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

Alameda Alliance for Health

Contract Number: 04-35399

Audit Period: June 1, 2015
Through
May 31, 2017

Report Issued: January 23, 2018

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I. INTRODUCTION

Alameda Alliance for Health (the Plan) is a public, non-profit managed care health plan with the objective to provide quality health care services to low income residents of Alameda County. The Alameda County Board of Supervisors established the Plan in 1994 in accordance with the Welfare and Institutions Code, Section 14087.54. While it is a part of the County's health system, the Plan is an independent entity that is separate and apart from the County.

The Plan was established to operate the Local Initiative for Alameda County under the State Department of Health Services' Strategic Plan for expanding Medi-Cal Managed Care. The Plan was initially licensed by the Department of Corporations in September 1995 and contracted with the California Department of Health Care Services (DHCS) in November 1995. The Plan began operations in January 1996 as the first Two-Plan Model health plan to be operational. The Plan contracted with the Managed Risk Medical Insurance Board for Healthy Families in May 1998.

As of March 31, 2016, the Plan had 268,172 members of which 262,572 (97.91%) were Medi-Cal members and 5,600 (2.09%) were Commercial members (IHSS).

II. EXECUTIVE SUMMARY

This report presents the audit findings of the DHCS medical audit of the initial audit period of June 1, 2015 through May 31, 2016. The initial onsite review was conducted from June 27, 2016 through July 7, 2016. The audit consisted of document review, verification studies, and interviews with Plan personnel.

The audit evaluated six categories of performance: Utilization Management (UM), Case Management and Coordination of Care, Access and Availability to Care, Members' Rights, Quality Improvement (QI), and Administrative and Organizational Capacity.

The prior DHCS medical audit (for the period of April 1, 2014 through March 31, 2015, with onsite review conducted from June 8, 2015 through June 18, 2015) was issued on November 13, 2015. This audit examined documentation for compliance and to determine to what extent the Plan has operationalized their Corrective Action Plan (CAP). Repeat findings were identified and appear in the body of the report.

Subsequent to the onsite, DHCS received anonymous complaints contradicting information previously provided by the Plan during the onsite.

In order to determine the validity of the information received, expanded onsite reviews were conducted in intervals between February 7, 2017 through May 9, 2017, covering the health plan, subcontractors, and delegated entities.

The expanded audit evaluated three categories of performance: Case Management and Coordination of Care, QI, and Administrative and Organizational Capacity. The audit period was extended through May 31, 2017. The expanded audit consisted of document review, verification studies, third-party confirmations of audit documents obtained, and interviews with the Plan, delegates, and contracted providers.

On September 11, 2017, a meeting was held with Plan executive management to discuss the anonymous complaints DHCS received. Both during and subsequent to the meeting, the Plan, while not admitting the accuracy of the anonymous complaints, identified corrective actions to be taken in response to identified weaknesses in its internal controls and submitted documents related to those efforts. Failure to establish effective controls in Plan functions and processes can affect the Plan's ability to comply with contractual and regulatory requirements.

The findings from the expanded audit based on the anonymous complaints are very serious and will be the focus of future audits. We strongly caution the Plan to thoroughly investigate and address these complaints to avoid the need for DHCS directed corrective action. The anonymous complaints that DHCS verified during its supplemental audit are embedded in this report.

An Exit Conference was held on December 13, 2017 with the Plan. The Plan was allowed 15 calendar days from the date of the Exit Conference to provide supplemental information addressing the draft audit report findings. The Plan submitted a response after the exit conference. The results of our evaluation of the Plan's response are reflected in this report.

The summary of the findings by category follows:

Category 1 – Utilization Management

The Plan's appeal policies contain inconsistent information regarding participation of Plan staff in appeal adjudication.

Category 2 – Case Management and Coordination of Care

The review of the Plan's processes identified deficiencies in its provision of Complex Case Management (CCM) services to eligible members, monitoring the program to address member needs, and ensuring Primary Care Provider (PCP) participation in the provision of CCM.

Category 3 – Access and Availability of Care

The Plan did not implement appropriate corrective actions for providers and delegates found to not meet the timely access requirements. The Plan did not initiate and implement steps to monitor member wait times at provider's offices, wait times to answer and return telephone calls, and initial prenatal visit appointment availability.

The Plan did not implement corrective action to correct deficiencies identified regarding providers availability for after-hours calls.

Category 4 – Member's Rights

The Plan did not have policies in place to address medical director oversight and resolution of quality of care grievances, grievances not resolved within the 30-day requirement, and grievances submitted by providers on behalf of members. A review of the Plan's grievance process identified deficiencies in capturing, classifying, processing, and resolving complaints and expressions of dissatisfaction.

The Plan did not consistently conduct background checks of employees prior to providing employees with access to protected health information.

Category 5 – Quality Management

The Plan did not demonstrate compliance with provider training requirements. New provider training was not conducted within the required time frames.

Category 6 – Administrative and Organizational Capacity

The Plan did not ensure qualified medical personnel were responsible for implementation of the Case Management Program. The Plan did not have policies and procedures in place to ensure that medical staff are qualified to conduct the Plan functions that involve clinical matters.

The Plan did not report the results of a preliminary investigation of suspected fraud or abuse to DHCS within 10-working days of the date the Plan first became aware.

III. SCOPE/AUDIT PROCEDURES

SCOPE

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

PROCEDURE

The initial onsite review was conducted from June 27, 2016 through July 7, 2016. The expanded onsite review was conducted in intervals between February 7, 2017 and May 9, 2017. The audit included a review of the Plan's policies for providing services, the procedures used to implement the policies, and verification studies of the implementation and effectiveness of the policies. Documents were reviewed and interviews were conducted with Plan administrators, staff, providers, and delegates.

The following verification studies were conducted:

Category 1 – Utilization Management

Prior authorization requests: 20 medical and 15 pharmacy prior authorization requests were reviewed for timeliness, consistent application of criteria, and appropriate review.

Appeal procedures: 20 prior authorization appeals were reviewed for appropriate and timely adjudication.

Category 2 – Case Management and Coordination of Care

Coordination of Care and Initial Health Assessment (IHA) requirements: 20 medical records were reviewed to confirm coordination of care and fulfillment of IHA requirements.

Complex Case Management: 50 Plan CCM files were reviewed to confirm the performance of services.

Disease management: 49 Plan disease management files were reviewed to confirm the performance of services.

Category 3 – Access and Availability of Care

Appointment availability verification: 28 providers of routine, urgent, specialty, and prenatal care from the Plan's directory were reviewed. The first and third next available appointments were used to measure access to care.

