

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

Alameda Alliance for Health

Contract Number: 04-35399

Audit Period: April 1, 2014
Through
March 31, 2015

Report Issued: November 13, 2015

TABLE OF CONTENTS

I.	INTRODUCTION	1
II.	EXECUTIVE SUMMARY	2
III.	SCOPE/AUDIT PROCEDURES	4
IV.	COMPLIANCE AUDIT FINDINGS	
	Category 1 – Utilization Management	6
	Category 2 – Case Management and Coordination of Care	17
	Category 3 – Access and Availability of Care	24
	Category 4 – Member’s Rights	37
	Category 5 – Quality Management	48
	Category 6 – Administrative and Organizational Capacity	55

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 Healthcare Services 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.

On May 8, 2014, the Department of Managed Health Care (DMHC) appointed Mark Abernathy of the Berkeley Research Group to serve as the Plan's conservator. The Plan had experienced dramatic growth in Membership and had problems with Plan functions, including a major back-log of claims and problems with the Plan's computer software systems. The conservatorship was overseeing the Plan through the issuance of the audit report.

As of 2015, the Plan's enrollment for Medi-Cal, Medi-Cal SPD Duals, and Group Care was approximately 241,835. Specific enrollment was as follows: Medi-Cal (234,119), Medi-Cal SPD Duals (2,370), and Group Care (5,346).

II. EXECUTIVE SUMMARY

This report presents the audit findings of the Department of Health Care Services (DHCS) medical audit for the period of April 1, 2014 through March 31, 2015. The onsite review was conducted from June 8, 2015 through June 18, 2015. The audit consisted of document reviews, verification studies, and interviews with Plan personnel.

The audit evaluated six categories of performance: Utilization Management (UM), Continuity of Care, Access and Availability of Care, Members' Rights, Quality Management (QM), and Administrative and Organizational Capacity.

The summary of the findings by category follows:

Category 1 – Utilization Management

The Utilization Management Program was not continuously updated and improved.

The Plan denied one pharmacy and two medical prior authorizations without sufficient Medical review. Prior authorizations were not processed timely and communications regarding prior authorization decisions were not consistently sent to Members.

The Plan's appeals system had significant deficiencies. The Plan withdrew and closed appeals without a resolution, improperly processed expedited appeals, and did not communicate with Members regarding decisions and changes in appeal status.

The Plan did not perform adequate oversight of delegates' UM functions, and did not ensure standards were met.

Category 2 – Case Management and Coordination of Care

The Plan did not monitor or coordinate care for Members requiring Early Intervention and Developmental Disabilities services.

The Plan did not ensure that Initial Health Assessments were provided within 120 calendar days following the date of enrollment.

The Plan did not ensure the provision of Complex Case Management to identified Members.

Category 3 – Access and Availability of Care

The Plan's method of monitoring access did not measure the length of time to obtain various appointments and did not reflect compliance with access requirements. The Plan did not monitor whether Providers answered calls timely or whether those calls were returned. The Plan's Provider Directory did not accurately reflect the number of primary care Providers and specialists available within the Plan's network.

The Plan's telephone procedures did not include an option to speak to a live person or to direct Members to an appropriately licensed professional. The Plan did not have an adequate number of specialists available to its Members.

The Plan experienced significant problems processing claims within the required time frame. Claims incorrectly sent to the Plan were not forwarded timely to the responsible entity. The Plan did not ensure that Members had access to a sufficient supply of medications prescribed in emergency circumstances.

Category 4 – Member's Rights

The Plan's grievance system did not capture and identify all grievances, and did not process or address problems identified. The Plan closed grievance cases and sent Members a resolution letter without reaching a resolution.

The Plan did not provide 24-hour access to oral interpreter services at all key points of contact.

The Plan did not report an actual breach of PHI, a suspected security incident, or ensure new Network Providers implemented safeguards to protect PHI.

Category 5 – Quality Management

The Plan's Governing Board did not conduct adequate oversight of Utilization Management and Quality Improvement. The Plan did not monitor, or continuously improve the quality of care within the Plan's network.

The Plan did not conduct annual oversight for entities with delegated QI activities. The Plan did not train new Providers.

Category 6 – Administrative and Organizational Capacity

The Plan did not ensure that medical care met acceptable standards in four instances.

The Plan did not investigate or report all cases of suspected Fraud or Abuse, and did not implement its Anti-Fraud and Abuse Program.

III. SCOPE/AUDIT PROCEDURES

SCOPE

This audit was conducted by the Department of Health Care Services (DHCS) Medical Review Branch to ascertain that the medical services provided to Plan Members comply with federal and state laws, Medi-Cal regulations and guidelines, and the State Contract.

PROCEDURE

The on-site review was conducted from June 8, 2015 through June 18, 2015. The audit included a review of the Plan's policies for providing services, the procedures used to implement the policies, and verification studies of the implementation and effectiveness of the policies. Documents were reviewed and interviews were conducted with Plan administrators and staff.

The following verification studies were conducted:

Category 1 – Utilization Management

Prior Authorization Requests: 45 medical and 39 pharmacy prior authorization requests were reviewed for timeliness, consistent application of criteria, and appropriate review.

Appeal Procedures: 44 prior authorization appeals were reviewed for appropriate and timely adjudication.

Category 2 – Case Management and Coordination of Care

California Children's Services (CCS): 6 medical records were reviewed for evidence of coordination of care between the Plan and CCS Providers.

Complex Case Management (CCM): 4 records were reviewed for coordination of care.

Category 3 – Access and Availability of Care

Claims: 25 emergency services and 20 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 to review.

HIPAA: 2 HIPAA cases were reviewed for appropriate reporting and processing.

Category 5 – Quality Management

New Provider Training: 11 new Provider training records were reviewed for timely Medi-Cal Managed Care program training.

Category 6 – Administrative and Organizational Capacity

Fraud and Abuse: 20 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) ❖

PLAN: Alameda Alliance for Health

AUDIT PERIOD: April 1, 2014 - March 31, 2015

DATE OF AUDIT: June 8, 2015 – June 18, 2015

CATEGORY 1 - UTILIZATION MANAGEMENT

1.1

UTILIZATION MANAGEMENT PROGRAM

Utilization Management (UM) Program Requirements:

Contractor shall develop, implement, and continuously update and improve, a Utilization Management (UM) program that ensures appropriate processes are used to review and approve the provision of Medically Necessary Covered Services. ... (as required by Contract)

2-Plan Contract A.5.1

There is a set of written criteria or guidelines for utilization review that is based on sound medical evidence, is consistently applied, regularly reviewed, and updated.

2-Plan Contract A.5.2.C

Review of Utilization Data:

Contractor shall include within the UM Program mechanisms to detect both under- and over-utilization of health care services. Contractor's internal reporting mechanisms used to detect Member Utilization Patterns shall be reported to DHCS upon request.

2-Plan Contract A.5.4

SUMMARY OF FINDINGS:

1.1.1 The Utilization Management (UM) program was not continuously updated, improved, and integrated into the Quality Improvement System (QIS)

The Plan must develop, implement, and continuously update and improve, a UM program that ensures appropriate processes were used to review and approve the provision of medically necessary covered services. (*Contract, Exhibit A, Attachment 5(1)(G)*)

The Plan did not update or improve its UM program to reflect its evaluation of overturned appeals. Plan prior authorization (PA) appeal data for 5 entities delegated UM was reviewed by DHCS. There were 1216 PA denials total, with 158 appealed and 131 of those overturned. One delegated entity had all 94 of their appeals overturned. This pattern of overturned appeals was not identified by the Plan and thus not investigated. With no results of an investigation, the Plan could not improve its UM system for prior authorizations (PAs) and appeals and integrate the findings into the QIS. Another example was lack of comparison (benchmarking) of inpatient utilization patterns to that of similar health plans, thus limiting UM process improvements and QIS integration.

RECOMMENDATIONS:

1.1.1 Improve the UM program by continuously updating and integrating UM PA appeals data into the QIS.

❖ COMPLIANCE AUDIT FINDINGS (CAF) ❖

PLAN: Alameda Alliance for Health

AUDIT PERIOD: April 1, 2014 - March 31, 2015

DATE OF AUDIT: June 8, 2015 – June 18, 2015

1.2

PRIOR AUTHORIZATION REVIEW REQUIREMENTS

Prior Authorization and Review Procedures:

Contractor shall ensure that its pre-authorization, concurrent review and retrospective review procedures meet the following minimum requirements...(as required by Contract)

2-Plan Contract A.5.2.A, B, D, F, H, and I.

Exceptions to Prior Authorization:

Prior Authorization requirements shall not be applied to emergency services, family planning services, preventive services, basic prenatal care, sexually transmitted disease services, and HIV testing.

2-Plan Contract A.5.2.G

Timeframes for Medical Authorization

Pharmaceuticals: 24 hours or one (1) business day on all drugs that require prior authorization in accordance with Welfare and Institutions Code, Section 14185 or any future amendments thereto.

2-Plan Contract A.5.3.F

Routine authorizations: Five (5) working days from receipt of the information reasonably necessary to render a decision (these are requests for specialty service, cost control purposes, out-of-network not otherwise exempt from prior authorization) in accordance with Health and Safety Code, Section 1367.01, or any future amendments thereto, but, no longer than 14 calendar days from the receipt of the request. The decision may be deferred and the time limit extended an additional 14 calendar days only where the Member or the Member's Provider requests an extension, or the Contractor can provide justification upon request by the State for the need for additional information and how it is in the Member's interest. Any decision delayed beyond the time limits is considered a denial and must be immediately processed as such.

2-Plan Contract A.5.2.H

Denial, Deferral, or Modification of Prior Authorization Requests:

Contractor shall notify Members of a decision to deny, defer, or modify requests for prior authorization, in accordance with Title 22 CCR Sections 51014.1 and 53894 by providing written notification to Members and/or their authorized representative...This notification must be provided as specified in 22 CCR Sections 51014.1, 51014.2, and 53894, and Health and Safety Code Section 1367.01.

2-Plan Contract A.13.8.A

SUMMARY OF FINDINGS:

1.2.1 The Plan denied one pharmacy and two medical prior authorizations (PAs) without sufficient Medical review

The Plan must ensure that (A) decisions to deny or authorize an amount, duration of scope less than requested must be made by a qualified health care professional with appropriate clinical expertise in treating the disease; (B) a qualified physician will review all denials on the basis of medical necessity, with a pharmacist able to make most pharmacy denial decisions; (C) a set of written criteria or guidelines are used for utilization review, based on sound medical evidence and consistently applied and (D) reasons for decision making are clearly documented. (*Contract, Exhibit A, Attachment 5(2)*)

The following three PA denials illustrated non-adherence to these contractual requirements:

- Victoza, an injectable diabetes medication, was denied for lack of medical necessity in a complex, uncontrolled diabetic Member on multiple diabetes medications with HgbA1C not being under 9%. Other decision criteria used were not documented and recommendations were not made to the Provider for formulary alternatives. There was no documentation of input by a qualified physician (Medical Director), as would be necessary with clinical issues outside of the scope of expertise of the pharmacist. The denial was overturned on appeal one month later.

❖ COMPLIANCE AUDIT FINDINGS (CAF) ❖

PLAN: Alameda Alliance for Health

AUDIT PERIOD: April 1, 2014 - March 31, 2015

DATE OF AUDIT: June 8, 2015 – June 18, 2015

- A 5 day inpatient stay for a Member with a complex history, including recurrent autoimmune pancreatitis, multiple past surgeries, and recent abdominal surgery and discharge 4 days prior was denied. Denial was for lack of medical necessity per MCG/Milliman criteria. The Member had nausea, vomiting, elevated WBC and elevated lactic acid level, with CT scan of the abdomen suggesting small bowel obstruction. Blood cultures were obtained, IV antibiotics started, oral intake was discontinued and IV fluids administered. The WBC remained elevated through the hospital stay. This Member had elevated risk and high intensity of service. The PA record documented no other criteria used to deny other than MCG/Milliman, regarded as only one tool used in medical decision making and not applicable to all decisions. The Plan did not document calls to the attending physician and other treating physicians.
- A 79 day inpatient stay for a Member with a complex medical history, including bipolar illness, polysubstance abuse, active cavitory pulmonary tuberculosis, cough, night sweats, fevers, failed attempts at outpatient supervised therapy and escape from house arrest was denied. The Member and the public were endangered by lack of proper treatment of this highly communicable disease. The Member arrived with a legal order for admission and treatment in the hospital. The entire inpatient stay was denied for lack of medical necessity per inpatient MCG/Milliman criteria for pulmonary disease. No other criteria to ascertain medical necessity were used and documented in this difficult scenario. The Plan did not document discussions and phone conversations with other Providers and medical professionals involved in the Member's care.

1.2.2 The Plan did not process medical PAs within the required time frames in 11 instances

The Plan is required to process routine medical PAs within five working days from receipt of information reasonable necessary to render a decision, but no longer than 14 calendar days from the receipt of the receipt of the routine medical PA request. This period may be extended another 14 calendar days if the Member or Provider requests an extension or if the Plan can show that it is in the best interest of the Member. (*Contract, Exhibit A, Attachment 5 (3) (G)*)

Time frames for routine medical PAs were exceeded in 11 instances.

1.2.3 Notice of action (NOA) letters in pharmacy PAs did not identify the decision maker or include contact information

The Plan must ensure that NOA letters include the name and telephone number of the health care professional responsible for the denial, delay, or modification of the PA. (*CA H&S Code Section 13.67.01(h)(4)*)

Thirty four pharmacy PAs did not include the name of the decision maker and contact telephone number.

1.2.4 One NOA letter was not clear and concise and did not specify criteria used in medical PA decision

The Plan is required to follow guidelines requiring that communications to Members and Providers include a clear and concise explanation for the decision and the criteria used (*CA H&S Code Section 1367.01(h) (4)*). One medical PA NOA letter for a CT scan of the abdomen and pelvis was not clear and concise and did not state exactly why the request was denied, instead listing all of the possible reasons for PA denial.

