48 standard grievance cases included 16 quality of service (non-clinical) and 32 quality of care (clinical) grievances. 26 grievances involved SPD members.

Confidentiality Rights: 34 (23 Sacramento GMC and 11 San Diego GMC) Health Insurance Portability and Accountability Act /Protected Health Information (PHI) breach and security incidents were reviewed for processing and timeliness requirements.

Category 5 – Quality Management

Potential Quality Issues (PQI): 17 (Seven Sacramento GMC and ten San Diego GMC) PQIs, including seven SPD cases, were reviewed for appropriate evaluation and effective action taken to address needed improvements.

Provider Training: 60 (30 Sacramento GMC and 30 San Diego GMC) new provider training records were reviewed for the timeliness of Medi-Cal Managed Care program training.

Category 6 – Administrative and Organizational Capacity

Fraud and Abuse: 14 (11 Sacramento GMC and three San Diego GMC) fraud and abuse cases were reviewed for appropriate reporting and processing.

A description of the findings for each category is contained in the following report.

CATEGORY 1 - UTILIZATION MANAGEMENT

1.2	PRIOR AUTHORIZATION REVIEW REQUIREMENTS

Sacramento GMC

1.2.1 Prior Authorization Decision Timeframes

The Plan is required to approve, modify or deny a provider's prospective or concurrent request for health care services for a member within the shortest applicable timeframe that is appropriate for the member's condition, but no longer than five business days from the Plan's receipt of information reasonably necessary and requested by the Plan to make a determination; and not to exceed 14 calendar days following the Plan's receipt of the request for service. *(Contract A20, Exhibit A, Attachment 5(3)(H))*

Finding: The Plan did not render decisions for routine prior authorization approvals within the required 14-calendar day timeframe.

A verification study of 27 prior authorization samples revealed that seven prior authorization requests were approved after the 14 calendar day timeframe. The decision timeframes ranged from 20 to 114 days.

Plan policy *17.0 - UM Denial of Practitioner Requested Services (approved 9/28/2021)* did not include requirements for timeframes for approval decisions.

In a written statement, the Plan stated prior authorization requests for approvals were delayed due to various reasons, such as technical issues, delayed provider responses, and UM staff shortages.

When the Plan does not process prior authorization service requests in a timely manner, members may not receive medically necessary services timely which could adversely impact members' health.

Recommendation: Revise policies and procedures to ensure decisions are rendered for routine prior authorization approvals within required timeframes.

Sacramento GMC

1.2.2 Prior Authorization Delay Notices

The Plan is required to render decisions for routine authorizations within five working days but no longer than 14 calendar days from the receipt of the request. The decision may be deferred and the time limit extended an additional 14 calendar days only when it is in the member's best interest. Any decision delayed beyond the time limits is considered a denial and must be immediately processed as such. *(Contract A20, Exhibit A, Attachment 5(3)(H))*

If the Plan requires an extension of the initial 14 calendar day authorization timeframe, the Plan must either deny the authorization request or immediately notify the requesting provider to submit all specific information the Plan still needs to make its authorization decision. The Plan's written notice requesting additional medical information must specify the information the Plan requested but did not receive, the expert reviewer to be consulted, or the additional examinations or tests required before the service can be approved or denied. The Plan must also include the anticipated date when its decision will be made, make a decision on the request as expeditiously as the member's health condition requires, and notify and advise the member that they have a right to file a grievance to dispute the delay. The Plan must send this written notice within the required timeframe, or as soon as the Plan becomes aware that it will not meet the initial authorization timeframe, whichever is earlier. (*APL 21-011, Grievance and Appeals Requirements, Notice and "Your Rights" Templates*)

Finding: The Plan did not notify both its requesting providers and its members of their intent to extend the processing time for routine prior authorization cases beyond the initial 14 calendar timeframe.

A verification study of 27 prior authorization samples revealed that in seven approved requests the Plan did not render decisions within 14 calendar days, did not immediately deny the cases exceeding the timeframe, and did not send delay notifications to providers and did not advise its members that they had a right to file a grievance to dispute the delay.

Plan policy *17.0 - UM Denial of Practitioner Requested Services (approved 9/28/2021)* did not include requirements for delay notifications for untimely approval decisions.

While the Plan provided reasons for untimely decisions, it did not explain why delay notifications were not sent.

When the Plan does not send notices of delays to its providers and members, medically necessary services may not be received timely and members may not be able to exercise their rights to file a grievance or appeal.

Recommendation: Implement policies and develop procedures to ensure delay notifications are sent to the requesting providers and members when extensions for processing routine prior authorization cases beyond the 14 calendar day timeframe are needed.

Sacramento GMC

1.2.3 Language Assistance Taglines

The Plan is required to comply with all existing policy letters and APLs issued by DHCS. *(Contract A20, Exhibit E, Attachment 2(1)(D))*

The LAT must be posted in all member informational notices, including written notices to an individual such as those pertaining to rights and benefits. DHCS updated its LAT template to conform to federal law and to include additional top California languages (Mien and Ukrainian). Although DHCS does not require Plans to use the DHCS-provided templates verbatim, notices must be compliant with requirements in this APL and with information in the DHCS-provided templates. The implementation date for required information in full-sized LAT was October 5, 2021. (*APL 21-004 Standards for Determining Threshold Languages, Nondiscrimination Requirements, and Language Assistance Services*)

Plan policy *20.0 Medi-Cal Translated NOAs (approved 5/24/2022)*, stated the Plan follows regulatory guidance per APL 21-004 for use of standards of language assistance services, determining threshold languages, and nondiscrimination requirements.

Plan Policy *CA.HP.Operations.LA 005001 (effective 11/01/2021)* states that Medi-Cal vital documents must be accompanied by the LAT, regardless of the size of the publication. Vital documents are defined as written materials for Medi-Cal members that are essential for understanding health plan benefits or accessing covered health care services. Vital documents include form letters including NOA letters.

Finding: The Plan did not include updated LAT information in prior authorization notices sent to members in accordance with APL 21-004.

A verification study of 27 prior authorization samples revealed that in 16 samples resolved after March 1, 2022, the Plan did not send updated LAT for Mien and Ukrainian languages to members in NOA and approval letters.

Although the Plan stated it implemented updated LAT on March 1, 2022, the verification study continued to show deficient samples resolved after this date. In a written response, the Plan acknowledged it did not include Mien and Ukrainian due to system errors when processing the cases.

When the Plan uses outdated and incomplete LAT, members may not be able to understand the Plan's decisions and exercise their rights.

Recommendation: Implement policies and processes to ensure the Plan sends updated LAT information in prior authorization notices.

San Diego GMC

1.2.4 Utilization Management Criteria for Dental Anesthesia

The Plan must comply with all existing policy letters and APLs issued by DHCS. *(Contract A17, Exhibit E, Attachment 2(1)(D))*

The Plan must provide prior authorization for intravenous sedation and general anesthesia for dental services using the following criteria:

If the provider provides clear medical record documentation of both number 1 and number 2 below, then the member should be considered for intravenous sedation or general anesthesia:

1. Use of local anesthesia to control pain failed or was not feasible based on the medical needs of the member.

2. Use of conscious sedation, either inhalation or oral, failed or was not feasible based on the medical needs of the member.

Or

If the provider documents any one of numbers 3 through 6 then the member should be considered for intravenous sedation or general anesthesia.

3. Use of effective communication techniques and the inability for immobilization (member may be dangerous to self or staff) failed or was not feasible based on the medical needs of the member.

4. Member requires extensive dental restorative or surgical treatment that cannot be rendered under local anesthesia or conscious sedation

5. Member has acute situational anxiety due to immature cognitive functioning.

6. Member is uncooperative due to certain physical or mental compromising conditions. *(APL 15-012, Dental Services – Intravenous Sedation and General Anesthesia Coverage)*

Plan policy *SC.HPHO.056 Dental Anesthesia Coverage for Medi-Cal Members (effective 10/6/21)* outlined criteria and indications for intravenous sedation and general anesthesia exactly as stated in APL15-012.

Plan criteria *2021 UM Criteria for Dental Anesthesia-Medi-Cal (approved 11/4/21)* stated general anesthesia is covered for Medi-Cal based on a mental or physical limitation or contraindication to a local anesthetic agent and the member meets one of the following criteria:

1. Member is under seven years of age, or

2. Member has a developmental disability, or

3. Member has an underlying clinical or medical condition for which general anesthesia is medically necessary.

In addition, the document listed “Clinical Review Criteria” for an unknown line of business as follows: Medical necessity for general anesthesia requires that the following three criteria are met:

1. There must exist a medical condition or clinical status (including behavioral factors) that require general anesthesia, and

2. The member must be less than seven years of age, or be developmentally disabled, or have compromised health (including mental/behavioral health) that requires general anesthesia, and

3. The dental needs must be of significant complexity such that delay in treatment could lead to infection or other systemic complications.

Plan policy *SC.RUM.011 (UM) Criteria and Guidelines (revised 9/15/21)* stated that the UM Committee reviews and approves UM criteria at least annually and updates criteria as appropriate. Medi-Cal rules and regulations are used to assist the physician in making medical necessity and benefit coverage determinations for Medi-Cal members per the Evidence of Coverage.

Finding: The Plan denied general anesthesia for dental services using UM criteria that were more restrictive than Medi-Cal guidelines described in APL 15-012.

A verification study of 25 prior authorization requests revealed that in two of two requests for dental general anesthesia, the Plan denied services based on its internally-developed criteria that were more restrictive than APL 15-012.

- In one sample, the provider requested general anesthesia due to difficulty of extracting numerous impacted teeth.

- In another sample, the provider requested general anesthesia because two prior attempts to perform extractions of numerous teeth with local anesthesia had failed, which was attributed to the member's extreme anxiety.

In both samples, the Plan determined members did not meet all three of the following criteria:

1. There must exist a medical condition or clinical status (including behavioral factors) that require general anesthesia, and

2. The member must be less than seven years of age, or be developmentally disabled, or have compromised health (including mental/behavioral health) that requires general anesthesia, and

3. The dental needs must be of significant complexity such that delay in treatment could lead to infection or other systemic complications.

The decision-makers denied the requests because the members did not meet all three criteria listed under the "Clinical Review Criteria" from the Plan's *UM Criteria for Dental Anesthesia-Medi-Cal*, which were more restrictive than Medi-Cal guidelines. APL 15-012 does not require meeting all three of the Plan's criteria and does not have an age limit. The Plan's criteria does not include Medi-Cal requirements for whether less invasive techniques were found to be not feasible or had failed.

In interviews and written responses, the Plan acknowledged that its dental anesthesia criteria did not reflect APL 15-012 appropriately. The Plan stated the UM department worked with the Medi-Cal compliance team to update policies and internally-developed criteria sets to ensure alignment with Medi-Cal guidelines. However, based on submitted documents, there was no evidence that the UM committee's process to annually review UM criteria sets included verification of alignment with current Medi-Cal guidelines.

When the Plan uses UM criteria that are more restrictive than Medi-Cal guidelines, members may not receive medically necessary services that are covered under the Medi-Cal program, which may adversely impact health outcomes.

Recommendation: Revise UM criteria and implement procedures to ensure decision-makers use criteria for dental anesthesia that align with APL 15-012.

San Diego GMC

1.2.5 Explicit Clinical Reason in NOA Letters

The Plan must comply with all existing policy letters and APLs issued by DHCS. *(Contract A17, Exhibit E, Attachment 2(1)(D))*

The Plan must provide members with written notice through a NOA for adverse benefit determinations, which include denial or limited authorization of a requested service. For adverse benefit determinations based in whole or in part on medical necessity, the written NOA must contain the clinical reasons for the decision, and the Plan must explicitly state how the member's condition does not meet the criteria or guidelines. (*APL 17-006, Grievance and Appeal Requirements and Revised Notice Templates and "Your Rights" Attachments, and APL 21-011, Grievance and Appeal Requirements, Notice And "Your Rights" Templates*)

Plan policy *SC. RUM.016 UM Denial of Practitioner Requested Services (revised 08/22/22)* stated written denial notices are required to include easy-to-understand language explaining the reason for denial, including reference to the specific criteria upon which the decision was made as they relate to the member's medical condition.

Finding: The Plan did not explicitly state how the member's condition did not meet criteria and did not provide clinical reasons for decisions within NOA letters for adverse benefit determinations based on medical necessity.

A verification study of 25 prior authorization requests showed that in five of 20 adverse benefit determinations based on medical necessity, the Plan did not provide explicit clinical reasons in the NOA letters. Examples of deficiencies included:

- In one request, the Plan denied a provider's request for a knee brace for a member under the age of 21 who was undergoing surgery. In the NOA, the Plan cited Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) criteria and provided the following rationale for the denial decision: "your child does not meet the coverage criteria because the requested item is not medically necessary to correct or ameliorate your child's health condition". The NOA did not contain a clinical reason for the denial, and the Plan did not explicitly explain how the member's specific condition, symptoms, and functional impairment did not meet the EPSDT criteria based on medical evidence.