Claims: 25 emergency services and 25 family planning claims were reviewed for appropriate and timely adjudication.

Category 4 – Member's Rights

Grievance procedures: 65 grievances were reviewed for timely resolution, response to complainant, and submission to the appropriate level for review.

Health Insurance Portability and Accountability Act (HIPAA): Eight HIPAA cases were reviewed for appropriate reporting and processing.

Category 5 – Quality Management

New provider training: 20 provider training records were reviewed for timely Medi-Cal Managed Care program training. Third-party confirmations of provider training records were performed to validate documentation submitted.

Category 6 – Administrative and Organizational Capacity

Fraud and abuse: 11 fraud and abuse cases were reviewed for appropriate reporting and processing.

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

❖ COMPLIANCE AUDIT FINDINGS (CAF) ❖	
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CATEGORY 1 - UTILIZATION MANAGEMENT

1.4	PRIOR AUTHORIZATION APPEAL PROCESS
Appeal Procedures: There shall be a well-publicized appeals procedure for both providers and patients. 2-Plan Contract A.5.2.E	

SUMMARY OF FINDING(S):

1.4.1 **Appeal policy and procedure**

The Plan is required to have a procedure ensuring that the person making final decisions for proposed resolution of a grievance has not participated in any prior decisions related to the grievance. (*Contract Amendment 11, Exhibit A, Attachment 14(2)(G)*)

Code of Federal Regulations, Title 42, § 438.406(3) "ensures that the individuals who make decisions on grievances and appeals are individuals who were not involved in any previous level of review or decision making".

California Code of Regulations, Title 28, §1300.68 defines an appeal as a type of grievance, so the above contract language applies to appeals as well as grievances.

Plan policy *MED-CGR-0001, Member Grievances and Appeals*, states that upon an appeal, the initial reviewer may be consulted when new information is presented that may cause the initial reviewer to reverse their original denial. It contradicts a different section of the same policy that states the Plan shall not allow a person previously involved in a prior decision to review the appeal of that decision. It also contradicts Plan policy *MED-CGR 0025, Prior Authorization Appeals Process*, which states the Plan appoints a reviewer who was not involved in the prior adverse decision to review the appeal.

Inconsistencies in the Plan's appeals policy might result in medical directors using the improper interpretation of the policy and involving themselves in an appeal for which they were the original decision maker. This has the potential for patient harm and denial of services.

RECOMMENDATION(S):

1.4.1 Revise Plan policy *MED-CGR-0001* to ensure the person making final decisions for proposed resolution of a grievance has not participated in any prior decisions related to the grievance.

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CATEGORY 2 – CASE MANAGEMENT AND COORDINATION OF CARE

2.5	COMPLEX CASE MANAGEMENT

Case Management and Coordination of Services:
Contractor shall ensure the provision of Comprehensive Medical Case Management to each Member.

Contractor shall maintain procedures for monitoring the coordination of care provided to Members, including but not limited to all Medically Necessary services delivered both within and outside the Contractor's provider network. These services are provided through either basic or complex case management activities based on the medical needs of the member.

Complex Case Management Services are provided by the Plan, in collaboration with the Primary Care Provider, and shall include, at a minimum:

1) Basic Case Management Services
2) Management of acute or chronic illness, including emotional and social support issues by a multidisciplinary case management team
3) Intense coordination of resources to ensure member regains optimal health or improved functionality
4) With Member and PCP input, development of care plans specific to individual needs, and updating of these plans at least annually

Contractor shall develop methods to identify Members who may benefit from complex case management services, using utilization data, the Health Information Form (HIF)/Member Evaluation Tool (MET), clinical data, and any other available data, as well as self and physician referrals.
2-Plan Contract A.11.1

SUMMARY OF FINDING(S):

2.5.1 **Identification and assessment of potential CCM members**

The Plan shall maintain procedures for monitoring the coordination of care provided to members. These services are provided through either basic or CCM activities based on the medical needs of the members.

CCM services are provided by the Plan, in collaboration with the PCP, and shall include, at minimum:

1. Basic Case Management Services

2. Management of acute or chronic illness, including emotional and social support issues by a multidisciplinary case management team
3. Intense coordination of resources to ensure member regains optimal health or improved functionality
4. With member and PCP input, development of care plans specific to individual needs, and updating of these plans at least annually.

(*Contract Amendment 11, Exhibit A, Attachment 11(1)(B)*)

Plan policy *MED-CM-0001 CCM Identification, Screening, Assessment, and Triage* states initial member telephonic outreach will be made during working hours to conduct general assessments. The general assessment will be completed on each member within 30 days of identification; will include an evaluation of member's medical and behavioral health status; and triage, to determine whether the member should be admitted to the CCM program. If unable to reach the member, a follow up attempt will be made and an unable to contact letter will be mailed to the member as a third attempt.

The Plan did not ensure the provision of CCM services to eligible members. The Plan did not fully implement their policies and procedures regarding the contact, assessment, and triage of potential members who would benefit from the CCM program.

The verification study found 40 of 41 sampled cases where members were identified as those who might benefit from CCM; however, they were not contacted, assessed, and triaged. These files in the Plan's case management system did not contain assessments and had no evidence or indication of the performance of any CCM activities. In 30 sampled cases, the Plan did not send a letter when the Plan was unable to contact the member regarding CCM services.

The prior DHCS audit found that the Plan did not ensure the provision of CCM services; only four open cases were found during the audit period. The Plan's corrective action plan (CAP) did not effectively address and resolve the deficiencies from the prior audit.

The open number of cases suggests that the Plan had addressed the prior year finding, when in fact the Plan followed up on only 1 of 41 CCM cases. This clearly reflects a failure to implement the previous CAP. The audit findings clearly reveal the Plan's current processes present a very serious potential for member harm that must be addressed immediately.

When the Plan does not engage identified members for CCM services, members are prevented from receiving the full benefits of CCM services. Improper administration of CCM program increases the potential for adverse health outcomes. It also prevents the Plan from managing the cost of care and overutilization of services.

This is a repeat finding.

2.5.2 **Monitoring**

The Plan shall maintain procedures for monitoring the coordination of care provided to members, including but not limited to all medically necessary services delivered both within and outside the Plan's provider network. These services are provided through either basic or CCM activities based on the medical needs of the member. (*Contract Amendment 11, Exhibit A, Attachment 11(1)*)

Plan policy *MED-CM-0003 CCM Plan Evaluation and Closure* states cases that fail to close within 90 days will be reviewed at Case Rounds as scheduled by the Case Management/Disease Management Director. At the time, the case may be extended for an additional time-defined period, but no greater than 90-additional days. After this period, if the case is still open, the case will return to Case Rounds for review.