1.2.5 NOA letters for pharmacy and medical PAs were not translated to the Plan's threshold languages

The Plan is required to fully translate informing materials, including NOA letters, into the Plan's threshold languages. (*Contract, Exhibit A, Attachment 9, (B) (2)*)

❖ COMPLIANCE AUDIT FINDINGS (CAF) ❖

PLAN: Alameda Alliance for Health

AUDIT PERIOD: April 1, 2014 - March 31, 2015

DATE OF AUDIT: June 8, 2015 – June 18, 2015

NOA letters were not sent in Spanish for 8 pharmacy PAs and 4 medical PAs, Vietnamese in one medical PA, and Chinese in one medical PA. A general statement was placed across the top of each letter to contact the Plan if the Member could not understand the letter content. This statement does not meet the requirement of fully translated informing materials.

1.2.6 The Plan did not notify its Members of medical PA decisions in 5 instances

The Plan is required to notify Members of a decision to deny, defer or modify PA requests by providing written notification to Members or their authorized representatives. (*CCR, Title 22, sections 51014.1 and 53894*)

The Plan did not send NOA letters for 5 medical PAs, as evidenced by their absence in the Members' PA case files.

1.2.7 The Plan did not include the date of completion in four NOA letters for medical PAs

PA decisions to deny, delay or modify a request for health care services must be communicated to the Member in writing within two business days of the decision (*CA H&S Code Section 1367.01, (h)(4)*).

The Plan did not include the date of completion in 4 NOA letters for medical PAs, and thus we could not ensure compliance with medical PA decision communications and time frames in these instances.

RECOMMENDATIONS:

- 1.2.1 Base PA decisions on consistent application of written utilization criteria, including evidence-based medicine guidelines. Document all sources of information used in decision making, including calls to other physicians.
- 1.2.2 Comply with all time frames for medical PAs.
- 1.2.3 Identify the primary decision maker and contact information on pharmacy NOA letters.
- 1.2.4 Specify the criteria used in decision making and provide Members with clear and concise NOA letters.
- 1.2.5 Translate all written materials sent to Members into the appropriate threshold language.
- 1.2.6 Provide written notification to Members for all denied, deferred, or modified medical PAs.
- 1.2.7 Include the date of completion on all NOA letters for medical PAs.

❖ COMPLIANCE AUDIT FINDINGS (CAF) ❖

PLAN: Alameda Alliance for Health

AUDIT PERIOD: April 1, 2014 - March 31, 2015

DATE OF AUDIT: June 8, 2015 – June 18, 2015

1.3

REFERRAL TRACKING SYSTEM

Referral Tracking System:

Contractor is responsible to ensure that the UM program includes: ... An established specialty referral system to track and monitor referrals requiring prior authorization through the Contractor. The system shall include authorized, denied, deferred, or modified referrals, and the timeliness of the referrals.

2-Plan Contract A.5.1.F

SUMMARY OF FINDINGS:

1.3.1 The Plan did not have a referral tracking system for authorized, denied, deferred, and modified prior authorizations (PAs)

The Plan is required to establish a specialty referral system to track and monitor referrals requiring PAs throughout the Plan including authorized, denied, deferred, or modified referrals and the timeliness of the referrals. (*Contract, Exhibit A, Attachment 5, (1) (F)*)

The Plan did not have a specialty referral tracking system for PAs that met the contractual requirements.

1.3.2 The Plan did not track or ensure that authorized PA services were completed in a timely manner

The Plan is responsible for a specialty referral tracking system which includes tracking authorized PA services to ensure timeliness of their completion. (*Contract, Exhibit A, Attachment 5, (1) (F)*)

The Plan did not track referral services for Members and relied on Plan Providers to refer them to the appropriate resources. The Plan had no mechanism to ensure that these services were completed in a timely manner.

RECOMMENDATIONS:

1.3.1 Develop and implement a system to track authorized, denied, deferred, and modified PAs.

1.3.2 Develop and implement a system to ensure that authorized PA services are completed in a timely manner.

❖ COMPLIANCE AUDIT FINDINGS (CAF) ❖

PLAN: Alameda Alliance for Health

AUDIT PERIOD: April 1, 2014 - March 31, 2015

DATE OF AUDIT: June 8, 2015 – June 18, 2015

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 FINDINGS:

1.4.1 Three of the Plan's appeal notification letters were unclear and contained misinformation

The Plan is required to communicate appeal decisions in clear and concise language. (*Contract, Exhibit A, Attachment 9(14) (B) (2)*)

The Plan sent appeal resolution letters containing complicated clinical information not pertinent to cases, erroneous or outdated content, and grammatically incorrect language. Denial letters mailed to Members erroneously documented that the FDA had not approved certain pharmaceuticals. In one case, an appeal resolution letter denied a spinal computed tomography (CT) scan while explaining why a nuclear medicine heart test was not medically needed by the Member. In another case, the Plan's letter stated that an expert had found no justification for "radiation treatment" of a Member's cancer when the consultant had reviewed and not supported "intensity modulated radiotherapy", a very specific type of treatment. In another, a pharmacist pointed out the error in a letter but the Plan did not send corrected information. Non-clinical staff prepared appeal notification letters.

1.4.2 The same Medical Director who reviewed prior authorizations also resolved related appeals

The Plan must ensure that a different Medical Director (MD) decide the appeal of a previously denied prior authorization. (*Contract, Exhibit A, Attachment 14(2) (G) (1)*)

When the Plan received additional information about a denied prior authorization on appeal, and that information resulted in a reversal of the original decision, the same Medical Director who reviewed the prior authorization resolved the appeal. A review of appeal files confirmed this practice.

1.4.3 The Plan did not process three expedited appeal cases within three working days

The Plan must resolve expedited appeals in three working days. (*Contract, Exhibit A, Attachment 14(6)(C)*)

The Plan denied expedited status of three appeals on the day of decision, which was more than three days after receipt. In one of these, a registered nurse (RN) reviewer initially approved expedited status for care of a possible foot infection but the Medical Director reversed the urgent status on the same day she resolved the appeal. In another case, the Medical Director resolved an appeal and demoted it from expedited to routine status at the same time. In another case, the Plan closed an expedited appeal without RN or Medical Director review after the Member lost Plan eligibility. Nineteen days passed between the date of appeal submission and the date of closure in each of the above cases.

1.4.4 The Plan did not notify five Members of a change in appeal status from expedited to non-expedited

The Plan must send a Member written notification of a change from expedited to non-expedited appeal status within 2 days. (*CFR, Title 42, Section 438.410*)

❖ COMPLIANCE AUDIT FINDINGS (CAF) ❖

PLAN: Alameda Alliance for Health

AUDIT PERIOD: April 1, 2014 - March 31, 2015

DATE OF AUDIT: June 8, 2015 – June 18, 2015

The Plan did not send letters or was late in notifying the Member of denial of expedited status in five cases, including cases initially entered as non-expedited and where the Member later asked for an expedited review. In one of these, the Plan sent a Member a combined denial of expedited status and denial of medication letter six days after appeal submission. Another case showed that the Plan denied expedited status of a request to continue non-formulary medication for severe cystic acne but never notified the Member in writing though the case required twenty eight days to resolve. In another case, the Plan required fourteen days to resolve a case involving referral to a geneticist and did not notify the Member in writing that the case was not considered urgent. Two cases showed that the Plan changed the case to non-expedited on the day of resolution and did not notify the Member of this.

1.4.5 **The Plan did not ensure that only qualified clinical professionals changed an appeal from expedited to non-expedited (NE) status**

The Plan must ensure that grievances are reported to the appropriate level and that medical necessity related appeals are resolved by qualified clinical professionals. (*Contract, Exhibit A, Attachment 14(2)(D)*)

Plan Policy *MED-CGR-0001 Member Grievances and Appeals* established that RN reviewers will approve or deny expedited status of an appeal.

In two cases, a non-clinical person changed an appeal to non-expedited instead of referring the case to an RN for review.

1.4.6 **The Plan did not change an appeal to expedited when circumstances indicated possible imminent danger to a Member in two instances**

The Plan must ensure that grievances are reported to the appropriate level and that medical necessity – related appeals are resolved by qualified clinical professionals. (*Contract, Exhibit A, Attachment 14(2)(D)*)

Plan Policy establishes that the Plan must ensure that an appeal is expedited and forwarded for RN review when requested by the Member or when case details indicate possible severe health complications. (*MED-CGR-0001 Member Grievances and Appeals*)

In one case a Member appealed the denial of his asthma medication in a letter noting his urgent need for this lifesaving medication; the Plan processed the case routinely without RN consultation. In another appeal, a patient called stating she had only five days' worth of her seizure medications; the matter was not referred to an RN to determine if the case should be expedited.

1.4.7 **The Plan closed an expedited appeal without resolution when it discovered Member non-eligibility and did not notify the Member of his right to a state fair hearing**

The Plan is required to provide appeal resolution notices which contain state fair hearing information, how to receive benefits while the hearing is pending and how to request the continuation of benefits. (*Contract, Exhibit A, Attachment 14(5) (B)*)

In one case, the Plan processed an expedited appeal late; the Member subsequently lost his eligibility. He was not informed of his final appeal rights as the Plan's resolution letter only informed the Provider that the case could not be completed due to ineligibility and directed the Provider to call with questions. The Plan did not notify the Member of his state fair hearing rights, how to receive benefits while the hearing was pending or about how to request the continuation of benefits.

❖ COMPLIANCE AUDIT FINDINGS (CAF) ❖

PLAN: Alameda Alliance for Health

AUDIT PERIOD: April 1, 2014 - March 31, 2015

DATE OF AUDIT: June 8, 2015 – June 18, 2015

1.4.8 The Plan closed three appeals before completion of the appeal process

The Plan must ensure that the final decision-maker of an appeal involving medical necessity is a Medical Director or licensed pharmacist. (*Contract, Exhibit A, Attachment 14(2)(G)(1)*)

In three instances, the Plan closed appeals without review by a Medical Director when denials were overturned. In one case, the Plan supplied a Member with his asthma medicine after it found that the original denial was an error. Plan staff notified the Member that the appeal could be considered withdrawn as the medication was approved; the Member agreed. Another case showed a Plan Grievances and Appeals (G&A) registered nurse (RN) obtained a delegated entity's approval for an Orthopedist after initial denial for a podiatrist referral. The Plan notified the Member who then withdrew her appeal. In another case, the same delegated entity overturned its denial for an out of Plan geneticist consultation upon discussion with the same Plan G&A RN after it could not find an in-Plan qualified geneticist. The Plan sent the Member an appeal resolution letter and closed the case without Medical Director review.

1.4.9 The Plan did not send acknowledgement or resolution letters to Providers who filed appeals on Members' behalf in 11 cases

The Plan must adjudicate appeals using requirements set forth in state regulations. This includes the requirement for sending written acknowledgement of an appeal and resolution letters to complainants. (*Contract, Exhibit A, Attachment 14(1); CCR, Title 28, Section 1300.68(d)(1)*) Additionally, the process for appeals must include as parties to the appeal the enrollee and his or her representative. (*CFR, Title 42, Section 438.406, (a), (b), (4)*)

In eleven cases of Provider appeal on Member's behalf, the Plan did not send an acknowledgement letter to the complainant. Six Providers did not receive appeal resolution letters though they submitted the initial appeal; in one of these cases, the Plan did not notify the Provider of a withdrawn appeal.

1.4.10 The Plan did not send appeal resolution letters in its threshold languages in three cases

The Plan is required to provide for the cultural and linguistic needs of health plan Members; this includes translating appeal responses into the Plan's threshold languages of English, Spanish, Vietnamese and Chinese when records or interaction with Members indicate a clear preference for one of these languages. (*Contract, Exhibit A, Attachment 9(14) (B)(2)*)

In three of forty-two cases, the Members received appeal letters in English when documentation clearly indicated a threshold language of Spanish, leaving them without understandable information about their requests for medical services. This problem was also noted in communications pertaining to grievances and Prior Authorization requests.

1.4.11 Plan policy had incorrect timeframes for processing appeals

The Plan is required to decide appeals within 45 calendar days, acknowledge appeal receipt within 5 calendar days, and allow extension of appeal resolution by up to 14 calendar days if more information is needed. (*Contract, A11, Exhibit A, Attachment 14(5) (A); CCR, Title 28, Section 1300.68; CFR, Title 42, Section 438.408*)

Plan policy *MED-GEN-0004 Review for Medical Necessity and Provider Appeals* contained incorrect timeframes for processing appeals. The policy established that appeals would be acknowledged within 15 working days, that the Plan had 45 working days to resolve an appeal, that the Plan would inform a Provider that it must receive additional information if needed to resolve an appeal within 45 working days of a request, and that an additional 30 days after receipt of this information were allowed to resolve an appeal. The Plan is using both incorrect timeframes (day count) and working days as the basis for deadlines, instead of the calendar day basis allowed by the requirements.

❖ COMPLIANCE AUDIT FINDINGS (CAF) ❖

PLAN: Alameda Alliance for Health

AUDIT PERIOD: April 1, 2014 - March 31, 2015

DATE OF AUDIT: June 8, 2015 – June 18, 2015

1.4.12 **The Plan reset the date of receipt for three appeals submitted by Providers on Member's behalf to the date the Member agreed to the action in writing**

The Plan's Contract requires that it resolve appeals and notify the member within 45 days of receipt of the appeal. (*Contract, Exhibit A, Attachment 14(5) (B)*)

In addition, CFR, Title 42, Section 438.408 establishes 45 days from the date of appeal receipt as the resolution date. It also allows for verbal submission of an appeal with later confirmation in writing to establish the earliest possible filing date for the appeal.

In three cases, the Plan reset the initial date of appeal to match the date the member approved of a provider/advocate-filed appeal in writing. This reset was out of compliance with the requirements for appeal processing which establishes that the date of receipt by the Plan is the initial date of the appeal.

RECOMMENDATIONS:

- 1.4.1 Ensure that all appeal resolution letters contain clear, concise and correct information regarding the Plan's decisions to deny or approve services.
- 1.4.2 Ensure that PA appeals are reviewed by a Medical Director not involved in the original PA decision.
- 1.4.3 Process expedited cases within regulatory timeframes.
- 1.4.4 Provide written notification of a change from expedited to non-expedited status within regulatory timeframes (within 2 days of change in status).
- 1.4.5 Ensure clinical staff change appeal status from expedited to non-expedited.
- 1.4.6 Categorize appeals as expedited and appropriate for RN review when the Member or Provider requests or when the details indicate a potential health crisis.
- 1.4.7 Include information about the right to a state fair hearing in appeal resolution letters.
- 1.4.8 Ensure proper completion of the appeal process. Comply with contractual requirements for timely processing, written communication and review by an appropriate clinical individual.
- 1.4.9 Send Providers acknowledgement and resolution letters when they file appeals on behalf of Members.
- 1.4.10 Send appeal acknowledgement and resolution letters in the Plan's threshold languages.
- 1.4.11 Adhere to correct timeframes for Provider appeals submitted on behalf of a Member (5 days for a written notification of appeal receipt; 45 days to resolve) in all Plan policies.
- 1.4.12 Use the date of appeal receipt by the Plan as the initial date of the appeal.

