

**DEPARTMENT OF MANAGED HEALTH CARE
DIVISION OF PLAN SURVEYS
CAL MEDICONNECT SURVEY**

TECHNICAL ASSISTANCE GUIDE

MEMBER RIGHTS

ROUTINE MEDICAL SURVEY

OF

PLAN NAME

DATE OF SURVEY:

PLAN COPY

Issuance of this October 27, 2015 Technical Assistance Guide renders all other versions obsolete.

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MEMBER RIGHTS REQUIREMENTS

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Requirement MR-001: The Health Plan complies with requirements established for the internal, i.e. plan-level, grievance and appeals process for Medicaid-based services under Cal MediConnect requirements.

STATUTORY/REGULATORY CITATIONS

Cal MediConnect Prime Contract

2.13. IHSS Related Complaints, Grievances and Appeals

2.13.1. For Enrollee complaints, grievances, or appeals related to IHSS, Contractor must comply with the established grievance and appeal process established by CDSS and by the county agencies responsible for IHSS, in compliance with WIC 14186.35(e).

2.14. Enrollee Grievances

2.14.1. Grievance Filing -- The Contractor shall inform Enrollees that they may file a grievance through either the Contractor or Cal Medi-Connect Ombuds Program for complaints relating to Medicare and Medi-Cal covered benefits and services. Medicare beneficiaries may also file a grievance through 1-800 Medicare. The Contractor must display a link to the electronic grievance form on the Medicare.gov Internet Web site on the Contractor's main web page pursuant to 42 C.F.R. § 422.504 (a)(15)(ii). The Contractor must inform Enrollees of the email address, postal address or toll-free telephone number where an Enrollee grievance regarding Medicare and Medi-Cal covered benefits and services may be filed. Authorized representatives may file grievances on behalf of Enrollees to the extent allowed under applicable federal or state law.

2.14.2. Internal (plan level) Grievance: An Enrollee may file an Internal Enrollee grievance regarding Medicare and Medi-Cal covered benefits and services at any time with the Contractor or its providers by calling or writing to the Contractor or provider. The Contractor must have a system in place for addressing Enrollee grievances, including grievances regarding reasonable accommodations and access to services under the ADA.

2.14.2.1. Reporting of plan level grievances: Contractor shall track and report to DHCS the number and types of inquiries, complaints, grievances, appeals, and resolutions related to Cal MediConnect, as described in WIC Section 14182.17(e)(4)(E), in the format specified by DHCS. DHCS will then make the required information publicly available on DHCS' internet web site.

2.14.2.1.1. Internal Grievance: Contractor shall establish and maintain a grievance process under which Enrollees may submit their grievance regarding all covered services and benefits to the Contractor. Contractor shall establish and maintain a grievance process approved by DHCS under which Enrollees may submit their grievances regarding all benefits and services, pursuant to the Knox-Keene Health Care Services Plan Act of 1975 and the regulations promulgated thereunder, WIC Section 14450 and CCR, Title 22, Section 53260.

2.14.2.1.2. The Contractor must maintain written records of all grievance activities, and notify CMS and DHCS of all internal grievances. The system must meet the following standards:

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- 2.14.2.1.2.1.** Timely acknowledgement of receipt of each Enrollee grievance;
- 2.14.2.1.2.2.** Timely review of each Enrollee grievance;
- 2.14.2.1.2.3.** Response, electronically, orally or in writing, to each Enrollee grievance within a reasonable time, but no later than thirty (30) days after the Contractor receives the grievance;
- 2.14.2.1.2.4.** Expedited response, orally or in writing, within twenty-four (24) hours after the Contractor receives the grievance to each Enrollee grievance whenever Contractor extends the Appeals timeframe or Contractor refuses to grant a request for an expedited Appeal; and
- 2.14.2.1.2.5.** Availability to Enrollees of information about Enrollee Appeals, as described in Section 2.15, including reasonable assistance in completing any forms or other procedural steps, which shall include interpreter services and toll-free numbers with TTY/TDD and interpreter capability.
- 2.14.2.1.2.6.** Procedures to ensure that decision makers on grievances were not involved in previous levels of review or decision-making and who are health care professionals with clinical expertise in treating the Enrollee's condition or disease if any of the following apply:
 - 2.14.2.1.2.6.1.** A grievance regarding denial of expedited resolutions of an appeal.
 - 2.14.2.1.2.6.2.** Any grievance or appeal involving clinical issues.

2.14.3. External Grievance: The Contractor shall inform Enrollees that they may file an external grievance for Medicare only covered benefits and services through 1-800 Medicare or for Medicare and Medi-Cal covered benefits and services through the Cal MediConnect Ombuds program. The Contractor must display a link to the electronic grievance form on the Medicare.gov Internet Web site on the Contractor's main web page. 42 C.F.R. § 422.504(a)(15)(ii). The Contractor must inform Enrollees of the email address, postal address or toll-free telephone number where an Enrollee grievance may be filed.

2.14.3.1 Pursuant to Health & Safety Code Section 1368(b), Contractor shall inform Enrollees that they may file an external grievance for Medi-Cal only covered benefits and services (not including IHSS) through DMHC's consumer complaint process. Contractor shall inform Enrollees of the DMHC's toll-free number, the DMHC's TDD line for the hearing and speech impaired, and the DMHC's website address pursuant to Health & Safety Code Section 1368.02.

2.15.1.2. Contractor must provide a member notice of resolution, as expeditiously as the Enrollee's health condition requires, within thirty (30) calendar days from the day Contractor receives the appeal. An Enrollee notice, at a minimum, must include the result and date of the appeal resolution. For decisions not wholly in the Enrollee's favor, Contractor, at a minimum must include:

- 2.15.1.2.1.** Enrollee's right to request a State Fair Hearing;
- 2.15.1.2.2.** How to request a State Fair Hearing;
- 2.15.1.2.3.** Right to continue to receive benefits pending a State Fair Hearing; and
- 2.15.1.2.4.** How to request the continuation of benefits.
- 2.15.1.2.5.** Enrollee's right to file an external grievance through DMHC's consumer complaint process or request an Independent Medical Review from the DMHC with respect to any and all disputes concerning Medi-Cal based services that are medical in nature and

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that relate to health care service plan obligations set forth under the Knox-Keene Act and the regulations promulgated thereunder.

2.15.1.2.6. How to file an external grievance through the DMHC's consumer complaint process or request an Independent Medical Review form DMHC.

2.15.1.3. Written material must use easily understood language and format, be available in alternative formats, and in an appropriate manner that takes into consideration those with special needs. The Contractor must inform Enrollees that information is available in alternative formats and how to access those formats.

2.15.2. Appeals relating to Medi-Cal covered benefits and services shall proceed pursuant to the laws and regulations governing Medi-Cal Appeals. Appeals relating to Medicare covered benefits and services shall proceed pursuant to the laws and regulations governing Medicare Appeals.

2.15.2.1. Written notice must be translated for Enrollees who speak Threshold Languages.

2.15.2.2. Written notices must include language clarifying that oral interpretation is available for all languages and how to access it.

2.15.3. Medi-Cal Appeals and beneficiary protections will be maintained for Appeals regarding Medi-Cal services.

2.15.3.1. Enrollee or provider may file an Appeal either orally or in writing and must follow an oral filing with a written, signed appeal.

2.15.3.2. Contractor must:

2.15.3.2.1. Ensure that oral inquiries seeking to Appeal an action are treated as Appeals and confirm those inquiries in writing unless the Enrollee or provider requests expedited **resolution.**

2.15.3.2.2. Provide a reasonable opportunity to present evidence and allegation of fact or law, in person, as well as in writing.

2.15.3.2.3. Allow the Enrollee and representative opportunity, before and during the Appeal process to examine the Enrollee's case file, including medical records, and any other documents and records.

2.15.3.2.4. Consider the Enrollee, representative, or estate representative of a deceased Enrollee as parties to the Appeal.

2.15.3.2.5. Ensure that decision makers on Appeals were not involved in previous levels of review or decision-making and are health care professionals with clinical expertise in treating the Enrollee's condition or disease if any of the following apply:

2.15.3.2.5.1. A denial of an Appeal based on lack of medical necessity;

2.15.3.2.5.2. A grievance regarding denial of expedited resolution of an Appeal; or

2.15.3.2.5.3. Any Appeal involving clinical issues.

2.15.3.3. Contractor shall implement and maintain an Enrollee internal Appeals system, which includes oversight of any First Tier, Downstream or Related Entity, in accordance with all applicable federal and state laws and regulations, including but not limited to the following:

2.15.3.3.1. Federal Medicaid regulations governing Medi-Cal Managed Care Appeals and Medi-Cal Appeals in general, at 42 C.F.R. 431 Subpart E and 42 C.F.R. 438 Subpart F.

2.15.3.3.2. Standards for expedited review of grievances involving an imminent and serious threat to the health of the Enrollee: Title 28, CCR, Sections 1300.68 and 1300.68.01;

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2.15.3.3.3. Internal Contractor Appeal processes, in accordance with the Knox-Keen Act and the regulations promulgated thereunder, as applicable, and external Appeal processes in accordance with the DMHC's Independent Medical Review System set forth in Article 5.55 of the Knox-Keene Act (commencing with Health & Safety Code Section 1374.30) and the regulations promulgated thereunder, and the fair hearing standards for Medi-Cal managed care, Title 22, CCR, Sections §51014.1, §51014.2, §53894, and §53858;

2.15.3.3.4. Twelve (12) month continuity of care under certain circumstances. WIC §14182.17 (d)(7)(A)(ii).

2.15.3.4. Expedited internal Medi-Cal Appeals. Contractor shall comply with all state law and regulations pertaining to expedited Appeals, as well as the following requirements:

2.15.3.4.1. Contractor shall implement and maintain procedures as described below to resolve expedited internal Appeals for Medi-Cal services. These procedures shall be followed whenever Contractor determines or the provider indicates that taking the time for a standard resolution could seriously jeopardize the Enrollee's life, health, or ability to attain, maintain, or regain maximum function.

2.15.3.4.2. Enrollee or provider may file an expedited Appeal either orally or in writing, and no additional Enrollee follow-up is required.

2.15.3.4.3. Contractor must inform the Enrollee of the limited time available for the Enrollee to present evidence and allegations of fact or law, in person and in writing.

2.15.3.4.4. Contractor must provide an Enrollee notice as quickly as the Enrollee's health condition requires or within three (3) working days from the day Contractor receives the Appeal.

2.15.3.4.5. Contractor may extend the timeframe to resolve an Appeal by up to fourteen (14) days if the Enrollee requests the extension, or Contractor shows that there is a need for additional information and how the delay is in the Enrollee's interest.

2.15.3.4.6. Contractor must make a reasonable effort to provide oral notice of expedited Appeal decision.

2.15.3.4.7. Contractor must ensure that punitive action is not taken against a provider who either requests an expedited resolution or supports an Enrollee's Appeal.

2.15.3.4.8. If Contractor denies a request for expedited resolution of an Appeal, it must

2.15.3.4.8.1. Transfer the Appeal to the standard timeframe of no longer than thirty (30) calendar days from the day the Contractor receives the Appeal with a possible fourteen (14) day extension, and

2.15.3.4.8.2. Give the Enrollee prompt oral notice of the denial of a request for expedited resolution and a written notice within two (2) calendar days.

2.15.3.6. Parties to an internal Medi-Cal Appeal or State Fair Hearing.

2.15.3.6.1. The parties to an internal plan Appeal or the State Fair Hearing related to a Medi-Cal benefit or service include the Contractor as well as the Enrollee and his or her representative or the representative of a deceased Enrollee's estate.