Plan policy *MED-CM-003* also states under monitoring that the Chief Medical Officer, Director of Case and Disease Management, and Chief Operating Officer will review the following: (1)Timeliness of Case Closure Reports from TruCare, (2)Progress of Cases at Case Rounds, and (3) Care Plan audits using the National Committee for Quality Assurance file review forms.

The Plan did not implement its policy to monitor its CCM program. The Plan did not identify cases that were not closed within 90 days. The Plan confirmed the lack of oversight from management in regards to monitoring open cases, staff assignments, productivity, and case completions.

The CCM verification study found 31 of 41 sampled cases where members were identified, had been opened, and remained open for over 334 days. These files in the Plan's case management system did not contain evidence or indication of the performance of any CCM activities.

The Plan's lack of a monitoring mechanism prevented the Plan from implementing its CCM policies and procedures. The lack of a monitoring mechanism prevents the Plan from addressing member needs on a recurring basis, reevaluation of current member conditions, and closure of open cases.

2.5.3 Primary care provider participation

The Plan is required to ensure the provision of comprehensive medical case management to each member through either basic or CCM activities based on the medical needs of the member. CCM services are to be provided by the Plan, in collaboration with the PCP. Care plans specific to individual needs must be developed with input from the member and PCP. (*Contract Amendment 11, Exhibit A, Attachment 11(1) and Amendment 14(V)*)

Plan policy *MED-CM-0002, CCM Plan Development and Management* states that a case manager was responsible in the development of an individualized care plan in collaboration with the member and care providers. With the member's permission, the PCP should be notified that the member is receiving care management services, a summary of the assessment report, and the care plan. The Plan's provider manual reflected the same information as the Plan's policy about the case manager's responsibility to complete, continually update, and evaluate the care plan based on the member's needs.

The Plan did not ensure PCP participation in the provision of CCM to each eligible member. The Plan's policy and *Provider Manual* did not address how the Plan will collaborate with the PCP in the provision of CCM services including the development of the care plan. The policy states that PCPs will be notified of the member's enrollment in CCM program, summary of assessment report, and the care plan with the member's permission.

According to Plan staff, care plans were initiated and developed by case managers based on the member's assessment with member input. During site visits, multiple Plan providers and their staff were interviewed and all were unfamiliar with the Plan's CCM policies, procedures, and services. Most of the providers interviewed did not know their patients were in the CCM program and were not aware of the CCM services being offered by the Plan.

A care plan individualized to the member's needs and based on the comprehensive assessment forms the foundation for care coordination. As a member of the multidisciplinary case management team, the primary care provider's participation is an important element in the care of members with complex needs, including in the care planning process.

RECOMMENDATION(S):

2.5.1. Implement policies to initiate and provide CCM services with identified and eligible members.

2.5.2 Implement policies to monitor and ensure the delivery and quality of CCM services provided.

2.5.3 Revise and implement policies and procedures to ensure PCP participation in the provision of CCM services to eligible members.

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CATEGORY 3 – ACCESS AND AVAILABILITY OF CARE

3.1	APPOINTMENT PROCEDURES AND MONITORING WAITING TIMES

Appointment Procedures:
Contractor shall implement and maintain procedures for Members to obtain appointments for routine care, urgent care, routine specialty referral appointments, prenatal care, children's preventive periodic health assessments, and adult initial health assessments. Contractor shall also include procedures for follow-up on missed appointments.
2-Plan Contract A.9.3.A

Members must be offered appointments within the following timeframes:
3) Non-urgent primary care appointments – within ten (10) business days of request;
4) Appointment with a specialist – within 15 business days of request;
2-Plan Contract A.9.4.B

Prenatal Care:
Contractor shall ensure that the first prenatal visit for a pregnant Member will be available within two (2) weeks upon request.
2-Plan Contract A.9.3.B

Monitoring of Waiting Times:
Contractor shall develop, implement, and maintain a procedure to monitor waiting times in the providers' offices, telephone calls (to answer and return), and time to obtain various types of appointments…
2-Plan Contract A.9.3.C

SUMMARY OF FINDING(S):

3.1.1 **Timely access corrective action plans for providers and medical groups**

The Plan is required to ensure the provision of acceptable accessibility standards in accordance with California Code of Regulations (CCR), Title 28, § 1300.67.2.2 and as specified in the Contract. The Plan is required to ensure that each member has a PCP who is available and physically present at the service site for sufficient time to ensure access for the assigned member when medically required. (*Contract, Amendment 11 Exhibit A, Attachment 9(1)*)

The Plan is required to communicate, enforce, and monitor provider's compliance with access standards. (*Contract, Amendment 11 Exhibit A, Attachment 9(4)*)

The Plan is required to implement prompt investigation and corrective action when compliance monitoring discloses that the Plan's provider network is not sufficient to ensure timely access, which includes but is not limited to taking all necessary and appropriate action to identify the causes underlying identified timely access deficiencies and to bring its network into compliance. (*CCR, Title 28, § 1300.67.2.2 (d)(3)*)

Plan policy, *AAH-CMP-0024 Monitoring of Access & Availability Standards,* stated that the Plan will issue a CAP to all affected providers and delegates. The Plan will close the CAP once responses provided address the deficiencies cited. Providers and delegates will continue to be monitored through tracking and trending monitoring activities to prevent issues from reoccurring.

The Plan did not consistently implement appropriate corrective action when providers did not comply with timely access standards.

The Plan's 2015 Appointment Availability survey identified three delegates and four providers that did not comply with the timely access requirements. The survey methodology defines deficiency as a larger group scoring less than 75 percent on the compliance rate on any of the survey questions related to appointment availability. CAPs were issued for the three delegates; however, the Plan did not issue CAPs for the four providers. The Plan did not implement corrective action to address all identified deficiencies in the Plan's provider network.

This is an ongoing finding.

3.1.2 Monitoring office wait times and telephone calls

The Plan is required to develop, implement, and maintain a procedure to monitor waiting times in the providers' offices, telephone calls (to answer and return), and time to obtain various types of appointments. (*Contract, Amendment 11 Exhibit A, Attachment 9(3)(C)*)

Plan policy, *AAH-CMP-0024 Monitoring of Access and Availability Standards*, states that the Plan's Access & Availability Committee reviews monitoring activities of access and availability of services within the Plan's network. The Committee reports to the Health Care and Quality Committee annually for review and feedback.

The Plan did not initiate and implement steps to monitor member wait times at provider's offices and wait times to answer and return telephone calls.