❖ COMPLIANCE AUDIT FINDINGS (CAF) ❖

PLAN: Alameda Alliance for Health

AUDIT PERIOD: April 1, 2014 - March 31, 2015

DATE OF AUDIT: June 8, 2015 – June 18, 2015

1.5

DELEGATION OF UTILIZATION MANAGEMENT

Delegated Utilization Management (UM) Activities:

Contractor may delegate UM activities. If Contractor delegates these activities, Contractor shall comply with Exhibit A, Attachment 4, Provision 6. Delegation of Quality Improvement Activities.
2-Plan Contract A.5.5

SUMMARY OF FINDINGS:

1.5.1 The Plan did not adequately monitor delegated entities

The Plan must continuously monitor, evaluate and approve the delegated functions of its subcontractors and ensure they meet Plan and DHCS standards. (*Contract, Exhibit A, Attachment 4, (6), (B)*).

The Plan's Compliance Committee identified a need to survey Plan departments regarding delegated entities' assigned responsibilities for the purpose of resolving conflicting information. Without accurately knowing its delegated functions, the Plan could not provide appropriate oversight of its subcontractors and ensure they met standards, including those for UM and QI.

The Plan delegated UM duties to seven entities during the audit period and did not complete annual audits for five of these subcontractors. In one of these five cases, the Plan conducted a scheduled review but determined that it would return to repeat part of the delegate's audit due to insufficient information. It did not specify a date for reexamination and issued the subcontractor a passing score in spite of incomplete data. The Plan did not perform adequate oversight of delegates' UM functions, and did not ensure standards, including the appropriate denial of requests for medical services and satisfactory communication of these decisions to Members and Providers, were met.

1.5.2 The Plan did not continuously monitor, evaluate and approve its delegates' UM activities

The Plan must continuously examine its subcontractors' performance of delegated duties and determine whether they satisfy requirements set by the Plan and DHCS. (*Contract, Exhibit A, Attachment 4(6) (B)*). Continued assessment of delegates' UM data allows the Plan to ensure its delegates identify important problems such as over- and under-utilization of medical services, provide appropriate written communications to Members, and comply with timeliness requirements for UM decisions and notifications.

The Plan did not enforce its requirement for delegated entities' regular submission of UM reports. Without routinely submitted UM data, the Plan could not meet its responsibility to ensure the appropriate implementation of UM processes by its delegates. The Compliance Committee identified this deficiency and the need for improved oversight by the Plan.

1.5.3 The Plan did not require a corrective action plan to address delegate's non-compliant UM policy

The Plan must conduct an initial evaluation of a new delegated entity's ability to perform delegated activities and ensure its subcontractors meet set standards. (*Contract, Exhibit A, Attachment 4(6)(B)*)

During an initial review of a delegated entity, the Plan noted the subcontractor's policy of dating all prior authorization reviews, including urgent requests, from the time of complete submission of all needed documentation. This was out of compliance with the Contract which requires resolving urgent PA requests within 3 working days from the time of submission, post service requests 30 days from the time of submission of all necessary information, and routine authorizations within 5 days of receipt all the necessary information.

❖ COMPLIANCE AUDIT FINDINGS (CAF) ❖

PLAN: Alameda Alliance for Health

AUDIT PERIOD: April 1, 2014 - March 31, 2015

DATE OF AUDIT: June 8, 2015 – June 18, 2015

The Plan did not require a correction and issued the delegate a passing mark. This is out of compliance with the Plan's requirement to ensure that its subcontractors meet set standards.

RECOMMENDATIONS:

- 1.5.1 Adequately monitor delegated entities.
- 1.5.2 Require and review delegates' UM reports.
- 1.5.3 Require corrective actions for non-compliant delegate audit findings.

❖ COMPLIANCE AUDIT FINDINGS (CAF) ❖

PLAN: Alameda Alliance for Health

AUDIT PERIOD: April 1, 2014 - March 31, 2015

DATE OF AUDIT: June 8, 2015 – June 18, 2015

CATEGORY 2 – CASE MANAGEMENT AND COORDINATION OF CARE

2.2

CALIFORNIA CHILDREN’S SERVICES (CCS)

California Children's Services (CCS):

Contractor shall develop and implement written policies and procedures for identifying and referring children with CCS-eligible conditions to the local CCS program....(as required by Contract)

Contractor shall execute a Memorandum of Understanding (MOU) with the local CCS program...for the coordination of CCS services to Members.

2-Plan Contract A.11.9.A, B

SUMMARY OF FINDINGS:

2.2.1 The Plan did not fully execute its MOU with the local CCS program

The Plan is required to execute a Memorandum of Understanding (MOU) with the local CCS program for the coordination of services to Members. (Contract, Exhibit A, Attachment 11(8)(B)).

The Plan had an unsigned MOU which outlined the responsibilities between the Plan and the local CCS program. According to the template, the Plan’s Liaison or designee is required to meet with CCS designated staff to review the MOU annually. The MOU hasn’t been reviewed or updated since July 2012. The Plan did not meet the requirement of an annual review of the MOU. Issues with coordination of care were not noted during the DHCS review.

RECOMMENDATIONS:

2.2.1 Sign and fulfill responsibilities with the local CCS program as outlined in the MOU.

❖ COMPLIANCE AUDIT FINDINGS (CAF) ❖

PLAN: Alameda Alliance for Health

AUDIT PERIOD: April 1, 2014 - March 31, 2015

DATE OF AUDIT: June 8, 2015 – June 18, 2015

2.3

EARLY INTERVENTION SERVICES / DEVELOPMENTAL DISABILITIES

Services for Persons with Developmental Disabilities:

Contractor shall develop and implement procedures for the identification of Members with developmental disabilities.

Contractor shall refer Members with developmental disabilities to a Regional Center for the developmentally disabled for evaluation and for access to those non-medical services provided through the Regional Centers such as but not limited to, respite, out-of-home placement, and supportive living. Contractor shall participate with Regional Center staff in the development of the individual developmental services plan required for all persons with developmental disabilities, which includes identification of all appropriate services, including medical care services, which need to be provided to the Member.

Contractor shall execute a Memorandum of Understanding (MOU) with the local Regional Centers...for the coordination of services for Members with developmental disabilities.

2-Plan Contract A.11.10.A, C, E

Early Intervention Services:

Contractor shall develop and implement systems to identify children who may be eligible to receive services from the Early Start program and refer them to the local Early Start program...Contractor shall collaborate with the local Regional Center or local Early Start program in determining the Medically Necessary diagnostic and preventive services and treatment plans for Members participating in the Early Start program. Contractor shall provide case management and care coordination to the Member to ensure the provision of all Medically Necessary covered diagnostic, preventive and treatment services identified in the individual family service plan developed by the Early Start program, with Primary Care Provider participation.

2-Plan Contract A.11.11

SUMMARY OF FINDINGS:

2.3.1 **The Plan did not monitor and coordinate care for Members receiving Early Intervention Services and Services for Persons with Developmental Disabilities**

The Plan is required to monitor and coordinate all medical services with the Regional Center (RC) including identification of appropriate services which need to be provided to the Member. The Plan was required to provide care coordination to the Member to ensure the provision of all Medically Necessary covered diagnostic, preventive and treatment services. (*Contract, Exhibit A, Attachment 11(9)(10)*)

Plan Policy #: *MED-UM-0021, Early Start*, specified the Plan's responsibility to coordinate care to ensure provision of all Medically Necessary covered diagnostic, preventive and treatment services to Members receiving RC services.

The Plan did not manage or monitor coordination of care for Members receiving Early Intervention and Developmental Disabilities (EI/DD) services. The Plan was not able to identify who was responsible for ensuring coordination of care for EI/DD Members. The Plan had no dedicated liaison to coordinate care for Members receiving EI/DD services.

The Plan received a monthly data file from Medi-Cal Eligibility. The Plan did not develop procedures on how to use the data made available to them to identify Members receiving EI/DD services. Without accurate identification of Members requiring services from the RC, the Plan did not demonstrate that it effectively coordinated care for its Members.

❖ COMPLIANCE AUDIT FINDINGS (CAF) ❖

PLAN: Alameda Alliance for Health

AUDIT PERIOD: April 1, 2014 - March 31, 2015

DATE OF AUDIT: June 8, 2015 – June 18, 2015

2.3.2 The Plan did not fully execute the terms of its MOU with the Regional Center (RC)

The Plan is required to execute an MOU with the RC for coordination of care for its Members. (Contract, Exhibit A, Attachment 11(D)). The MOU outlined the liaison's role and functions, including meeting with RC staff to promote continuous communication and to resolve operational, administrative and policy issues. The MOU also indicated that the liaison would review the MOU with the RC at least annually.

The Plan had no dedicated liaison to coordinate care for Members receiving EI/DD services and that coordination of care for these Members was not monitored during the audit period. The MOU has not been reviewed or updated since September 2009. The Plan did not meet the requirement of an annual review of the MOU.

RECOMMENDATIONS:

- 2.3.1 Monitor and coordinate care for Members receiving Early Intervention Services and Services for Persons with Developmental Disabilities.
- 2.3.2 Fulfill responsibilities with the RC as required by its MOU for the coordination of services.

❖ COMPLIANCE AUDIT FINDINGS (CAF) ❖

PLAN: Alameda Alliance for Health

AUDIT PERIOD: April 1, 2014 - March 31, 2015

DATE OF AUDIT: June 8, 2015 – June 18, 2015

2.4

INITIAL HEALTH ASSESSMENT

Provision of Initial Health Assessment:

Contractor shall cover and ensure the provision of an IHA (complete history and physical examination) in conformance with Title 22, CCR, Sections 53851(b)(1) to each new Member within timelines stipulated in Provision 5 and Provision 6 below.

2-Plan Contract A.10.3.A

Provision of IHA for Members under Age 21

For Members under the age of 18 months, Contractor is responsible to cover and ensure the provision of an IHA within 120 calendar days following the date of enrollment or within periodicity timelines established by the American Academy of Pediatrics (AAP) for ages two and younger whichever is less.

For Members 18 months of age and older upon enrollment, Contractor is responsible to ensure an IHA is performed within 120 calendar days of enrollment.

2-Plan Contract A.10.5

IHAs for Adults, Age 21 and older

- 1) Contractor shall cover and ensure that an IHA for adult Members is performed within 120 calendar days of enrollment.
- 2) Contractor shall ensure that the performance of the initial complete history and physical exam for adults includes, but is not limited to:
 - a) blood pressure,
 - b) height and weight,
 - c) total serum cholesterol measurement for men ages 35 and over and women ages 45 and over,
 - d) clinical breast examination for women over 40,
 - e) mammogram for women age 50 and over,
 - f) Pap smear (or arrangements made for performance) on all women determined to be sexually active,
 - g) chlamydia screen for all sexually active females aged 21 and older who are determined to be at high-risk for chlamydia infection using the most current CDC guidelines. These guidelines include the screening of all sexually active females aged 21 through 25 years of age,
 - h) screening for TB risk factors including a Mantoux skin test on all persons determined to be at high risk, and,
 - i) health education behavioral risk assessment.

2-Plan Contract A.10.6

Contractor shall make reasonable attempts to contact a Member and schedule an IHA. All attempts shall be documented. Documented attempts that demonstrate Contractor's unsuccessful efforts to contact a Member and schedule an IHA shall be considered evidence in meeting this requirement.

2-Plan Contract A.10.3.D

SUMMARY OF FINDINGS:

2.4.1 The Plan did not ensure the provision of an Initial Health Assessment (IHA) to each new Member within the required timelines

The Plan must ensure the provision of an IHA to each new Member within 120 calendar days following the date of enrollment. The Plan is responsible for making reasonable attempts to contact a Member to schedule an IHA and that all attempts to contact the Member are documented. (*Contract, Exhibit A, Attachment 10*)

According to *MMCD Policy Letter 08-003, Initial Comprehensive Health Assessment*, the Plan shall promote IHA completion rate through mechanisms such as quality improvement strategies and training of Providers.

❖ COMPLIANCE AUDIT FINDINGS (CAF) ❖

PLAN: Alameda Alliance for Health

AUDIT PERIOD: April 1, 2014 - March 31, 2015

DATE OF AUDIT: June 8, 2015 – June 18, 2015

The Plan's methodology defined using a select set of CPT codes to measure IHA encounters. This methodology measured a compliance rate of 30%. No quality improvement strategies to address the low rate of compliance were documented in the HCQC Meeting minutes during the audit period. The Plan's measures to improve low IHA compliance rate were not included in the Plan's 2014 and 2015 Quality Improvement Work Plan.

Our review included site visits of the Plan's Providers. Providers interviewed during site visits were unaware of the Plan's policies and procedures for ensuring new Members receive an IHA within 120 days and for documenting attempts to contact new Members. The Plan did not have the staff needed to provide training on IHA requirements.

The requirement for ensuring the provision of an Initial Health Assessment within the required timelines for each new Member was not met.

2.4.2 The Plan had not validated its methodology for monitoring IHA completion

The Plan must ensure the provision of an Initial Health Assessment (comprehensive history and physical examination) in conformance with Title 22 CCR section 53851 (b)(1) and 53910.5 (a)(1) to each new Member within 120 calendar days of enrollment (*Contract, Exhibit A, Attachment 10, (3) (A)*). The Plan must have procedures for monitoring IHA completion (*MMCD Policy Letter No.08-003 Initial Comprehensive Health Assessment*).

MMCD Policy Letter 02-02, Site Review, specified that the Plan shall systematically monitor all PCP sites between each regularly scheduled site review survey. Monitoring methods may include site visits and other methodologies.