2.15.3.7. Responsibilities in Independent Medical Reviews (IMR) Related to Medi-Cal Benefits and Services. Contractor shall comply with all statutes, regulations and procedures regarding the DMHC's Independent Medical Review System, as set forth in the Knox-Keene Act and the regulations promulgated thereunder, including but not limited to the following requirements:

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2.15.3.7.1. Enrollees may request an IMR regarding Medi-Cal services from the DMHC within six (6) months of a denial, modification or delay of a Medi-Cal service based on Contractor's determination in whole or in part that the service is not medically necessary. Health & Safety Code Section 1374.30.

2.15.3.7.2. Enrollees shall not be required to participate in Contractor's Internal Appeal process for more than thirty (30) days before applying for an IMR. Health & Safety Code Section 1368(b)(1)(A).

2.15.3.7.3. Enrollees whose Appeal requires expedited review pursuant to Health & Safety Code Section 1368.01 shall not be required to participate in the Contractor's Internal Appeal process for more than three (3) days before applying for an IMR. Health & Safety Code Section 1374.31(a)

2.15.3.7.4. Enrollees may apply for an IMR without first participating in Contractor's Internal Appeal process in extraordinary and compelling cases, as determined by DMHC, and in cases where Enrollee's request for an experimental treatment was denied. Health & Safety Code Sections 1368.03 and 1374.31(a).

2.15.3.7.5. Contractor must notify Enrollee in writing of the opportunity to request an IMR of a decision denying an experimental therapy within five (5) business days of the decision to deny coverage. Health & Safety Code Section 1300.70.4(b)(2)

2.15.3.7.6. Enrollees may not request an IMR if a State Fair Hearing has already been held on the issue. Title 28, CCR Section 1300.74.30(f)(3)

2.15.3.7.7. If the DMHC determines that Enrollee is not eligible for an IMR, the Enrollee's case will be reviewed through DMHC's consumer complaint process. Health & Safety Code Section 1368(b)

2.15.5. Continuation of Benefits Pending an Appeal

2.15.5.2. Medi-Cal Benefits and Services

2.15.5.2.1. The Contractor must continue providing all prior approved Medi-Cal benefits for which a Contractor has issued a NOA for termination or modification pending completion of the internal Contractor Appeal or per timeframes in 42 C.F.R. § 438.420, whichever comes first. This means that such benefits will continue to be provided to Enrollees and that the Contractor must continue to pay providers for providing such services or benefits pending a plan level Appeal or per timeframes in 42 C.F.R. § 438.420, whichever comes first.

2.17.5.1. Consistent with the timelines specified in the Medicare-Medicaid marketing guidance, the Contractor must provide new Enrollees with the following materials which, with the exception of the materials specified in Sections 2.17.5.3 and 2.17.5.4, must also be provided annually thereafter:

2.17.5.1.4. How to file grievances and internal and external Appeals, including:

2.17.5.1.4.1. Grievance, Appeal and fair hearing procedures and timeframes;

2.17.5.1.4.2. Toll free numbers that the Enrollee can use to file a grievance or an Appeal by phone;

Health & Saf. Code, Section 1368.02

(b) Every health care service plan shall publish the department's toll-free telephone number, the department's TDD line for the hearing and speech impaired, the plan's telephone number, and

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the department's Internet Web site address, on every plan contract, on every evidence of coverage, on copies of plan grievance procedures, on plan complaint forms, and on all written notices to Enrollees required under the grievance process of the plan, including any written communications to an Enrollee that offer the Enrollee the opportunity to participate in the grievance process of the plan and on all written responses to grievances. The department's telephone number, the department's TDD line, the plan's telephone number, and the department's Internet Web site address shall be displayed by the plan in each of these documents in 12-point boldface type in the following regular type statement:

“The California Department of Managed Health Care is responsible for regulating health care service plans. If you have a grievance against your health plan, you should first telephone your health plan at (insert health plan's telephone number) and use your health plan's grievance process before contacting the department. Utilizing this grievance procedure does not prohibit any potential legal rights or remedies that may be available to you. If you need help with a grievance involving an emergency, a grievance that has not been satisfactorily resolved by your health plan, or a grievance that has remained unresolved for more than 30 days, you may call the department for assistance. You may also be eligible for an Independent Medical Review (IMR). If you are eligible for IMR, the IMR process will provide an impartial review of medical decisions made by a health plan related to the medical necessity of a proposed service or treatment, coverage decisions for treatments that are experimental or investigational in nature and payment disputes for emergency or urgent medical services. The department also has a toll-free telephone number (1-888-HMO-2219) and a TDD line (1-877-688-9891) for the hearing and speech impaired. The department's Internet Web site <http://www.hmohelp.ca.gov> has complaint forms, IMR application forms and instructions online.”

28 CCR 1300.68(b)(7)

(7) Grievance forms and a description of the grievance procedure shall be readily available at each facility of the plan, on the plan's website, and from each contracting provider's office or facility. Grievance forms shall be provided promptly upon request.

28 CCR 1300.68(e)

(e) The plan's grievance system shall track and monitor grievances received by the plan, or any entity with delegated authority to receive or respond to grievances. The system shall:

- (1) Monitor the number of grievances received and resolved; whether the grievance was resolved in favor of the Enrollee or plan; and the number of grievances pending over 30 calendar days. The system shall track grievances under categories of Commercial, Medicare and Medi-Cal/other contracts. The system shall indicate whether an Enrollee grievance is pending at: 1) the plan's internal grievance system; 2) the Department's consumer complaint process; 3) the Department's Independent Medical Review system; 4) an action filed or before a trial or appellate court; or 5) other dispute resolution process. Additionally, the system shall indicate whether an Enrollee grievance has been submitted

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to: 1) the Medicare review and appeal system; 2) the Medi-Cal fair hearing process; or 3) arbitration.

- (2) The system shall be able to indicate the total number of grievances received, pending and resolved in favor of the Enrollee at all levels of grievance review and to describe the issue or issues raised in grievances as 1) coverage disputes, 2) disputes involving medical necessity, 3) complaints about the quality of care and 4) complaints about access to care (including complaints about the waiting time for appointments), and 5) complaints about the quality of service, and 6) other issues.

28 CCR 1300.68(f)(1)

(f) Quarterly Reports

(1) All plans shall submit a quarterly report to the Department describing grievances that were or are pending and unresolved for 30 days or more. The report shall be prepared for the quarters ending March 31st, June 30th, September 30th and December 31st of each calendar year. The report shall also contain the number of grievances referred to external review processes, such as reconsiderations of Medicare Managed Care determinations pursuant to 42 C.F.R. Part 422, the Medi-Cal fair hearing process, the Department's complaint or Independent Medical Review system, or other external dispute resolution systems, known to the plan as of the last day of each quarter.

28 CCR 1300.68.01(a) and (b)

(a) Every plan shall include in its grievance system, procedures for the expedited review of grievances involving an imminent and serious threat to the health of the Enrollee, including, but not limited to, severe pain, potential loss of life, limb, or major bodily function ("urgent grievances"). At a minimum, plan procedures for urgent grievances shall include:

- (1) Immediate notification to the complainant of the right to contact the Department regarding the grievance. The plan shall expedite its review of the grievance when the complainant, an authorized representative, or treating physician provides notice to the plan. Notice need not be in writing, but may be accomplished by a documented telephone call.
- (2) A written statement to the Department and the complainant on the disposition or pending status of the urgent grievance within three (3) calendar days of receipt of the grievance by the Plan.
- (3) Consideration by the plan of the Enrollee's medical condition when determining the response time.
- (4) No requirement that the Enrollee participate in the plan's grievance process prior to applying to the Department for review of the urgent grievance.

(b) Each plan's grievance system shall allow for the Department to contact the plan regarding urgent grievances 24 hours a day, 7 days a week. During normal work hours, the plan shall respond to the Department within 30 minutes after initial contact from the Department. During non-work hours, the plan shall respond to the Department within 1 hour after initial contact from the Department.

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(1) The system established by the plan shall provide for the availability of a plan representative with authority on the plan's behalf to resolve urgent grievances and authorize the provision of health care services covered under the Enrollee's plan contract in a medically appropriate and timely manner. Such authority shall include making financial decisions for expenditure of funds on behalf of the plan without first having to obtain approval from supervisors or other superiors within the plan. Nothing in this subsection shall restrict the plan representative from consulting with other plan staff on urgent grievances.

(2) Plans shall provide the Department with the following information concerning urgent grievances:

(A) A description of the system established by the plan to resolve urgent grievances. The description shall include the system's provisions for scheduling qualified plan representatives, including back-up plan representatives as necessary, to be available twenty-four (24) hours a day, seven days a week to respond to Department contacts regarding urgent grievances. Provisions for scheduling shall include the names and titles of those plan representatives who will be available under the system, their telephone numbers, and, as applicable, pager numbers, answer service numbers, voice-mail numbers, e-mail addresses, or other means for contact.

(B) A description of how the Department may access the grievance system established by the plan.

(3) If the plan revises the system established pursuant to subsection (b), the plan shall notify the Department at least thirty (30) days in advance of implementing the revisions.

(c) The plan shall notify the Department before changing or modifying any benefit or services that relates to the urgent grievance submitted to the Department pursuant to subsection (b)(1)(A) of Section 1368 of the Act if the Enrollee or the Enrollee's representative objects to the change or modification.

INDIVIDUAL(S)/POSITION(S) TO BE INTERVIEWED

Staff responsible for the activities described above, for example:

- Individual designated as compliance officer for the Cal MediConnect program
- Medical or Clinical Director
- Officer or manager with primary responsibility for the grievance system
- Officer or manager with primary responsibility for the appeals system
- Manager of Member Services
- Manager of Call Centers
- Individual designated as the Cal MediConnect QI Director, such as Quality Management or Quality Improvement Director
- QM Director
- Director of Operations

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DOCUMENT(S) TO BE REVIEWED

- Enrollee newsletters or other communications explaining grievance procedures
- Plan website
- Description of the grievance and appeal system, including how the Plan defines a grievance or appeal (appeal, complaint, inquiry, concern, grievance, etc.)
- Resume of individuals responsible for oversight of the Cal MediConnect program as referenced above
- Job description of the staff interviewed, including the managers or officers with primary responsibility for the grievance and appeal system
- Policy and procedure for generation and review of grievance reports
- Grievance logs, including grievance logs from any subcontracting entity delegated the responsibility to maintain and resolve grievances
- Appeals forms
- Grievance forms
- Policies and procedures to maintain a system of aging of grievances pending and unresolved for 30 calendar days or more
- Documentary evidence of DHCS approval of Plan's grievance and appeals processes
- Policy and procedure to report to CMS, DMHC, and DHCS all grievances
- Policies and procedures for the processing of grievances, including processes, timeframes, criteria, staffing, etc.
- Policies and procedures for the processing of appeals, including timeframes and information necessary for each appeal resolution notification
- Policies and procedures for receiving and resolving expedited grievances
- Policies and procedures for receiving and resolving expedited appeals
- Committee Minutes (Governing Body, QA, Public Policy, Grievance Committee, etc.), including grievance reports reviewed
- Reports and analysis on the timeliness of processing and responding to grievances and appeals including expedited grievances and appeals
- Sample notification letters for appeals and grievances resolutions

MR-001 - Key Element 1:

- 1. The Plan has a plan-level (internal) complaint and grievance system for the receipt, review, and resolution of Cal MediConnect Enrollee grievances for Medicaid-based services that complies with the requirements of the contract between the Plan, CMS and DHCS (“three-way contract”) and applicable law.**