As part of the prior year audit's CAP, the Plan revised its *Monitoring of Access and Availability Standards policy* to address office wait times and telephone calls. The Plan's revised policies did not address monitoring of office wait times and times to answer and

return telephone calls. The Plan's annual 2016 Timely Access Report (TAR) did not have any reports verifying the monitoring of wait times to answer and return telephone calls timely by the providers' offices.

This is an ongoing finding.

3.1.3 Monitoring of initial prenatal visit

The Plan is required to ensure that the first prenatal visit for a pregnant member will be available within two weeks upon request. (*Contract Amendment 11, Exhibit A, Attachment 9(3)(B)*)

The Plan is required to implement and maintain procedures for members to obtain appointments for prenatal care. (*Contract Amendment 11, Exhibit A, Attachment 9(3)(A)*)

The Plan is required to develop, implement, and maintain a procedure to monitor waiting times in the providers' offices, telephone calls (to answer and return), and time to obtain various types of appointments. (*Contract Amendment 11, Exhibit A, Attachment 9(3)(C)*)

Plan policy, *MED-DEL-0025 Appointment Access & Availability*, states that the initial prenatal appointment be available within two weeks of request.

The Plan did not monitor the initial prenatal visit appointment availability. The Plan's policies and procedures did not address monitoring of initial prenatal visit appointment availability.

The Plan's 2016 TAR did not contain any survey results for initial prenatal visit appointment availability.

The DHCS appointment and availability verification survey found three of five obstetricians did not comply with the two-week appointment access requirement for the initial prenatal visit. The average of the first available appointments for initial prenatal visits was 37 days.

RECOMMENDATION(S):

3.1.1 Implement corrective action for identified deficiencies in the provider network.

3.1.2 Maintain a procedure to monitor wait times in providers' offices. Maintain a procedure to monitor wait times for providers to answer and return telephone calls.

3.1.3 Develop and implement procedures to monitor appointments for initial prenatal visits.

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3.3	TELEPHONE PROCEDURES / AFTER HOURS CALLS

Telephone Procedures:
Contractor shall require providers to maintain a procedure for triaging Members' telephone calls, providing telephone medical advice (if it is made available) and accessing telephone interpreters.
2-Plan Contract A.9.3.D

Contractor shall maintain the capability to provide Member services to Medi-Cal Members or potential members through sufficient assigned and knowledgeable staff
2-Plan Contract A.13.2.A

After Hours Calls:
At a minimum, Contractor shall ensure that a physician or an appropriate licensed professional under his/her supervision will be available for after-hours calls.
2-Plan Contract A.9.3.E

SUMMARY OF FINDING(S):

3.3.1 **Providers' after-hours calls corrective action plans**

The Plan is required to ensure that a physician or an appropriate licensed professional under his/her supervision will be available for after-hours calls. (*Contract Amendment 11, Exhibit A, Attachment 9(3)(E)*)

The Plan is required to implement prompt investigation and corrective action when compliance monitoring discloses that the Plan's provider network is not sufficient to ensure timely access, which includes but is not limited to taking all necessary and appropriate action to identify the causes underlying identified timely access deficiencies and to bring its network into compliance. (*CCR, Title 28, § 1300.67.2.2 (d)(3)*)

Plan policy, *AAH-CMP-0024, Monitoring of Access & Availability Standards*, states in part, "if the Plan discovers deficiencies within the provider through the monitoring process, prompt investigation and corrective action is implemented to correct the deficiencies. The Plan will take all necessary and appropriate actions to maintain compliance of the access and availability standards for its provider network."

The Plan did not implement appropriate corrective action when providers were found to be unavailable for after-hours calls.

In the 2015 Provider After-Hour Access Survey Report, the Plan identified 21 of the 150 PCPs who failed to provide contact information for after-hours physicians. In the same survey, the Plan identified 139 of 242 Specialists who failed to provide contact information for after-hours physicians. The Plan did not conduct any other corrective action to address identified deficiencies regarding providers' availability for after-hours calls in the Plan's provider network.

RECOMMENDATION(S):

3.3.1 Implement corrective action to address identified deficiencies of providers' availability for after-hours calls.

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CATEGORY 4 – MEMBER'S RIGHTS

4.1	GRIEVANCE SYSTEM

Member Grievance System and Oversight:
Contractor shall implement and maintain a Member Grievance System in accordance with Title 28, CCR, Section 1300.68 and 1300.68.01, Title 22 CCR Section 53858, Exhibit A, Attachment 13, Provision 4, Paragraph D.13), and 42 CFR 438.420(a)-(c).
2-Plan Contract A.14.1

Contractor shall implement and maintain procedures…to monitor the Member's grievance system and the expedited review of grievances required under Title 28, CCR, Sections 1300.68 and 1300.68.01 and Title 22 CCR Section 53858….(as required by Contract)
2-Plan Contract A.14.2

Contractor shall maintain, and have available for DHCS review, grievance logs, including copies of grievance logs of any subcontracting entity delegated the responsibility to maintain and resolve grievances. Grievance logs shall include all the required information set forth in Title 22 CCR Section 53858(e).
2-Plan Contract A.14.3.A

SUMMARY OF FINDING(S):

4.1.1 **Medical director oversight of quality of care grievances**

The Plan is required to implement and maintain procedures to ensure that grievances related to medical quality of care issues are referred to the Plan's medical director. (*Contract Amendment 11, Exhibit A, Attachment 14(2)(E)*)

The medical director shall resolve grievances related to medical quality of care. (*Contract Amendment 11, Exhibit A, Attachment 1(6)(E)*)

Plan policy *MED-CGR-0001, Member Grievance and Appeals,* states that a Member Services reviewer examines the case, assigns various classifications, and documents these classifications in the electronic system. All grievances and appeals received by the Plan will be thoroughly investigated, including any aspects of clinical care involved. However, the Plan's policies did not address how the grievance and appeals analyst will refer quality of care grievances to the medical director.

The Plan did not consistently refer quality of care grievances to the medical director for oversight and resolution.

Sixteen of 20 medical quality of care grievances reviewed showed no evidence of medical director oversight. The Plan stated that the medical director was not involved in resolving quality of care grievances. The Plan did not have a process for medical director oversight and resolution of quality of care grievances.

The medical director is responsible for addressing quality of care grievances to ensure quality of care is preserved, members receive appropriate care, and are accorded services available to members.