Plan Policy #: MED-GEN-0002, Member Assessment: IHA/ SHA/ IHEBA Prenatal Risk, the Plan monitored compliance with IHA requirements through the Medical Record Review process and by analyzing encounter data submitted by clinics. The Plan defined IHA encounters using a select set of CPT codes. The Plan's methodology was not tested for validity to ensure it monitored IHA completion. The Plan had no interim monitoring procedures in place between the triennial Medical Record Reviews to monitor compliance with IHA requirements. The Plan has not validated its methodology for monitoring IHA completion.

RECOMMENDATIONS:

- 2.4.1 Develop and implement quality improvement strategies including Primary Care Provider training to improve IHA completion.
- 2.4.2 Establish a valid methodology to monitor IHA compliance.

❖ COMPLIANCE AUDIT FINDINGS (CAF) ❖

PLAN: Alameda Alliance for Health

AUDIT PERIOD: April 1, 2014 - March 31, 2015

DATE OF AUDIT: June 8, 2015 – June 18, 2015

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 Contractor, 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.

-

SUMMARY OF FINDINGS:

2.5.1 The Plan did not ensure the provision of Complex Case Management

The Plan is required to ensure the provision of Comprehensive Medical Case Management to each Member. 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 complex case management activities based on the medical needs of the Member. *(Contract, Exhibit A, Attachment 11(1))*

Plan policy#: MED-CM-0001, Complex Case Management (CCM) Identification, Screening, Assessment and Triage, defines Complex Case Management as "the systematic coordination and assessment of care and services provided to Members who have experienced a critical event or diagnosis that requires the extensive use of resources and need help navigating the system to facilitate appropriate delivery of care and services." The policy establishes that the Plan is responsible for ensuring that all its Members are identified and, as appropriate, screened, assessed and triaged for CCM.

The Plan's non-SPD CCM Universe was comprised of 43 Members who have been identified as those who would benefit from Complex Case Management. The Plan had 4 open cases during the audit period. 39 out of 43 Members in the CCM Universe had no open case with an explanation of "unable to contact". The Plan did not screen, assess, and triage the potential Members and failed to ensure the provision of Complex Case Management to these Members.

2.5.2 The Plan did not provide Complex Case Management services to eligible Members

Complex Case Management Services shall include, at a minimum: a) Basic Case Management Services b) Management of acute or chronic illness, including emotional and social support issues by a multidisciplinary case management team c) Intense coordination of resources to ensure Member regains optimal health or improved functionality d) with Member and PCP input, development of care plans specific to individual needs, and updating of these plans at least annually. *(Contract, A11, Exhibit A, Attachment 11(1))*

❖ COMPLIANCE AUDIT FINDINGS (CAF) ❖

PLAN: Alameda Alliance for Health

AUDIT PERIOD: April 1, 2014 - March 31, 2015

DATE OF AUDIT: June 8, 2015 – June 18, 2015

Plan Providers that were interviewed as part of our audit were unaware of the Plan's Complex Case Management policies, procedures or services. Some Providers explained that it would have been beneficial if the Plan had case managed their complex patients so they would have more time to see new Members.

One Member had financial concerns, difficulty ambulating with leg pain and congestive heart failure (CHF) that contributed to his low energy levels. The RN Case Manager did not provide intense coordination of resources as the Member was not referred to a social worker or to pain management assistance. The RN Case Manager did not provide patient education about the disease such signs and symptoms of hypoglycemia and hyperglycemia, CHF, when to call PCP, RN Case Manager, or 911 as part of the Plan of Care.

RECOMMENDATIONS:

- 2.5.1 Ensure the provision of Complex Case Management services to all qualified Members.
- 2.5.2 Include Basic Case Management Services, Management of acute or chronic illness, intense coordination of resources and development of care plans to all Members within Complex Case Management.

❖ COMPLIANCE AUDIT FINDINGS (CAF) ❖

PLAN: Alameda Alliance for Health

AUDIT PERIOD: April 1, 2014 - March 31, 2015

DATE OF AUDIT: June 8, 2015 – June 18, 2015

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 FINDINGS:

The Plan monitored the average wait time to obtain routine, specialty, urgent, initial prenatal appointments and length of time beyond scheduled appointment before seeing a Provider through the 2014 Appointment and Availability Audit. The survey included both the Plan’s directly contracted Providers and Providers in its delegated entities.

3.1.1 The Plan did not ensure Providers met timely access requirements

The Plan is required to 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 (*Contract A11, Exhibit A, Attachment 9(3)(a)*).

The Plan is required to ensure that each Member has a Primary Care Provider who is available and physically present at the service site for sufficient time to ensure access for the assigned Member when medically required (*Contract A11, Exhibit A, Attachment 9(1)*). The Plan is required to ensure that Members are offered appointments for covered health care services within a time period appropriate for their condition (*Contract A11, Exhibit A, Attachment 9(4)(a)*).

The Plan did not ensure that Providers met timely access requirements. These factors indicate Providers were not in compliance with timely access requirements:

- Providers who chose to not participate in the Plan’s 2014 Appointment and Availability Audit were excluded from the survey results. When the survey did identify deficiencies, it did not take appropriate actions to ensure Providers met timely access requirements.

❖ COMPLIANCE AUDIT FINDINGS (CAF) ❖

PLAN: Alameda Alliance for Health

AUDIT PERIOD: April 1, 2014 - March 31, 2015

DATE OF AUDIT: June 8, 2015 – June 18, 2015

- Several grievances were related to access issues including appointment wait times. For instance, a Member assigned to an outpatient clinic called incessantly for 3 months until the Member was placed on a waitlist with no estimated time of when an appointment would be available. At the time of the call, the clinic was already booked up to 4 months out and yet the Plan continued to assign new Members to the practice when it was aware the clinic could not meet appointment wait time requirements.
- The DHCS medical audit team conducted an appointment verification study to assess the Member wait times to obtain appointments for routine, urgent and initial prenatal care. This study measured the average length of time between the date of the interview and the third available appointment. A total of 27 Providers (9 PCPs, 9 OBs and 9 specialists) from both the Plan's network and delegated entities were randomly selected for review. This study illustrates Providers' non-compliance with access standards. The results of the verification study are the following:

Provider Type	Contract Standards	Average Third Next Available Appointment
Non-urgent primary care	within ten business days of request	22 business days
Urgent care for services without prior authorization	within 48 hours of a request	16 days
Specialty care	within 15 business days of request	16 business days for established patients
First prenatal visit for a pregnant Member	within two weeks upon request	28.8 days

3.1.2 No Correction Action Plan for Providers who were non-compliant with timely access standards

The Plan is required to ensure the provision of acceptable accessibility standards in accordance with CCR, Title 28 § 1300.67.2.2 and as specified in the Contract. The Plan is required to ensure that each Member has a Primary Care Provider who is available and physically present at the service site for sufficient time to ensure access for the assigned Member when medically required (*Contract A11, Exhibit A, Attachment 9 (1)*). The Plan is required to communicate, enforce and monitor Provider's compliance with access standards (*Contract A11, 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)*).

Providers who failed three or more of the Plan's survey questions received additional appointment standards education and were surveyed again in 3 months. The Plan did not investigate or identify the cause of the timely access deficiencies nor did it request a corrective action plan from Providers as required by the Contract and CCR, Title 28 §1300.67.2.2(d)(3)).

When the Plan did identify deficiencies, the Plan did not take the appropriate corrective action. Delegated Providers who had a compliance rate above 65% were not required to take any actions. The 65% compliance rate was a Plan established threshold. The Plan's basis was to set a lower score for the first few years and increase the threshold as Providers build an understanding and have the resources for meeting the timely access regulations. This compliance rate is in violation of the Contract requirement of ensuring that each Member has a PCP who is available for a sufficient time to ensure access for assigned Member.

❖ COMPLIANCE AUDIT FINDINGS (CAF) ❖

PLAN: Alameda Alliance for Health

AUDIT PERIOD: April 1, 2014 - March 31, 2015

DATE OF AUDIT: June 8, 2015 – June 18, 2015

3.1.3 The Plan did not ensure Providers answered or returned Member telephone calls in a timely manner

The Plan is responsible for developing, implementing, and maintaining 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 A11, Exhibit A, Attachment 9 (3)(c)*).

Policy#: PRO-GEN-0001, Provider Availability and Access established that all telephone calls to Providers must be answered within 6 rings. Initial answer by an automatic answering system is acceptable if it has an option to directly access a live person. When a Member leaves a message with a Provider, the office must attempt to return the Member's call in the following timeframes and to log that attempt: within 3 working days for non-urgent matters and no later than the same day for an urgent matter. A minimum of three attempts must be made to return the Member's call.

The Plan did not monitor whether Providers answered calls timely or whether those calls were returned. The Plan's policy did not establish how the daytime call wait time and return call attempts would be monitored. The Plan's annual Access and Availability Survey asked Providers for the average wait time beyond the Member's scheduled time to be seen but it did not measure the average wait time in a call or whether requests for a return call were actually returned.

Many grievances complaining about office telephone wait times were identified. For example: Member who was feeling ill complained about continuously trying to call a clinic to set up an appointment but no one answered the phone. The Member went to the clinic in person and waited for 7 hours to get an appointment scheduled.

The DHCS appointment wait time verification study found 2 Providers whose calls went unanswered with no option to leave a voice message during business hours and 1 Provider whose telephone line had a 15 minute wait time.

3.1.4 The Plan did not ensure Members were able to speak with a Plan representative in a timely manner

The Plan shall ensure that, during normal business hours, the waiting time for a Member to speak with a plan Member service representative knowledgeable and competent regarding the Member's questions and concerns shall not exceed ten minutes (*CCR, Title 28 § 1300.67.2.2(10)*).

Policy#: PRO-GEN-0001, Provider Availability and Access established that daytime telephone wait time to speak to a person must be within 30 seconds or less, 85% of the time.

The Plan did not ensure Members were able to speak with a Plan representative during normal business hours within ten minutes. The Plan's Member service call center had telephone wait times of up to 60 minutes and abandoned call rates of up to 50% during the audit period. To alleviate some of the wait, the Plan included an introductory voice message informing callers of their wait time and a message on their website. In addition, the Plan contracted with a call center vendor and hired additional staff. Call center reports for 2015 show an improvement in the rate of calls answered and in the abandoned call rates compared to 2014. As of March 2015, reports showed that 71% of calls were answered within 60 seconds and 5.3% were abandoned.

❖ COMPLIANCE AUDIT FINDINGS (CAF) ❖

PLAN: Alameda Alliance for Health

AUDIT PERIOD: April 1, 2014 - March 31, 2015

DATE OF AUDIT: June 8, 2015 – June 18, 2015

3.1.5 The Plan did not ensure accurate Provider listings in its Provider directory

The Plan is required to distribute a Provider directory that included the following information: a) the name, Provider number, address and telephone number of each service location b) the hours and days each facility is open (*Contract, Exhibit A, Attachment 13(4)*). The Plan is required to provide, upon request, a list of contracting Providers. This list is required to indicate which Providers have notified the Plan that they have closed practices or are otherwise not accepting new patients at that time. The Plan is required to update this information at least quarterly. The plan may satisfy this update requirement by providing an insert or addendum to any existing Provider listing. If a Plan delegates the responsibility of complying with this requirement to its contracting Providers, the Plan is required to ensure that these requirements are met (*H&S Code §1367.26*).

The Plan's Provider Directory did not accurately reflect the number of PCPs and specialists available within the Plan's network. The Plan's printed Provider directory is updated twice a year and the online database is updated daily. However, Providers who have left the Plan for months or have never been contracted with the Plan continued to be listed as accepting new Members. The DHCS appointment availability verification study concluded the following inaccuracies:

- 2 PCPs and 1 OB were not accepting new Members but were listed as accepting
- 1 OB was no longer providing services to Plan Members.
- 1 OB was on maternity leave for 3 months but was still listed as accepting new Members.
- 1 specialist practice had the incorrect phone number listed.
- 1 specialist practice has the incorrect medical group listed.
- 1 specialist practice was not part of the Plan's network and did not know why Members continued to call them.

The DHCS review included visits to Provider sites. During the visits, Providers reported having difficulty finding specialists for Members due to the Plan's outdated Provider Directory. Providers also reported having difficulty reaching the Plan's Provider relations department for help.

RECOMMENDATIONS:

- 3.1.1 Monitor and ensure compliance with all access standards.
- 3.1.2 Implement prompt investigation and corrective action when compliance monitoring discloses access deficiencies.
- 3.1.3 Develop and maintain a system to monitor Providers' telephone wait times and return of Member calls
- 3.1.4 Ensure Members can speak to a Plan Member service representative in a timely manner.
- 3.1.5 Update Provider directory to reflect accurate information.

❖ COMPLIANCE AUDIT FINDINGS (CAF) ❖

PLAN: Alameda Alliance for Health

AUDIT PERIOD: April 1, 2014 - March 31, 2015

DATE OF AUDIT: June 8, 2015 – June 18, 2015

3.2

URGENT CARE / EMERGENCY CARE

Urgent Care:

Members must be offered appointments within the following timeframes:

- 1) Urgent care appointment for services that do not require prior authorization – within 48 hours of a request;
- 2) Urgent appointment for services that do require prior authorization – within 96 hours of a request;

2-Plan Contract A.9.4.B

Emergency Care:

Contractor shall ensure that a Member with an emergency condition will be seen on an emergency basis and that emergency services will be available and accessible within the Service Area 24-hours-a-day.

2-Plan Contract A.9.7

Contractor shall have, as a minimum, a designated emergency service facility, providing care on a 24-hour-a-day, 7-day-a-week basis. This designated emergency services facility will have one or more physicians and one nurse on duty in the facility at all times.

2-Plan Contract A.6.5

SUMMARY OF FINDINGS:

3.2.1 The Plan does not have or maintain protocols for communicating and interacting with Emergency Departments (EDs)

The Plan is required to develop and maintain protocols for communicating and interacting with Emergency Departments. Protocols shall be distributed to all emergency departments in contracted Service Areas and shall include at a minimum the following: a) description of telephone access to triage and advice systems used by the Plan, b) Plan contact person responsible for coordinating services and can be contacted 24 hours a day, c) written referral procedures including afterhours instructions and d) procedure for emergency departments to report system and/ or protocol failures and process for ensuring corrective action (*Contract A11, Exhibit A, Attachment 7(7)*).