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Assessment Questions	Yes	No	N/A
<p>1.1 Does the Plan inform Cal MediConnect Enrollees that they may file a grievance through either the Plan, DMHC or Cal MediConnect Ombuds Program for complaints related to Medicaid-based services?</p> <p>(§2.14)</p>			
<p>1.2 Does the Plan inform Enrollees and providers of plan-level grievance procedures for Medicaid-based services?</p> <p>(§2.17.5.1.4)</p>			
<p>1.3 Are plan-level grievance forms and procedures available at the offices of providers contracted by the Plan to provide Medicaid-based services?</p> <p>(CCR 28 section 1300.68(b)(7))</p>			
<p>1.4 Does the Plan inform Cal MediConnect Enrollees of the email address, postal address, and telephone number where a plan-level grievance regarding Medicaid-based services may be filed?</p> <p>(§2.14.1.)</p>			
<p>1.5 Do the Plan's policies and procedures allow authorized representatives to file plan-level grievances on behalf of Cal MediConnect Enrollees to the extent allowed under applicable federal or state law?</p> <p>(§2.14.1.)</p>			
<p>1.6 Does the Plan ensure that Cal MediConnect Enrollees may file a plan-level grievance at any time with the Plan by calling or writing to the Plan?</p> <p>(§2.14.2.)</p>			
<p>1.7 Does the Plan ensure that Cal MediConnect Enrollees may file an plan-level grievance at any time with any provider by calling or writing to the provider?</p> <p>(§2.14.2.)</p>			
<p>1.8 Does the Plan have a DHCS-approved process for the receipt of all Cal MediConnect Enrollees' grievances regarding any covered service or benefit?</p> <p>(§2.14.2.1.1)</p>			

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Assessment Questions	Yes	No	N/A
<p>1.9 Does the Plan have a system in place to address Cal MediConnect Enrollees' plan-level grievances regarding Medicaid- based services, including plan-level grievances regarding reasonable accommodations and access to services under ADA?</p> <p>(§2.14.2.)</p>			
<p>1.10 Does the Plan consistently acknowledge Cal MediConnect plan-level grievances regarding Medicaid based services in writing within five (5) calendar days of receipt (except as noted in 28 CCR 1300.68(d)(8))?</p> <p>(28 CCR section 1300.68(g)(6))</p>			
<p>1.11 Does the Plan's grievance system provide for prompt review of grievances by the appropriate level of management/supervisory staff and/or clinical staff responsible for the service and/or quality of care which is the subject of the grievance?</p> <p>(28 CCR section 1300.68(d)(2))</p>			
<p>1.12 Does the Plan grievance system respond electronically, orally, or in writing to each plan-level Cal MediConnect Enrollee grievance regarding Medicaid based services within a reasonable time, but no later than 30 days after the Plan receives the grievance?</p> <p>(§2.14.2.1.2.3.)</p>			
<p>1.13 Does the Plan respond orally or in writing to each plan-level Cal MediConnect Enrollee expedited grievance regarding Medicaid based services within twenty-four (24) hours of the receipt of the grievance?</p> <p>(§2.14.2.1.2.4.)</p>			
<p>1.14 Does the Plan's grievance system's policies and procedures indicate that information on Enrollee's appeal rights is made available to Cal MediConnect Enrollees during the grievance process?</p> <p>(§2.14.2.1.1.)</p>			

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Assessment Questions	Yes	No	N/A
<p>1.15 Does the Plan ensure that those who make decisions about plan-level Cal MediConnect Enrollee grievances were not involved in previous levels of review or decision-making on the issues complained about in the plan-level grievance in the following instances?</p> <p style="margin-left: 40px;">a) A grievance regarding denial of expedited resolutions of an appeal, or;</p> <p style="margin-left: 40px;">b) Any grievance or appeal involving clinical issues?</p> <p>(§2.14.2.1.2.6.)</p>			
<p>1.16 Does the Plan maintain procedures to ensure that those who make decisions about Cal MediConnect plan-level grievances regarding denial of an appeal regarding clinical issues are health care professionals with clinical expertise in treating Enrollee’s condition or disease? (Denial of Medicaid-based services only)</p> <p>(§2.14.2.1.2.6)</p>			
<p>1.17 Does the Plan regularly submit grievance reports to CMS, DMHC and DHCS?</p> <p>(§2.14.2.1.; §28 CCR section 1300.68(f)(1))</p>			
<p>1.18 Does the Plan’s plan-level grievance system provide the mechanisms and staff to respond to DMHC contacts regarding urgent grievances 24 hours per day, 7 days per week, pursuant to 1300.68.01?</p> <p>(§28 CCR section 1300.68.01(b))</p>			

MR-001 - Key Element 2:

2. The Plan has a plan-level (internal) system for the receipt, review, and resolution of Cal MediConnect Enrollee appeals regarding Medicaid-based services that complies with the requirements of the three-way contract and applicable law.

Assessment Questions	Yes	No	N/A
<p>2.1 Do the Plan’s policies and procedures ensure that Medicaid Appeals and beneficiary protections are maintained for plan-level Appeals regarding Medicaid-based services?</p> <p>(§2.15.3.)</p>			

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Assessment Questions	Yes	No	N/A
<p>2.2 Does the Plan ensure that Cal MediConnect Enrollees may file a plan-level appeal regarding Medicaid-based services either orally or in writing?</p> <p>(§2.15.3.1.)</p>			
<p>2.3 Does the Plan ensure that Cal MediConnect providers may file a plan-level appeal regarding Medicaid-based services on behalf of an Enrollee either orally or in writing?</p> <p>(§2.15.3.1.)</p>			
<p>2.4 Does the Plan ensure that oral inquiries seeking a plan-level appeal of an action regarding Medicaid-base services are treated as appeals and confirms those inquiries in writing unless the Enrollee or provider requests expedited resolution?</p> <p>(§2.15.3.2.1.)</p>			
<p>2.5 Does the Plan provide a reasonable opportunity for Cal MediConnect Enrollees to present evidence of fact or law, in person or in writing, regarding a plan-level appeal?</p> <p>(§2.15.3.2.2.)</p>			
<p>2.6 Does the Plan allow a Cal MediConnect Enrollee and/or their representative the opportunity to examine the case file (including medical records and any other documents) before and during the plan-level appeals process?</p> <p>(§2.15.3.2.3.)</p>			
<p>2.7 Does the Plan’s policies and procedures ensure that MediConnect Enrollees and/or their representative, or estate representatives (of a deceased Enrollee) who have an appeal regarding Medicaid-based services are considered parties to any plan-level appeal?</p> <p>(§2.15.3.2.4.)</p>			
<p>2.8 Does the Plan continue to provide benefits for all prior approved Medicaid-based services for which there is a pending plan-level appeal for denied or modified services until completion of all external and internal appeals or per timeframes in 42 C.F.R § 438.420, whichever comes first?</p> <p>(§2.15.5.2.1.)</p>			

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Assessment Questions	Yes	No	N/A
<p>2.9 Does the Plan have policies and procedures in place to address MediConnect Enrollee plan-level appeals regarding Medicaid-based services?</p> <p>(§2.15.3.3.)</p>			
<p>2.10 Does the Plan's policies and procedures regarding plan-level appeals of issues related to Medicaid-based services comply with federal Medicaid regulations governing Medi-Cal Managed Care appeals?</p> <p>(§2.15.3.3.1.)</p>			
<p>2.11 Does the Plan's policies and procedures ensure that decision-makers on Cal MediConnect plan-level appeals were not involved in previous levels of review or decision-making on the issues complained of in the plan-level appeal?</p> <p>(§2.15.3.2.5.)</p>			

MR-001 - Key Element 3:

3. The Plan has a system for the receipt, review, and resolution of Cal MediConnect Enrollee expedited plan-level appeals related to Medicaid-based services.

Assessment Questions	Yes	No	N/A
<p>3.1 Does the Plan have policies and procedures for Cal MediConnect Enrollee plan-level expedited appeals for Medicaid-based services?</p> <p>(§2.15.3.4.1.)</p>			
<p>3.2 Does the Plan follow expedited plan-level appeal procedures whenever the Plan or the provider indicates that the standard resolution time could seriously jeopardize the Enrollee's life, health, or ability to attain, maintain, or regain maximum function?</p> <p>(§2.15.3.4.1.)</p>			
<p>3.3 Does the Plan allow Enrollees or provider to file an expedited appeal in writing or orally without requiring additional Enrollee follow-up?</p> <p>(§2.15.3.4.2.)</p>			
<p>3.4 Does the Plan inform the Enrollees filing an expedited plan-level appeal of the limited time available to present evidence and allegations of fact or law in person or in writing?</p> <p>(§2.15.3.4.3.)</p>			

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Assessment Questions	Yes	No	N/A
<p>3.5 Does the Plan notify the Enrollee filing an expedited plan-level appeal of the determination within three 3 working days or as quickly as the Enrollees' health condition requires (whichever is shorter)?</p> <p>(§2.15.3.4.4.)</p>			
<p>3.6 Does the Plan extend the time to resolve the expedited plan-level appeal (but no more than 14 days) upon request of the Cal MediConnect Enrollee, or if there is need of additional information and the delay is in the Enrollee's interest?</p> <p>(§2.15.3.4.4.)</p>			
<p>3.7 Do the Plan's policies and procedures require the Plan to make a reasonable effort to provide oral notice of the expedited plan-level appeal determination to Enrollees?</p> <p>(§2.15.3.4.6.)</p>			
<p>3.8 Do the Plan's policies and procedures ensure that no punitive action is taken against any provider who requests an expedited appeal or supports an Enrollee's appeal?</p> <p>(§2.15.3.4.7.)</p>			
<p>3.9 If the Plan denies the request for an expedited resolution of a plan-level appeal, does the Plan:</p> <ul style="list-style-type: none"> a) Transfer the appeal to the standard appeal process? b) Give the Cal MediConnect Enrollee prompt oral notice of the denial of the request for expedited resolution? c) Provide a written notice within two (2) calendar days? <p>(§2.15.3.4.8.)</p>			
<p>3.10 Does the Plan's plan-level appeals system provide the mechanisms and staff to respond to DMHC contacts regarding urgent appeals 24 hours per day, 7 days per week, pursuant to 1300.68.01?</p> <p>(§28 CCR 1300.68.01 (b))</p>			

End of Requirement MR-001: The Health Plan complies with requirements established for the internal, i.e. plan-level, grievance and appeals process for Medicaid-based services under Cal MediConnect requirements.

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Requirement MR-002: The Health Plan complies with requirements established for Enrollee and Plan participation in external grievance and appeals processes (State-level grievance and appeals) for Medicaid-based services under Cal MediConnect requirements.

STATUTORY/REGULATORY CITATIONS

2.12.1.13.7. The procedures available to an Enrollee and Network Provider(s) to challenge or Appeal the failure of the Contractor to provide a Covered Service and to Appeal any adverse actions (denials);

2.12.3. Coverage Determinations and Appeals Call Center Requirements

2.12.3.1. The Contractor must operate a toll-free call center with live ESRs available to respond to Network Providers or Enrollees for information related to requests for coverage under Medicare or Medi-Cal, and Medicare and Medi-Cal appeals (including requests for Medicare exceptions and prior authorizations). The Contractor is required to provide immediate access to requests for Medicare and Medi-Cal covered benefits and services, including Medicare coverage determinations and redeterminations, via its toll-free call centers. The call centers must operate during normal business hours and never less than from 8:00 a.m. to 6:00 p.m. (PST), Monday through Friday. The Contractor must accept requests for Medicare or Medi-Cal coverage, including Medicare coverage determinations /redeterminations, outside of normal business hours, but is not required to have live Enrollee service representatives available to accept such requests outside normal business hours. Voicemail may be used outside of normal business hours provided the message:

2.12.3.1.1. Indicates that the mailbox is secure;

2.12.3.1.2. Lists the information that must be provided so the case can be worked (e.g., provider identification, beneficiary identification, type of request (coverage determination or Appeal), physician support for an exception request, and whether the Enrollee is making an expedited or standard request);

2.12.3.1.3. For coverage determination calls (including exceptions requests), articulates and follows a process for resolution within twenty-four (24)

hours of call for expedited requests and seventy-two (72) hours for standard requests; and

2.12.3.1.4. For Appeals calls, information articulates the process information needed and provide for a resolution within seventy-two (72) hours for expedited Appeal requests and seven (7) calendar days for standard Appeal requests.