4.1.2 **Grievance identification and processing**

The Plan is required to establish and maintain written procedures for submittal, processing, and resolution of all grievances and complaints. (*CCR, Title 22, § 53858 (a)*)

Plan policy *MED-CGR-0001, Member Grievances and Appeals,* stated that grievances received orally by Member Services over the phone will be documented electronically for processing. Grievances are initially reviewed upon receipt in Member Services and/or Grievance and Appeals unit. The Member Services reviewer examines the case and assigns various classifications and documents these classifications in the electronic system.

Plan policy *MEM-GEN-0024*, states in part “an exempt grievance is a complaint that is not coverage disputes, disputed health care services involving medical necessity, or experimental or investigational treatment, and that are resolved by the close of the next business day following receipt.”

The Plan’s grievance system did not capture and process all complaints and expressions of dissatisfaction. Three out of 45 standard grievance resolution letters did not address all complaints and expressions of dissatisfaction. The Plan’s coordinator noted the complaints in the intake form but they were not addressed in the resolution letter to the member.

The Plan did not consistently implement their policy regarding exempt grievance classification and processing. Member Services representatives and grievance analysts inconsistently classified and processed multiple grievances as exempt grievances instead of processing them as a standard grievance. These complaints and expressions of dissatisfaction were not properly classified, processed, and resolved.

For example, a member filed a grievance stating they did not receive the proper service for their condition. The Plan classified this complaint as an exempt grievance even though it involved quality of care concern, which resulted in the case being closed before the member’s complaint was resolved.

The Plan did not consistently apply the process of standard grievance and exempt grievance identification and processing as stated in the policies and procedures. As a result, the members did not receive the full benefits and resolution of the grievance process.

4.1.3 **Monitoring and oversight of the grievance system**

The Plan is required to implement and maintain procedures to monitor the member's grievance system and the expedited review of grievances. (*Contract Amendment 11, Exhibit A, Attachment 14(2)*)

The Plan is required to ensure that grievances submitted are reported to the appropriate level, i.e., medical issues versus health care delivery issues. The Plan shall ensure that a health care professional with appropriate clinical expertise resolves medical issues. (*Contract Amendment 11, Exhibit A, Attachment 14(2)(D)*)

Plan policy *MED-CGR-0001, Member Grievances and Appeals*, states that Member Services reviewer examines the case, assigns various classifications, and documents these classifications in the electronic system. All grievances and appeals received by the Plan will be thoroughly investigated, including any aspects of clinical care involved. However, the Plan's policies did not address oversight and monitoring of grievance classification by clinical personnel.

The Plan did not have a process for monitoring and reviewing grievances designated as non-clinical to ensure quality of care issues were not missed. No oversight was conducted by clinical personnel to ensure proper identification of clinical/quality of care grievances. The grievances were first classified as clinical or administrative by non-clinical employees. All grievances classified as non-clinical were processed by the grievance coordinators who were non-clinical employees.

The Plan's corrective action from the prior audit stated that they would alter the grievance workflow to include a clinical review. Although the Plan was in the process of hiring nurses to incorporate into the oversight of the grievance classification process, during audit period non-clinical staff were still determining all initial classifications.

This is a repeat finding.

4.1.4 **Grievance resolutions**

The Plan is required to establish and maintain written procedures for submittal, processing, and resolution of all grievances and complaints. (*CCR, Title 22, § 53858 (a)*) A grievance log shall include a description of the action taken by the Plan or provider to

investigate and resolve the grievance, the proposed resolution by the Plan or provider, and the date of notification of the member of the proposed resolution. (*CCR, Title 22, § 53858 (e)*)

Plan policy *MED-CGR-0001, Member Grievances and Appeals,* stated that the decision on a grievance
or appeal is documented and communicated to the member in a determination letter. The determination letter will be sent to the complainant as expeditiously as the member's health condition requires and within 30-calendar days of receipt of the grievance. The determination letter will include information on the decision and additional information about the appeals process. Plan policy did not address how the Plan will process grievances that are not resolved within 30 days.

Seven of 45 grievances reviewed showed the Plan sent member resolution letters without resolving the grievance. In response to the prior audit, Plan staff was only trained on their regulatory time frames; however, the Plan's CAP did not address how the Plan would resolve grievances beyond 30 days. As a result, the Plan did not ensure that members' grievances were consistently resolved.

This is a repeat finding.

4.1.5 **Grievance status notification**

In the event a resolution is not reached within 30-calendar days, the Plan is required to notify the member in writing of the status of the grievance and provide an estimated completion date of resolution. (*CCR, Title 22, § 53858(g)(2)*)

Plan policy *MED-CGR-0001 Member Grievances and Appeals* did not address how the Plan will notify members when their grievances are not resolved within 30 days.

In seven grievances reviewed, the Plan did not notify the member in writing when a resolution to their grievance would not be reached within 30 days and did not provide an estimated completion date of resolution. The Plan only called to notify members that a follow-up would occur. In response to the prior audit, Plan staff were trained on the regulatory time frames; however, the Plan did not send a notification in writing. The Plan's CAP was ineffective in notifying members in writing when a grievance was not resolved within 30 days.

This is a repeat finding.

4.1.6 **Grievance submitted by provider on behalf of a member**

The Plan is required to provide a written acknowledgement to the complainant within 5-calendar days of receipt. (*CCR, Title 28, § 1300.68 (d)(1)*)

The Plan's resolution, containing a written response to the grievance, shall be sent to the complainant within 30-calendar days of receipt (*CCR, Title 28, § 1300.68 (d)(3)*). Complainant means the person who filed the grievance including the member, a representative designated by the member, or other individual with authority to act on behalf of the member. (*CCR, Title 28, § 1300.68 (a)(3)*)

Plan policy *MED-CGR-0001, Member Grievances and Appeals*, did not address how to process grievances submitted by a provider on behalf of a member.

The Plan did not send acknowledgement or resolution letters to providers who submitted grievances on behalf of members. The Plan had one grievance submitted by a provider on behalf of a member within the selected audit sample.

The Plan did not have policies and procedures to process grievances submitted by a provider on behalf of a member. The grievance and appeal coordinator would contact the member to retrieve all pertinent information and process the grievance as if the member filed it on that day. The provider was excluded from all communication and resolution, which prevents the provider from assisting the member through the grievance process.

RECOMMENDATION(S):

4.1.1 Develop and implement policies and procedures to ensure all quality care grievances are referred to and resolved by the medical director. Document medical director's involvement in all quality of care grievances.

4.1.2 Consistently apply policies and procedures to capture and process all complaints and expressions of dissatisfaction. Ensure that exempt grievances not fully resolved within 24 hours are processed as standard grievances.

4.1.3 Develop and implement policies and procedures to monitor and review appropriate classification of grievances.

4.1.4 Develop and implement policies and procedures to ensure grievances are completely resolved prior to sending resolution letters.