Plan policy#: MED-UM-0015 Emergency Services and Post-Stabilization Services specified that the Plan's Contract requires PCPs to be available 24 hours, seven days a week for urgent/emergent requests from assigned Members or from Emergency Department personnel about the PCP's Members to/for: a) coordinate the transfer of care of a Member whose condition is stabilized b) authorize medically necessary post-stabilization services c) general communication with emergency room personnel and d) provide medical advice and supervision (triage services) to assigned Members either directly or through coverage arrangements with another credentialed Provider.

The Plan did not have or maintain protocols for communicating and interacting with emergency departments. The Plan did not designate an internal health professional contact or a contracting physician to be available 24 hours per day, seven days per week to coordinate transfer of care in emergent care situations, authorize medically necessary post-stabilization services and communicate with emergency room personnel.

Plan policy#: MED-UM-0015 Emergency Services and Post-Stabilization Services stated that contracted PCPs are required to be available 24 hours per day, seven days a week and in charge of coordinating, communicating, triaging and approving medically necessary services for Emergency Departments. The Plan did not monitor Providers or ensure communication and coordination of services with EDs.

❖ COMPLIANCE AUDIT FINDINGS (CAF) ❖

PLAN: Alameda Alliance for Health

AUDIT PERIOD: April 1, 2014 - March 31, 2015

DATE OF AUDIT: June 8, 2015 – June 18, 2015

RECOMMENDATIONS:

3.2.1 Develop and implement protocols for communicating with Emergency Departments.

❖ COMPLIANCE AUDIT FINDINGS (CAF) ❖

PLAN: Alameda Alliance for Health

AUDIT PERIOD: April 1, 2014 - March 31, 2015

DATE OF AUDIT: June 8, 2015 – June 18, 2015

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 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 FINDINGS:

3.3.1 The Plan did not ensure that a physician or an appropriate licensed professional was available for after hour calls

The Plan is required to provide or arrange for the provision, 24 hours per day, 7 days per week, of triage or screening services by telephone (CCR, Title 28 § 1300.67.2.2(8)). At a minimum, the Plan shall ensure that a physician or an appropriate licensed professional under his/her supervision will be available for after-hour calls (Contract A11, Exhibit A, Attachment 9 (3)(E)).

Plan Policy#: PRO-GEN-0001, Provider Availability and Access specified that the Plan requires that PCPs and delegated medical groups have arrangements in place for telephone access 24 hours a day, seven days a week. Providers are required to meet minimum standards for access to after hour care by including the following information: a) emergency instructions b) instruction to contact a physician c) ability to speak to a physician or leave a message.

The Plan relied on its network Providers and delegated medical groups for after-hours telephone access. The Plan monitored after-hours access through the 2014 Appointment Availability Audit. The survey identified several Providers who failed to have an option to speak to a live person or to direct Members to an appropriate license professional contact. However, the Plan did not take any actions to address the deficiencies found in the survey and did not implement additional measures to ensure that a physician or appropriate license professional was available to Members after-hours. The Plan did not have a nurse advice line or an appropriate license professional available after-hours. The Plan had a nurse advice line available for its In-Home Supportive Services (IHSS) Members but that service was not available for its Medi-Cal Members.

3.3.2 The Plan did not maintain knowledgeable Member Services staff, and did not take corrective action when deficiencies were identified

The Plan is required to maintain the level of knowledgeable and trained Member Services staff sufficient to provide covered services to Members and all other services covered under the Contract (Contract A11, Exhibit A, Attachment 13(2)(A) and (B)).

❖ COMPLIANCE AUDIT FINDINGS (CAF) ❖

PLAN: Alameda Alliance for Health

AUDIT PERIOD: April 1, 2014 - March 31, 2015

DATE OF AUDIT: June 8, 2015 – June 18, 2015

The Plan did not maintain knowledgeable Member Services staff, and did not take corrective action when deficiencies were identified. The Plan did not conduct any Member Services staff performance reviews to ensure staff was trained on all contractually required member Services functions. A total of 9 exempt grievances in 2014 and 1 exempt grievance in 2015 were complaints about Member Services staff. There was no evidence that any actions were taken or that a corrective action plan was implemented as a result of the exempt grievances.

RECOMMENDATIONS:

- 3.3.1 Provide or arrange to provide 24 hours per day, 7 days per week triage or screening services by telephone and access to a physician or an appropriate license professional after-hours.
- 3.3.2 Maintain knowledgeable Member Services staff. Identify deficiencies and take corrective actions when necessary.

❖ COMPLIANCE AUDIT FINDINGS (CAF) ❖

PLAN: Alameda Alliance for Health

AUDIT PERIOD: April 1, 2014 - March 31, 2015

DATE OF AUDIT: June 8, 2015 – June 18, 2015

3.4

SPECIALISTS AND SPECIALTY SERVICES

Specialists and Specialty Services:

Contractor shall maintain adequate numbers and types of specialists within their network to accommodate the need for specialty care in accordance with Title 22 CCR Section 53853(a) and W & I Code Section 14182(c)(2) 2-Plan Contract A.6.6

Contractor shall arrange for the provision of seldom used or unusual specialty services from specialists outside the network if unavailable within Contractor's network, when determined Medically Necessary. 2-Plan Contract A.9.3.F

SUMMARY OF FINDINGS:

3.4.1 The Plan did not ensure an adequate number of specialists were available within its network

The Plan is required to ensure and monitor an appropriate network, including PCPs and specialists within each service area. (*Contract A11, Exhibit A, Attachment 6(2)*) The Plan is required to maintain adequate numbers and types of specialists within their network to accommodate the need for specialty care (*Contract A11, Exhibit A, Attachment 6(6), CCR, Title 22 § 53853(a) and W&I Code § 14182 (c)(2)*).

The Plan did not maintain an adequate number of specialists within its network. A number of factors indicate such shortage:

- The DHCS review included visits to its Network Providers' sites. During the visits, Providers reported having difficulty finding specialists for Members. When the clinics did find a specialist, Members experienced appointment wait times of up to 70 days, which was in excess of the 15 working day appointment standard.
- The Plan did not monitor whether the volume of specialty care practitioners (SCP) who were not listed under high volume report was appropriate. High volume SCPs were defined as the top eleven specialty care practitioners within the highest number of unique Member claims in a calendar year.
- The Plan's 2014 Provider Satisfaction Survey rate indicated Providers were dissatisfied with the number of specialists available in network. Satisfaction decreased from 33.7% in 2013 to 22.9 % in 2014.
- A Provider in the Plan's 2014 Appointment and Availability Audit follow-up log had problems adhering to the access time standards due to being the only neurologist Provider accepting Medi-Cal in the County. Another Provider reported that the increasing volume of referred Members exceeded their capacity. The Provider did not know how to handle the overwhelming number of Members.

RECOMMENDATIONS:

- 3.4.1 Maintain an adequate number of specialists within the Plan's network.

❖ COMPLIANCE AUDIT FINDINGS (CAF) ❖

PLAN: Alameda Alliance for Health

AUDIT PERIOD: April 1, 2014 - March 31, 2015

DATE OF AUDIT: June 8, 2015 – June 18, 2015

3.5

EMERGENCY SERVICES AND FAMILY PLANNING CLAIMS

Emergency Service Providers (Claims):

Contractor is responsible for coverage and payment of Emergency Services and post stabilization care services and must cover and pay for Emergency Services regardless of whether the Provider that furnishes the services has a contract with the plan.

2-Plan Contract A.8.13.A

Contractor shall pay for emergency services received by a Member from non-contracting Providers. Payments to non-contracting Providers shall be for the treatment of the emergency medical condition including Medically Necessary inpatient services rendered to a Member until the Member's condition has stabilized sufficiently to permit referral and transfer in accordance with instructions from Contractor or the Member is stabilized sufficiently to permit discharge....

2-Plan Contract A.8.13.C

At a minimum, Contractor must reimburse the non-contracting emergency department and, if applicable, its affiliated Providers for Physician services at the lowest level of emergency department evaluation and management Physician's Current Procedural Terminology (CPT) codes, unless a higher level is clearly supported by documentation, and for the facility fee and diagnostic services such as laboratory and radiology.

2-Plan Contract A.8.13.D

For all other non-contracting Providers, reimbursement by Contractor, or by a subcontractor who is at risk for out-of-plan emergency services, for properly documented claims for services rendered on or after January 1, 2007 by a non-contracting Provider pursuant to this provision shall be made in accordance with Provision 5, Claims Processing, and 42 USC Section 1396u-2(b)(2)(D). 3

2-Plan Contract A.8.13.E

Contractor shall cover emergency medical services without prior authorization pursuant to Title 28 CCR, Section 1300.67(g) and Title 22 CCR Section 53216.

2-Plan Contract A.9.7.A

Family Planning (Claims):

Contractor shall reimburse non-contracting family planning Providers at no less than the appropriate Medi-Cal FFS rate...(as required by Contract)

2-Plan Contract A.8.9

Claims Processing—Contractor shall pay all claims submitted by contracting Providers in accordance with this section...Contractor shall comply with Section 1932(f), Title XIX, Social Security Act (42 U.S.C. Section 1396u-2(f), and Health and Safety Code Sections 1371 through 1371.36.

2-Plan Contract A.8.5

Time for Reimbursement. A plan and a plan's capitated Provider shall reimburse each complete claim, or portion thereof, whether in state or out of state, as soon as practical, but no later than thirty (30) working days after the date of receipt of the complete claim by the plan or the plan's capitated Provider, or if the plan is a health maintenance organization, 45 working days after the date of receipt of the complete claim by the plan or the plan's capitated Provider, unless the complete claim or portion thereof is contested or denied, as provided in subdivision (h).

CCR, Title 28, Section 1300.71(g)

SUMMARY OF FINDINGS:

The Plan was unable to process and pay claims from January 2014 to May 2014 due to implementation problems of a new claims processing system in January 2014. This resulted in delayed processing of 300,000 claims. Claims processing resumed after the Plan was placed under conservatorship in May 2014. The Plan's previous system was used to process claims and to prevent further increases of claims in backlog.

❖ COMPLIANCE AUDIT FINDINGS (CAF) ❖

PLAN: Alameda Alliance for Health

AUDIT PERIOD: April 1, 2014 - March 31, 2015

DATE OF AUDIT: June 8, 2015 – June 18, 2015

3.5.1 The Plan did not process claims within 45 working days

The Plan is required to reimburse each complete claim, or portion thereof, whether in state or out of state, as soon as practical, but no later than 45 working days after the date of receipt of the complete claim. (*CCR, 28, §1300.71(g)*)

During the audit period, the Plan did not meet claims processing times as specified in the Plan's ER Claims Processing Policy, Family Planning and Sensitive Services Policy, and Provider Dispute Resolution Policy.

- 24 of 25 emergency services sample claims reviewed were paid or denied after 45 working days
- 17 of 20 family planning sample claims reviewed were paid or denied after 45 working days
- 3 of 5 family planning sample claims that were subsequently disputed by Providers took the Plan over 45 working days to resolve

3.5.2 Claims incorrectly sent to the Plan were not forwarded to responsible entity timely

The Plan is required to maintain sufficient claims processing/tracking/payment systems capability to: comply with applicable State and Federal law, regulations and Contract requirements. (*Contract, A11, Exhibit A, Attachment 8,5(D)*).

The Plan's Claims Processing Policy established that the Plan and its delegated Providers must redirect or deny claims that are not their financial responsibility within 10 working days.

The Plan did not have sufficient claims processing systems capability in place to completely process misdirected claims timely. The Plan's process for identifying misdirected claims was not integrated into their claims processing system. Misdirected claims had to be manually pulled out of the Plan's processed claims' database before they were forwarded thus misdirected claims were not forwarded timely. **This is a repeat finding.**

- 5 of 7 emergency services sample claims incorrectly sent to the Plan were not forwarded to the appropriate delegated Provider within 10 working days.
- 5 of 6 family planning sample claims incorrectly sent to the Plan were not forwarded to the appropriate delegated Provider within 10 working days.

3.5.3 The Plan did not pay interest on seven claims processed in excess of 45 working days after receipt

The Plan is required to automatically include in its payment of the claim all interest that has accrued if a complete claim is not reimbursed within 45 working days of receipt. (*Contract, A11, Exhibit A, Attachment 8,5(A)*) (*Health and Safety Code, §1371*)

The Plan had significant problems processing claims due to implementation problems of a new claims processing system during the audit period. The Plan made advance payments to Providers based on their historical claims paid to avoid causing financial difficulties to Providers due to unprocessed claims. However, not all Providers agreed to receive advance payments and not all billing Providers had previously submitted claims to the Plan. The Contract requires interest payment on complete claims not processed within 45 working days. Advance payments made to providers does not constitute the timely processing of complete claims and does not exempt the Plan from paying interest.

❖ COMPLIANCE AUDIT FINDINGS (CAF) ❖

PLAN: Alameda Alliance for Health

AUDIT PERIOD: April 1, 2014 - March 31, 2015

DATE OF AUDIT: June 8, 2015 – June 18, 2015

- 4 emergency service sample claim were not paid interest despite being processed after 45 working days
- 3 family planning sample claim were not paid interest despite being processed after 45 working days.

3.5.4 The Plan improperly denied an emergency service claim due to Member's CCS status

The Plan is required, upon rejecting a claim from a health care Provider, to disclose the specific rationale used in determining why the claim was rejected. (*H&S Code § 1399.55*)

Although CCS is responsible for claims related to a CCS diagnosis, the Plan is responsible for claims related to Non-CCS diagnoses. The Plan verifies Member's CCS status when processing claims. If a claim is related to a Member with a CCS condition, it is automatically denied with a CCS denial reason. 1 of 2 emergency service sample claims was denied with CCS as the denial reason even though a non-CCS diagnosis was indicated on the Member's eligibility profile and on the claim. A Member's CCS status is not a sufficient basis to deny a claim.

3.5.5 The Plan did not identify all reasons for denial in written notification to Provider

The Plan may contest or deny a claim by notifying Provider in writing that the claim is contested or denied. The notice that a claim is denied shall identify the portion of the claim that is denied and the specific reasons for the denial. (*Contract, A11, Exhibit A, Attachment 8,5(A)*) (*Health and Safety Code, §1371*)

The Plan's method of denial written notification is through the Remittance Advice sent to Provider. The current claim processing system used by the Plan can only include the first reason on Remittance Advice as the Denial Reason. Therefore when there are multiple reasons associated with a claim denial, Provider is only made aware of the primary reason, while all other reasons are not communicated.