- In another request, the Plan denied a provider's request for a chest compression vest for a child with autism. In the NOA, the Plan cited EPSDT criteria and provided the following rationale for the denial decision: "your child does not meet the coverage criteria because the requested item is not medically necessary to correct or ameliorate your child's health condition". The NOA did not contain a clinical reason why the vest was not indicated for autism symptoms. The Plan did not explicitly state how the member's behavioral issue and sensory symptoms did not meet the EPSDT criteria based on medical evidence.

- In two other requests, the Plan denied providers' requests for portable home oxygen for members with lung disease who required continuous oxygen. In each request, the provider submitted oxygen measurements taken while the member was using an oxygen tank instead of room air measurements without an oxygen tank. In each NOA, the Plan did not explicitly state that the member's oxygen level did not meet its criteria because the providers submitted incorrect measurements. If the Plan had informed the members and providers of the room air requirements and explicit reasons for denial, the providers would have had an opportunity to submit correct measurements for review.

During interviews and in written statements, the Plan stated UM nurses drafted NOA letters and were required to include the criteria used and the denial rationale provided by the physician decision-maker. In response to the deficient samples, the Plan stated it would update EPSDT and home oxygen NOA letter language to include specific clinical reasons for denial.

When the Plan does not provide an explicit reason why the member's condition does not meet criteria, providers may not receive enough clinical information to make treatment plan decisions and members may not receive medically necessary services.

Recommendation: Implement policies and procedures to ensure the Plan explicitly states how the member's condition does not meet criteria and provides a clinical reason for adverse benefit determinations based on medical necessity.

San Diego GMC

1.2.6 Translation of Authorization Letters

The Plan must provide fully translated written informing materials to all monolingual or Limited English-Proficient (LEP) members that speak the identified threshold or concentration language. *(Contract A22, Exhibit A, Attachment 9 (14)(C))*

Threshold and concentration languages for San Diego County were English, Arabic, Spanish, Tagalog and Vietnamese. *APL 17-011, Standards for Determining Threshold Languages and Requirements for Section 1557 of the Affordable Care Act)*

The Plan is required to provide translated written member information to population groups who indicate their primary language as other than English and that meet certain numeric thresholds or concentration standards. Member information is essential information regarding access to and usage of Plan services and includes documents that are vital or critical to obtaining services or benefits including, but not limited to, form letters and any notices related to actions. San Diego County acquired additional threshold and concentration languages, Chinese and Farsi, as of July 6, 2022. (*APL 21-004, Standards for Determining Threshold Languages, Nondiscrimination Requirements, and Language Assistance Services*)

Plan policy *CA.HP.Operations.LA 005001 Quality Translation Process for Member Informing Materials (effective 11/1/2020)* stated that the Plan must produce and distribute vital documents to members in their preferred Medi-Cal threshold language. Vital documents include information regarding the use of health plan services, process for accessing covered services that require prior authorization, and form letters (denial letters).

Finding: The Plan did not provide translated written member information for authorization notices to members whose primary language was an identified threshold language.

A verification study of 25 prior authorization requests revealed that in one approved request in which the member had a threshold language, the Plan did not send a translated authorization notice to the member. The member's primary language was Tagalog. The Plan sent an authorization letter, which was written in English and informed the member of an approval for speech therapy referral, including contact information and instructions on how to schedule an appointment with the provider.

During interviews, the Plan stated it does not automatically translate authorization letters for approval decisions into threshold languages; the Plan sends LAT, which inform the member how to request translation or interpreter services. If the member specifically requests a translation of the authorization letter, the Plan will complete the request. In contrast, for adverse benefit determinations, the Plan automatically translates the entire NOA letter packet using semi-translated letter templates and a translation vendor when a member's preferred written language is a threshold language.

When the Plan does not translate written member information such as authorization letters into threshold and concentration languages, members may not receive important information on outcomes of UM decisions and how to access approved services.

Recommendation: Revise and implement policies and procedures to ensure that all written member information for authorization letters are translated into threshold and concentration languages.

San Diego GMC

1.2.7 Consistent Application of Criteria

The Plan is required to ensure that its prior authorization, concurrent review, and retrospective review procedures meet the following minimum requirement: There is a set of written criteria or guidelines for utilization review that is based on sound medical evidence, is consistently applied, regularly reviewed, and updated. *(Contract A17, Exhibit A, Attachment 5 (2)(D))*

Plan policy *SC.RUM.008 Consistency in Utilization Review Criteria/Guideline Application (effective 7/23/21)* stated the Plan ensures consistency of decision-making through review of cases overturned by outside regulators, Inter-Rater Reliability (IRR) testing, case reviews at UM trainings, and denial notice audits. The UM department processes all denial notices for decision-makers, conducts real-time IRR during the review of the denial notice, and makes recommendations if other considerations should be made prior to finalizing denials. Annually, the Plan conducts IRR testing of all

licensed UM decision-makers using a passing rate of 90%. The Plan conducts scheduled audits of denial notices and may request action plans for departments that do not meet established compliance requirements.

Finding: The Plan did not ensure that written criteria or guidelines used for utilization review were consistently applied.

The Plan did not submit evidence that all UM decision-makers completed annual IRR testing and UM training.

During interviews and in written statements, the Plan stated it ensured consistent application of UM criteria through the following methods: Immediate written feedback by UM nurses regarding correct application of criteria, annual IRR testing, annual UM training, and monthly audits of a random sample of previously resolved denial cases. In a written response, the Plan stated there were 84 physician decision-makers for the San Diego GMC area.

Based on submitted documents, only 24 of 84 San Diego physician decision-makers completed 2021 IRR testing. The Plan acknowledged that IRR testing does not always have 100% participation by all decision-makers. The Plan did not provide evidence it enforced actions for those who did not complete testing.

The Plan's annual UM trainings showed the Plan trained decision-makers on criteria application using Medi-Cal specific criteria sets and example cases. The Plan stated that annual UM trainings are required for all decision-makers and can be accessed through a portal if a decision-maker cannot attend the live training. However, based on submitted evidence, only 25 of 84 San Diego physician decision-makers completed annual UM training.

The Plan's monthly audits of denial cases revealed the Plan did not check for correct selection of criteria, accurate application of criteria, or appropriate decisions based on the clinical circumstances.

When the Plan does not enforce completion of annual IRR testing and UM training by all decision-makers, UM decisions may be inconsistent and may lead to inappropriate denial of medically necessary services for members.

Recommendation: Develop and implement procedures to ensure that the Plan's set of written criteria and guidelines are consistently applied.

1.3	PRIOR AUTHORIZATION APPEAL PROCESS

Sacramento GMC

1.3.1 Appeals Decision Timeframes

The Plan must resolve standard appeals cases within 30 calendar days and expedited appeals cases within 72-hours. If the Plan does not meet the required timeframes, the member is deemed to have exhausted the Plan's internal appeal process and can request a State Fair Hearing. A resolution notice sent to the member must, at a minimum, include the result and date of the appeal resolution. *(Contract A20, Exhibit A, Attachment 14(5)(B and C))*

The timeframe for resolving standard appeals is within 30 calendar days. The timeframe for resolving expedited appeals must be no longer than 72-hours. The timeframe for resolutions begins at the time and date the appeal is received. (*APL 21-011, Grievance and Appeals Requirements, Notice and "Your Rights" Templates*)

Plan policy *CA.MR.003 - CA Non-Medicare G&A Policy (revised 2/28/2022)*, stated standard prior authorization appeals will be resolved within 30 calendar days, and a written notification will be sent to the member. Expedited appeals must be resolved within 72-hours and a verbal and written notification must be sent to the member based on the date and time of receipt. The appeal process will be deemed exhausted and members may file for a state hearing if the Plan does not adhere to the notice and timing requirements.

Finding: The Plan did not resolve standard and expedited prior authorization appeals within the required 30 calendar day and 72-hour timeframes, respectively.

The Plan received a total of five prior authorization appeal requests for the audit period. A review of all five revealed that in three appeals, the Plan did not render a decision within the required timeframes.

- For the standard appeal, the Plan resolved the case in 40 days
- For two expedited appeals, resolution timeframes ranged from 90 to 175 hours

The Plan stated that it monitored appeals through its tracking system to ensure that UM prior authorization appeals cases were processed in a timely manner.

In a written response, the Plan described the following reasons for delayed resolutions, such as increased volume of cases, inadequate staff, and the COVID-19 pandemic.

When the Plan does not process UM prior authorization appeals within the required timeframes, this may significantly delay the member's ability to receive services in a timely manner and potentially lead to patient harm.

Recommendation: Implement policies and procedures to ensure that the Plan resolves standard and expedited prior authorization appeals within the required 30 calendar day and 72-hour timeframes, respectively.

Sacramento GMC

1.3.2 Language Assistance Taglines for Appeals

The Plan's written communications materials must include LAT which provide information on how members may request auxiliary aids or services, alternative formats for receiving information materials, and corresponding state required threshold and concentration languages. *(Contract A20, Exhibit A, Attachment 13(4)(D)(2 and 3) and Exhibit A, Attachment 9(14))*

The LAT must be posted in all member informational notices, including written notices to an individual such as those pertaining to rights and benefits. DHCS updated its LAT template to conform to federal law and to include additional top California languages (Mien and Ukrainian). Although DHCS does not require Plans to use the DHCS-provided templates verbatim, notices must be compliant with requirements in this APL and with information in the DHCS-provided templates. The implementation date for required information in full-sized LAT was October 5, 2021. *APL 21-004 Standards for Determining Threshold Languages, Nondiscrimination Requirements, and Language Assistance Services*)

Plan Policy *CA.HP.Operations.LA 005001 (effective 11/01/2021)* states that Medi-Cal vital documents must be accompanied by the LAT, regardless of the size of the publication. Vital documents are defined as written materials for Medi-Cal members that are essential for understanding health plan benefits or accessing covered health care services. Vital documents include notices related to appeals including acknowledgement and resolution letters.

Finding: The Plan did not send updated LAT information in accordance with APL 21-004 for prior authorization appeal notices.

The Plan received a total of five prior authorization appeal requests for the audit period. A review showed that in all five appeals, the Plan did not send updated LAT to members with resolution letters. The LAT was missing required information in Mien and Ukrainian.

In a written response, the Plan stated that it did not include updated LAT information with appeal notices due to system errors.

When the Plan uses outdated and incomplete LAT, members may not be able to understand the Plan's decisions and exercise their rights.

Recommendation: Implement policies and processes to ensure updated LAT is included in appeals letters to members.

1.5	DELEGATION OF UTLIZATION MANAGEMENT

Sacramento GMC

1.5.1 Notice of Action "Your Rights" Attachment

The Plan is accountable for all functions and responsibilities, including UM, that are delegated. The Plan is required to maintain a system to ensure accountability for delegated activities that at a minimum ensures a delegate meets standards set forth by the Plan and DHCS. *(Contract A20, Exhibit A, Attachment 4(6) (A and B))*

The Plan must provide members with written notice of an adverse benefit determination using the appropriate DHCS standardized NOA template and the DHCS standardized NOA "Your Rights" template. DHCS updated the Knox-Keene NOA "Your Rights" attachment template with additional information on deemed exhaustion (exceptions when a member can file a state hearing), Aid Paid Pending (continuation of treatment), and new contact information for California Department of Social Services (CDSS) and Department of Managed Health Care (DMHC). Knox-Keene licensed Plans must use the Knox-Keene "Your Rights" attachment template attached to this APL. Plans are not permitted to make changes to NOA or "Your Rights" templates without prior review and approval from DHCS, except to insert information specific to the member as required. The implementation date of the templates was February 28, 2022. *(APL 21-011, Grievance and Appeal Requirements, Notice and "Your Rights" Templates))*

Plan policy *28.0 – KPNC Delegation of UM Activities for Delegated Entities (approved 04/26/2022)* stated that the Plan's delegated UM activities will be evaluated annually, which also included annual desktop audits, to ensure that it complies with all regulatory requirements.

The Delegation Agreement between the Plan and delegate *(effective 5/1/21)* stated the delegate will conduct its UM program in compliance with the contract between the Plan and DHCS, guidance documents issued by DHCS such as APLs, and all applicable state and federal laws, which may be amended from time to time.

Delegate policy *CA UM 2 Revision 6 Medi-Cal: Medical Necessity Review-California-Medi-Cal (approved 5/19/22)* stated the members are informed of adverse benefit determinations according to applicable state, federal, and contract requirements. The delegate uses DHCS' NOA template, including the "Your Rights" attachment.

Finding: The Plan did not ensure a delegate sent updated NOA "Your Rights" Attachments to members for adverse benefit determinations in accordance with APL 21-011.