2.13. IHSS Related Complaints, Grievances and Appeals

2.13.1. For Enrollee complaints, grievances, or appeals related to IHSS, Contractor must comply with the established grievance and appeal process established by CDSS and by the county agencies responsible for IHSS, in compliance with WIC 14186.35(e).

2.14.3. External Grievance: The Contractor shall inform Enrollees that they may file an external grievance for Medicare only covered benefits and services through 1-800 Medicare or for Medicare and Medi-Cal covered benefits and services through the Cal MediConnect Ombuds program. The Contractor must display a link to the electronic grievance form on the Medicare.gov Internet Web site on the Contractor's main web page. 42 C.F.R. §

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422.504(a)(15)(ii). The Contractor must inform Enrollees of the email address, postal address or toll-free telephone number where an Enrollee grievance may be filed.

2.14.3.1 Pursuant to Health & Safety Code Section 1368(b), Contractor shall inform Enrollees that they may file an external grievance for Medi-Cal only covered benefits and services (not including IHSS) through the DMHC's consumer complaint process. Contractor shall inform Enrollees of the DMHC's toll-free telephone number, the DMHC's TDD line for the hearing and speech impaired, and the DMHC's website address pursuant to Health & Safety Code Section 1368.02.

2.15. Enrollee Appeals

2.15.1. Integrated Notice of Action— In accordance with 42 C.F.R. § 438.404 and 42 C.F.R. §§ 422.568-572, the Contractor must give the Enrollee written notice of any adverse action. Enrollees will be notified of all applicable Cal MediConnect, Medicare and Medi-Cal Appeal rights through a single notice. The form and content of the notice must be prior approved by CMS and DHCS. The Contractor shall notify the Enrollee of its decision at least ten (10) days in advance of the date of its action.

2.15.1.1. The notice must explain:

2.15.1.1.1. The action the Contractor has taken or intends to take;

2.15.1.1.2. The reasons for the action;

2.15.1.1.3. The citation to the regulations supporting such action

2.15.1.1.4. The Enrollee's or the provider's right to file an Appeal;

2.15.1.1.5. Procedures for exercising Enrollee's rights to Appeal;

2.15.1.1.6. Circumstances under which expedited resolution is available and how to request it; and

2.15.1.1.7. If applicable, the Enrollee's rights to have benefits continue pending the resolution of the plan level Appeal.

2.15.1.2. Contractor must provide a member notice of resolution, as expeditiously as the Enrollee's health condition requires, within thirty (30) days from the day Contractor receives the appeal. An Enrollee notice, at a minimum, must include the result and date of the appeal resolution. For decisions not wholly in the Enrollee's favor, Contractor, at a minimum must include:

2.15.1.2.1. Enrollee's right to request a State Fair Hearing;

2.15.1.2.2. How to request a State Fair Hearing;

2.15.1.2.3. Right to continue to receive benefits pending a State Fair Hearing; and

2.15.1.2.4. How to request the continuation of benefits.

2.15.1.2.5. Enrollee's right to file an external grievance through the DMHC's consumer complaint process or request an Independent Medical Review from the DMHC with respect to any and all disputes concerning Medi-Cal based services that are medical in nature and that relate to health care service plan obligations set forth under the Knox-Keene Act and the regulations promulgated thereunder.

2.15.1.2.6 How to file an external grievance through the DMHC's consumer complaint process or request an Independent Medical Review from the DMHC.

2.15.1.3. Written material must use easily understood language and format, be available in alternative formats, and in an appropriate manner that takes into consideration those with

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special needs. The Contractor must inform Enrollees that information is available in alternative formats and how to access those formats.

2.15.2. Appeals relating to Medi-Cal covered benefits and services shall proceed pursuant to the laws and regulations governing Medi-Cal Appeals. Appeals relating to Medicare covered benefits and services shall proceed pursuant to the laws and regulations governing Medicare Appeals.

2.15.2.1. Written notice must be translated for Enrollees who speak Threshold Languages.

2.15.2.2. Written notices must include language clarifying that oral interpretation is available for all languages and how to access it.

2.15.3. Medi-Cal Appeals and beneficiary protections will be maintained for Appeals regarding Medi-Cal services.

2.15.3.1. Enrollee or provider may file an Appeal either orally or in writing and must follow an oral filing with a written, signed appeal.

2.15.3.2. Contractor must:

2.15.3.2.1. Ensure that oral inquiries seeking to Appeal an action are treated as Appeals and confirm those inquiries in writing unless the Enrollee or provider requests expedited resolution.

2.15.3.2.2. Provide a reasonable opportunity to present evidence and allegation of fact or law, in person, as well as in writing.

2.15.3.2.3. Allow the Enrollee and representative opportunity, before and during the Appeal process to examine the Enrollee's case file, including medical records, and any other documents and records.

2.15.3.2.4. Consider the Enrollee, representative, or estate representative of a deceased Enrollee as parties to the Appeal.

2.15.3.2.5. Ensure that decision makers on Appeals were not involved in previous levels of review or decision-making and are health care professionals with clinical expertise in treating the Enrollee's condition or disease if any of the following apply:

2.15.3.2.5.1. A denial of an Appeal based on lack of medical necessity;

2.15.3.2.5.2. A grievance regarding denial of expedited resolution of an Appeal; or

2.15.3.2.5.3. Any Appeal involving clinical issues.

2.15.3.3.3. Internal Contractor Appeal processes, in accordance with the Knox-Keen Act and the regulations promulgated thereunder, as applicable, and external Appeal processes in accordance with the DMHC's Independent Medical Review System set forth in Article 5.55 of the Knox-Keene Act (commencing with Health & Safety Code Section 1374.30) and the regulations promulgated thereunder, and the fair hearing standards for Medi-Cal managed care, Title 22, CCR, Sections §51014.1, §51014.2, §53894, and §53858;

2.15.3.3.4. Twelve (12) month continuity of care under certain circumstances. WIC §14182.17 (d)(7)(A)(ii).

2.15.3.5. Responsibilities in State Fair Hearings Related to Medi-Cal Benefits and Services. Contractor shall comply with all regulations and procedures regarding State Fair Hearings, set forth in the Manual of Policies and Procedures issued by the California Department of Social Services, pursuant to Title 22, CCR, Section 50953. Contractor shall have the

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following responsibilities with respect to State Fair Hearings that are expedited, in compliance with CDSS All County Letter 13-40.

2.15.3.6. Parties to an internal Medi-Cal Appeal or State Fair Hearing.

2.15.3.6.1. The parties to an internal plan Appeal or the State Fair Hearing related to a Medi-Cal benefit or service include the Contractor as well as the Enrollee and his or her representative or the representative of a deceased Enrollee's estate.

2.15.3.7. Responsibilities in Independent Medical Reviews (IMR) Related to Medi-Cal Benefits and Services. Contractor shall comply with all statutes, regulations and procedures regarding the DMHC's Independent Medical Review System, as set forth in the Knox-Keene Act and the regulations promulgated thereunder, including but not limited to the following requirements:

2.15.3.7.1 Enrollees may request an IMR regarding Medi-Cal services from the DMHC within six (6) months of a denial, modification or delay of a Medi-Cal service based on Contractor's determination in whole or in part that the service is not medically necessary. Health & Safety Code Section 1374.30.

2.15.3.7.2. Enrollees shall not be required to participate in Contractor's Internal Appeal process for more than thirty (30) days before applying for an IMR. Health & Safety Code Section 1368(b)(1)(A).

2.15.3.7.3. Enrollees whose Appeal requires expedited review pursuant to Health & Safety Code Section 1368.01 shall not be required to participate in the Contractor's Internal Appeal process for more than three (3) days before applying for an IMR. Health & Safety Code Section 1374.31(a)

2.15.3.7.4. Enrollees may apply for an IMR without first participating in Contractor's Internal Appeal process in extraordinary and compelling cases, as determined by DMHC, and in cases where Enrollee's request for an experimental treatment was denied. Health & Safety Code Section 1368.03 and 1374.31(a)

2.15.3.7.5. Contractor must notify Enrollee in writing of the opportunity to request an IMR of a decision denying an experimental therapy within five (5) business days of the decision to deny coverage. Health & Safety Code Section 1300.70.4(b)(2)

2.15.3.7.6. Enrollees may not request an IMR if a State Fair Hearing has already been held on the issue. Title 28, CCR Section 1300.74.30(f)(3)

2.15.3.7.7. If the DMHC determines that Enrollee is not eligible for an IMR, the Enrollee's case will be reviewed through DMHC's consumer complaint process. Health & Safety Code Section 1368(b)

2.15.5. Continuation of Benefits Pending an Appeal

2.15.5.2. Medi-Cal Benefits and Services

2.15.5.2.1. The Contractor must continue providing all prior approved Medi-Cal benefits for which a Contractor has issued a NOA for termination or modification pending completion of the internal Contractor Appeal or per timeframes in 42 C.F.R. § 438.420, whichever comes first. This means that such benefits will continue to be provided to Enrollees and that the Contractor must continue to pay providers for providing such services or benefits pending a plan level Appeal or per timeframes in 42 C.F.R. § 438.420, whichever comes first.

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42 C.F.R. § 438.420

Continuation of benefits while the MCO or PIHP appeal and the State fair hearing are pending.

- (a) Terminology. As used in this section, “timely” filing means filing on or before the later of the following:
- (1) Within ten days of the MCO or PIHP mailing the notice of action.
 - (2) The intended effective date of the MCO's or PIHP's proposed action.
- (b) Continuation of benefits. The MCO or PIHP must continue the Enrollee's benefits if—
- (1) The Enrollee or the provider files the appeal timely;
 - (2) The appeal involves the termination, suspension, or reduction of a previously authorized course of treatment;
 - (3) The services were ordered by an authorized provider;
 - (4) The original period covered by the original authorization has not expired; and
 - (5) The Enrollee requests extension of benefits.
- (c) Duration of continued or reinstated benefits. If, at the Enrollee's request, the MCO or PIHP continues or reinstates the Enrollee's benefits while the appeal is pending, the benefits must be continued until one of following occurs:
- (1) The Enrollee withdraws the appeal.
 - (2) Ten days pass after the MCO or PIHP mails the notice, providing the resolution of the appeal against the Enrollee, unless the Enrollee, within the 10-day timeframe, has requested a State fair hearing with continuation of benefits until a State fair hearing decision is reached.
 - (3) A State fair hearing Office issues a hearing decision adverse to the Enrollee.
 - (4) The time period or service limits of a previously authorized service has been met.
- (d) Enrollee responsibility for services furnished while the appeal is pending. If the final resolution of the appeal is adverse to the Enrollee, that is, upholds the MCO's or PIHP's action, the MCO or PIHP may recover the cost of the services furnished to the Enrollee while the appeal is pending, to the extent that they were furnished solely because of the requirements of this section, and in accordance with the policy set forth in § 431.230(b) of this chapter.