RECOMMENDATIONS:

- 3.5.1 Process all original and Provider disputed claims within 45 working days of receipt.
- 3.5.2 Forward misdirected claims to responsible entity within 10 working days of receipt.
- 3.5.3 Pay interest on all claims processed after 45 working days.
- 3.5.4 Disclose specific denial rationale. Ensure that when claims are denied, the reasons are appropriate.
- 3.5.5 Include all denial reasons for denied/contested claims in written notification to Provider.

❖ COMPLIANCE AUDIT FINDINGS (CAF) ❖

PLAN: Alameda Alliance for Health

AUDIT PERIOD: April 1, 2014 - March 31, 2015

DATE OF AUDIT: June 8, 2015 – June 18, 2015

3.6

ACCESS TO PHARMACEUTICAL SERVICES

Pharmaceutical Services and Prescribed Drugs:

Contractor shall cover and ensure the provision of all prescribed drugs and Medically Necessary pharmaceutical services. Contractor shall provide pharmaceutical services and prescription drugs in accordance with all Federal and State laws and regulations...

At a minimum, Contractor shall arrange for pharmaceutical services to be available during regular business hours, and shall ensure the provision of drugs prescribed in emergency circumstances in amounts sufficient to last until the Member can reasonably be expected to have the prescription filled.

2-Plan Contract A.10.8.G.1

SUMMARY OF FINDINGS:

3.6.1 The Plan did not properly monitor or ensure the provision of sufficient amounts of drugs prescribed in emergency situations

The Plan is required to at a minimum, arrange for pharmaceutical services to be available during regular business hours, and is required to ensure the provision of drugs prescribed in emergency circumstances in amounts sufficient to last until the Member can reasonably be expected to have the prescription filled (*Contract A11, Exhibit A, Attachment 10 (g)(1) and CCR, Title 22§ 53854(1),(2) & (3)*).

Plan network specialists, pharmacies, hospitals and other Providers must be located within 15 miles or 30 minutes travel time from assigned Members' residence (*Policy#: PRO-GEN-0001, Provider Availability and Access*).

The Plan did not ensure that Members had access to a sufficient supply of medications prescribed in emergency circumstances. Emergency Departments in the County did not dispense emergency supplies of drugs upon discharge. Members can fill prescriptions in any of the 24 hour pharmacies in the Plan's network. The Plan's directory listed a total of five 24-hour-pharmacies located throughout the County; however, only 3 of 5 were actually open 24 hours. Two of the pharmacies closed at 10:00 pm. The Plan did not have pharmacies located within 15 miles or 30 minutes travel time from assigned Members' residence. Members were limited to one of the three 24-hour pharmacies.

The Plan monitored whether Members had access to an urgent supply of drugs by reviewing one claim from each contracted hospital per month between April 2014 to December 2014. The claim sample was selected by a specific condition (UTI) to see if the Member filled a medication related to that condition by the next day. The monitoring report did not account for Members who had a condition other than the one selected for review. There was no indication in the report that Members had access to a sufficient quantity of medication prescribed until the Member could reasonably be expected to have a prescription filled or that the Plan had reached out to Members who did not have a prescription filled within the next day.

RECOMMENDATIONS:

3.6.1 Develop and implement a system to adequately monitor and ensure the provision of prescribed drugs dispensed in emergency situations, and meet timeliness and sufficiency requirements.

❖ COMPLIANCE AUDIT FINDINGS (CAF) ❖

PLAN: Alameda Alliance for Health

AUDIT PERIOD: April 1, 2014 - March 31, 2015

DATE OF AUDIT: June 8, 2015 – June 18, 2015

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 FINDINGS:

The Plan received grievances from Members through the Member Services call line, in person and online through the Member portal. Member Services (MS) representatives handled telephone and walk-in complaint intake. Grievances were sent to the Grievance and Appeals (G&A) Department via email to the G&A inbox. Grievances filed online through the portal were downloaded by the lead G&A coordinator on a daily basis.

4.1.1 Improper reporting of grievances

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

The Plan’s grievance system did not capture all complaints and expressions of dissatisfaction regarding the Plan and Providers. A clinic under one of the Plan’s delegated medical groups resolved grievances internally and did not report those to the delegated medical group or to the Plan. The Plan did not delegate grievance responsibilities to this medical group.

Grievances received were logged on an “experience of care form” and investigated by the clinic’s CMO. The delegated medical group did not require clinics to report grievances that had a favorable outcome. Only grievances that had an unfavorable impact on Members were reported to the delegated medical group.

4.1.2 Inadequate 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 A11, Exhibit A, Attachment 14(1)*). The Plan is required to ensure that grievances submitted are reported to the appropriate level i.e. medical issues versus health care delivery issues and resolved by a health care professional with appropriate clinical expertise (*Contract A11, Exhibit A, Attachment 14(1) (D)*).

❖ COMPLIANCE AUDIT FINDINGS (CAF) ❖

PLAN: Alameda Alliance for Health

AUDIT PERIOD: April 1, 2014 - March 31, 2015

DATE OF AUDIT: June 8, 2015 – June 18, 2015

No oversight was conducted by clinical personnel to ensure proper identification of clinical/quality of care grievances. 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. The grievances were first classified as clinical versus administrative by the lead G&A coordinator, a non-clinical employee. Grievance cases classified as clinical were sent to the G&A nurses for potential PQI determination. All grievance cases classified as non-clinical were handled by the Grievance coordinators, who were non-clinical employees.

The Plan did not have an adequate process to review and monitor the grievance process. The G&A staff conducted meetings with the G&A manager to discuss complex G&A cases and performed self-audits of two cases on a weekly basis. The Plan did not have a written procedure describing the process, the scoring system or a process for corrective actions. The G&A manager reviewed all the appeals resolution letters, however; nobody reviewed the grievance resolution letters for appropriate resolution. The Plan did not perform an internal audit of the G&A Department during the audit period. The Plan was not in compliance with the requirements for grievance monitoring.

4.1.3 **Quality of care grievances were not processed adequately, timely or consistently reviewed**

The Plan is required to maintain a full time physician as Medical Director, whose responsibilities include, but are not limited to the following: a) ensuring medical decisions are: 1) rendered by qualified medical personnel, 2) are not influenced by fiscal or administrative management considerations, b) ensuring 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 procedure (*Contract A11, Exhibit A, Attachment 1(6) and CCR, Title 22 § 53857*).

The Plan is required to ensure that grievances submitted are reported to the appropriate level i.e. medical issues versus health care delivery issues and resolved by a health care professional with appropriate clinical expertise. The Plan is required to have a procedure to ensure the participation of individuals with authority to require corrective action. Grievances related to medical quality of care issues shall be referred to the Plan's Medical Director. (*Contract A11, Exhibit A, Attachment 14(1) (D) & (E)*).

Quality of care grievances were not consistently presented to the Medical Director for review prior to resolution. Grievances classified as Quality of Care grievances were sent to the G&A nurses for potential PQI determination. Grievances determined to be a potential PQI were escalated to the Medical Director for review and determination. Grievances that were not a potential PQI were closed, logged onto the potential PQI log and not reviewed by the Medical Director and not resolved.

Although there was evidence of some review during the Ongoing Oversight Workgroup meetings and evidence that the Medical Director and CMO participated in these sessions, items reviewed were not consistently identified nor were the details of discussions delineated. The Medical Director closed two quality related grievances in collaboration with an RN reviewer during Ongoing Monitoring meetings and kept another quality grievance open for further study during the audit period. However, the cases were not identified.

❖ COMPLIANCE AUDIT FINDINGS (CAF) ❖

PLAN: Alameda Alliance for Health

AUDIT PERIOD: April 1, 2014 - March 31, 2015

DATE OF AUDIT: June 8, 2015 – June 18, 2015

Review of 28 grievances referred for potential PQI determination revealed the following:

- a) 2 of 28 grievances were referred to the Medical Director as a potential PQI.
- b) 2 of 28 grievances had a notation that the Medical Director had reviewed the records during the monitoring meeting. However, the meeting was held after the resolution letter was mailed out to the Member.
- c) 26 of 28 grievances did not have a determination of whether quality of care issues were noted.

The Plan was not in compliance with the requirements of quality of care grievance review and Medical Director participation.

4.1.4 **Unresolved grievances were closed and final resolution not communicated to the Member**

A grievance logged 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(1)&(2)*)

According to its policy, the Plan will thoroughly investigate all grievances, including any aspects of clinical care involved. The determination for a grievance will be made and communicated to the Member within 30 calendar days of the receipt of a standard grievance. This information will include: a) the determination or result including the specific reasons for the decision, in easy-to-understand language b) the date the decision was made. (*Policy#: MED-CGR-0001, Member Grievances and Appeals*)

The Plan closed grievance cases and sent Members a resolution letter prior to reaching a resolution. The Plan sent resolution letters to Members prior to receiving a response from the Provider whom the grievance was filed against. The resolution letter stated that the Member would be contacted upon receipt of the response from the Provider. In many cases, there were no records of a follow-up conducted to inform Members of the outcome of the grievance.

Grievances classified as quality of care were not consistently presented to the Medical Director for review prior to the submission of the resolution letter and therefore, a final determination was not made or provided to the Member. Quality of care grievances reviewed and closed by the G&A nurses did not always have a determination other than whether it was a potential PQI or not. The decision on quality of care grievances were not communicated to the Member.

A review of 65 grievances files disclosed the following:

- a) 8 of 65 grievances were closed and a resolution letter sent to the Member prior to receiving a response from the Provider whom the grievance was filed against. 6 of 8 grievance files did not contain any follow-up telephone calls or correspondence sent to the Member to address the pending complaint.
- b) 21 of 65 grievances were classified as quality of care issues. 20 of 21 grievances classified as a quality of care were referred for a potential PQI determination. 10 of 20 grievances referred for a potential PQI determination were not reviewed by a nurse until 70 or more days after the grievance resolution was sent to the Member. These grievances were not processed within the required 30 calendar day time frame. There was no evidence that the decision on those grievances was communicated to the Member.

❖ COMPLIANCE AUDIT FINDINGS (CAF) ❖

PLAN: Alameda Alliance for Health

AUDIT PERIOD: April 1, 2014 - March 31, 2015

DATE OF AUDIT: June 8, 2015 – June 18, 2015

- c) 20 of 21 grievances classified as quality of care were not reviewed by the Medical Director prior to the submission of the resolution letter and a final determination was not made or provided to the Member.

The Plan was not in compliance with grievance resolution, communication and reporting requirements.

4.1.5 **Grievance status notification letters were not sent to Members when a resolution was not reached within 30 days**

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

The Plan informed Members that they would be contacted upon receipt of the response from the Provider. However, the Plan did not provide an estimated completion date of resolution to the Member. The Plan was not in compliance with the requirements for grievance status notification.

4.1.6 **The Plan incorrectly reported grievance status to DHCS**

Grievances that are not resolved within 30 calendar days shall be reported as “pending” grievances (*CCR, Title 28 §1300.68(a)(4)(B)*).

The Plan reported grievances that were unresolved to DHCS as resolved. The Plan was not in compliance with the grievance reporting requirements.

4.1.7 **Three acknowledgement and resolution letters were not translated to the Plan’s threshold languages**

The Plan is required to fully translate written informing materials, including but not limited to grievance acknowledgment and resolution letters (*Contract A11, Exhibit A, Attachment 9(14)(B)(2)* and *CCR, Title 28, §1300.68(b)(3)*).

The Plan did not translate grievance acknowledgment and resolution letters to its threshold languages. The Plan used the Member demographic information provided by Medi-Cal eligibility to determine whether Members speak a language other than English. Members who had an “undetermined” language listed were assessed based on communication records with the Member. Review of grievances filed revealed the following:

Eight of 65 grievances were for Members who had a language other than English listed. Three of 8 acknowledgment and resolution letters sent to Members were not translated to the Plan’s threshold languages. The Plan was not in compliance with the requirements for translation of written materials.

4.1.8 **The Plan did not specify whether resolved grievances were in favor of the Member or the Plan**

The Plan is required to monitor the number of grievances received and resolved; whether the grievance was resolved in favor of the Member or the Plan (*CCR, Title 28 §1300.68(e)(1)*).

The Plan did not specify whether a resolved grievance was in favor of the Member or the Plan. The Plan was not in compliance with the grievance monitoring requirements.

❖ COMPLIANCE AUDIT FINDINGS (CAF) ❖

PLAN: Alameda Alliance for Health

AUDIT PERIOD: April 1, 2014 - March 31, 2015

DATE OF AUDIT: June 8, 2015 – June 18, 2015

4.1.9 The Plan did not consistently inform Members of expedited grievances criteria determination

The Plan is required to provide the complainant a written statement on the disposition or pending status of the urgent grievance within 3 calendar days of the receipt of the grievance (*CCR, Title 28 §1300.68.01(A)(2)*).

The Plan did not consistently inform Members that did not meet the expedited grievance review criteria of its status change to standard grievance. Five of 16 grievances initially classified as expedited and later changed to standard did not have records of a telephone call or a letter informing the Member of the change.

4.1.10 Grievance data was not appropriately reported, monitored or used for Quality Improvement

The grievance system shall provide for a prompt review of grievances by the management or supervisory staff responsible for the services or operations which are the subject of the grievance (*CCR, Title 28 §1300.68 (d) (2)*). The Plan is required to have procedures for systematic aggregation and analysis of the grievance data and use for Quality Improvement. The Plan is required to ensure that grievances submitted are reported to the appropriate level i.e. medical issues versus health care delivery issues and resolved by a health care professional with appropriate clinical expertise. The plan is required to have a procedure to ensure the participation of individuals with authority to require corrective action. Grievances related to medical quality of care issues shall be referred to the Plan's Medical Director. (*Contract A11, Exhibit A, Attachment 14(1)(C),(D)&(E)*).

There was no evidence that grievance data related to various departments of the Plan (cultural and linguistic, HIPAA, claims, Provider relations and access) was communicated to those departments to ensure appropriate corrective action and to ensure that this data was used as part of a Plan Quality Improvement System. Grievances related to medical quality of care issues were not consistently referred to the Plan's Medical Director for review and appropriate action.