4.1.5 Develop and implement policies and procedures to notify members in writing of the status of the grievance and provide an estimated completion date of resolution when a resolution is not reached within 30 days.

4.1.6 Develop and implement policies and procedures to send acknowledgement and resolution letters to all complainants, including providers, when they file a grievance on behalf of members.

4.3	CONFIDENTIALITY RIGHTS

Members' Right to Confidentiality
Contractor shall implement and maintain policies and procedures to ensure the Members' right to confidentiality of medical information.

1) Contractor shall ensure that Facilities implement and maintain procedures that guard against disclosure of confidential information to unauthorized persons inside and outside the network.
2) Contractor shall counsel Members on their right to confidentiality and Contractor shall obtain Member's consent prior to release of confidential information, unless such consent is not required pursuant to Title 22 CCR Section 51009.

2-Plan Contract A.13.1.B

Health Insurance Portability and Accountability Act Responsibilities:
Business Associate agrees:

Safeguards. To implement administrative, physical, and technical safeguards that reasonably and appropriately protect the confidentiality, integrity, and availability of the PHI, including electronic PHI, that it creates, receives, maintains, uses or transmits on behalf of DHCS, in compliance with 45 CFR sections 164.308, 164.310 and 164.312, and to prevent use or disclosure of PHI other than as provided for by this Agreement. Business Associate shall implement reasonable and appropriate policies and procedures to comply with the standards, implementation specifications and other requirements of 45 CFR section 164, subpart C, in compliance with 45 CFR section 164.316. Business Associate shall develop and maintain a written information privacy and security program that includes administrative, technical and physical safeguards appropriate to the size and complexity of the Business Associate's operations and the nature and scope of its activities, and which incorporates the requirements of section 3, Security, below. Business Associate will provide DHCS with its current and updated policies.

2-Plan Contract G.3.B.2.

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Breaches and Security Incidents. During the term of this Agreement, Business Associate agrees to implement reasonable systems for the discovery and prompt reporting of any breach or security incident, and to take the following steps:

1**. Notice to DHCS**. (1) To notify DHCS **immediately by telephone call plus email or fax** upon the discovery of a breach of unsecured PHI or PI in electronic media or in any other media if the PHI or PI was, or is reasonably believed to have been, accessed or acquired by an unauthorized person, or upon the discovery of a suspected security incident that involves data provided to DHCS by the Social Security Administration. (2) To notify DHCS **within 24 hours by email or fax** of the discovery of any suspected security incident, intrusion or unauthorized access, use or disclosure of PHI or PI in violation of this Agreement and this Addendum, or potential loss of confidential data affecting this Agreement. A breach shall be treated as discovered by Business Associate as of the first day on which the breach is known, or by exercising reasonable diligence would have been known, to any person (other than the person committing the breach) who is an employee, officer or other agent of Business Associate.

2. **Investigation and Investigation Report***.* To immediately investigate such security incident, breach, or unauthorized access, use or disclosure of PHI or PI. Within 72 hours of the discovery, Business Associate shall submit an updated "DHCS Privacy Incident Report" containing the information marked with an asterisk and all other applicable information listed on the form, to the extent known at that time, to the DHCS Program Contract Manager, the DHCS Privacy Officer, and the DHCS Information Security Officer:

3. **Complete Report**. To provide a complete report of the investigation to the DHCS Program Contract Manager, the DHCS Privacy Officer, and the DHCS Information Security Officer within ten (10) working days of the discovery of the breach or unauthorized use or disclosure.

2-Plan Contract G.3.H

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SUMMARY OF FINDING(S):

4.3.1 **Background check of employees**

The Plan is required to conduct a thorough background check of employees before the Plan's employee may access DHCS Protected Health Information (PHI) and evaluate the results to assure there is no indication that the worker may present a risk for theft of confidential data. (*Contract Amendment 11, Exhibit G(3)(C)(3)(b)*)

The Plan did not have policies and procedures to address conducting background checks of employees before Plan employees are allowed access to PHI.

Internal correspondence revealed that Plan management became aware of the invalid references a senior case manager provided to obtain employment. The Plan did not conduct a thorough background check of the person when it did not verify the person's listed professional credentials nor act upon discrepancies noted on documents provided by the employee at the time of hire.

DHCS used the Plan's human resources personnel files and government resources to determine that the identity and information used by the Plan's senior case manager to gain employment were invalid. The Plan was unaware of the problem until DHCS informed the Plan's compliance department. Further, the compliance department learned the Plan was not consistently verifying professional licenses of medical staff prior to employment until DHCS pointed out the finding.

The Plan did not consistently verify professional licenses for medical staff prior to their employment. Verifications were not conducted for four staff. On October 26, 2016, the Plan conducted first time license verifications for nine staff hired from January 4, 2016 to August 15, 2016.

The Plan's lack of human resources policies and procedures resulted in access of PHI by employees who did not receive a thorough background check.

RECOMMENDATION(S):

4.3.1 Develop and implement policies and procedures to conduct thorough background checks before employees are allowed access to PHI.

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CATEGORY 5 – QUALITY MANAGEMENT

5.2	PROVIDER QUALIFICATIONS

Credentialing and Re-credentialing:
Contractor shall develop and maintain written policies and procedures that include initial credentialing, recredentialing, recertification, and reappointment of Physicians including Primary Care Physicians and specialists in accordance with the MMCD Policy Letter 02-03, Credentialing and Re-credentialing.
Contractor shall ensure those policies and procedures are reviewed and approved by the governing body, or designee. Contractor shall ensure that the responsibility for recommendations regarding credentialing decisions will rest with a credentialing committee or other peer review body.
2-Plan Contract A.4.12

Standards:
All providers of Covered Services must be qualified in accordance with current applicable legal, professional, and technical standards and appropriately licensed, certified or registered….Providers that have been terminated from either Medicare or Medicaid/Medi-Cal cannot participate in Contractor's provider network.
2-Plan Contract A.4.12.A

Medi-Cal Managed Care Provider Training:
Contractor shall ensure that all providers receive training regarding the Medi-Cal Managed Care program in order to operate in full compliance with the Contract and all applicable Federal and State statutes and regulations. Contractor shall ensure that provider training relates to Medi- Cal Managed Care services, policies, procedures and any modifications to existing services, policies or procedures. Training shall include methods for sharing information between Contractor, provider, Member and/or other healthcare professionals. Contractor shall conduct training for all providers within ten (10) working days after the Contractor places a newly contracted provider on active status….
2-Plan Contract A.7.*5*