A verification study of eight service requests demonstrated that in six of eight adverse benefit determinations resolved after 2/28/22, the delegate did not send an updated NOA "Your Rights" attachment with written NOA letters sent to members. In all six requests, the following information was missing from the "Your Rights" attachment:

- Information about and how to request Aid Paid Pending
- Information pertaining to the member's right to request a state hearing without having to exhaust the Plan's internal appeal process in instances of "Deemed Exhaustion".
- Information regarding the CDSS online web address www.cdss.ca.gov that members may use to file a request for a state hearing.

In a written statement, the Plan informed the delegate of updated "Your Rights" attachments in March 2022. The delegate updated its letter templates and the Plan approved them in June 2022. However, the verification study did not show compliance with the new requirements in a case that was resolved after June 2022.

When the delegate does not update the information required by DHCS, such as NOA "Your Rights" templates, members may not receive updated information necessary to exercise their rights.

Recommendation: Implement Plan policies and oversight processes to ensure that delegated entities comply with new DHCS requirements as required by APL 21-011.

San Diego GMC

1.5.1 Notice of Action "Your Rights" Attachment

The Plan is accountable for all functions and responsibilities, including UM, that are delegated. The Plan is required to maintain a system to ensure accountability for delegated activities that at a minimum ensures a delegate meets standards set forth by the Plan and DHCS. (*Contract A17, Exhibit A, Attachment 4(6) (A and B))*

The Plan must provide members with written notice of an adverse benefit determination using the appropriate DHCS standardized NOA template and the DHCS standardized NOA "Your Rights" template. DHCS updated the Knox-Keene NOA "Your Rights" attachment template with additional information on deemed exhaustion (exceptions when a member can file a state hearing), Aid Paid Pending (continuation of treatment), and new contact information for CDSS and DMHC. Knox-Keene licensed Plans must use the Knox-Keene "Your Rights" attachment template attached to this APL. Plans are not permitted to make changes to NOA or "Your Rights" templates without prior review and approval from DHCS, except to insert information specific to the member as required. The implementation date of the templates was February 28, 2022. *APL 21-011, Grievance and Appeal Requirements, Notice and "Your Rights" Templates*))

Plan Policy *SC.RUM.033 Delegation of UM Activities (effective 4/13/20)* stated the Plan performs an annual audit of the delegate's UM program to ensure compliance with all applicable state and federal laws and regulations, advisory information, contract requirements, and reporting requirements.

The Delegation Agreement between the Plan and delegate *(effective 5/1/21)* stated the delegate will conduct its UM program in compliance with the contract between the Plan and DHCS, guidance documents issued by DHCS such as APLs, and all applicable state and federal laws, which may be amended from time to time.

Delegate policy *CA UM 2 Revision 6 Medi-Cal: Medical Necessity Review-California-Medi-Cal (approved 5/19/22)* stated the members are informed of adverse benefit determinations according to applicable state, federal, and contract requirements. The delegate uses DHCS' NOA template, including the "Your Rights" attachment.

Finding: The Plan did not ensure a delegate sent the updated NOA "Your Rights" Attachments to members for adverse benefit determinations in accordance with APL 21-011.

A verification study of 14 service requests demonstrated that in seven of seven adverse benefit determinations resolved after 2/28/22, the delegate did not send an updated NOA "Your Rights" attachment with written NOA letters sent to members.

In all seven requests, the Knox-Keene NOA "Your Rights" attachment did not contain required information on deemed exhaustion, Aid Paid Pending, and updated contact information for CDSS and DMHC.

In March 2022, the Plan informed the delegate of new requirements from APL 21-011 and shared the Plan's NOA decision templates, which included the updated "Your Rights" attachment. In interviews and written responses, the delegate stated it does not make changes to NOA letter templates or member informational notices without written approval from the Plan. The delegate updated its letter templates and the Plan approved them in September 2022. However, the verification study did not contain samples resolved after September 2022, and subsequent compliance with updated NOA "Your Rights" attachments could not be confirmed.

In interviews and written statements, the Plan acknowledged it was responsible for communicating new requirements and sharing the Plan's updated letter templates with the delegate.

When the delegate does not update information required by DHCS, such as NOA "Your Rights" templates, members may not receive updated information necessary to exercise their rights.

Recommendation: Implement Plan policies and oversight processes to ensure that delegated entities comply with new DHCS requirements.

San Diego GMC

1.5.2 Translation of NOA Letter Packets

The Plan is accountable for all functions and responsibilities, including UM, that are delegated. The Plan is required to maintain a system to ensure accountability for delegated activities that at a minimum ensures a delegate meets standards set forth by the Plan and DHCS. *(Contract A17, Exhibit A, Attachment 4(6) (A and B))*

The Plan must provide fully translated written informing materials to all monolingual or LEP members that speak the identified threshold or concentration language. *(Contract A22, Exhibit A, Attachment 9 (14)(C))*

The threshold and concentration languages for San Diego County were English, Arabic, Spanish, Tagalog and Vietnamese. *(APL 17-011, Standards for Determining Threshold Languages and Requirements for Section 1557 of the Affordable Care Act)*

The Plan is required to provide translated written member information to population groups who indicate their primary language as other than English and that meet certain numeric thresholds or concentration standards. Member information includes documents that are vital or critical to obtaining services or benefits and includes, but is not limited to, form letters and any notices related to actions. San Diego County acquired additional threshold and concentration languages, Chinese and Farsi, as of July 6, 2022. (*APL 21-004, Standards for Determining Threshold Languages, Nondiscrimination Requirements, and Language Assistance Services*)

The Plan must provide an immediate, full translation of the entire NOA, including the clinical rationale for the Plan's decision, with an implementation date of 2/28/2022. *(APL 21-011, Grievance and Appeal Requirements, Notice and "Your Rights" Templates*)

Plan policy *SC.RUM.033 Delegation of UM Activities (effective 4/13/20)* stated the Plan performs an annual audit of the delegate's UM program to ensure compliance with all applicable state and federal laws and regulations, advisory information, contract requirements, and reporting requirements.

The Delegation Agreement between the Plan and delegate *(effective 5/1/21)* stated the delegate will conduct its UM program in compliance with the contract between the Plan and DHCS, guidance documents issued by DHCS such as APLs, and all applicable state and federal laws, which may be amended from time to time.

Delegate policy *CA LA 1 Revision 15 DMHC – Language Assistance Program – California – DMHC (approved 1/27/2022)* stated that for documents such as denial, modification, and delay/extension letters, the delegate sends the documents to the member in English with a LAT notice in the Plan's threshold languages. The delegate only performs translation within 21 days if the member requests it.

Delegate policy *CA UM 2 Revision 6 Medi-Cal: Medical Necessity Review-California-Medi-Cal (approved 5/19/22)* stated that for the Medi-Cal line of business, the delegate will provide NOA information in a culturally and linguistically appropriate manner.

Finding: The Plan did not ensure a delegate provided immediate, full translation of written member information in the NOA letter packet, including translation of the clinical rationale, for threshold languages.

A verification study revealed that in one of one sample requiring translation, which was resolved after 2/28/22, the delegate did not send the NOA letter packet to the member in the threshold language. The member's primary language was Vietnamese. The Plan sent the NOA letter with clinical rationale, "Your Rights" attachment, and NDN to the member in English.

In interviews and written responses, the delegate stated a member's preferred written language determines whether translation into threshold languages is needed. The delegate drafts NOA letter packets using semi-translated NOA letter templates, available in all threshold languages, and contracts with a vendor to translate the clinical rationale within one business day. Regarding the deficient sample, the delegate acknowledged it did not translate the NOA letter packet due to a system error. The delegate stated it resolved the system error in November 2022; however, it did not submit supporting evidence.

During the Plan's annual audit of the delegate, the Plan documented that in five of five samples requiring translation into Spanish, the delegate did not send the NOA letter in the member's primary language. However, the Plan did not take corrective actions.

When the delegate does not fully translate written member information such as NOA letter packets into threshold and concentration languages, members may not receive important information on reasons and outcomes of UM decisions or how to exercise their rights.

Recommendation: Implement Plan policies and oversight procedures to ensure the delegate maintains updated policies and provides fully translated NOA letter packets, including the clinical rationale, to members in their threshold and concentration languages.

San Diego GMC

1.5.3 Nondiscrimination Notice and Language Assistance Taglines

The Plan is accountable for all functions and responsibilities, including UM, that are delegated. The Plan is required to maintain a system to ensure accountability for delegated activities that at a minimum ensures a delegate meets standards set forth by the Plan and DHCS. (*Contract A17, Exhibit A, Attachment 4(6) (A and B))*

The NDN and LAT must be posted in all member informational notices, including written notices to an individual such as those pertaining to rights and benefits. DHCS updated its templates for NDN to include additional characteristics protected under state nondiscrimination law, including ethnic group identification and medical condition (as described in *APL 20-015*), as well as contact information for members to file a discrimination grievance directly with the DHCS Office of Civil Rights (OCR). DHCS also updated its LAT template to conform to federal law and to include additional top California languages (Mien and Ukrainian). Although DHCS does not require Plans to use the DHCS-provided templates verbatim, notices must be compliant with

requirements in this APL and with information in the DHCS-provided templates. The implementation date for required information in full-sized NDN and LAT was October 5, 2021. *(APL 21-004, Standards for Determining Threshold Languages, Nondiscrimination Requirements, and Language Assistance Services)*

Plan Policy *SC.RUM.033 Delegation of UM Activities (effective 4/13/20)* stated the Plan performs an annual audit of the delegate's UM program to ensure compliance with all applicable state and federal laws and regulations, advisory information, contract requirements, and reporting requirements.

The Delegation Agreement between the Plan and delegate *(effective 5/1/21)* stated the delegate will conduct its UM program in compliance with the contract between the Plan and DHCS, guidance documents issued by DHCS such as APLs, and all applicable state and federal laws, which may be amended from time to time.

Delegate policy *CA UM 2 Revision 6 Medi-Cal: Medical Necessity Review-California-Medi-Cal (approved 5/19/22)* stated the members are informed of adverse benefit determinations according to applicable state, federal, and contract requirements. Information submitted to the member includes a notice regarding the availability of language assistance.

Finding: The Plan did not ensure a delegate sent updated NDN and LAT information to members with all written notices for UM decisions in accordance with APL 21-004.

A verification study demonstrated that in 14 of 14 service requests resolved after 10/5/21, the delegate did not send updated NDN and LAT information with written NOA letters or authorization letters that were sent to members. In all 14 samples:

- The NDN did not contain information on how to file a discrimination grievance directly with DHCS OCR and did not list additional protected discrimination characteristics, including ethnic group identification and medical condition.

- The LAT did not contain language assistance information in Mien and Ukrainian.

In interviews and written responses, the Plan stated that in March 2022 it informed the delegate of new requirements from APL 21-004 and shared the Plan's NOA letter templates, which included updated NDN and LAT. the delegate stated it does not make changes to its NOA letter and member informational notice templates without written approval from the Plan. The delegate stated it updated its letter templates and the Plan approved them in September 2022. However, since the verification study did not contain samples resolved after September 2022, subsequent compliance with updated NDN and LAT notices could not be confirmed.

In addition, the Plan acknowledged it was responsible for communicating new requirements and sharing the Plan's updated letter templates with the delegate. The Plan stated new requirements from APL 21-004 were not added to the scope of the annual delegation audit.

When the delegate does not update information required by DHCS, members may not receive information necessary to exercise their rights.

Recommendation: Implement Plan policies and oversight processes to ensure that delegated entities comply with new DHCS requirements.

CATEGORY 2 – CASE MANAGEMENT AND COORDINATION OF CARE

2.1	BASIC CASE MANAGEMENT

San Diego GMC

2.1.1 Use of Long-Term Services and Support Referral Questions

The Plan must use the HRA survey to comprehensively assess each newly enrolled SPD member's current health risk. In addition, the HRA must include specific LTSS referral questions. These questions are intended to assist the Plan in identifying members who may qualify for, and benefit from LTSS services. (*APL 17-013 Requirements for HRA of Medi-Cal Seniors and Persons with Disabilities*).

Plan policy *SCAL Medi-Cal Case Management Policy 30 Medi-Cal Comprehensive Case Management and Coordination of Care (revised 6/30/2022)* states that DHCS approved HRAs are conducted to assess newly enrolled members' case management and care coordination needs. Initial and annual HRA components include LTSS referral questions to identify and ensure the proper referral of members who may qualify for and benefit from LTSS services.

Finding: The Plan did not use LTSS referral questions to assess SPD members under 21 years of age when conducting HRA surveys.

A verification study on three members under the age of 21 showed that the LTSS referral questions were not completed. In each HRA form, the Plan documented that LTSS questions were not applicable for pediatric members.

In an interview, Plan stated that LTSS questions are focused on adults and are not administered to pediatric members.

In a written statement, the Plan determined that it would not ask LTSS questions for pediatric members based on APL 14-010 Care Coordination Requirements for Managed LTSS. However, APL 17-012 (implemented 7/11/2017), which supersedes APL 14-010, requires the Plan to follow HRA requirements for all SPD members as set forth in APL 17-013.