Grievance data was not consistently used for Quality Improvement even in cases where there was evidence of harm to a Member. For example: In one grievance case documenting severe consequences for a Member (i.e., uncontrolled undiagnosed glaucoma and resultant monocular blindness), the Plan's Medical Director assigned a zero level severity rating to the case with no plan for further intervention in a failure-of-care episode mislabeled as an access issue. The case indicated multiple areas for quality improvements (i.e., no complete eye exam at the first hospital though the Member insisted on seeing a specialist and one was present; labeling the case as an access issue though evidence indicated that the Member complained about the quality of care; no assurance of follow up with a Plan ophthalmologist because the Plan required a referral from a PCP which had to be assigned urgently by G& A personnel). Dissatisfaction with Provider service was noted to be a driver of multiple grievances.

The Plan was not in compliance with the requirements for grievance monitoring and reporting for quality improvement.

RECOMMENDATIONS:

- 4.1.1 Capture all complaints and expressions of dissatisfaction regarding the Plan and Providers.
- 4.1.2 Develop and implement a process for monitoring and reviewing grievances designated as non-clinical to ensure quality of care issues are not missed and ensuring grievance resolutions are clear, concise and appropriate.
- 4.1.3 Refer all quality of care grievances to the Medical Director for review, resolution and appropriate action.

❖ COMPLIANCE AUDIT FINDINGS (CAF) ❖

PLAN: Alameda Alliance for Health

AUDIT PERIOD: April 1, 2014 - March 31, 2015

DATE OF AUDIT: June 8, 2015 – June 18, 2015

- 4.1.4 Thoroughly investigate complaints, including any aspects of clinical care involved before closing a grievance. Communicate grievance determination (decision) to the Member.
- 4.1.5 Send a written notice of the status of the grievance and estimated completion date of resolution to Members when a resolution is not reached within 30 days.
- 4.1.6 Report unresolved grievances to DHCS accurately.
- 4.1.7 Send acknowledgment and resolution letters to Members that are fully translated to the Plan's threshold languages.
- 4.1.8 Determine whether grievances classified as "favorable" are classified in favor of the Member or the Plan. Consistently apply that terminology.
- 4.1.9 Inform Members of Expedited grievance criteria determination.
- 4.1.10 Communicate grievance data to the appropriate departments at the Plan. Consistently utilize grievance data for Quality Improvement.

❖ COMPLIANCE AUDIT FINDINGS (CAF) ❖

PLAN: Alameda Alliance for Health

AUDIT PERIOD: April 1, 2014 - March 31, 2015

DATE OF AUDIT: June 8, 2015 – June 18, 2015

4.2

CULTURAL AND LINGUISTIC SERVICES

Cultural and Linguistic Program:

Contractor shall have a Cultural and Linguistic Services Program that incorporates the requirements of Title 22 CCR Section 53876. 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 their cultural and linguistic services consistent with the group needs assessment requirements...

2-Plan Contract A.9.13

Contractor will assess, identify and track the linguistic capability of interpreters or bilingual employed and contracted staff (clinical and non-clinical).

2-Plan Contract A.9.13.B

Contractor shall develop and implement policies and procedures for assessing the performance of individuals who provide linguistic services as well as for overall monitoring and evaluation of the Cultural and Linguistic Services Program.

2-Plan Contract A.9.13.F

Linguistic Services:

Contractor shall ensure compliance with Title 6 of the Civil Rights Act of 1964 (42 U.S.C. Section 2000d, 45 C.F.R. Part 80) that prohibits recipients of Federal financial assistance from discriminating against persons based on race, color, religion, or national origin.

2-Plan Contract A.9.12

Contractor shall comply with Title 22 CCR Section 53853(c) and ensure that all monolingual, non-English-speaking, or limited English proficient (LEP) Medi-Cal beneficiaries receive 24-hour oral interpreter services at all key points of contact...either through interpreters, telephone language services, or any electronic options...

2-Plan Contract A.9.14.A

Types of Linguistic Services:

Contractor shall provide, at minimum, the following linguistic services at no cost to Medi-Cal Members or potential Members:

- 1) Oral Interpreters, signers, or bilingual Providers and Provider staff at all key points of contact. These services shall be provided in all languages spoken by Medi-Cal beneficiaries and not limited to those that speak the threshold or concentration standards languages.
- 2) Fully translated written informing materials...
- 3) Referrals to culturally and linguistically appropriate community service programs.
- 4) Telecommunications Device for the Deaf (TDD).

2-Plan Contract A.9.14.B

Key Points of Contact Include:

- 1) Medical care settings: telephone, advice and urgent care transactions, and outpatient encounters with health care Providers including pharmacists.
- 2) Non-medical care setting: Member services, orientations, and appointment scheduling.

2-Plan Contract A.9.14.D

SUMMARY OF FINDINGS:

4.2.1 The Plan did not ensure that Members and potential Members receive 24 hour oral interpreter services at all key points of contact

The Plan is required to ensure that Members and potential Members have 24-hour access to interpreter services (*Contract, A11, Exhibit A, Attachment 9,14(A)*)(CCR, 22, §53853(c)).

❖ COMPLIANCE AUDIT FINDINGS (CAF) ❖

PLAN: Alameda Alliance for Health

AUDIT PERIOD: April 1, 2014 - March 31, 2015

DATE OF AUDIT: June 8, 2015 – June 18, 2015

The Plan retained responsibility for providing interpreter services to Members by employing bilingual staff and contracting with an interpreter vendor. Although the provision of interpreter services was not delegated to Providers, the Plan did not ensure that Providers had signage posted to inform Members of the availability of interpreter services through the Plan. During the audit period, the Plan received multiple complaints regarding the unavailability of interpreter services at Providers' facilities.

4.2.2 The Plan did not monitor the quality of linguistic services provided by employees

The Plan is required to develop and implement policies and procedures for assessing the performance of individuals who provide linguistic services (*Contract, A11, Exhibit A, Attachment 9,13(F)*).

Plan policy#: MED-CL-0010 Cultural and Linguistic Services Program: Staff Training Policy established that the Plan will review the quality of communication of bilingual or multilingual staff with Members through periodic telephonic monitoring.

The Plan did not monitor the quality of linguistic services provided by Member Services' staff. During the audit period, the Plan experienced a high volume of calls which resulted in long wait times as well as high call abandonment rates. The Plan's priority was to answer calls and to improve the wait time and abandonment rates thus quality of communication was not reviewed.

4.2.3 The Plan did not conduct oversight reviews of PBM, Interpretation Service, and Call Center vendors' staff qualifications and quality of linguistic services provided

The Plan is required to assess, identify and track linguistic capability of interpreters or bilingual employees and contracted staff (*Contract, A11, Exhibit A, Attachment 9,13(B)*).

Although the Plan's Interpretation Service Agreement with vendor includes providing evidence of interpreter qualifications, the Plan did not request or review this information from vendor. The Plan also did not monitor the quality of interpretation services provided by its Interpretation Services vendor. Reports received from the Interpretation Services vendor were limited to weekly invoices of interpretation service provided in person or telephonic by vendor. Similarly, quality reviews of staff had been delegated to its Call Center vendor but the Plan did not conduct any oversight reviews during the audit period.

The Plan delegated the provision of cultural and linguistic appropriate services to its Pharmacy Benefits Manager (PBM). The Pharmacy Benefit Management Services Agreement with the vendor stated that the PBM and its Network Pharmacies will ensure access to care for limited/non-English speaking Members through the PBM and/or the pharmacies' own multilingual staff or qualified interpreter. However, the Plan did not conduct oversight monitoring of PBM's reviews of qualification of its and the Network Pharmacies' staff who are providing language services, nor the quality of linguistic services provided by the PBM and its Network Pharmacies.

RECOMMENDATIONS:

- 4.2.1 Provide Members and potential Members access to 24-hour oral interpreter services at all key points of contact.
- 4.2.2 Implement policies and procedures for monitoring quality of linguistic services provided by direct employees.
- 4.2.3 Conduct oversight monitoring of all vendors to whom cultural and linguistic services have been delegated by the Plan.

❖ COMPLIANCE AUDIT FINDINGS (CAF) ❖

PLAN: Alameda Alliance for Health

AUDIT PERIOD: April 1, 2014 - March 31, 2015

DATE OF AUDIT: June 8, 2015 – June 18, 2015

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 (HIPAA) 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.III.C.2.

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.III.J

❖ COMPLIANCE AUDIT FINDINGS (CAF) ❖

PLAN: Alameda Alliance for Health

AUDIT PERIOD: April 1, 2014 - March 31, 2015

DATE OF AUDIT: June 8, 2015 – June 18, 2015

SUMMARY OF FINDINGS:

4.3.1 The Plan did not report an actual breach of PHI, and did not report a suspected security incident to DHCS

The Plan is required to notify DHCS immediately upon discovery of breach of security of PHI in computerized form; or within 24 hours of any suspected security incident, unauthorized use or disclosure of PHI, or potential loss of confidential data. Plan is required to notify DHCS Contracting Officer, DHCS Privacy Officer and DHCS Information Security Officer (*Contract, A11, Exhibit G, H(1)*).

The Plan's notification of PHI breach to DHCS depends on result of Compliance Department's investigation and risk assessment. If an incident is determined to be no or low risk, the Plan will not report the incident.

Plan did not notify DHCS of breach reported by its Pharmacy Benefit Manager. Several grievances filed and fraud and abuse incidents reported to the plan had components of actual or suspected PHI breach but were not reported to DHCS. For example, a member filed a grievance due to delivery of his/her health card to the wrong address and clearly put "Privacy Issue" as the subject of the email. This incident was not forwarded to the Plan's Department responsible for processing PHI breaches. The HIPAA incidents were not reported to DHCS Contracting Officer, DHCS Privacy Officer, and DHCS Information Security Officer.

Also during the audit period, there was an IT security incident which involved unauthorized attempts to gain illegal access to Plan's network. Although the Plan was able to prevent the unauthorized user from penetrating their network, the Plan did not report the suspected security incident to DHCS.

4.3.2 The Plan did not notify DHCS upon discovery of a security incident, breach, or unauthorized use or disclosure of PHI within the required timeframes

The Plan is required to notify DHCS immediately or within 24 hours of discovery, to submit an initial investigation report within 72 hours, and provide a complete written report of investigation within 15 working days (*Contract, A11, Exhibit G, H(1)-(2)*).

During the audit period, the Plan notified the DHCS Contract Manager of one suspected security incident. Although the Plan notified the DHCS Contract Manager regarding the incident, the Plan did not submit their initial investigation report within 72 hours of discovery nor a complete written report within 15 working days.

4.3.3 The Plan did not ensure network Providers had safeguards to protect PHI

The Plan is required to implement administrative, physical, and technical safeguard that reasonably and appropriately protect the confidentiality, integrity, and availability of the PHI. The Plan is also required to implement reasonable systems to ensure the discovery and prompt reporting of any breach or security incident. (*Contract, Exhibit G(3)(B)*)

The Plan's method for ensuring network Provider's compliance with Member's Right to Confidentiality and HIPAA Responsibilities is through Provider Training. However, the Plan did not conduct new Provider training during the audit period. The Plan also did not conduct monitoring of delegated entities' electronic information security and all other HIPAA requirements in Contract.

❖ COMPLIANCE AUDIT FINDINGS (CAF) ❖

PLAN: Alameda Alliance for Health

AUDIT PERIOD: April 1, 2014 - March 31, 2015

DATE OF AUDIT: June 8, 2015 – June 18, 2015

RECOMMENDATIONS:

- 4.3.1 Notify DHCS Contract Manager, Privacy Officer, and Information Security Officer of all suspected and actual PHI breaches upon discovery
- 4.3.2 Notify DHCS immediately or within 24 hours of discovery of suspected and actual breaches. Submit initial investigation report containing all information required by Contract, A11, Exhibit G, H(2) within 72 hours.
- 4.3.3 Conduct Provider Training on New Providers. Conduct monitoring of Delegated Entities' compliance with Confidentiality Rights.

❖ COMPLIANCE AUDIT FINDINGS (CAF) ❖

PLAN: Alameda Alliance for Health

AUDIT PERIOD: April 1, 2014 - March 31, 2015

DATE OF AUDIT: June 8, 2015 – June 18, 2015

CATEGORY 5 – QUALITY MANAGEMENT

5.1

QUALITY IMPROVEMENT SYSTEM

General Requirements:

Contractor shall implement an effective Quality Improvement System (QIS) in accordance with the standards in Title 28, CCR, Section 1300.70. Contractor shall monitor, evaluate, and take effective action to address any needed improvements in the quality of care delivered by all Providers rendering services on its behalf, in any setting. Contractor shall be accountable for the quality of all Covered Services regardless of the number of contracting and subcontracting layers between Contractor and the Provider.

2-Plan Contract A.4.1

Written Description: Contractor shall implement and maintain a written description of its QIS (Quality Improvement System)...(as required by Contract)

2-Plan Contract A.4.7.A-I

Accountability: Contractor shall maintain a system of accountability which includes the participation of the governing body of the Contractor's organization, the designation of a quality improvement committee with oversight and performance responsibility, the supervision of activities by the medical director, and the inclusion of contracted physicians and contracted Providers in the process of QIS development and performance review. Participation of non-contracting Providers is discretionary.

2-Plan Contract A.4.2

Governing Body: Contractor shall implement and maintain policies that specify the responsibilities of the governing...(as required by Contract)

2-Plan Contract A.4.3.A-D

Provider Participation: Contractor shall ensure that contracting physicians and other Providers from the community shall be involved as an integral part of the QIS. Contractor shall maintain and implement appropriate procedures to keep contracting Providers informed of the written QIS, its activities, and outcomes.

2-Plan Contract A.4.5

SUMMARY OF FINDINGS:

5.1.1 There was inadequate oversight of UM and QI by the Governing Board and the Health Care Quality Committee (HCQC)

The Plan must appoint an accountable entity or entities within the Plan's organization to provide oversight of the QIS. *(Contract, Exhibit A, Attachment 4,(3)(B))* The Plan must implement and maintain a QIC designated by, and accountable to, the Governing Board *(Contract, Exhibit A, Attachment 4,(4)(A))*. The committee shall meet at least quarterly but as frequently as necessary to demonstrate follow-up on all findings and required actions, which are then reported to the Governing Board in writing on a scheduled basis. *(Contract, Exhibit A, Attachment 4,(4)(B))*.

One month into the audit period, the Plan was placed into a conservatorship and assumed the responsibilities of the Governing Board. There had been dramatic growth in Membership and problems with Plan function, including a major back-log of claims and the lack of communication of the Plan's computer software systems.