Welfare and Institutions Code 14186.35(e)(3)

(e) In accordance with Section 14186.2, as the provision of IHSS transitions to managed care health plans in a phased-in approach, the State Department of Social Services shall do all of the following:

- (3) Retain responsibilities related to the hearing process for IHSS recipient appeals as set forth in Chapter 7 (commencing with Section 10950) of Part 2.

DHCS All Plan Letter 15-002

This All Plan letter provides guidance for Medicaid Plans regarding the grievance and appeals process for clients of the Multipurpose Senior Services Program.

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INDIVIDUAL(S)/POSITION(S) TO BE INTERVIEWED

Staff responsible for the activities described above, for example:

- Individual designated as compliance officer of the Cal MediConnect Program
- Medical or Clinical Director
- Officer or manager with primary responsibility for the grievance system
- Officer or manager with primary responsibility for the appeals system
- Manager of Member Services
- Manager of Call Centers
- QM Director
- Individual designated as Cal MediConnect QI Director, such as Quality Management or Quality Improvement Director
- Director of Operations

DOCUMENT(S) TO BE REVIEWED

- Description of the grievance system, including how the Plan defines a grievance (appeal, complaint, inquiry, concern, grievance, etc.)
- Position description of the officer with primary responsibility for the grievance system
- Grievance logs, including grievance logs from any subcontracting entity delegated the responsibility to maintain and resolve grievances
- Grievance forms
- Evidence that the Plan provides contact information for the Cal MediConnect Ombuds program to Enrollees
- Policies and procedures to maintain a system of aging of grievances pending and unresolved for 30 calendar days or more
- Policy and procedure to report quarterly to the DMHC and DHCS all grievances pending and unresolved for 30 calendar days or more.
- Policies and procedures for the processing of grievances, including processes, timeframes, criteria, staffing, etc.
- Policies and procedures for receiving and resolving urgent grievances
- Committee Minutes (Governing Body, QA, Public Policy, Grievance Committee, etc.), including grievance reports reviewed
- Reports and analysis by Plan's grievance officer regarding emergent patterns of grievances for most recent 6-12 month period.

MR-002 - Key Element 1:

- 1. The Plan informs Enrollees of their external grievance and appeals rights for issues related to Medicaid-based services, i.e. the grievance and appeals processes available from State of California agencies and the Cal MediConnect Ombuds program.**

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Assessment Questions	Yes	No	N/A
<p>1.1 Does the Plan have policies and procedures regarding the communication of external grievance procedures to Enrollees?</p> <p>(§2.14.3.)</p>			
<p>1.2 Does the Plan’s written acknowledgment of a plan-level grievance display the DMHC’s telephone number, TDD line, and Internet address in 12-point boldface type with the required statement about Independent Medical Reviews as contained in Section 1368.02(b)?</p> <p>(§1368.02(b))</p>			
<p>1.3 Does the Plan ensure that Enrollees are informed of their right to file an external grievance with the Cal MediConnect Ombuds Service Provider?</p> <p>(§2.14.1.)</p>			
<p>1.4 Does the Plan ensure that Enrollees receive information about the email address, postal address or toll-free telephone number of their local Ombuds Service Provider?</p> <p>(§2.14.1.)</p>			
<p>1.5 Do the Plan’s policies and procedures ensure that Enrollees are informed that the State Department of Social Service retains responsibilities related to the hearing process for IHSS recipient appeals?</p> <p>(§2.13.1.)</p>			
<p>1.6 Does the Plan inform Enrollees that MSSP providers retain responsibility for complaints, grievances, and appeals of their participants who are also Plan Enrollees?</p> <p>(§DHCS All Plan Letter 15-002)</p>			
<p>1.7 Do the Plan’s policies and procedures require Enrollee Service Representatives to inform Cal MediConnect Enrollees of the process for filing internal appeals and external appeals, i.e. State Fair Hearings, in order to appeal the Plan’s failure to provide Medicaid-based services or to appeal an adverse action?</p> <p>(§2.12.1.6; §2.12.1.13.7.)</p>			

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Assessment Questions	Yes	No	N/A
<p>1.8 Do the Plan’s policies and procedures require Enrollee service representatives to inform Cal MediConnect Enrollees of the timeframes for filing an internal and external grievance and internal and external appeals for issues related to Medicaid-based services?</p> <p>(§2.12.3.1.4.)</p>			
<p>1.9 Does the Plan require Enrollee service representatives to be trained to provide reasonable assistance with completion of forms and procedures for internal and external grievances and appeals for Cal MediConnect Enrollees?</p> <p>(§2.14.2.1.2.5.)</p>			
<p>1.10 Does the Plan require Enrollee Service Representatives to make reasonable accommodations when providing assistance to Cal MediConnect Enrollees by providing written materials in simple, clear language, a means for Enrollees to identify a disability and individualized guidance to ensure that materials are understood?</p> <p>(§2.14.2.)</p>			

MR-002 - Key Element 2:

2. The Health Plan gives the Enrollee written notice of any adverse action related to the provision of Medicaid-based services

Assessment Questions	Yes	No	N/A
<p>2.1 Does the Plan have written policies and procedures regarding the communication of adverse actions related to the provision of Medicaid-based services?</p> <p>(§2.15.1.)</p>			
<p>2.2 Does the Plan provide Enrollees with a written notice of any adverse action (“Notice of Action”) related to the provision of Medicaid-based services?</p> <p>(§2.15.1.)</p>			
<p>2.3 Was the content of the Notice of Action form approved by CMS and DHCS prior to use?</p> <p>(§2.15.1.)</p>			

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Assessment Questions	Yes	No	N/A
<p>2.4 Do the Plan’s policies and procedures ensure that all Notices of Action inform Enrollees of all applicable Cal MediConnect, Medicare and Medi-Cal Appeal rights?</p> <p>(§2.15.1.)</p>			
<p>2.5 Does the Plan ensure that Notices of Action include:</p> <ul style="list-style-type: none"> a) The action the Plan has taken or intends to take? b) A clear and concise explanation of the reasons for the adverse action? c) The regulatory citation supporting the action? d) The Enrollee’s or their provider’s right to file a plan-level appeal or a state fair hearing at the same time e) Procedures for exercising the Enrollee’s rights to appeal f) That a member may represent themselves or be represented by an authorized third party in the state fair hearing g) The time limits for requesting a state fair hearing h) Circumstances under which expedited resolution is available and how to request it? i) The Enrollee’s rights to have benefits continue pending the resolution of the plan level appeal, how to request that benefits may be continued and the circumstances under which the Enrollee may be required to pay the cost of these benefits? <p>(§2.15.1.1.)</p>			
<p>2.6 Do the Plan’s Notices of Action include a description of the clinical criteria or guidelines used when services that are medical in nature are denied, delayed, or modified?</p> <p>(§1300.68(d)(4))</p>			
<p>2.7 Does the Plan ensure that Enrollees are provided a notice of resolution of a plan-level appeal within 30 calendar days of receiving the appeal or as the Enrollee’s health condition requires (whichever is shorter)?</p> <p>(§2.15.1.2.)</p>			
<p>2.8 Does the Plan ensure that if the decision resolving a plan-level appeal is not wholly in favor of the Cal MediConnect Enrollee, that the notice of resolution includes Enrollee rights to request a State fair hearing and how to request a State fair hearing?</p> <p>(§2.15.1.2.1; §2.15.1.2.2.)</p>			

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Assessment Questions	Yes	No	N/A
<p>2.9 Does the Plan ensure that if the decision resolving a plan-level appeal is not wholly in favor of the Cal MediConnect Enrollee, that the notification includes Enrollee rights to continue to receive benefits pending a State fair hearing and how to request the continuation of benefits?</p> <p>(§2.15.1.2.3.)</p>			
<p>2.10 Does the Plan ensure that if the decision resolving a plan-level appeal of Medicaid-based services (which are medical in nature) is not wholly in favor of the Cal MediConnect Enrollee, that the notification includes Enrollee rights to file an external grievance or Independent Medical Review through the DMHC IMR?</p> <p>(§2.15.1.2.5.)</p>			
<p>2.11 Does the Plan ensure that Notices of Action and notices of resolution:</p> <ul style="list-style-type: none"> a) Use an easily understood language and format? b) Are available in alternative languages and formats? c) Are written in an appropriate manner that takes into consideration those with special needs? <p>(§2.15.1.3.)</p>			
<p>2.12 Does the Plan ensure that Notices of Action and notices of resolution inform Enrollees in threshold languages about how to request translation services and alternate formats?</p> <p>(§2.15.1.3.)</p>			
<p>2.13 Does the Plan ensure that Notices of Action and notices of resolution inform Enrollees that information is available in alternative formats and how to access those formats?</p> <p>(§2.15.1.3.)</p>			

MR-002 - Key Element 3:

3. The Plan ensures that Medicaid appeals and beneficiary protections will be maintained for external appeals regarding Medicaid services.

Assessment Questions	Yes	No	N/A
<p>3.1 Do the Plan's policies and procedures ensure that Medicaid Appeals and beneficiary protections are maintained for external appeals regarding Medicaid-based services?</p> <p>(§2.15.3.)</p>			

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Assessment Questions	Yes	No	N/A
<p>3.2 Does the Plan ensure that the Enrollee and/ or their representative is given an opportunity, before and during the external appeal process to examine the Enrollee’s case file (including medical records), and any other documents or records to be used at the hearing?</p> <p>(§2.15.3.1.)</p>			
<p>3.3 Does the Plan ensure that Cal MediConnect Enrollees are given an opportunity to request an Independent Medical Review (IMR) from the DMHC for appeals related to Medicaid-based services that are medical in nature, provided that the Enrollee has not completed a State Fair Hearing?</p> <p>(§2.15.3.7.5.)</p>			
<p>3.4 Does the Plan inform Enrollees that they may request an IMR for Medicaid-based services that are medical in nature from the DMHC within six months of a denial, modification or delay of the service based on the Plan’s determination that the service is not medically necessary?</p> <p>(§2.15.3.7.1.)</p>			
<p>3.5 Does the Plan inform Enrollees that they may apply for an IMR without first participating in the Plan’s Internal Appeal process in extraordinary and compelling cases, or as determined by DMHC?</p> <p>(§2.15.3.7.4.)</p>			
<p>3.6 Does the Plan inform Enrollees that they are not required to participate in Contractor’s Internal Appeal process for more than thirty days (three days for appeals which require expedited review) before applying for an IMR?</p> <p>(§2.15.3.7.2.)</p>			
<p>3.7 Does the Plan’s policies and procedures ensure that Enrollees continue receiving all prior approved Medi-Cal benefits for which the Plan has issued a Notice of Action for termination or modification pending completion of the Appeal or per timeframes in 42 C.F.R. § 438.420, whichever comes first?</p> <p>(§2.15.5.2.1.)</p>			
<p>3.8 Does the Plan keep a record of all complaints, grievances, and appeals using an internal tracking system?</p> <p>(§28 CCR 1300.68(e))</p>			

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Assessment Questions	Yes	No	N/A
3.9 Does the Plan keep records of both referrals and resolutions of all MSSP beneficiary complaints, grievances, and appeals that are received internally and from MSSP sites? (§DHCS All Plan Letter 15-002)			

End of Requirement MR-002: The Health Plan complies with requirements established for Enrollee and Plan participation in external grievance and appeals processes (State-level grievance and appeals) for Medicaid-based services under Cal MediConnect requirements.

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Requirement MR-003: The Health Plan meets its Cal MediConnect obligations concerning the availability of interpreter services and beneficiary materials in the languages required under Cal MediConnect.

Cal MediConnect Prime Contract

1. Definition of Terms

1.8.9. Threshold Languages — As specified in annual guidance to Contractors on specific translation requirements for their service areas.