When the Plan does not use the LTSS referral questions to assess members under 21 years of age, the Plan may not identify members who may qualify for and benefit from LTSS services.

Recommendation: Implement policy and revise procedures to use LTSS referral questions to assess all newly enrolled SPD members, including members under 21 years old.

2.5	MENTAL HEALTH AND SUBSTANCE ABUSE

San Diego GMC

2.5.1 Implementation of Eating Disorder Coverage

The Plan is required to comply with all existing policy letters and APLs issued by DHCS. *(Contract A17, Exhibit E, Attachment 2(1)(D))*

For partial hospitalization and residential eating disorder programs, the Plan is responsible for medically necessary physical health components. In addition, the Plan is responsible for providing comprehensive medical case management services, including coordination of care, to ensure provision of all medically necessary services, whether those services are delivered within or outside of the Plan's provider network. The Plan must coordinate all medically necessary care, including locating, arranging, and following up to ensure services were rendered for partial hospitalization and residential programs. DHCS recommends the Plan and county MHP proactively come to an agreement on the bundle of services, unit costs, and total costs associated with eating disorder treatment and agree on the division of the financial responsibility. If the Plan and MHP cannot agree on financial responsibility, DHCS recommends both entities split the costs equally. The Plan must not delay case management and care coordination, as well as coverage of medically necessary services, pending the resolution of a dispute. The Plan should review and submit updated policies and procedures, or an email confirming no changes are necessary to policies and procedures, to DHCS within 90 days of release of this APL. The implementation date was 6/15/22. *(APL 22-003, Medi-Cal Managed Care Health Plan Responsibility to Provide Services To Members With Eating Disorders)*

The Memorandum of Understanding (MOU) between the Plan and MHP *(signed 8/21/2019)* stated that the Plan and MHP will develop policies and procedures for coordination of inpatient and outpatient medical and mental health care and transitions of care. The dispute resolution review process may not result in delays in members' access to services while the final decision is pending.

Draft Plan policy *Services to Medi-Cal Members with Eating Disorders* stated that the Plan is responsible for providing physical health components of eating disorder treatment. The policy included all Plan requirements for eating disorder coverage including comprehensive case management, care coordination, division of financial responsibility, and dispute resolution exactly as listed in APL 22-003.

Finding: The Plan did not implement all requirements for eating disorder coverage in accordance with APL 22-003.

The Plan did not implement coordination of care, comprehensive case management, and division of financial responsibility with the county MHP for eating disorder treatment by 6/15/22.

Based on interviews and written responses, the Plan acknowledged it had not finalized its draft eating disorder policy, which was undergoing a lengthy internal approval process.

During interviews, the Plan stated it began operationalizing a process for APL 22-003 with the county MHP but the division of financial responsibility was not completed. The Plan did not develop and implement a procedure for the Plan to provide care coordination and comprehensive case management for eating disorder cases, including arranging services and following up on partial hospitalization and residential treatment programs, by 6/15/22. The Plan did not submit evidence of division of financial responsibility with the MHP.

When the Plan does not implement APL requirements within expected timeframes, members may not have access to Medi-Cal eating disorder treatment services in a timely manner.

Recommendation: Implement policies and develop procedures for eating disorder coverage in accordance with APL 22-003.

San Diego GMC

2.5.2 Implementation of No Wrong Door Mental Health Coverage

The Plan is required to comply with all existing policy letters and APLs issued by DHCS. *(Contract A17, Exhibit E, Attachment 2 (1)(D))*

The Plan is required to cover clinically appropriate and covered NSMHS. The Plan must cover clinically appropriate NSMHS during the assessment process prior to the determination of a diagnosis or a determination that the member meets criteria for NSMHS. The Plan must cover NSMHS, whether or not the services were included in an individual treatment plan. The Plan must cover NSMHS for a member who meets criteria, whether or not the member has a co-occurring Substance Use Disorder (SUD). Members may concurrently receive NSMHS from a Plan provider and SMHS from a county MHP provider when the services are clinically appropriate, coordinated, and not

duplicative. The Plan must coordinate with MHPs to facilitate care transitions and guide referrals, ensuring that the new provider accepts the care of the member. Members with established therapeutic relationships with a MHP provider may continue receiving SMHS from the MHP, even if the member simultaneously receives NSMHS from a Plan provider, as long as the services are coordinated between delivery systems and are non-duplicative. The Plan should review and submit updated policies and procedures, or an email confirming no changes are necessary to policies and procedures, to DHCS within 90 days of release of this APL. The implementation date was 6/28/22. *(APL 22-005, No Wrong Door for Mental Health Services Policy)*

The MOU between Plan and MHP *(signed 8/21/2019)* stated that the Plan and MHP will develop and agree to written policies and procedures for screening, assessment, and referrals.

Draft Plan policy *No Wrong Door for Medi-Cal Members for Mental Health Services* stated that the Plan is required to cover clinically appropriate NSMHS even when services are provided prior to a determination of a diagnosis, when services are not included in an individual treatment plan, or the member has a co-occurring SUD. The Plan is required to cover NSMHS and SMHS services that are provided concurrently if those services are coordinated and not duplicated. For referrals and care transitions, the Plan will ensure the referral loop is closed and the new provider accepts the care of the member. The policy included all coverage requirements for NSMHS exactly as listed in APL 22-005.

Finding: The Plan did not implement all new requirements for NSMHS coverage and coordination with the county MHP in accordance with APL 22-005.

The Plan did not implement the following requirements by 6/28/22:

1. Coverage of NSMHS for members of any age with potential mental health disorders not yet diagnosed or undergoing assessment.

2. Coverage of NSMHS whether or not they were included in an individual treatment plan.

3. Coverage of NSMHS whether or not the member has a co-occurring SUD.

4. Coverage of NSMHS while a member is receiving concurrent specialty mental health (SMH) care from a county MHP when services are coordinated and not duplicative.

5. Coordination of transitions of care with the MHP to ensure that the new provider accepts care of the member.

Based on interviews and written responses, the Plan acknowledged it had not finalized its draft No Wrong Door policy, which was undergoing a lengthy internal approval process.

The Plan did not submit evidence that it covered NSMHS by 6/28/22 for members of any age with potential mental health disorders not yet diagnosed or undergoing assessment, whether or not NSMHS were included in an individual treatment plan, and whether or not the member has a co-occurring SUD.

During interviews, the Plan acknowledged it had not finalized detailed processes, workflows, and claims system changes for coordination of mental health services and coverage with the county MHP. Therefore, by 6/28/22, the Plan was not compliant with new requirements to cover NSMHS when a member is receiving concurrent care from a MHP if services are coordinated and not duplicative.

The Plan also stated it already conducted warm handoffs to the county MHP for members who needed SMHS. However, the grievance verification study revealed that in one of one standard grievance involving a warm handoff to MHP after 6/28/22, the Plan did not document whether the MHP provider accepted care for the member. There was no evidence that the Plan implemented new requirements by 6/28/22 to ensure that the new MHP provider accepts care of the member.

The Plan's 2020 Provider Manual, 2022 Behavioral Health Program Description, 2022 Evidence of Coverage/Member Handbook, and Plan Policy SC.HPHO.041 *Outpatient Mental Health Services within Scope of Practice of Primary Care and Mental Health Care Providers* did not describe new coverage requirements from APL 22-005.

When the Plan does not implement new APL requirements within expected timeframes, members may not have access to Medi-Cal NSMHS in a timely manner.

Recommendation: Implement policies and develop procedures for No Wrong Door mental health coverage in accordance with APL 22-005.

San Diego GMC

2.5.3 Implementation of Non-Specialty Mental Health Services

The Plan is required to comply with all existing policy letters and APLs issued by DHCS. *(Contract A17, Exhibit E, Attachment 2(1)(D))*

NSMHS include provision of mental health evaluation, testing, treatment, psychotherapy, psychiatric consultation, and outpatient services for members based on criteria. The Plan must provide psychotherapy to members under the age of 21 with specified risk factors or with persistent mental health symptoms in the absence of a mental health disorder. The Plan is required to cover up to 20 individual and/or group counseling sessions for pregnant and postpartum individuals with specific risk factors for perinatal depression when sessions are delivered during the prenatal period and/or during the 12 months following childbirth. Details regarding coverage requirements, such as codes covered and risk factors that qualify for coverage, can be found in the DHCS Provider Manual's section on NSMHS: Psychiatric and Psychological Services. The Plan should review and submit updated policies and procedures, or an email confirming no changes are necessary to policies and procedures, to DHCS within 90 days of release of this APL. The implementation date was 7/7/22. *(APL 22-006, Medi-Cal Managed Care Health Plan Responsibilities for NSMHS)*

Draft Plan policy *NSMHS and Specialty Mental Health Services* stated that the Plan must provide or arrange for the provision of NSMHS. The policy listed all criteria, conditions, populations, and covered benefits for NSMHS exactly as listed in APL 22-006, including coverage of psychotherapy for members under the age of 21 with specified risk factors or with persistent mental health symptoms in the absence of a mental health disorder, and coverage of up to 20 prenatal and postpartum counseling sessions for members with specified risk factors according to the DHCS Provider Manual.

Finding: The Plan did not implement all requirements for coverage of NSMHS, including new benefits and covered populations, in accordance with APL 22-006.

The Plan did not implement the following requirements by 7/7/22:

1. Provide psychotherapy to members under the age of 21 with specified risk factors listed in the DHCS Provider Manual or with persistent mental health symptoms in the absence of a mental health disorder.

2. Cover up to 20 counseling sessions for pregnant and postpartum individuals with specified risk factors listed in the DHCS Provider Manual.

Based on interviews and written responses, the Plan acknowledged it had not finalized its draft policy for NSMHS, which was undergoing a lengthy internal approval process.

The Plan did not submit evidence that it implemented a process to cover psychotherapy for members under the age of 21 who met specific risk factor criteria listed in the DHCS Provider Manual, such as food insecurity, experience of discrimination, severe and persistent bullying, incarceration of a parent, or job loss of a parent. Furthermore, the Plan did not submit evidence that it covered up to 20 counseling sessions for pregnant and postpartum members who met risk factor criteria listed in the DHCS Provider Manual, such as being a single parent or recent intimate partner violence.

The Plan's 2020 Provider Manual, 2022 Behavioral Health Program Description, 2022 Evidence of Coverage/Member Handbook, and Plan Policy SC.HPHO.041 *Outpatient Mental Health Services within Scope of Practice of Primary Care and Mental Health Care Providers* did not describe new NSMHS coverage requirements. The Plan did not submit evidence that it informed treating providers of new requirements from APL 22-006. There was no evidence the Plan implemented new NSMH coverage requirements by 7/7/22.

When the Plan does not implement APL requirements within expected timeframes, members may not have access to covered NSMHS in a timely manner.

Recommendation: Revise and implement policies and develop procedures for coverage of NSMHS in accordance with APL 22-006.

CATEGORY 3 – ACCESS AND AVAILABILITY OF CARE

3.6	EMERGENCY SERVICES AND FAMILY PLANNING CLAIMS

Sacramento GMC

3.6.1 Family Planning Payment Reductions

The Plan is required to maintain sufficient claims processing, tracking, and payment systems capability to comply with applicable state and federal law, regulations, and contract requirements. *(Contract A20, Exhibit A, Attachment 8(5)(D))*

The Plan is required to ensure covered services are provided in an amount no less than what is offered under the Medi-Cal Fee-For-Service Program. (*Contract A20, Exhibit A(10)(1)(A)*)

Service code 58300 is exempt from the fifty-percent reduction applicable to service codes billed with modifier 51. *(DHCS Provider Manual: Part 2 Surgery Billing with Modifiers)*

Plan policy *POL-005 Payments to Providers (updated 6/27/22)* stated Medicaid claims must be adjudicated in accordance with requirements for each individual state contract.

Finding: The Plan inappropriately applied a fifty-percent payment reduction to service code 58300 (Insertion of birth control device).

A verification study found in one of ten family planning claims, the Plan applied a fifty-percent payment reduction to code 58300 when it was billed with modifier 51. However, the DHCS Provider Manual explicitly exempts code 58300 from this payment reduction.

In a written response, the Plan stated code 58300 billed with modifier 51 was not on the Plan's claim system exception list that would prevent the fifty-percent payment reduction from being applied.

When the Plan does not follow Medi-Cal reimbursement guidelines, this may discourage providers from participating with the Plan and limit members' access to care.

Recommendation: Revise and implement procedures to ensure codes exempt from modifier 51's payment reduction are appropriately processed.

Sacramento and San Diego GMC

3.6.2 Family Planning Payments

The Plan is required to comply with all existing policy letters and APL issued by DHCS. *(Contract A17 and A20, Exhibit E, (2)(1)(D))*

The Plan is required to directly pay qualified family planning providers a fixed add-on amount for specified family planning services listed in APL 20-013, using Proposition 56 appropriated funds. This payment obligation applies to contracted and non-contracted providers. The uniform dollar add-on amounts for the services listed are in addition to whatever other payments eligible providers would normally receive from the Plan. *(APL 20-013; Superseded by APL 22-011, Proposition 56 Directed Payments for Family Planning Services)*

Plan policy *POL-005 Payments to Providers (updated 6/27/22)* stated that claims adjudication complies with the rules of governing/regulatory bodies such as state and Federal law, and other requirements which may be applicable.