Delegated Credentialing:
Contractor may delegate credentialing and recredentialing activities. If Contractor delegates these activities, Contractor shall comply with Provision 6, Delegation of Quality Improvement Activities…
2-Plan Contract A.4.12.B

Disciplinary Actions:
Contractor shall implement and maintain a system for the reporting of serious quality deficiencies that result in suspension or termination of a practitioner to the appropriate authorities. Contractor shall implement and maintain policies and procedures for disciplinary actions including reducing, suspending, or terminating a practitioner's privileges. Contractor shall implement and maintain a provider appeal process.
2-Plan Contract A.4.12.D

Fraud:
Fraud means an intentional deception or misrepresentation made by a person with knowledge that the deception could result in some unauthorized benefit to himself or some other person. It includes any act that constitutes fraud under applicable Federal or State law (42 CFR 455.2; W. & I. Code Section 14043.1(i).)
2-Plan Contract E.2.26.A

SUMMARY OF FINDING(S):

5.2.1 **Provider training attestation**

The Plan is required ensure that all providers receive training regarding the Medi-Cal managed care services, policies, procedures, and any modifications to existing services, policies or procedures. The Plan is required to conduct training for all providers within ten (10) working days after the Plan places a newly contracted provider on active status. (*Contract Exhibit A, Attachment 7(5)(A)*)

Plan policy *PRV-001 New Provider Orientation,* states within ten (10) business days of the newly contracted provider's effective date, the assigned provider relations representative schedules and conducts provider orientation with the newly contracted provider, which includes the physician and applicable office staff. The providers will acknowledge receipt of the training and materials by signing an attestation of provider training.

The Plan submitted two provider training attestation forms to DHCS that contained information that did not match information on the same original forms received from its directly contracted providers. The Plan also submitted seven provider training attestation forms from the Plan's delegated entity that were dated prior to the implementation of their provider training program.

As part of the verification, DHCS conducted onsite confirmations with the contracted providers as to the accuracy and completeness of the signed attestation of provider training forms obtained from the Plan. DHCS verified with the contracted providers when provider training was conducted, when and what documents were signed, and verification that the provider training attestation obtained from the Plan was as submitted

by the provider. Two provider training attestation forms received from the Plan had dates of completion that did not match the original forms received from the providers.

Seven provider training attestation forms were submitted to DHCS by the Plan for a delegated entity. These forms were signed and dated between October 2015 and March 2016 by a delegated entity representative. The Plan initially stated that provider training responsibilities were delegated to the delegated entity; however, the delegation agreement between the Plan and that entity did not include provider training as a delegated function. The Plan's 2015 annual delegation audit conducted, December 7, 2015, shows that the Plan reviewed the delegated entity's provider training program and found that the delegated entity did not have a provider orientation training policy, procedures, log of provider training, or any other evidence that provider training was conducted. As part of their CAP, the delegated entity submitted provider training materials to the Plan on April 1, 2016. The Plan was aware that the delegated entity did not have a mechanism to conduct provider training prior to April 1, 2016.

The Plan did not implement its policy or have controls in place to ensure the completion of new provider training within 10-working days. The Plan's inability to explain or identify how this discrepancy occurred, reflects not only serious process deficiencies but also inadequate oversight efforts.

5.2.2 **Completion of provider training**

The Plan is required to ensure that all providers receive training regarding the Medi-Cal managed care services, policies, procedures, and any modifications to existing services, policies or procedures. The Plan is required to conduct training for all providers within 10-working days after the Plan places a newly contracted provider on active status. *(Contract Exhibit A, Attachment 7(5)(A))*

Plan policy *PRV-001, New Provider Orientation,* states within ten (10) business days of the newly contracted provider's effective date, the assigned provider relations representative schedules and conducts provider orientation with the newly contracted provider, which includes the physician and applicable office staff. The providers will acknowledge receipt of the training and materials by signing a provider visit form.

The Plan's new provider workflow document shows that subsequent to the provider's credentialing, a provider relations representative is to conduct provider orientation within 10-business days of the effective date of the provider's contract.

The Plan did not conduct provider training to newly contracted providers within 10-working days of placing a new provider on active status.

The verification study found nine of 20 sampled provider training attestations were not completed within 10 working days.

The Plan submitted two provider training attestation forms that contained information that did not match information on the same original forms received from its directly contracted providers. The Plan also submitted seven provider training attestation forms from the Plan's delegated entity that were dated prior to the implementation of their provider training program.

The Plan stated provider training responsibilities were delegated; however, the delegation agreement provided to DHCS did not include provider training as a delegated responsibility. As a result, the Plan was responsible for conducting and ensuring the completion of new provider training within 10-business days.

The prior DHCS audit found the Plan did not conduct provider training within 10-working days. As part of the CAP, the Plan reinstated provider training, effective August 1, 2015. Providers were required to sign an attestation upon completion of provider training. However, based on the review of sampled provider training attestation forms, the Plan did not consistently conduct provider training for all newly contracted providers within 10-working days.

When newly contracted providers do not receive training regarding the Plan's processes and Medi-Cal Managed Care services, members may not be provided the full array of services available to them.

This is an ongoing finding.

RECOMMENDATION(S):

5.2.1 Develop and implement controls to ensure the accuracy of provider training documentation

5.2.2 Implement policies and procedures to conduct training for all providers within 10-working days.

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CATEGORY 6 – ADMINISTRATIVE AND ORGANIZATIONAL CAPACITY

6.1	MEDICAL DIRECTOR AND MEDICAL DECISIONS

Medical Director:
Contractor shall maintain a full time physician as medical director pursuant to Title 22 CCR Section 53857 whose responsibilities shall include, but not be limited to, the following:

A. Ensuring that medical decisions are:
   1) Rendered by qualified medical personnel.
   2) Are not influenced by fiscal or administrative management considerations.
B. Ensuring that the medical care provided meets the standards for acceptable medical care.
C. Ensuring that medical protocols and rules of conduct for plan medical personnel are followed.
D. Developing and implementing medical policy.
E. Resolving grievances related to medical quality of care.
F. Direct involvement in the implementation of Quality Improvement activities.
G. Actively participating in the functioning of the plan grievance procedures.

2-Plan Contract A.1.6

Medical Decisions:
Contractor shall ensure that medical decisions, including those by sub-contractors and rendering providers, are not unduly influenced by fiscal and administrative management.
2-Plan Contract A.1.5

Contract Performance:
The Contractor shall maintain the organization and staffing for implementing and operating the Contract in accordance with Title 28, CCR, Section 1300.67.3 and Title 22 CCR Sections 53800, 53851, 53857. Contractor shall ensure the following:

D. Staffing in medical and other health services, and in fiscal and administrative services sufficient to result in the effective conduct of the plan's business.