2.8 Health Risk Assessments, ICP, and Care Coordination

2.8.4.1.8. The DHCS will distribute an enrollment choice packet that will provide descriptions of continuity of care rights, developed in all Threshold Languages, and distributed to Enrollees in their enrollment choice packet, distributed sixty (60) days before they are enrolled in a Cal MediConnect Plan.

2.8.4.1.8.1. Contractors in COHS will distribute an enrollment package that will provide descriptions of continuity of care rights, developed in all Threshold Languages, and distributed to Enrollees in their enrollment packet, distributed sixty (60) days before they are enrolled in a Cal MediConnect Plan.

2.9 Provider Network

2.9.7. The Provider Network shall be responsive to the linguistic, cultural, and other unique needs of any minority, person who is homeless, Enrollees with disabilities, or other special population served by the Contractor, including the capacity to communicate with Enrollees in languages other than English, when necessary, as well as those who are deaf, hard-of-hearing or deaf and blind.

2.9.7.1. Contractor shall have a cultural and linguistic services program that incorporates the requirements of Title 22 CCR Section 53876 regardless of whether it operates in a Two-Plan County. Contractor shall monitor, evaluate, and take effective action to address any needed improvement in the delivery of culturally and linguistically appropriate services. Contractor shall review and update its cultural and linguistic services consistent with the group needs assessment requirements as specified by DHCS.

2.9.7.2. Contractor shall implement and maintain a written description of its cultural and linguistic services program, which shall include at minimum the following:

2.9.7.2.1. An organizational commitment to deliver culturally and linguistically appropriate health care services;

2.9.7.2.2. Goals and objectives;

2.9.7.2.3. A timetable for implementation and accomplishment of the goals and objectives;

2.9.7.2.4. An organizational chart showing the key staff persons with overall responsibility for cultural and linguistic services and activities. A narrative shall explain the chart and describe the oversight and direction to the community advisory committee, provisions for support staff, and reporting relationships. Qualifications of staff, including appropriate education, experience and training shall also be described; and

2.9.7.2.5. Standards and performance requirements for the delivery of culturally and linguistically appropriate health care services.

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2.9.7.3. Linguistic Capability of Employees: Contractor shall assess, identify and track the linguistic capability of interpreters or bilingual employees and contracted staff (clinical and non- clinical).

2.9.7.4. The Contractor shall educate Network Providers through a variety of means including, but not limited to, provider alerts or similar written issuances, about their legal obligations under state and federal law to communicate with Enrollees with limited English proficiency, including the provision of interpreter services, and the resources available to help providers comply with those obligations.

2.9.7.5. The Contractor shall ensure that multilingual Network Providers and, to the extent that such capacity exists within the Contractor's Service Area, all Network Providers, understand and comply with their obligations under state or federal law to assist Enrollees with skilled medical interpreters and the resources that are available to assist Network Providers to meet these obligations.

2.9.7.6. The Contractor shall ensure that Network Providers have interpreters/translators that are available for those who are deaf or hearing-impaired within the Contractor's Service Area.

2.9.7.7. The Contractor shall ensure that its Network Providers are responsive to the unique linguistic, cultural, ethnic, racial, religious, age, gender or other unique needs of Enrollees, including Enrollees who are homeless, disabled (both congenital and acquired disabilities) and other special populations served under the Contract.

2.9.10.4. Cultural Competency Training. Contractor shall provide cultural competency, sensitivity, or diversity training for staff, Network Providers and First Tier, Downstream and Related Entities with direct Enrollee interaction. The training shall cover information about the identified cultural groups in the Contractor's Service Areas, such as the groups' beliefs about illness and health; methods of interacting with providers and the health care structure; and, language and literacy needs.

2.11 Enrollee Access to Services

2.11.4.5. The Contractor must notify the requesting Network Provider, either orally or in writing, and give the Enrollee written notice of any decision by the Contractor to deny a service authorization request, or to authorize a service in an amount, duration, or scope that is less than requested. The notice must meet the requirements of 42 C.F.R. § 438.404 and Title 22 CCR § 53261, and must:

2.11.4.5.2. Be made available in Threshold Languages, upon request;

2.11.4.5.3. Include information, in Threshold Languages about how to request translation services and alternative formats. Alternative formats shall include materials which can be understood by persons with limited English proficiency.

2.12. Enrollee Services

2.12.1. Enrollee Service Representatives (ESRs). The Contractor must employ ESRs trained to answer Enrollee inquiries and concerns from Enrollees and potential Enrollees, consistent with the requirements of 42 C.F.R. §§ 422.111(h) and 423.128(d) as well as the following requirements:

2.12.1.3. Be capable of speaking directly with, or arranging for an interpreter to speak with, Enrollees in their primary language, including American Sign Language (ASL), or through an alternative language device or telephone translation service;

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2.12.1.4. Inform callers that interpreter services are free;

2.12.1.7. Make oral interpretation services available free-of-charge to Enrollees in all non-English languages spoken by Enrollees, including ASL;

2.12.1.13. Ensure that ESRs make available to Enrollees and potential Enrollees, upon request, information concerning the following:

2.12.1.13.3. How to access oral interpretation services and written materials in Threshold Languages and alternative formats;

2.12 Enrollee Service Telephone Responsiveness

2.12.2.2. The Contractor's ESR's must answer eighty percent (80%) of all Enrollee telephone calls within thirty (30) seconds or less. The Contractor must limit average hold time to two (2) minutes, with the average hold time defined as the time spent on hold by the caller following the interactive voice response (IVR) system, touch tone response system, or recorded greeting and before reaching a live person. The Contractor must limit the disconnect rate of all incoming calls to five percent (5%). The Contractor must have a process to measure the time from which the telephone is answered to the point at which an Enrollee reaches an ESR capable of responding to the Enrollee's question in a manner that is sensitive to the Enrollee's language and cultural needs.

Enrollee Appeals

2.15.2.1. Written notice must be translated for Enrollees who speak Threshold Languages.

2.15.2.2. Written notices must include language clarifying that oral interpretation is available for all languages and how to access it.

2.17 Marketing, Outreach, and Enrollee Communications Standards

2.17.2. The Contractor's Marketing, Outreach, and Enrollee Communications materials must be:

2.17.2.2. Provided in a manner, format and language that may be easily understood by persons with limited English proficiency, or for those with developmental disabilities or cognitive impairments; and

2.17.2.3. Translated into Threshold Languages for all required vital materials, as specified in the Medicare-Medicaid Marketing Guidelines and annual guidance to Contractors on specific translation requirements for their Service Areas; and

2.17.2.4. Mailed with a language card that indicates that the Enrollee can access free interpreter services to answer questions about the plan. This message shall be written in the languages required in the Medicare Marketing Guidelines and Medicare-Medicaid marketing guidance provisions on the multi-language insert (see Section 1.63).

2.17.2.5. Distributed to the Contractor's entire Service Area, as specified in Appendix I of this Contract.

2.17.3.1. (As Amended) Contractor shall ensure that Marketing, Outreach, and Enrollee Communications Materials involving Medi-Cal based services comply with the requirements of the Knox-Keene Act and the regulations promulgated thereunder, as applicable. Contractor shall submit to DMHC any Marketing, Outreach, and Enrollee Communications required to be reviewed by DMHC pursuant to the Knox-Keene Act.

2.17.5.11. Content of Provider/Pharmacy Network Directory. The Provider/Pharmacy Network directory must include, at a minimum, the following information for all providers/pharmacies in the Contractor's Provider/Pharmacy Network:

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2.17.5.11.4. The cultural and linguistic capabilities of Network Providers, including languages spoken by the Network Provider or by skilled medical interpreter at the Network Provider's site;

2.17.5.11.9. Languages other than English spoken by providers or by skilled medical interpreters at the provider's site, including ASL, and whether interpretation services are available;

Appendix B: Enrollee Rights

The Contractor must have written policies regarding the Enrollee rights specified in this appendix, as well as written policies specifying how information about these rights will be disseminated to Enrollees. Enrollees must be notified of these rights and protections at least annually, and in a manner that takes in to consideration cultural considerations, Functional Status and language needs. Enrollee rights include, but are not limited to, those rights and protections provided by 42 C.F.R. § 438.100, 42 C.F.R. §422 Subpart C, and the CFAM-MOU. Specifically, Enrollees must be guaranteed:

c. Be provided information on all program services and health care options, including available treatment options and alternatives, presented in a culturally appropriate manner, taking in to consideration Enrollee's condition and ability to understand. A participant who is unable to participate fully in treatment decisions has the right to designate a representative. This includes the right to have translation services available to make information appropriately accessible. Information must be available:

- i. Before enrollment.
- ii. At enrollment.
- iii. At the time a participant's needs necessitate the disclosure and delivery of such information in order to allow the participant to make an informed choice.

P. The right to receive their Medicare and Medi-Cal appeals rights in a format and language understandable and accessible to them.

MMCD Policy Letter 10-012

Provides guidance to Plans on conducting cultural and linguistic Group Needs Assessments

MMCD All Plan Letter 14-008 (Revised) – Provides revised standards for determining threshold languages in Medi-Cal managed care health plans.

Title 22 CCR Section 53876

53876. Cultural and Linguistic Requirements.

(a) Each plan in a designated region shall implement and adhere to the cultural and linguistic services requirements of the contract between the plan and the department. The contract at a minimum shall include requirements for:

- (1) Interpreters.
- (3) Translated written materials.
- (4) Referrals to culturally and linguistically appropriate community services programs.

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(b) In consultation with representatives from contracting plans and community-based diverse cultural and linguistic groups, the department shall develop, and update as appropriate, a set of comprehensive cultural and linguistic requirements which shall be incorporated into the contract between the department and each plan in a designated region.

(c) The plan shall establish and maintain a community advisory committee, and meet periodically with the committee concerning the development and implementation of its cultural and linguistic accessibility standards and procedures.

28 CCR Section 1300.67.04(c)(2)(F)-(H)

(c) Language Assistance Program Requirements.

Every plan shall develop and implement a language assistance program, which shall comply with the requirements and standards established by Section 1367.04 of the Act and this section. The language assistance program shall be documented in written policies and procedures, and shall address, at a minimum, the following four elements: standards for Enrollee assessment; standards for providing language assistance services; standards for staff training; and standards for compliance monitoring.

(2) Providing Language Assistance Services. Every plan shall develop language assistance program policies and procedures, which shall describe, at a minimum, the information outlined below.

(F) Processes and standards for providing translation services, including, but not limited to:

(i) A list of the threshold languages identified by the plan;

(ii) A list of the types of standardized and Enrollee-specific vital documents that must be translated and the applicable standards for making translated vital documents available to subscribers and Enrollees. Plans need not translate subscriber contracts, evidences of coverage and other large disclosure forms and Enrollee handbooks in their entirety, but may excerpt from large documents the disclosures specified at subsection (b)(7)(G) for translation in a format that permits cost-effective and timely production and distribution, so long as there is no loss of accuracy or meaning by doing so. A plan may demonstrate compliance regarding translation of the disclosures specified at subsection (b)(7)(G) if the plan provides a standardized matrix that lists the major categories of health care services covered under the plan's subscriber contracts, together with the corresponding copayments and coinsurance, and exclusions and limitations, and disclosing any applicable deductibles and lifetime maximums, using the same sequence as the uniform matrix described at Section 1363(b)(1) of the Act.

(iii) A description of how the plan will provide or arrange for the provision of translation of vital documents at no charge to Enrollees in accordance with the requirements of Section 1367.04 of the Act and this section. This subsection is not intended to prohibit or discourage a plan from providing translation of vital documents into a greater number of languages than the threshold languages;

(iv) A requirement that non-English translations of vital documents must meet the same standards required for English language versions of those documents; and

(v) A requirement that, with respect to vital documents that are not standardized, but which contain Enrollee-specific information, a plan shall provide the English version together with the Department-approved written notice of the availability of interpretation and translation services

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and, if a translation is requested, the plan shall provide the requested translation in accordance with the requirements of Section 1367.04 of the Act and this section.