Finding: The Plan did not distribute add-on payments for specified family planning claims in accordance with APL 20-013.

A verification study of ten Sacramento GMC and ten San Diego GMC family planning services claims revealed the Plan did not make add-on payments for one Sacramento GMC and one San Diego GMC family planning service claim.

In a written response, the Plan stated a system change led to claims for certain members with dates of service starting in January 2022 to not be paid the APL 20-013 add-on payments. A total of 2,434 Sacramento GMC and 5,920 San Diego GMC claims were impacted. The Plan stated it discovered this incorrect system change and made corrections in October 2022. However, the Plan did not submit documentation showing this correction had been made.

When the Plan does not distribute applicable add-on payments, this may discourage providers from participating with the Plan and limit members' access to care.

Recommendation: Revise and implement procedures to distribute add-on payments for applicable specified family planning claims in accordance with APL 20-013 and APL 20-011.

CATEGORY 4 – MEMBER'S RIGHTS

4.1	GRIEVANCE SYSTEM

Sacramento GMC

4.1.1 Nondiscrimination Notice and Language Assistance Taglines

The Plan is required to comply with all existing policy letters and APLs issued by DHCS. *(Contract A20, Exhibit E, Attachment 2(1)(D))*

The NDN and LAT must be posted in all member informational notices, including written notices to an individual such as those pertaining to rights and benefits. DHCS updated its templates for NDN to include additional characteristics protected under state nondiscrimination law, including ethnic group identification and medical condition (as described in *APL 20-015*), as well as contact information for members to file a discrimination grievance directly with the DHCS OCR. DHCS also updated its LAT template to conform to federal law and to include additional top California languages (Mien and Ukrainian). Although DHCS does not require Plans to use the DHCS-provided templates verbatim, notices must be compliant with requirements in this APL and with information in the DHCS-provided templates. The implementation date for required information in full-sized NDN and LAT was October 5, 2021. *(APL 21-004, Standards for Determining Threshold Languages, Nondiscrimination Requirements, and Language Assistance Services)*

Plan Policy *CA.HP.Operations.LA 005001* (*effective 11/01/2021*) states that Medi-Cal vital documents must be accompanied by the LAT as well as the NDN, regardless of the size of the publication. Vital documents are defined as written materials for Medi-Cal members that are essential for understanding health plan benefits or accessing covered health care services. Notices related to grievances include acknowledgement and resolution letters.

Finding: The Plan did not ensure that updated NDN and LAT information were posted in grievance acknowledgement and resolution letters in accordance with APL 21-004.

A verification study of 15 expedited and 30 standard grievances resolved after October 5, 2021 revealed the Plan did not include updated NDN and LAT information with all the acknowledgement and resolution letters in this verification study:

- The NDN did not have the DHCS OCR's contact information and all protected discrimination characteristics, such as ethnic group identification and medical condition.

- The LAT did not contain language assistance information in Mien and Ukrainian as required.

In an interview and written statements, the Plan acknowledged that a system error had caused the outdated NDN and LAT to be enclosed with the acknowledgement and resolution letters.

When the Plan does not ensure updated NDN and LAT are included in all member notices related to grievances, members may not receive information necessary to exercise their rights.

Recommendation: Implement policies and procedures to ensure updated NDN and LAT are included in all member informational notices related to grievances.

San Diego GMC

4.1.1 Nondiscrimination Notice and Language Assistance Taglines

The Plan is required to comply with all existing policy letters and APLs issued by DHCS. *(Contract A17, Exhibit E, Attachment 2(1)(D))*

The NDN and LAT must be posted in all member informational notices, including written notices to an individual such as those pertaining to rights and benefits. DHCS updated its templates for NDN to include additional characteristics protected under state nondiscrimination law, including ethnic group identification and medical condition (as described in *APL 20-015*), as well as contact information for members to file a discrimination grievance directly with the DHCS OCR. DHCS also updated its LAT template to conform to federal law and to include additional top California languages (Mien and Ukrainian). Although DHCS does not require Plans to use the DHCS-provided templates verbatim, notices must be compliant with requirements in this APL and with information in the DHCS-provided templates. The implementation date for required information in full-sized NDN and LAT was October 5, 2021. *(APL 21-004, Standards for Determining Threshold Languages, Nondiscrimination Requirements, and Language Assistance Services)*

Plan policy *CA.HP.Operations.LA 005001* (*effective 11/01/2021*) states that Medi-Cal vital documents must be accompanied by the LAT as well as the NDN, regardless of the size of the publication. Vital documents are defined as written materials for Medi-Cal members that are essential for understanding health plan benefits or accessing covered health care services. Notices related to grievances include acknowledgement and resolution letters.

Finding: The Plan did not ensure that updated NDN and LAT information were posted in grievance acknowledgement and resolution letters in accordance with APL 21-004.

A verification study of San Diego GMC grievances resolved after October 5, 2021, demonstrated that, the Plan did not send updated NDN and LAT information with all the acknowledgement and resolution letters:

- In all 15 expedited and 30 standard grievances, the NDN did not have the DHCS OCR's contact information and all protected discrimination characteristics, such as ethnic group identification and medical condition.

- In 15 expedited and 29 out of 30 standard grievances, the LAT did not contain language assistance information in Mien and Ukrainian as required.

In an interview and written statements, the Plan acknowledged that a system error had caused the outdated NDN and LAT to be enclosed with the acknowledgement and resolution letters.

When the Plan does not ensure updated NDN and LAT are included in all member informational notices related to grievances, members may not receive information necessary to exercise their rights.

Recommendation: Implement policies and procedures to ensure updated NDN and LAT are included in all member informational notices related to grievances.

Sacramento GMC

4.1.2 Standard Grievance Resolution Timeframe

The Plan is required to provide a written notice of resolution to the member within 30 calendar days from the receipt date of the standard grievance. *(Contract A20, Exhibit A, Attachment 14 (1)(B))*

The Plan must follow grievance requirements in APL 21-011. *(Contract A29, Exhibit A, Attachment 14(1))*

The Plan is required to comply with the State's established timeframe of 30 calendar days for standard grievance resolution. Federal regulations allow for a 14-calendar day extension for standard and expedited Appeals. This allowance does not apply to Grievances*. (APL 21-011, Grievance and Appeals Requirements, Notice and "Your Rights" Templates)*

Plan policy *CA.MR.003 California Non-Medicare Grievance and Appeals (revised 02/28/2022)* states that all standard grievances will be resolved within 30 calendar days. Extension of standard grievance timeframe is not allowed.

Finding: The Plan did not provide written resolution to members within 30 calendar days from the date of receipt of the grievance.

A verification study revealed 15 of 30 standard grievances had late resolution letters that ranged from 32 to 79 calendar days.

In written responses and interviews, the Plan acknowledged that delays in case handoff between grievance teams impacted the timeliness to resolve some grievances. In addition, other factors such as the surge in access and service requests due to the COVID-19 pandemic, staff shortages and delayed investigation responses also had an impact in the grievance processing system.

As part of the CAP to the prior audit finding, the Plan re-trained all grievance staff and updated its grievance policy to include additional timeliness metrics and monitoring. However, the verification study did not show the finding was corrected.

Delayed member notifications of grievance resolutions may result in missed opportunities for improved health care delivery and in poor health outcomes for members.

This is a repeat of prior audit finding 4.1.2 - Standard Grievance Resolution.

Recommendation: Implement policies and procedures to ensure the Plan provides written resolution to members within 30 calendar days from the date of receipt of grievances.

San Diego GMC

4.1.2 Standard Grievance Resolution Timeframe

The Plan is required to provide a written notice of resolution to the member within 30 calendar days from the receipt date of the standard grievance. *(Contract A17, Exhibit A, Attachment 14 (1)(B))*

The Plan must follow grievance requirements in APL 21-011. *(Contract A26, Exhibit A, Attachment 14(1))*
The Plan is required to comply with the State's established timeframe of 30 calendar days for standard grievance resolution. Federal regulations allow for a 14-calendar day extension for standard and expedited Appeals. This allowance does not apply to Grievances. (*APL 21-011, Grievance and Appeals Requirements, Notice and "Your Rights" Templates*)

Plan policy *CA.MR.003 California Non-Medicare Grievance and Appeals (revised 02/28/2022)* states that all standard grievances will be resolved within 30 calendar days. Extension of standard grievance timeframe is not allowed.

Finding: The Plan did not provide written resolution to members within 30 calendar days from the date of receipt of the grievance.

A verification study revealed eight of 30 standard grievances had late resolution letters that ranged from 32 to 69 calendar days.

In written responses and interviews, the Plan acknowledged that delays in case handoff between grievance teams impacted the timeliness to resolve some grievances. In addition, other factors such as the surge in access and service requests due to the COVID-19 pandemic, staff shortages and delayed investigation responses also had an impact in the grievance processing system.

As part of the CAP to the prior audit finding, the Plan re-trained all grievance staff and updated its grievance policy to include additional timeliness metrics and monitoring. However, the verification study did not show the finding was corrected.

Delayed member notifications of grievance resolutions may result in missed opportunities for improved health care delivery and in poor health outcomes for members.

This is a repeat of prior audit finding 4.1.2 - Standard Grievance Resolution.

Recommendation: Implement policies and procedures to ensure the Plan provides written resolution to members within 30 calendar days from the date of receipt of grievances.

Sacramento GMC

4.1.3 Expedited Grievance Resolution

The Plan is required to provide oral notice of the resolution of an expedited review within 72 hours. *(Contract A20, Exhibit A, Attachment 14(H))*

The Plan is required to provide resolution of expedited grievances to the member within 72 hours of receipt of the grievance. (*APL 21-011, Grievance and Appeals Requirements, Notice and "Your Rights" Templates*)

Plan policy *CA.MR.003 California Non-Medicare Grievance and Appeals (revised 2/28/2022)* states that, for expedited grievances, resolution must be provided with 72 hours from the receipt time.

Finding: The Plan did not provide oral resolution to the member within the required 72 hours timeframe for expedited grievances.

A verification study revealed that six of 15 expedited grievances had late oral resolution notices that ranged from 92 to 170 hours from the receipt times.

In written responses and interviews, the Plan acknowledged that delays in case handoff between grievance teams impacted the timeliness to resolve some grievances. In addition, other factors such as the surge in access and service requests due to the COVID-19 pandemic, staff shortages and delayed investigation responses also had an impact in the grievance processing system.

As part of the CAP to the prior audit finding, the Plan re-trained all grievance staff and updated its grievance policy to include additional timeliness metrics and monitoring. However, the verification study did not show the finding was corrected.

Delayed resolution notification of expedited member grievances may result in poor health outcomes for members.

This is a repeat of prior audit finding 4.1.3 – Expedited Grievance Resolution.

Recommendation: Implement policies and procedures to provide expedited grievance oral resolution within 72 hours of receipt.

Sacramento GMC

4.1.4 Written Notification of Grievance Resolution Delays

The Plan is required to comply with all existing policy letters and APLs issued by DHCS. *(Contract A20, Exhibit E, Attachment 2(1)(D))*

The Plan is required to provide written resolution to the member that is dated within 30 days of receipt of the grievance. However, in the event that 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 should not exceed 14 calendar days. *(APL 17-006, Grievance and Appeal Requirements and Revised Notice Templates and "Your Rights" Attachments, and APL 21-011, Grievance and Appeals Requirements, Notice and "Your Rights" Templates)*

Plan policy *CA.MR.003 California Non-Medicare Grievance and Appeals (revised 2/28/2022)* stated that if a resolution cannot be provided within 30 days, the member must be notified in writing within the 30-day resolution time frame for grievances.

Finding: The Plan did not notify members of resolution delays in writing for grievances not resolved within 30 calendar days.

A verification study revealed in three of 15 late standard grievances, the Plan did not send written notices of delayed resolution to members.

In a written response, the Plan stated that the resolution delay notices were sent to members automatically by the Plan's tracking system when the resolutions could not be reached within 30 calendar days. Due to an unknown system error, the resolution delay notices were not sent automatically as expected.

When the Plan does not send written notification of delay for grievances, members may not be aware of resolution status which may result in poor health outcomes.

Recommendation: Revise and implement procedures to ensure that members are notified in writing of grievance resolution delays.