2-Plan Contract A.1.4

References Cited:

Title 22 CCR Section 53857 - Medical Director

SUMMARY OF FINDING(S):

6.1.1 **Qualified medical personnel**

The Plan shall maintain a full time physician as medical director pursuant to Title 22 CCR Section 53857 whose responsibilities shall include ensuring that medical decisions are

rendered by qualified medical personnel. (*Contract Amendment 11, Exhibit A, Attachment 1(6)*)

The Plan shall maintain the organization and staffing for implementing and operating the Contract. The Plan shall ensure staffing in medical and other health services sufficient to result in the effective conduct of the plan's business. (*Contract Amendment 11, Exhibit A, Attachment 1(4)*)

The Plan did not ensure qualified medical personnel were responsible for implementation of the Case Management Program. The Plan had a senior case manager who provided an invalid license and credentials to obtain employment. The Plan did not have policies and procedures in place to ensure that medical staff are qualified to conduct the Plan functions that involve clinical matters. The Plan was not consistently verifying professional licenses for medical staff prior to their employment. The duties of a case manager include assistance in managing the care of medically complex members by coordinating services that will ensure the improvement of patient outcomes and member satisfaction.

The Plan's lack of policies and procedures allowed unqualified staff to manage the care and services of Plan members.

RECOMMENDATION(S):

6.1.1 Develop and implement policies, procedures, and controls to ensure that qualified medical personnel are responsible for the execution of the Plan's contract requirements that involve clinical matters.

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6.3	FRAUD AND ABUSE

Fraud and Abuse Reporting
Contractor shall meet the requirements set forth in 42 CFR 438.608 by establishing administrative and management arrangements or procedures, as well as a mandatory compliance plan, which are designed to guard against fraud and abuse….

1) Contractor shall establish an Anti-Fraud and Abuse Program in which there will be a compliance officer and a compliance committee for all fraud and/or abuse issues, and who shall be accountable to senior management. This program will establish policies and procedures for identifying, investigating and providing a prompt response against fraud and/or abuse in the provision of health care services under the Medi-Cal Program, and provide for the development of corrective action initiatives relating to the contract.
2) Contractor shall provide effective training and education for the compliance officer and all employees.
3) Contractor shall make provision for internal monitoring and auditing including establishing effective lines of communication between the compliance officer and employees and enforcement of standards through well-publicized disciplinary guidelines.
4) Fraud and Abuse Reporting—Contractor shall report to DHCS all cases of suspected fraud and/or
abuse where there is reason to believe that an incident of fraud and/or abuse has occurred by subcontractors, members, providers, or employees. Contractor shall conduct, complete, and report to
DHCS, the results of a preliminary investigation of the suspected fraud and/or abuse within 10 working days of the date Contractor first becomes aware of, or is on notice of, such activity….
5) Tracking Suspended Providers—Contractor shall comply with 42 CFR 438.610. Additionally, Contractor is prohibited from employing, contracting or maintaining a contract with physicians or other health care providers that are excluded, suspended or terminated from participation in the Medicare or Medi-Cal/Medicaid programs….

2-Plan Contract E.2.26.B

Fraud:
Fraud means an intentional deception or misrepresentation made by a person with knowledge that the deception could result in some unauthorized benefit to himself or some other person. It includes any act that constitutes fraud under applicable Federal or State law (42 CFR 455.2; W. & I. Code Section 14043.1(i).)
2-Plan Contract E.2.26.A

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SUMMARY OF FINDING(S):

6.3.1 **Fraud and abuse case reporting**

The Plan shall report to DHCS all cases of suspected fraud and/or abuse where there is reason to believe that an incident of fraud and/or abuse has occurred by subcontractors, members, providers, or employees. The Plan shall conduct, complete, and report the results of a preliminary investigation of the suspected fraud and/or abuse to DHCS within 10-working days of the date the Plan first becomes aware of, or is on notice of, such activity. (*Contract Amendment 11, Exhibit E, Attachment 2(26)(B)(4)*)

Plan policy *CMP-002, Fraud, Waste, and Abuse,* states, "if after preliminary investigation, the Plan finds reason to believe that a Fraud, Waste, and Abuse (FWA) incident has occurred by subcontractors, members, or providers, the Plan's Compliance Department will report the suspected FWA incident to the Department of Health Care Services within 10 working days of the date the Plan becomes first aware or notified of the suspected activity."

The Plan did not report all suspected cases of fraud and/or abuse to DHCS within 10-working days.

The Plan's FWA log showed 11 cases for the audit period. Seven of 11 cases were not reported to DHCS within 10-working days. The Plan conducted preliminary investigations to determine whether there was potential fraud and only reported cases where it determined that there was potential fraud. The Plan's policies and procedures did not reflect the contract requirement of reporting all suspected cases fraud and/or abuse within 10-working days of becoming aware of the incident.

RECOMMENDATION(S):

6.3.1 Revise and implement policies and procedures to report all cases of suspected fraud or abuse to DHCS within 10-working days.

MEDICAL REVIEW - NORTH SECTION
AUDITS AND INVESTIGATIONS
DEPARTMENT OF HEALTH CARE SERVICES

Alameda Alliance for Health

Contract Number:	03-75793 State Supported Services
Audit Period:	June 1, 2015 Through May 31, 2017
Report Issued:	January 23, 2018

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INTRODUCTION

This report presents the audit findings of the Alameda Alliance for Health (the Plan) State Supported Services contract No. 03-75793. The State Supported Services contract covers contracted abortion services with the Plan.

The onsite audit was conducted in intervals between June 27, 2016 through May 9, 2017. The audit period was June 1, 2015 through May 31, 2017 and consisted of document review, verification study, and interviews with Plan personnel.

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STATE SUPPORTED SERVICES CONTRACT REQUIREMENTS
Abortion *Contractor agrees to provide, or arrange to provide, to eligible Members the following State Supported Services:* *Current Procedural Coding System Codes*: 59840 through 59857* *HCFA Common Procedure Coding System Codes*: X1516, X1518, X7724, X7726, Z0336* **These codes are subject to change upon the Department of Health Services' (DHS') implementation of the Health Insurance Portability and Accountability Act of 1996 (HIPAA) electronic transaction and code sets provisions. Such changes shall not require an amendment to this Contract.* *State Supported Services Contract Exhibit A.1*

SUMMARY OF FINDINGS:
There were no deficiencies identified in the current audit.

RECOMMENDATIONS:
N/A