(G) Processes and standards for providing individual Enrollee access to interpretation services at points of contact at no charge, including, but not limited to:

(i) A list of the non-English languages likely to be encountered among the plan's Enrollees.

(ii) A requirement that the plan shall provide LEP Enrollees with interpretation services for information contained in plan-produced documents.

(iii) A requirement that qualified interpretation services be offered to LEP Enrollees, at no cost to the Enrollee, at all points of contact, including when an Enrollee is accompanied by a family member or friend that can provide interpretation services. The offer of a qualified interpreter, and the Enrollee's refusal if interpretation services are declined, shall be documented in the medical record or plan file, as applicable.

(iv) When an Enrollee needs interpretation services at a point of contact that occurs in a hospital, facility or provider office subject to federal or state law that requires the hospital, facility or provider office to provide interpretation services, the plan is not relieved of its obligation to comply with the requirements of Section 1367.04 of the Act or this section. Full service plans shall have reasonable processes in place to ensure that LEP Enrollees can obtain the plan's assistance in arranging for the provision of timely interpretation services at all points of contact as defined at subsection (b)(4). This subsection does not prohibit a plan from incorporating into its language assistance program a contracting hospital's language assistance program if: the hospital's language assistance program provides access to interpretation services consistent with the requirements of Section 1367.04 of the Act and this section; the plan monitors for deficiencies in delivery of interpretation services by the hospital; and the plan takes appropriate corrective action to address hospital deficiencies in delivery of interpretation services to the plan's Enrollees. This subsection is not intended to limit or expand any existing state or federal law.

(v) A description of the arrangements the plan will make to provide or arrange for the provision of timely interpretation services at no charge to LEP Enrollees at all points of contact where language assistance is needed. For purposes of this subsection "timely" means in a manner appropriate for the situation in which language assistance is needed. Interpretation services are not timely if delay results in the effective denial of the service, benefit, or right at issue. A plan's language assistance program shall specify quality assurance standards for timely delivery of language assistance services for emergency, urgent, and routine health care services, and shall include standards for coordinating interpretation services with appointment scheduling.

(vi) The range of interpretation services that will be provided to Enrollees as appropriate for the particular point of contact.

(H) The plan's policies and standards for ensuring the proficiency of the individuals providing translation and interpretation services. A plan may develop and apply appropriate criteria for ensuring the proficiency of translation and interpretation services or may adopt certification by an association acceptable to the Department at the time of certification. A plan's language assistance proficiency standards shall require:

(i) A documented and demonstrated proficiency in both English and the other language;

(ii) A fundamental knowledge in both languages of health care terminology and concepts relevant to health care delivery systems; and

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(iii) Education and training in interpreting ethics, conduct and confidentiality. The Department will accept plan standards for interpreter ethics, conduct, and confidentiality that adopt and apply, in full, the standards promulgated by the California Healthcare Interpreters Association or the National Council on Interpreting in Healthcare.

INDIVIDUAL(S)/POSITION(S) TO BE INTERVIEWED

Staff responsible for the activities described above, for example:

- Medical Director and/or officer who has primary responsibility for the cultural and linguistic services program.
- Medical Director and/or officer who has primary responsibility for cultural competency and language needs training to Providers and others with direct Enrollee interaction.
- Medical Director and/or officer who has primary responsibility for Enrollee Services and ESRs.
- Medical Director and/or officer who has primary responsibility for the Marketing, Outreach, and Enrollee Communications materials.
- Medical Director and/or officer who has primary responsibility for Enrollee access to services.
- Medical Director and/or officer who has primary responsibility for Enrollee Appeals.

DOCUMENT(S) TO BE REVIEWED

- Policies and procedures related to Threshold Languages, including annual guidance to Contractors on specific translation requirements for their service areas.
- COHS Plan Enrollment Packages
- Policies and procedures related to the Plan's cultural and linguistic services program.
- Policies and procedures related to the Plan's cultural competency training, addressing language and literacy needs.
- Policies and procedures related to the availability of service authorization request denials in Threshold Languages;
- Policies and procedures related to the availability and timely telephone response by ESRs capable of language interpretation, or an alternative interpretation service available to Enrollees and prospective Enrollees.
- Policies and procedures for notifying Enrollees that oral interpretation is available for all languages and how to access it, and examples of Enrollee Appeal information translated into Threshold Languages.
- Marketing, Outreach, and Enrollee communication materials translated into Threshold Languages, including but not limited to the language card mailed to Enrollees notifying them of interpreter services.
- Provider/Pharmacy Network Directory.
- Policies and procedures for communicating with deaf and deaf and blind Enrollees.

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- Advisory Committee meeting notes concerning cultural and linguistic accessibility standards and procedures.
- Language Assistance Program Requirements.

MR-003 - Key Element 1:

1. The Health Plan ensures the availability of interpreter services and beneficiary materials in the languages required under Cal MediConnect.

Assessment Questions	Yes	No	N/A
1.1 Does the Plan have procedures in place to identify and meet the Threshold Languages translation requirements specific to its service area? (§ 1.89)			
1.2 Do enrollment packages for COHS Plans contain descriptions of continuity of care rights in all Threshold Languages? (For San Mateo and Orange Counties only) (§2.8.4.1.8.1)			
1.3 Does the Plan maintain a cultural and linguistic services program that incorporates the requirements of which includes standards and performance requirements for the delivery of the following: a) Interpreters; b) Translated written materials; c) Referrals to culturally and linguistically appropriate community services programs? (§2.9.7; § 2.9.7.1; 22 CCR § 53876.)			
1.4 Are the Plan’s cultural and linguistic services consistent with DHCS’s group needs assessment requirements? (§2.9.7.1; See also MMCD Policy Letter 10-012)			

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Assessment Questions	Yes	No	N/A
<p>1.5 Does the Plan maintain a cultural and linguistic services program, which includes:</p> <ul style="list-style-type: none"> a) An organizational commitment to deliver culturally and linguistically appropriate health care services; b) Goals and objectives; c) A timetable for implementation and accomplishment of the goals and objectives; d) An organizational chart showing the key staff persons with overall responsibility for cultural and linguistic services and activities; e) A narrative explaining the chart, describing the oversight and direction to the community advisory committee, provisions for support staff, reporting relationships, and qualifications of staff; and f) Standards and performance requirements for the delivery of culturally and linguistically appropriate health care services? <p>(§2.97.; §2.9.7.2.; §2.9.7.2.1.; §2.9.7.2.2.; §2.9.7.2.3.; §2.9.7.2.4.; §2.9.7.2.5.)</p>			
<p>1.6 Does the Plan assess, identify, and track the linguistic capability of interpreters or bilingual employees and contracted staff?</p> <p>(§2.9.7.3.)</p>			
<p>1.7 Has the Plan established a community advisory committee that it meets with periodically concerning the development and implementation of its cultural and linguistic accessibility standards and procedures?</p> <p>(§2.9.7.1; 22 CCR Section 53876(c).)</p>			
<p>1.8 Are there policies and procedures in place that require the Plan to monitor, evaluate, and take effective action to address any needed improvement in the delivery of culturally and linguistically appropriate services?</p> <p>(§2.9.7.1.)</p>			
<p>1.9 Are there policies and procedures in place to that require the Plan to assess, identify, and track the linguistic capability of interpreters or bilingual employees and contracted staff? ?</p> <p>(§2.9.7.3.)</p>			

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Assessment Questions	Yes	No	N/A
<p>1.10 Does the Plan provide Network Providers with written materials concerning their legal obligation to communicate with Enrollees with limited English proficiency, to provide interpreter services to Enrollees, and resources available to meet this obligation?</p> <p>(§2.9.7.4.)</p>			
<p>1.11 Does the Plan have a process to ensure that multilingual Network Providers (and all Providers if the capacity exists in the Service Area) understand and comply with their legal obligation to assist Enrollees with skilled medical interpreters, and the resources available to meet this obligation?</p> <p>(§2.9.7.5.)</p>			
<p>1.12 Does the Plan have a process to ensure that Network Providers are able to communicate with Enrollees in languages other than English and with deaf, hard-of-hearing or deaf and blind Enrollees?</p> <p>(§2.9.7.; § 2.9.7.6.; § 2.9.7.7.)</p>			
<p>1.13 Does the Plan train Network Providers (and First Tier, Downstream and Related Entities with direct Enrollee interaction) on the language and literacy needs of identified cultural groups in the Plan Service Areas?</p> <p>(§2.9.10.4.)</p>			
<p>1.14 When the Plan gives an Enrollee written notice of a decision to deny or reduce a service authorization request, is the notice:</p> <ul style="list-style-type: none"> a) Made available in Threshold languages, upon request; and b) Does it include information in Threshold languages about how to request translation services and alternative formats? <p>(§2.11.4.5.; §2.11.4.5.2.; §2.11.4.5.3.)</p>			

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Assessment Questions	Yes	No	N/A
<p>1.15 Does the Plan employ trained ESRs that will:</p> <ul style="list-style-type: none"> a) Speak directly with Enrollees in their primary language (including ASL), or arrange for an interpreter, alternative language device, or telephone translation service; b) Inform callers that interpreter services are free; c) Make oral interpretation services available free-of-charge to Enrollees in all non-English languages spoken, including ASL; d) Make available to Enrollees and potential Enrollees, upon request, information concerning how to access oral interpretation services and written materials in Threshold Languages and alternative formats. <p>(§2.12.1.; §2.12.1.3.; §2.12.1.4.; §2.12.1.7.; §2.12.1.13.; §2.12.1.13.3.)</p>			
<p>1.16 Does the Plan measure the amount of time it takes for an Enrollee to reaches an ESR capable of responding to the Enrollee’s question in the Enrollee’s language? Is this consistent with response time obligations for all Enrollees?</p> <p>(§2.12.2.2.)</p>			
<p>1.17 Are the Plan’s written notices concerning Enrollee Appeals translated for Enrollees who speak Threshold Languages?</p> <p>(§2.15. 2.1.)</p>			
<p>1.18 Does the Plan’s written notices concerning Enrollee Appeals state that oral interpretation is available in all languages, and how to access it?</p> <p>(§2.15. 2.2.)</p>			
<p>1.19 Are the Plan Marketing, Outreach, and Enrollee Communication materials translated into Threshold Languages for all required vital materials?</p> <p>(§2.17.2.3.)</p>			
<p>1.20 Does the Plan include with Marketing, Outreach, and mailed Enrollee communications a language card that indicates that the Enrollee can access free interpreter services to answer questions about the plan?</p> <p>(§2.17.2.4.)</p>			
<p>1.21 Does the Plan ensure that the language card specified above is written in the languages required in the three way contract?</p> <p>(§2.17.2.4.)</p>			

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Assessment Questions	Yes	No	N/A
<p>1.22 Does the Plan ensure that the language card specified above is distributed to the entire service area delineated in the three way contract?</p> <p>(§2.17.2.5.; Appendix I)</p>			
<p>1.23 Does the Plan’s Provider/Pharmacy Network directory include the cultural and linguistic capabilities of Network Providers, including languages spoken by the Network Provider (including ASL) or by skilled medical interpreters at the Provider’s site?</p> <p>(§2.17.5.11.; §2.17.5.11.4.; §2.17.5.11.9.)</p>			
<p>1.24 Does the Plan ensure that translation services are available to Enrollees prior to enrollment, at the time of enrollment, and whenever a participant’s needs require disclosure and delivery of information in order to allow the participant to make an informed choice?</p> <p>(Appendix B.)</p>			
<p>1.25 Does the Plan have a language assistance program, which addresses standards for Enrollee assessment, standards for providing language assistance services, standards for staff training, and standards for compliance monitoring?</p> <p>(§2.17.3.1. (as Amended); 28 CCR Section 1300.67.04(c)(2).)</p>			
<p>1.26 Does the Plan’s Marketing, Outreach, and Enrollee Communication Materials involving Medi-Cal based services comply with the language requirements of the Knox-Keene Act and the accompanying regulations?</p> <p>(§2.17.3.1 (as Amended); H&S Code §1367(e)(3), H&S Code §1367.04; 28 CCR §1300.67.04.)</p>			

End of Requirement MR-003: The Health Plan meets its Cal MediConnect obligations concerning the availability of interpreter services and beneficiary materials in the languages required under Cal MediConnect.