Sacramento GMC

4.1.5 Investigation and Resolution of Discrimination Complaints

The Plan is required to comply with all existing policy letters and APLs issued by DHCS. *(Contract A20, Exhibit E, Attachment 2(1)(D))*

The Plan must ensure that all discrimination grievances are investigated by the Plan's designated discrimination grievance coordinator. The Plan is prohibited from using a medical peer review body to investigate and resolve discrimination grievances. The Plan must not claim that a discrimination grievance investigation or resolution is confidential. Concurrent or subsequent referral of a discrimination grievance to a peer review body for provider disciplinary or credentialing purposes may be appropriate if quality of care issues are implicated. (*APL 21-004, Standards for Determining Threshold Languages, Nondiscrimination Requirements, and Language Assistance Services*)

The Plan must ensure adequate consideration of grievances and rectification when appropriate. If multiple issues are presented by the member, the Plan must ensure that each issue is addressed and resolved. "Resolved" means that the grievance has reached a final conclusion with respect to the member's submitted grievance as delineated in state regulations. (*APL 21-011, Grievance and Appeal Requirements, Notice and "Your Rights" Templates*)

Plan's policy *CA.MR.003 California Non-Medicare Grievance and Appeals (revised 2/28/2022)* states that the program representative is required to ensure all issues and requests raised by the member or authorized representative are properly captured in the grievance processing system. Each issue and request will be accounted for under the appropriate level. The written resolution must include the outcome for all issues and requests in a clear and concise manner. The Plan has a designated discrimination grievance coordinator to coordinate compliance with civil rights laws. Member Relations and the discrimination grievance coordinator will jointly address any allegations of civil rights discrimination.

Finding: The Plan did not ensure that grievances with alleged discrimination were investigated by the discrimination grievance coordinator and resolved within the grievance system.

A verification study of 30 standard grievances revealed that in two of two discrimination grievances, the Plan did not investigate and resolve the discrimination issues within the grievance system.

- In one grievance, the member stated they were being racially discriminated against after calling a transportation provider. However, the Plan did not identify it as an alleged discrimination grievance and, therefore, it was not investigated or resolved. The Plan agreed that the member's discrimination allegation was not identified as a complaint in the grievance system due to staff error.

- In another grievance, the Plan sent the member's concerns to the Compliance Officer, who was the designated discrimination grievance coordinator. However, the Plan did not provide evidence of the investigation and resolution of the complaint, nor did the Plan provide evidence of the Compliance Officer's involvement in the investigation and resolution of the discrimination complaint within the grievance process. In the resolution letter, the Plan stated that the appropriate departments would address the discrimination issue and, due to privacy laws of health care services, the Plan could not share the results of the discrimination reviews.

In an interview and written responses, the Plan stated departments affected by the allegation would address the discrimination issue with consultation from the designated discrimination grievance coordinator. The results of the investigation were confidential and not documented in the grievance system.

When the Plan does not ensure that all discrimination grievances are identified, investigated and resolved within the grievance system and with the involvement of the discrimination grievance coordinator, this can lead to limits in access to healthcare and poor quality of treatment.

Recommendation: Revise and implement procedures to ensure that grievances with alleged discrimination are investigated and resolved within the grievance process, and with the involvement of the discrimination grievance coordinator.

San Diego GMC

4.1.5 Investigation and Resolution of Discrimination Complaints

The Plan is required to comply with all existing policy letters and APLs issued by DHCS. *(Contract A17, Exhibit E, Attachment 2(1)(D))*

The Plan must ensure that all discrimination grievances are investigated by the Plan's designated discrimination grievance coordinator. The Plan is prohibited from using a medical peer review body to investigate and resolve discrimination grievances. The Plan must not claim that a discrimination grievance investigation or resolution is confidential. Concurrent or subsequent referral of a discrimination grievance to a peer review body for provider disciplinary or credentialing purposes may be appropriate if quality of care issues are implicated. (*APL 21-004, Standards for Determining Threshold Languages, Nondiscrimination Requirements, and Language Assistance Services*)

The Plan must ensure adequate consideration of grievances and rectification when appropriate. If multiple issues are presented by the member, the Plan must ensure that each issue is addressed and resolved. "Resolved" means that the grievance has reached a final conclusion with respect to the member's submitted grievance as delineated in state regulations. (*APL 21-011, Grievance and Appeal Requirements, Notice and "Your Rights" Templates*)

Plan's policy *CA.MR.003 California Non-Medicare Grievance and Appeals (revised 2/28/2022)* states that the Program Representative is required to ensure all issues and requests raised by the member or authorized representative are properly captured in the grievance processing system. Each issue and request will be accounted for under the appropriate level. The written resolution must include the outcome for all issues and requests in a clear and concise manner. The Plan has a designated discrimination grievance coordinator to coordinate compliance with civil rights laws. Member Relations and the discrimination grievance coordinator will jointly address any allegations of civil rights discrimination.

Finding: The Plan did not ensure that grievances with alleged discrimination were investigated by the discrimination grievance coordinator and resolved within the grievance system.

A verification study of 30 standard grievances revealed that in four of four discrimination grievances, the Plan did not investigate and resolve the discrimination issues within the grievance system.

- In two grievances, the Plan did not identify the complaints as alleged discrimination grievances and, therefore, were not investigated or resolved. The Plan agreed that the members' discrimination allegations were not identified as complaints in the grievance system due to staff error.

- In another two grievances, the Plan did not provide evidence of the investigation and resolution of the complaints, nor did the Plan provide evidence of the designated discrimination grievance coordinator's involvement in the investigation and resolution of the discrimination complaint within the grievance process.

    - In one grievance, the Plan sent the member's discrimination allegation to the discrimination grievance coordinator and it was investigated and resolved outside of the grievance process. In the resolution letter, the Plan stated that the appropriate departments would address the discrimination issue and, due to privacy laws of health care services, the Plan could not share the results of the discrimination reviews.

    - In the other grievance, the Plan identified the discrimination allegation as an issue but did not forward the grievance to the discrimination grievance coordinator. The resolution letter did not mention the discrimination issue.

In an interview and written responses, the Plan stated departments affected by the allegation would address the discrimination issue with consultation from the designated discrimination grievance coordinator. The results of the investigation were confidential and not documented in the grievance system.

When the Plan does not ensure that all discrimination grievances are identified, investigated and resolved within the grievance system and with the involvement of the discrimination grievance coordinator, this can lead to limits in access to healthcare and poor quality of treatment.

Recommendation: Revise and implement procedures to ensure that grievances with alleged discrimination are investigated and resolved within the grievance process, and with the involvement of the discrimination grievance coordinator.

Sacramento GMC

4.1.6 Timeliness of Discrimination Complaints Reporting

The Plan must forward all grievances with alleged discrimination against members to DHCS for review and appropriate action. *(Contract A20, Exhibit E, Attachment 2(C))*

The Plan is required to comply with all existing policy letters and APLs issued by DHCS. *(Contract A20, Exhibit E, Attachment 2(1)(D))*

Within ten calendar days of mailing a discrimination grievance resolution letter to a member, the Plan must submit detailed information regarding the grievance to DHCS OCR designated discrimination grievance email box. (*APL 21-004, Standards for Determining Threshold Languages, Nondiscrimination Requirements, and Language Assistance Services*)

Plan policy *CA.MR.003 California Non-Medicare Grievance and Appeals* (*revised 2/28/2022*) states that the Plan is required to submit discrimination related grievances to the DHCS OCR within ten days of mailing a discrimination grievance letter.

Finding: The Plan did not forward all grievances with alleged discrimination to DHCS within ten calendar days of the grievance resolution.

A verification study of 30 standard grievances revealed that in two of two grievances with alleged discrimination, the Plan did not forward the grievances to DHCS within ten calendar days of the resolution dates. The Plan did not forward these grievances until after DHCS inquired during the audit. DHCS did not receive these grievances until 106 and 218 calendar days after their resolution dates.

In written responses, the Plan stated its internal tracking system automatically generated a weekly report to identify grievances with alleged discrimination that were recently resolved. The Plan acknowledged that, in some cases, the members' discrimination grievances were not forwarded to DHCS due to system errors.

When the Plan does not ensure that all discrimination grievances are reported timely, DHCS may not be able to take appropriate actions for members.

Recommendation: Implement policies and procedures to ensure that all discrimination grievances are reported to DHCS within the ten calendar day timeframe.

San Diego GMC

4.1.6 Timeliness of Discrimination Complaints Reporting

The Plan must forward all grievances with alleged discrimination against members to DHCS for review and appropriate action. (*Contract A17, Exhibit E, Attachment 2(C)*)

The Plan is required to comply with all existing policy letters and APLs issued by DHCS. (*Contract A17, Exhibit E, Attachment 2, (1) (D)*)

Within ten calendar days of mailing a discrimination grievance resolution letter to a member, the Plan must submit detailed information regarding the grievance to DHCS OCR designated discrimination grievance email box. (*APL 21-004, Standards for Determining Threshold Languages, Nondiscrimination Requirements, and Language Assistance Services*)

Plan policy *CA.MR.003 California Non-Medicare Grievance and Appeals* (revised *2/28/2022*) states that the Plan is required to submit discrimination related grievances to the DHCS OCR within ten days of mailing a discrimination grievance letter.

Finding: The Plan did not ensure that all grievances with alleged discrimination were forwarded to DHCS within ten calendar days of the grievance resolution.

A verification study of 30 standard grievances revealed that in three of four grievances with alleged discrimination, the Plan did not forward the grievances to DHCS within ten calendar days of the resolution dates. The Plan did not forward these grievances until after DHCS inquired during the audit. DHCS did not receive these grievances until 121, 144, and 281 calendar days after their resolution dates.

In written responses, the Plan stated its internal tracking system automatically generated a weekly report to identify grievances with alleged discrimination that were recently resolved. The Plan acknowledged that, in some cases, the members' discrimination grievances were not forwarded to DHCS due to system errors.

When the Plan does not ensure that all discrimination grievances are reported timely, DHCS may not be able to take appropriate actions for members.

Recommendation: Implement policies and procedures to ensure that all discrimination grievances are reported to DHCS within the ten calendar day timeframe.

Sacramento GMC

4.1.7 Discrimination Grievances Email to DHCS Office for Civil Rights

The Plan agrees that copies of all grievances with alleged discrimination against members will be forwarded to DHCS for review and appropriate action. *(Contract A20, Exhibit E, Attachment 2(27)(C))*

The Plan is required to comply with all existing policy letters and APLs issued by DHCS. *(Contract A20, Exhibit E, Attachment 2(1)(D))*

The Plan must submit detailed information regarding the grievance to DHCS OCR designated discrimination grievance email box for all grievances with alleged discrimination. The Plan must submit the following information in a secure format:

1) The original complaint;

2) The provider's or other accused party's response to the grievance;

3) Contact information for the Plan's personnel responsible for the Plan's investigation and response to the grievance;

4) Contact information for the member filing the grievance and for the provider or other accused party that is the subject of the grievance;

5) All correspondence with the member regarding the grievance, including the grievance acknowledgment and grievance resolution letter(s) sent to the member; and

6) The results of the Plan's investigation, copies of any corrective action taken, and any other information that is relevant to the allegation of discrimination.

   (APL 21-004, Standards for Determining Threshold Languages, Nondiscrimination Requirements, and Language Assistance Services)

Plan policy *CA.MR.003 California Non-Medicare Grievance and Appeals (revised 2/28/2022)* states that the Plan is required to submit discrimination related grievances to the DHCS OCR within ten days of mailing a discrimination grievance letter.

Finding: The Plan's emails to DHCS regarding grievances with alleged discrimination did not have all required information as specified in APL 21-004.

A verification study of 30 standard grievances revealed that in two of two grievances with alleged discrimination, the emails to DHCS did not have the following information:

- The provider's or other accused party's responses to the grievances;

- The results of the Plan's investigation, copies of any corrective action taken, and any other information that is relevant to the allegation of discrimination.

In interviews and written responses, the Plan stated that the appropriate departments would address the discrimination issue and, due to privacy laws of health care services, the Plan could not share the results of the discrimination reviews. The Plan acknowledged that the grievance case files did not have any documentation of the investigation and resolution of discrimination complaints.

When the Plan does not ensure that all required information is included in the discrimination grievance emails to DHCS, it does not meet the requirements of APL 21-004.

Recommendation: Develop and implement policies and procedures to ensure the Plan's emails to DHCS regarding grievances with alleged discrimination have all required information as specified in APL 21-004.

San Diego GMC

4.1.7 Discrimination Grievances Email to DHCS Office for Civil Rights

The Plan agrees that copies of all grievances with alleged discrimination against members will be forwarded to DHCS for review and appropriate action. *(Contract A17, Exhibit E, Attachment 2(27)(C))*

The Plan is required to comply with all existing policy letters and APLs issued by DHCS. *(Contract A17, Exhibit E, Attachment 2(1)(D))*

The Plan must submit detailed information regarding the grievance to DHCS OCR designated discrimination grievance email box for all grievances with alleged discrimination. The Plan must submit the following information in a secure format:

1) The original complaint;

2) The provider's or other accused party's response to the grievance;

3) Contact information for the Plan's personnel responsible for the Plan's investigation and response to the grievance;

4) Contact information for the member filing the grievance and for the provider or other accused party that is the subject of the grievance;

5) All correspondence with the member regarding the grievance, including the grievance acknowledgment and grievance resolution letter(s) sent to the member; and

6) The results of the Plan's investigation, copies of any corrective action taken, and any other information that is relevant to the allegation of discrimination.

   (APL 21-004, Standards for Determining Threshold Languages, Nondiscrimination Requirements, and Language Assistance Services)

Plan policy *CA.MR.003 California Non-Medicare Grievance and Appeals (revised 2/28/2022)* states that the Plan is required to submit discrimination related grievances to the DHCS OCR within ten days of mailing a discrimination grievance letter.

Finding: The Plan's emails to DHCS regarding grievances with alleged discrimination did not have all required information as specified in APL 21-004.

A verification study of 30 standard grievances revealed that in four of four grievances with alleged discrimination, the emails to DHCS did not have the following information:

- The provider's or other accused party's responses to the grievances;

- The results of the Plan's investigation, copies of any corrective action taken, and any other information that is relevant to the allegation of discrimination.

In interviews and written responses, the Plan stated that the appropriate departments would address the discrimination issue and, due to privacy laws of health care services, the Plan could not share the results of the discrimination reviews. The Plan acknowledged that the grievance case files did not have any documentation of the investigation and resolution of discrimination complaints.

When the Plan does not ensure that all required information is included in the discrimination grievance emails to DHCS, it does not meet the requirements of APL 21-004.

Recommendation: Develop and implement policies and procedures to ensure the Plan's emails to DHCS regarding grievances with alleged discrimination have all required information as specified in APL 21-004.

Sacramento GMC

4.1.8 Resolution of Complaints in Grievances

The Plan is required to comply with all existing policy letters and APLs issued by DHCS. *(Contract A20, Exhibit E, Attachment 2(1)(D))*

The grievance system must be established in writing and provide for procedures that will receive, review, and resolve grievances. "Resolved" means that the grievance has reached a final conclusion with respect to the member's submitted grievance. The Plan must ensure adequate consideration of grievances and appeals and rectification when appropriate. If multiple issues are presented by the member, the Plan must ensure that each issue is addressed and resolved. *(APL 17-006, Grievance and Appeal Requirements and Revised Notice Templates and "Your Rights" Attachments, and APL 21-011, Grievance and Appeal Requirements, Notice And "Your Rights" Templates)*

Plan policy *CA.MR.003 California Non-Medicare Grievance and Appeals (revised 2/28/22)* stated the case processor must complete a thorough review of the case synopsis and additional information to ensure adequate investigation of all issues and requests. At least one licensed practitioner must review cases involving medical necessity decisions or clinical issues and the details of the decision must be documented within the Plan's system. The written resolution must contain the outcome for all issues and requests, including any follow up information to assist the member with next steps, and a statement that the member's issues were shared with the responsible management or supervisory staff.

Finding: The Plan sent resolution letters for grievances without completely resolving all member complaints.

A verification study revealed that in three of 43 standard grievances and two of 15 expedited grievances, the Plan did not completely resolve all complaints within the grievance prior to finalizing the resolution letter. A few examples of the five deficient samples include:

- In one standard grievance, the Plan only addressed one of two requests by the member. The member requested two types of backup wheelchairs: A powered backup wheelchair, and a manual backup wheelchair. The Plan only addressed the powered back-up wheelchair. The Plan did not resolve the request for the manual backup wheelchair and did not perform a medical necessity review for Medi-Cal coverage.

- In another standard grievance, the Plan did not address the member's concern of receiving the wrong type of durable medical equipment. The member requested a raised toilet seat; however, they received a toilet frame with rails. The member explained that their living facility did not allow a toilet frame with rails. The Plan did not take this information into consideration during its medical necessity review.

- In an expedited grievance, the Plan did not address the member's request for an image scan of the mouth due to persistent pain. The Plan did not investigate and conduct a medical necessity review of the request for the imaging of the mouth. The Plan sent two resolution letters which discussed imaging of the chest at the Emergency Department for respiratory complaints and did not address the member's request regarding their mouth pain.

During interviews, the Plan stated that monitoring of grievance cases for appropriate processing was done through quarterly reviews where case files were pulled and reviewed. In a written response, the Plan stated that operational leaders in the grievance department oversee resolutions to ensure their accuracy.

When the Plan does not completely resolve all issues and requests within grievances, members may not receive pertinent health care services.

Recommendation: Implement policies and procedures to ensure that the Plan completely resolves all member complaints within grievances prior to sending resolution letters.

San Diego GMC

4.1.8 Resolution of Complaints in Grievances

The Plan is required to have in place a grievance system in accordance with Title 28 California Code of Regulations (CCR) Section 1300.68. The Plan must follow grievance requirements in APL 21-011. *(Contract A26, Exhibit A, Attachment 14 (1)(A))*

The grievance system must be established in writing and provide for procedures that will receive, review, and resolve grievances. "Resolved" means that the grievance has reached a final conclusion with respect to the member's submitted grievance. The Plan must ensure adequate consideration of grievances and appeals and rectification when appropriate. If multiple issues are presented by the member, the Plan must ensure that each issue is addressed and resolved. *(APL 17-006, Grievance and Appeal Requirements And Revised Notice Templates and "Your Rights" Attachments, and APL 21-011, Grievance and Appeal Requirements, Notice And "Your Rights" Templates)*

Plan policy *CA.MR.003 California Non-Medicare Grievance and Appeals (revised 2/28/22)* stated the case processor must complete a thorough review of the case synopsis and additional information to ensure adequate investigation of all issues and requests. At least one licensed practitioner must review cases involving medical necessity decisions or clinical issues and the details of the decision must be documented within the Plan's system. The written resolution must contain the outcome for all issues and requests, including any follow up information to assist the member with next steps, and a statement that the member's issues were shared with the responsible management or supervisory staff.

Finding: The Plan sent resolution letters for grievances without completely resolving all member complaints.

A verification study revealed that in nine of 48 standard grievances and two of 15 expedited grievances, the Plan did not completely resolve all complaints within the grievance prior to finalizing the resolution letter. A few examples of the 11 deficient samples include:

- In one standard grievance, a member submitted two complaints on the same day, which were grouped into a single case. The Plan investigated the first complaint about a quality of service issue involving a nurse practitioner. However, the Plan did not investigate or resolve the second quality of care complaint regarding prior surgery, surgical complications, and current treatment from multiple surgeons. In a written response, the Plan stated the second complaint was not addressed due to staff error.

- In another standard grievance, a member complained of psychiatric symptoms and quality of care received from their current psychiatrist and requested an appointment with a different psychiatrist. A supervisory behavioral health clinician reviewed the case and stated a therapist would talk to the member and consult with their psychiatrist on next steps. The Plan sent two resolution letters to the member. Although the Plan stated it approved the member's request in the first resolution letter, there was no evidence the Plan scheduled an appointment with a different psychiatrist. In the second resolution letter, the Plan stated the member had an appointment with their current psychiatrist one day prior to the grievance filing and claimed that a therapist reached out to the member to discuss their needs. However, the Plan did not submit evidence that a therapist or other behavioral health clinician evaluated the quality of care received by the member, conducted member outreach, assessed the member's current condition, or consulted their psychiatrist on next steps after the member filed the grievance and prior to closure of the case.

- In another standard grievance, the member claimed a clinic physician stated they would have a heart attack in five years and recommended cholesterol-lowering medication. The member was upset that their primary care provider (PCP) had never discussed the increased risk of heart attack. A supervisory physician reviewer investigated the complaint and replied that the risk of heart attack increases with aging and the member should discuss further with her PCP. The physician reviewer did not document review of medical records, whether the assessments and treatment plans from both providers were clinically appropriate, if there was a missed opportunity for treatment by the PCP, or if discussions took place with the providers. The resolution letter stated the member could discuss the concern with their PCP. The Plan did not document investigation and resolution of the quality of care issue. In a written response to this sample, the Plan stated some internal actions taken by reviewers, such as speaking to the treating provider about the member's concerns, are considered privileged and confidential information that cannot be shared.

- In one expedited grievance, a member requested a knee scooter for transportation due to extreme pain, which was documented by the case processor. The Plan denied the knee scooter because other mobility devices would meet the member's needs; however, the resolution letters did not inform the member that the request was denied or that other covered benefits were available to them. The Plan did not resolve the member's request because it did not inform the member in writing of the decision. In a written response, the Plan stated it could not validate that the member requested a knee scooter.

- In another expedited grievance, a member shared numerous complaints including shoulder pain, blood in the urine, an appointment cancellation and delayed care by their PCP, and failure of a Physical Medicine provider to treat a rotator cuff tear with a need for referral. Although all other complaints were investigated and resolved, the Plan did not send an inquiry to the Physical Medicine department and did not resolve the member's complaints against the Physical Medicine provider. In a written response, the Plan stated the primary focus of the investigation was the member's cancelled PCP appointment.

During interviews, the Plan stated non-clinical case processors receive training on how to identify issues from members' complaints, investigate complaints, and ensure that reviewers' responses are appropriate for resolution of cases.

When the Plan does not ensure grievances are completely resolved, members' health and future health care decisions may be adversely impacted.

Recommendation: Implement policies and procedures to ensure that the Plan completely resolves all member complaints within grievances prior to sending resolution letters.

San Diego GMC

4.1.9 Clear and Concise Grievance Resolution Letter

The Plan is required to have in place a grievance system in accordance with Title 28 CCR Section 1300.68. The Plan must follow grievance requirements in APL 21-011. *(Contract A26, Exhibit A, Attachment 14(1)(A))*

The Plan's written response must contain a clear and concise explanation of the Plan's decision. *(All Plan Letter (APL) 21-011, Grievance and Appeal Requirements, Notice And "Your Rights" Templates)*

Plan policy *CA.MR.003 California Non-Medicare Grievance and Appeals (revised 2/28/22)* stated that written resolution letters must contain the outcome for all issues and requests in a clear and concise manner. For grievance cases in which the Plan denied or modified the member's request for services, the written resolution must identify any criterion or guideline used as the basis for the decision in sufficient detail and must include a clear and concise clinical explanation as to why the member does not meet the criterion or guideline. Written information must provide sufficiently clear content to enable a layperson to make informed decisions. For the Medi-Cal line of business, the Plan must provide all written information to members at the sixth grade reading level.

Finding: The Plan did not ensure grievance resolution letters contained a clear and concise explanation of the Plan's decision.

A verification study showed that in seven of 48 standard grievances and five of 15 expedited grievances, the resolution letters did not contain a clear and concise explanation. A few examples of complex, difficult to understand, lengthy, or confusing language from the 12 deficient samples include:

- In one expedited grievance, the Plan denied a member's request for an out-of-Plan surgical consult based on vendor-based clinical guidelines for schwannoma, the type of tumor the member was diagnosed with. The resolution letter contained extraneous complex clinical paragraphs that were not relevant to the Plan's denial decision. For example, the resolution letter quoted complex clinical language from the guidelines, such as "Melanotic schwannomas show dense melanin pigmentation but are otherwise typical. Plexiform schwannomas are rare, usually occurring along

nerve plexuses as conglomerations of multiple schwannomas, and can be sporadic or associated with NF2 or schwannomatosis. Long-standing schwannomas can show degenerative changes, such as marked nuclear pleomorphism, widespread blood vessel hyalinization, sings of remote hemorrhage, focal necrosis, and calcifications."

- In another expedited grievance, the Plan denied the member's request for urgent hernia surgery using vendor-based clinical guidelines criteria. The resolution letter quoted criteria with multiple clinical terms that were not explained, such as: "incarcerated or strangulated hernia, ventral or incisional hernia, Spigelian hernia, uncontrollable ascites, stenosis, perforation of stoma, difficulty in attaching ostomy bag, and perineal hernia". The resolution letter stated the reason for denial was "there is no evidence of bowel obstruction, strangulation warranting an urgent surgery".

- In one standard grievance, the Plan denied the member's request to have a colonoscopy without a prior COVID-19 test based on the Plan's clinical library guidelines, which were written for providers and contained contradictory information. The resolution letter quoted criteria language such as, "If pre-operative or pre-procedural SARS-CoV-2 RNA testing is done (within 48-72 hours prior to intervention) and is positive, defer non-emergent surgeries until at least symptom and time-based criteria are met… Fully vaccinated people with no COVID-19-like symptoms and no known exposure should be exempted from routine screening testing programs, if feasible. However, results might continue to be useful in some situations to inform management, for example, room assignment/cohorting, or personal protective equipment used."

- In another standard grievance, a member complained the Plan informed them to make an appointment at the Psychiatry Department even though the member was requesting a therapist and not a psychiatrist. This is the second time the member requested care from a therapist and not a psychiatrist. However, the Plan did not clearly explain in the resolution letter that the Psychiatry Department assigns a therapist to the member after an initial intake appointment. The resolution letter informed the member to get a referral from the local medical center but did not explain in detail how to access a therapist.