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Requirement MR-004: The Health Plan meets its Cal MediConnect obligations concerning availability of beneficiary materials in alternative formats or other methods of communication required under Cal MediConnect.

STATUTORY/REGULATORY CITATIONS

Cal MediConnect Prime Contract

2.11. Enrollee Access to Services

2.11.1. General. The Contractor must provide services to Enrollees as follows:

2.11.1.2. Reasonably accommodate Enrollees and ensure that the programs and services are as accessible (including physical and geographic access) to an Enrollee with disabilities as they are to an Enrollee without disabilities, and shall have written policies and procedures to assure compliance, including ensuring that physical, communication, and programmatic barriers do not inhibit Enrollees with disabilities from obtaining all Covered Services from the Contractor by:

2.11.1.2.3. Ensuring that Enrollees with disabilities are provided with reasonable accommodations to ensure effective communication, including auxiliary aids and services. Reasonable accommodations will depend on the particular needs of the Enrollee and include but are not limited to:

2.11.1.2.3.1. Providing large print (at least 16-point font) versions of all written materials to Enrollees with visual impairments;

2.11.1.2.3.2. Ensuring that all written materials are available in formats compatible with optical recognition software;

2.11.1.2.3.3. Reading notices and other written materials to Enrollees upon request;

2.11.1.2.3.4. Assisting Enrollees in filling out forms over the telephone;

2.11.1.2.3.5. Ensuring effective communication to and from Enrollees with disabilities through email, telephone, and other electronic means;

2.11.1.2.3.6. TTY, computer-aided transcription services, telephone handset amplifiers, assistive listening systems, closed caption decoders, videotext displays and qualified interpreters for the deaf; and

2.11.1.2.3.7. Individualized assistance.

2.11.4.5. The Contractor must notify the requesting Network Provider, either orally or in writing, and give the Enrollee written notice of any decision by the Contractor to deny a service authorization request, or to authorize a service in an amount, duration, or scope that is less than requested. The notice must meet the requirements of 42 C.F.R. § 438.404 and Title 22 CCR § 53261, and must:

2.11.4.5.3. Include information, in Threshold Languages about how to request translation services and alternative formats. Alternative formats shall include materials which can be understood by persons with limited English proficiency.

2.12. Enrollee Services

2.12.1. Enrollee Service Representatives (ESRs). The Contractor must employ ESRs trained to answer Enrollee inquiries and concerns from Enrollees and potential Enrollees, consistent

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with the requirements of 42 C.F.R. §§ 422.111(h) and 423.128(d) as well as the following requirements:

2.12.1.1. Be trained to answer Enrollee inquiries and concerns from Enrollees and potential Enrollees regarding medical, behavioral, and LTSS services provided;

2.12.1.2. Be trained in the use of TTY, video relay services, remote interpreting services, how to provide accessible PDF materials, and other alternative formats;

2.12.1.8. Maintain the availability of services, such as TTY services, computer-aided transcription services, telephone handset amplifiers, assistive listening systems, closed caption decoders, videotext displays and qualified interpreters and other services for Deaf and hard of hearing Enrollees;

2.12.1.11. Provide reasonable accommodations needed to assure effective communication and provide Enrollees with a means to identify their disability to the Contractor

2.12.1.13. Ensure that ESRs make available to Enrollees and potential Enrollees, upon request, information concerning the following:

2.12.1.13.3. How to access oral interpretation services and written materials in Threshold Languages and alternative formats;

2.15. Enrollee Appeals

2.15.1.3. Written material must use easily understood language and format, be available in alternative formats, and in an appropriate manner that takes into consideration those with special needs. The Contractor must inform Enrollees that information is available in alternative formats and how to access those formats.

2.17. Marketing, Outreach, and Enrollee Communications Standards

2.17.2. The Contractor's Marketing, Outreach, and Enrollee Communications materials must be:

2.17.2.1. Made available in alternative formats, upon request and as needed to assure effective communication for blind and vision-impaired Enrollees;

2.17.2.2. Provided in a manner, format and language that may be easily understood by persons with limited English proficiency, or for those with developmental disabilities or cognitive impairments;

2.17.5.9. The Contractor must ensure that all information provided to Enrollees and potential Enrollees (and families when appropriate) is provided in a manner and format that is easily understood and that is:

2.17.5.9.1. Made available in large print (at least 16 point font) to Enrollees as an alternative format, upon request;

2.17.5.9.4. Available in alternative formats, according to the needs of Enrollees and potential Enrollees, including Braille, oral interpretation services in non-English languages, as specified in Section 2.3 of this Contract; audiotape; ASL video clips, and other alternative media, as requested.

Appendix B: Enrollee Rights

The Contractor must have written policies regarding the Enrollee rights specified in this appendix, as well as written policies specifying how information about these rights will be disseminated to Enrollees. Enrollees must be notified of these rights and protections at least annually, and in a manner that takes in to consideration cultural considerations, Functional Status

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and language needs. Enrollee rights include, but are not limited to, those rights and protections provided by 42 C.F.R. § 438.100, 42 C.F.R. §422 Subpart C, and the CFAM-MOU. Specifically, Enrollees must be guaranteed:

F. Access to an adequate network of primary and specialty providers who are capable of meeting the Enrollee's needs with respect to physical access, and communication and scheduling needs, and are subject to ongoing assessment of clinical quality including required reporting.P. The right to receive their Medicare and Medi-Cal appeals rights in a format and language understandable and accessible to them.

INDIVIDUAL(S)/POSITION(S) TO BE INTERVIEWED

Staff responsible for the activities described above, for example:

- Medical Director and/or officer who has primary responsibility for Enrollee access to services.
- Medical Director and/or officer who has primary responsibility for Enrollee Services and ESRs.
- Medical Director and/or officer who has primary responsibility for the Marketing, Outreach, and Enrollee Communications materials.
- Medical Director and/or officer who has primary responsibility for Enrollee Appeals.

DOCUMENT(S) TO BE REVIEWED

- Policies and procedures related to the provision of materials in alternative formats
- Sample of documents with large print
- Policies and procedures for communicating with Enrollees with disabilities, including deaf, blind, or deaf and blind Enrollees;
- Policies and procedures for reasonably accommodating Enrollees and potential Enrollees with disabilities, with respect to written materials and communications;
- Policies and procedures related to the availability of ESRs capable of reasonably accommodating individuals with disabilities and providing materials in alternative formats;
- Marketing, Outreach, and Enrollee communication materials available in alternative formats.
- Service authorization request denials in alternative formats;
- Appeal documents in alternative formats;

MR-004 - Key Element 1:

- 1. The Plan meets its Cal MediConnect obligations concerning the availability of beneficiary materials in alternative formats or other methods of communication.**

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Assessment Questions	Yes	No	N/A
<p>1.1 Does the Plan have policies and procedures to ensure reasonable accommodations are made when providing beneficiary materials for Cal MediConnect Enrollees and potential Enrollees with disabilities?</p> <p>(§2.11.1.1; §2.11.1.2; §2.11.1.2.3; §2.17.5.9.)</p>			
<p>1.2 Does the Plan provide large print (at least 16-point font) versions of all written materials for Cal MediConnect Enrollees and potential Enrollees with visual impairments?</p> <p>(§2.11.1.2.3.1; §2.17.5.9.1.)</p>			
<p>1.3 Does the Plan ensure that all written materials are available in formats compatible with optical recognition software?</p> <p>1.1 (§2.11.1.2.3.2.)</p>			
<p>1.4 Does the Plan read notices and other written materials to Cal MediConnect Enrollees upon request?</p> <p>(§2.11.1.2.3.3)</p>			
<p>1.5 Does the Plan assist Cal MediConnect Enrollees in filling out forms over the telephone?</p> <p>(§2.11.1.2.3.4.)</p>			
<p>1.6 Does the Plan ensure effective communication to and from Cal MediConnect Enrollees with disabilities through email, telephone, and other electronic means?</p> <p>(§2.11.1.2.3.5.)</p>			
<p>1.7 Does the Plan utilize TTY services, computer-aided transcription services, telephone handset amplifiers, assistive listening systems, closed caption decoders, videotext displays and qualified interpreters and other services for the deaf and hearing-impaired Cal MediConnect Enrollees?</p> <p>(§2.11.1.2.3.6.)</p>			
<p>1.8 Does the Plan provide individualized assistance to reasonably accommodate the particular needs of an Enrollee?</p> <p>(§2.11.1.2.3.7.)</p>			

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Assessment Questions	Yes	No	N/A
<p>1.9 When the Plan gives an Enrollee written notice of a decision to deny or reduce a service authorization request, does the notice include information about how to request materials in alternative formats?</p> <p>(§2.11.4.5; §2.11.4.5.3.)</p>			
<p>1.10 Does the Plan employ trained ESRs that are:</p> <ul style="list-style-type: none"> a) Trained in the use of TTY, video relay services, remote interpreting services, how to provide accessible PDF materials, and other alternative formats; b) Making services available such as TTY services, computer-aided transcription services, telephone handset amplifiers, assistive listening systems, closed caption decoders, videotext displays and qualified interpreters and other services for Deaf and hard of hearing Enrollees; c) Providing reasonable accommodations to assure effective communication and provide Enrollees with a means to identify their disability; d) Making available to Enrollees and Potential Enrollees, upon request, information concerning how to access interpretation services and written materials in alternative formats. <p>(§2.12.1; §2.12.1.2; §2.12.1.8; §2.12.1.11; §2.12.1.13; §2.12.1.13.3.)</p>			
<p>1.11 Are the plan’s written notices concerning Employee Appeals available in alternative formats, and does the Plan inform Enrollees how to access those formats?</p> <p>(§2.15.1.3.)</p>			
<p>1.12 Are the Plan’s Marketing, Outreach, and Enrollee Communication materials provided in a manner, format and language that may be easily understood by persons with limited English proficiency, or for those with developmental disabilities or cognitive impairments?</p> <p>(§2.17.2; §2.17.2.2.)</p>			
<p>1.13 Are the Plan’s Marketing, Outreach, and Enrollee Communication materials available in alternative formats upon request, and do they:</p> <ul style="list-style-type: none"> a) Assure effective communication for blind and vision-impaired Enrollees? b) Include Braille, oral interpretation services, audiotape, ASL video clips, and other alternative media, as requested? <p>(§2.17.2; §2.17.2.1; §2.17.5.9.4)</p>			

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Assessment Questions	Yes	No	N/A
1.14 Does the Plan provide access to a network of primary and specialty providers who are capable of meeting an Enrollee's communication needs? (Appendix B, section F.)			

End of Requirement MR-004: The Health Plan meets its Cal MediConnect obligations concerning availability of beneficiary materials in alternative formats or other methods of communication required under Cal MediConnect.