In an interview, the Plan explained that resolution letter language and relevant criteria are drafted by non-clinical case processors based on investigative review results. Clinical decision-makers confirm whether the case processor selected appropriate criteria for medical necessity decisions. Case processors are trained and required to check for 6th grade reading level using readability tools prior to mailing letters. The Plan stated case processors do not change medical terminology or criteria language to maintain accuracy of clinical information communicated to members.

If the Plan does not provide grievance resolution letters with a clear and concise explanation, members may not understand the resolution of their complaints or the clinical rationale for medical necessity decisions, which may adversely impact their health care.

Recommendation: Implement policies and procedures to ensure that grievance resolution letters contain clear and concise explanations of the Plan's decisions.

San Diego GMC

4.1.10 Public Policy Body's Review of Grievances

The Plan is required to have in place a grievance system in accordance with Title 28 CCR Section 1300.68. The Plan must follow grievance requirements in APL 21-011. *(Contract A26, Exhibit A, Attachment 14(1)(A))*

The written record of grievances must be reviewed periodically by the governing body, the public policy body, and a Plan officer or their designee. The review must be thoroughly documented. *(APL 17-006, Grievance and Appeal Requirements and Revised Notice Templates and "Your Rights" Attachments, and APL 21-011, Grievance and Appeal Requirements, Notice and "Your Rights" Templates)*

Plan document *San Diego GMC Member Advisory Committee (MAC) Charter (updated 12/19/19)* stated that the MAC, the Plan's public policy body, is a formal mechanism to involve Medi-Cal members as partners in identifying improvement opportunities for the Southern California region. Membership includes San Diego GMC Medi-Cal members, Plan physicians, and Plan leadership and staff. The MAC meets quarterly and develops objectives based on Medi-Cal regulatory changes, performance improvement needs, Medi-Cal member needs, and operational needs.

Finding: The Plan's public policy body did not periodically review written grievance logs or reports and did not thoroughly document the review.

Submitted meeting minutes revealed the MAC did not discuss or review grievance reports during the audit period. In written responses, the Plan stated the MAC served as the public policy body and consisted of Medi-Cal members. The Plan acknowledged the MAC does not review appeals and grievance reports and did not clarify the reason why it did not.

When the Plan does not comply with grievance review requirements, important trends, analyses, and details regarding member grievances may be missed by key Plan entities.

Recommendation: Develop and implement procedures to ensure the public policy body periodically reviews written grievance reports and thoroughly documents its review.

4.2	CULTURAL AND LINGUISTIC SERVICES

Sacramento GMC

4.2.1 Written Program Description

The Plan is required to implement and maintain a written description of its CLS Program, which should include an organizational chart of its CLS Program. This organization chart should have the following elements:

- It should show the key staff persons with overall responsibility for the program;
- It should include a narrative that explains the chart and describes the oversight and direction to the Community Advisory Committee, provisions for supporting staff and reporting relationships;
- It should also show the qualifications of staff, including appropriate education, experience and training.

  (*Contract A20, Exhibit A, Attachment 9(13)(A)(4)*)

Finding: The Plan's CLS Program organizational chart did not have all required elements.

A review of the Plan's CLS organizational chart and the job description for CLS Program Manager showed the following required elements were missing:

- Key staff persons with overall responsibility for CLS and activities.
- Description of the oversight and direction to the Community Advisory Committee, provisions for support staff, and reporting relationships.
- Description of the qualifications of staff, including appropriate education, experience and training. The submitted job description, which was not part of the organizational chart, did not include any job duties related to CLS.

In an interview, the Plan could not explain why the organizational chart submitted did not include the required elements.

The Plan subsequently submitted a comprehensively revised organizational chart after the deficiencies were discussed in an interview. However, there is no evidence this chart was implemented during the audit period.

When required elements are missing from the organizational chart in the written program description, the Plan does not meet contractual requirements.

Recommendation: Develop and include an organizational chart with all the required elements in the Plan's CLS written program description.

Sacramento GMC

4.2.2 Nondiscrimination Notice and Language Assistance Taglines

The Plan is required to comply with all existing policy letters and APLs issued by DHCS. *(Contract A20, Exhibit E, Attachment 2(1)(D))*

The NDN and LAT must be posted in all member informational notices, including written notices to an individual such as those pertaining to rights and benefits. DHCS updated its templates for NDN to include additional characteristics protected under state nondiscrimination law, including ethnic group identification and medical condition (as described in *APL 20-015*), as well as contact information for members to file a discrimination grievance directly with the DHCS Office of Civil Rights (OCR). DHCS also updated its LAT template to conform to federal law and to include additional top California languages (Mien and Ukrainian). Although DHCS does not require Plans to use the DHCS-provided templates verbatim, notices must be compliant with requirements in this APL and with information in the DHCS-provided templates. The implementation date for required information in full-sized NDN and LAT was October 5, 2021. *(APL 21-004, Standards for Determining Threshold Languages, Nondiscrimination Requirements, and Language Assistance Services)*

Plan policy *CA.HP.Operations.LA 005001 (effective 11/01/2021)* states that Medi-Cal vital documents must be accompanied by the LAT as well as the NDN, regardless of the size of the publication. Vital documents are defined as written materials for Medi-Cal members that are essential for understanding health plan benefits or accessing covered health care services. Notices related to CLS Program include Member Handbook, Medi-Cal Provider Directory, Plan's website, member surveys, newsletters, etc.

Finding: The Plan did not ensure updated NDN and LAT information were posted in all member informational notices in accordance with APL 21-004.

A verification study revealed that the Plan did not use updated full-sized NDN and LAT templates on the Plan's website, newsletters and Medi-Cal provider directories:

- The LAT did not include Mien and Ukrainian languages
- The NDN did not have the DHCS OCR contact information and all protected discrimination categories, such as ethnic group identification and medical condition.

In an interview, the Plan acknowledged that an error had caused the outdated NDN and taglines to be accompanied with the aforementioned documents.

When the Plan does not ensure updated NDN and LAT are included in all member informational notices, members may not receive information necessary to exercise their rights.

Recommendation: Implement policies and procedures to ensure updated NDN and LAT are included in all member informational notices.

San Diego GMC

4.2.2 Nondiscrimination Notice and Language Assistance Taglines

The Plan is required to comply with all existing policy letters and APLs issued by DHCS. (*Contract A17, Exhibit E, Attachment 2(1)(D)*)

The Plan must comply with all of the nondiscrimination requirements set forth under federal and state law and APLs. This includes the posting of the NDN in member information and all other informational notices, and the provision of the required taglines that inform LEP individuals of the availability of free language assistance services and auxiliary aids and services for people with disabilities. (*All Plan Letter (APL) 21-004, Standards for Determining Threshold Languages, Nondiscrimination Requirements, and Language Assistance Services*)

The Plan's NDN must include information about how to file a discrimination grievance directly with DHCS Office for Civil Rights (OCR), in addition to information about how to file a discrimination grievance with the Plan's OCR and the United States Department of Health and Human Services (HHS) OCR. (*APL 21-004*)

DHCS updated its templates for NDN to conform to state laws to include additional characteristics protected under state nondiscrimination law as well as contact information for members to file a discrimination grievance directly with the DHCS OCR. DHCS also updated its LAT template to conform to federal law and to include additional top California languages (Mien and Ukrainian). The NDN and LAT must be posted in all member informational notices, including written notices to an individual such as those pertaining to rights and benefits. Although DHCS does not require Plans to use the DHCS-provided templates verbatim, notices must be compliant with requirements in this APL and with information in the DHCS-provided templates. The implementation date for required information in full-sized NDN and LAT was October 5, 2021. (*APL 21-004*)

Plan Policy *CA.HP.Operations.LA 005001* (effective 11/01/2021) states that Medi-Cal vital documents must be accompanied by the LAT as well as the NDN, regardless of the size of the publication. Vital documents are defined as written materials for Medi-Cal members that are essential for understanding health plan benefits or accessing covered health care services. Notices related to CLS Program include Member Handbook, Medi-Cal Provider Directory, Plan website, Member Surveys, Newsletters, etc.

Finding: The Plan did not ensure that correct NDN and LAT information were posted in all Medi-Cal vital documents in accordance with APL 21-004.

A verification study revealed that the Plan did not use the current NDN and LAT templates in the following Medi-Cal vital documents: kp.org website, Partner in Health Newsletters, Medi-Cal Provider directories.

- The LAT accompanied by the Plan's website, newsletters and Medi-Cal Provider Directories did not have Mien and Ukrainian languages as required.

- The accompanied NDN did not have the DHCS OCR contact information. It also did not have all protected discrimination categories, such as ethnic group identification and medical condition.

In an interview, the Plan acknowledged that an error had caused the outdated NDN and taglines to be accompanied by the aforementioned documents. The Plan is actively resolving the issue to ensure the updated NDN and taglines are used as required.

When the Plan does not ensure that the current NDN and LAT are included in all members' vital documents, members may not receive information necessary to exercise their rights.

Recommendation: Implement policies and procedures to ensure that the correct NDN and LAT are included in all member informational notices.

CATEGORY 6 – ADMINISTRATIVE AND ORGANIZATIONAL CAPACITY

6.1	HEALTH EDUCATION PROGRAM

Sacramento and San Diego GMC

6.1.1 Educational Interventions

The Plan is required to maintain a health education system that provides educational interventions addressing the three health categories and ensure that these programs are available and accessible to members upon referral by providers and also upon the member's request. The three health categories and topics are as follow:

1. Effective Use of MHCS: Health education services, the managed health care system, preventive and primary healthcare services, obstetrical care, and complementary and alternative care.

2. Risk-Reduction and Healthy Lifestyles

3. Self-Care and Management of Health Conditions

   (Contract A17 and A20, Exhibit A, Attachment 10(8)(A)(7)(a))

Plan draft policy *Medi-Cal Health Education Policy* stated the Plan ensures compliance with Medi-Cal members' health education communications requirements.

Finding: The Plan did not provide educational interventions to address two topics within the Effective Use of MHCS category: Managed Health Care and Health Education Services.

In submitted documents, the Plan acknowledged that it did not have educational interventions addressing the use of Managed Health Care and Health Education Services. The Plan's member educational materials did not address these two topics.

In the written response, the Plan stated that it relied on resources provided by its regional entities for the topics of Managed Health Care and Health Education Services. The Plan provided regional materials related to wellness coaching and information regarding changing from pediatric to adult health care. However, these documents do not directly address the two above-mentioned topics.

The Plan's draft policy and 2022 Quality Program Descriptions did not address educational intervention categories or topics.

When the Plan does not provide education on the use of the managed health care system and available health educational services, members may not effectively use health care services.

Recommendation: Develop and implement educational interventions addressing the missing topics in the Effective Use of MHCS category.

6.2	FRAUD AND ABUSE

Sacramento and San Diego GMC

6.2.1 Prompt Referral of Any Potential Fraud or Abuse

The Plan is required to promptly refer any potential Fraud, Waste, or Abuse that the Plan identifies to the DHCS Audits and Investigations Intake Unit. The Plan is required to conduct, complete, and report to DHCS, the results of a preliminary investigation of the suspected Fraud and/or Abuse within ten working days of the date Plan first becomes aware of, or is on notice of, such activity. *(Contract A17 and A20, Exhibit E, Attachment 2(25)(B)(7))*

Plan policy NATL.NCO.011, Fraud, Waste, and Abuse Control (Last approved 6/23/2021), stated the Plan is committed to complying with all laws and regulations associated with the control of fraud, waste, and abuse.

Finding: The Plan did not report suspected fraud and/or abuse to DHCS within ten working days of the date it first became aware.

A verification study revealed two of 13 cases reported to DHCS were not promptly referred:

- In one case for both Sacramento and San Diego GMC, the Plan identified an external Medi-Cal provider who was potentially billing for antibody testing excessively. The provider billed multiple COVID-19 testing codes for members on the same date of service. The case discovery date was 8/20/2021, but DHCS did not receive a report until eight months later on 4/29/2022.

- In one case for San Diego GMC, the Plan identified an external Medi-Cal provider who was potentially billing for excessive, high-cost COVID-19 related services. The Plan discovery date was 10/21/2021, but DHCS did not receive a report until nine months later on 7/22/2022.

In an interview, the Plan stated it does not report suspected fraud and/or abuse to DHCS for external providers until after unsupported payment is confirmed.

However, DHCS contracts do not require confirmation of fraud and/or abuse before reports may be sent to DHCS. The required reporting timeframe is within ten working days of the date Plan first becomes aware of, or is on notice of, suspected fraud and/or abuse.

If the Plan does not promptly report suspected fraud and/or abuse, there may be cases under Plan investigation that DHCS won't be able to address timely.

Recommendation: Develop and implement processes to ensure reports of preliminary investigation are submitted to DHCS within ten working days of the date the Plan becomes aware of, or is on notice of, any suspected fraud and/or abuse.