❖ COMPLIANCE AUDIT FINDINGS (CAF) ❖

PLAN: Alameda Alliance for Health

AUDIT PERIOD: April 1, 2014 - March 31, 2015

DATE OF AUDIT: June 8, 2015 – June 18, 2015

The Plan's 2014 Quality Improvement Program Description and Plan was not approved by the Governing Board (conservatorship) until 8/13/2014. Thus, the Plan's Quality Improvement System was operated without an executed and approved plan for the majority of the year. At the time of DHCS's audit onsite on June 2015, the 2015 Quality Improvement Program Description and Plan was still not executed. The Plan is reorganizing its processes to approve this important document earlier in the year.

The HCQC had major responsibilities for Plan UM and QI activities. Despite these considerations, the HCQC met the mandated yearly minimum of four times, with the average meeting duration of about one hour. This would not be sufficient for comprehensive oversight of all Plan QI and UM activities and numerous other important issues affecting Plan function, especially with the Plan's conservatorship status. The Plan (conservatorship) identified a lack of oversight related to the above issues and developed a new system of 6 sub-committees which would be accountable to the HCQC. This was being operationalized as the audit period ended, with the Plan hoping that this system will better address their complex and evolving needs and issues.

5.1.2 **The Plan did not monitor, evaluate and take effective actions to address needed improvements in the quality of care delivered by all Providers in all settings**

The Plan shall monitor, evaluate, and take effective action to address any needed improvements in the quality of care delivered by all Providers rendering services on its behalf in any setting. The Plan shall be accountable for the quality of all covered services regardless of the number of contracting and subcontracting layers between the Plan and the Providers of services. (*Contract, Exhibit A, Attachment 4(1)*).

The Plan did not always monitor, evaluate and take actions to improve quality of care when specific problems were identified. Some examples included:

- When the Plan identified that Providers did not meet timely access requirements, it did not take appropriate actions for correction with corrective action plans. (This is discussed in detail in section 3.1, Appointment Procedures and Monitoring of Waiting Times.)
- Several grievances were related to access issues, including appointment wait times. Even when a Provider's practice was identified via the grievance system as not having new patient visits for 4 or more months, the Plan continued to assign new Members to the Provider, further compounding the problem. (This is also discussed in section 3.1.)
- The Plan did not use appeals data to effect quality improvements. The HCQC meeting minutes of February 2015 revealed a discussion of group care's appeals reports but not specifically that of Medi-Cal Members. Any initiatives to improve problems related to delegate-related appeals occurred on an ad hoc basis. (This is discussed in section 1.4, PA Appeal Process.) The Plan did not identify problems with appeals overturns and use information from appeals overturns to improve the UM system and quality of care. (This is discussed in section 5.1, Quality Improvement System.)
- The Plan did not ensure the provision of an Initial Health Assessment (IHA) to each new Member within the required time frames. When the Plan's methodology for IHA monitoring revealed a compliance rate of only 30%, there was no quality improvement strategy enacted to address this low rate. Proposed correction measures were not included in the 2014 and 2015 QI Work Plan. (This is discussed in section 2.4, Initial Health Assessment.)
- Grievance data was not appropriately reported, monitored or used for quality improvement. Grievance data from various Plan departments were not communicated to those departments to ensure appropriate corrective actions and use of the data for Plan quality improvement. (This is discussed in section 4.1, Grievances)

❖ COMPLIANCE AUDIT FINDINGS (CAF) ❖

PLAN: Alameda Alliance for Health

AUDIT PERIOD: April 1, 2014 - March 31, 2015

DATE OF AUDIT: June 8, 2015 – June 18, 2015

5.1.3 **The Plan did not document metric data demonstrating whether or not all QI initiatives resulted in improved health outcomes**

The Plan must perform comprehensive assessments of the quality improvement activities undertaken and evaluate areas of success and needed improvements in services rendered within the quality improvement program, including but not limited to, the collection of aggregate data on utilization, the review to quality of services rendered, the results of external accountability set measures and outcomes from quality improvement projects, consumer satisfaction surveys and collaborative initiatives. (*Contract, Exhibit A, Attachment 4(8)(A)*)

DHCS review of Plan documents indicated little or no objective metric data demonstrating that quality initiatives did or did not improve the quality of care of Members. DHCS reviewed 4 sets of HCQC committee minutes and several Medical Services Reports to the Conservator for the audit period. Although there was occasional quality initiative metric data reporting, there was little or no reporting of objective metrics actually demonstrating improvement in health outcomes from the initiatives.

The 2014 Medicaid CAHPS (Consumer Assessment of Healthcare Providers and Systems Survey) adjusted composite scores revealed 2 scores at the 25th percentile and 6 below the 25th percentile. The 2014 Provider Satisfaction Report indicated that all 8 composite scores had worsened from 2013 to 2014, with one of these composites being utilization and quality management. Objective metric data linking identification of these areas of concern, plans for improvement and improved health outcomes from interventions were not noted.

5.1.4 **Information from overturned appeals was not incorporated into the Quality Improvement System (QIS)**

The Plan is required to integrate UM activities into the QIS, including a process to integrate reports on review of the number and types of appeals, denials, deferrals, and modifications to the appropriate QIS staff. (*Contract, Exhibit A, Attachment 5(1)(G)*)

DHCS reviewed PA and appeal data submitted by the Plan for 5 entities delegated UM. One entity denied 94 of 883 PAs, with all 94 overturned on appeal. Another denied 222 PAs, with 31 of 57 overturned on appeal. There were 1216 total denials for the 5 delegates, with 131 of 158 overturned on appeal. The Plan was not aware of this denial-appeal-overturn pattern and did not investigate why this was occurring. As a result, there was no new information gained to update and improve the UM program and to integrate into the QIS.

5.1.5 **Not all Potential Quality Issues (PQIs) were resolved within acceptable time frames**

The PQI resolution time of 30 days starts when all required documentation has been received and ends with the Medical Director renders a decision on the PQI (*Plan Policy and Procedure MED-QM-0002*)

DHCS reviewed 6 Medi-Cal non-SPD PQIs. Total resolution time for three of these was 180, 187 and 238 days respectively. This was easily in excess of PQI time frame guidelines as per the Plan's own policy and procedure for PQIs in effect at that time.

❖ COMPLIANCE AUDIT FINDINGS (CAF) ❖

PLAN: Alameda Alliance for Health

AUDIT PERIOD: April 1, 2014 - March 31, 2015

DATE OF AUDIT: June 8, 2015 – June 18, 2015

RECOMMENDATIONS:

- 5.1.1 Ensure increased oversight of Plan UM and QI activities by the Governing Board and the HCQC.
- 5.1.2 Develop and utilize mechanisms to monitor, evaluate, and take effective actions to address needed improvements in the quality of care delivered by Providers in all settings.
- 5.1.3 Objectively measure and document metric data demonstrating whether or not all QI initiatives result in improved health outcomes for Members.
- 5.1.4 Incorporate information derived from evaluation of overturned appeals into the QIS.
- 5.1.5 Resolve PQIs within the time frame specified in the Plan's policy and procedure.

❖ COMPLIANCE AUDIT FINDINGS (CAF) ❖

PLAN: Alameda Alliance for Health

AUDIT PERIOD: April 1, 2014 - March 31, 2015

DATE OF AUDIT: June 8, 2015 – June 18, 2015

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

SUMMARY OF FINDINGS:

5.2.1 The Plan did not conduct Provider Training

The Plan is required to ensure that all Providers receive training regarding the Medi-Cal Managed Care program. (*Contract Exhibit A, Attachment 7(5)*).

The Plan did not conduct Provider Training within 10 working days of placing a new Provider on active status.

RECOMMENDATIONS:

5.2.1 Complete training for all newly active Providers within 10 working days of placing a new Provider on active status. Document and track completion of new Provider Training.

❖ COMPLIANCE AUDIT FINDINGS (CAF) ❖

PLAN: Alameda Alliance for Health

AUDIT PERIOD: April 1, 2014 - March 31, 2015

DATE OF AUDIT: June 8, 2015 – June 18, 2015

5.3

DELEGATION OF QUALITY IMPROVEMENT ACTIVITIES

Delegation of Quality Improvement Activities:

- A. Contractor is accountable for all quality improvement functions and responsibilities (e.g. Utilization Management, Credentialing and Site Review) that are delegated to subcontractors. If Contractor delegates quality improvement functions, Contractor and delegated entity (subcontractor) shall include in their Subcontract, at minimum:
 - 1) Quality improvement responsibilities, and specific delegated functions and activities of the Contractor and subcontractor.
 - 2) Contractor's oversight, monitoring, and evaluation processes and subcontractor's agreement to such processes.
 - 3) Contractor's reporting requirements and approval processes. The agreement shall include subcontractor's responsibility to report findings and actions taken as a result of the quality improvement activities at least quarterly.
 - 4) Contractor's actions/remedies if subcontractor's obligations are not met.
- B. Contractor shall maintain a system to ensure accountability for delegated quality improvement activities, that at a minimum:
 - 1) Evaluates subcontractor's ability to perform the delegated activities including an initial review to assure that the subcontractor has the administrative capacity, task experience, and budgetary resources to fulfill its responsibilities.
 - 2) Ensures subcontractor meets standards set forth by the Contractor and DHCS.
 - 3) Includes the continuous monitoring, evaluation and approval of the delegated functions.

2-Plan Contract A.4.6

SUMMARY OF FINDINGS:

5.3.1 The Plan did not perform annual QI delegation oversight audits for entities with delegated QI activities

The Plan is responsible for an annual QI report, with the report including a comprehensive assessment of the QI activities undertaken and an evaluation of areas of success and needed improvements in services rendered within the QI program and an assessment of the delegated entity performance of QI activities. (*Contract, Exhibit A, Attachment 4,(8)(A&C)*)

An annual QI oversight audit of delegated entities is performed to assess how the delegated entities are performing their QI activities. For the audit period, there were no annual QI delegation oversight audits performed for the two entities to whom the Plan had delegated QI activities.

5.3.2 The Plan did not maintain a system for ensuring the accountability of delegated QI activities, including continuous monitoring, evaluation, and approval of delegated functions

The Plan is responsible for ensuring accountability of all QI functions and responsibilities delegated to entities and to maintain a system to ensure accountability for delegated QI activities, that including the continuous monitoring, evaluation, and approval of the delegated functions. (*Contract, Exhibit A, Attachment 4,(6)*)

The Plan did not maintain a system of accountability, continuous monitoring, evaluation, and approval of delegated functions for two entities to whom the Plan had delegated QI activities.

❖ COMPLIANCE AUDIT FINDINGS (CAF) ❖

PLAN: Alameda Alliance for Health

AUDIT PERIOD: April 1, 2014 - March 31, 2015

DATE OF AUDIT: June 8, 2015 – June 18, 2015

RECOMMENDATIONS:

- 5.3.1 Perform annual QI delegation oversight audits for all entities with delegated QI activities.
- 5.3.2 Continuously monitor, evaluate and ensure accountability for entities to whom QI activities are delegated.

❖ COMPLIANCE AUDIT FINDINGS (CAF) ❖

PLAN: Alameda Alliance for Health

AUDIT PERIOD: April 1, 2014 - March 31, 2015

DATE OF AUDIT: June 8, 2015 – June 18, 2015

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

SUMMARY OF FINDINGS:

6.1.1 The Plan did not ensure that medical care met acceptable standards in four instances

The Plan's Medical Director is accountable for ensuring that the medical care provided meets acceptable standards. (*Contract, Exhibit A, Attachment 1(6)(B)*)

Examples of cases where this did not occur include:

- In a PQI case involving an incomplete eye exam, there was a missed diagnosis of chronic glaucoma and resultant blindness. The Medical Director issued a severity level of zero and recommended no system improvements or consequences for the treating team.
- A grievance alleging inappropriate follow up of a mammogram and demonstrating care out of compliance with the recommended standard received no physician attention, only rising to the level of a registered nurse (RN) review.
- In a review of appeals, one case clearly indicated treatment failure after multiple medications tried and intolerance of other treatments. A request to continue a non-formulary medication that was resolving the Member's dermatological problem was denied. The physician reviewer instead suggested taking a formulary medication not effective for this condition when used alone per literature review.
- In another case, a Member indicated that she could not continue to take non-steroidal medications for continuing pain due to gastrointestinal side effects. Documentation revealed prescriptions for acid-reducing medications in the Member's pharmacy list, adding to evidence of routine treatment failure/medication intolerance and reasons for additional testing. The appeal for additional imaging studies in the face of treatment failure and continuing symptoms was denied again on appeal.

❖ COMPLIANCE AUDIT FINDINGS (CAF) ❖

PLAN: Alameda Alliance for Health

AUDIT PERIOD: April 1, 2014 - March 31, 2015

DATE OF AUDIT: June 8, 2015 – June 18, 2015

- A review of 2 of 2 appeals referred to specialists for an opinion revealed strict adherence to the consultant's view rather than use of the recommendation as a starting point for additional investigation by the Medical Director.

Beyond bi-annual Inter-rater reliability testing for both of the Plan's Medical Directors, there was no additional monitoring of physician decisions.

6.1.2 **There was insufficient Medical Director action in four cases of questionable Provider behavior**

The Medical Director must ensure Plan medical personnel follow medical protocols and rules of conduct. (*Contract, Exhibit A, Attachment 1(6)(C)*)

A number of grievances concerned physicians' behavior. These included:

- One physician dismissed new, complicated patients from his practice without performing full evaluations or arranging follow up. One scenario involved a Member with concern for an infection. The cases were not referred to the Medical Director for follow up.
- A Provider who charged Medi-Cal Members inappropriate fees and required them to leave credit card information on file. Instead of directing the case to the Medical Director's attention, Provider Relations warned the physician about his practices.
- A Provider threatened Members during clinic visits that the practice would soon close due to Plan non-payment of claims. The Medical Director was aware of the Provider's complaints but did not address the matter of the Member's concern or discomfort over this Provider's inappropriate behavior.
- An incidence occurred where a specialist did not complete a physical examination due to a reported dispute with the Member's wife during a clinic visit. The Provider subsequently complained to the primary care Provider (PCP), asking that she not refer such patients in the future. The Plan had limited specialists for referral, such events further jeopardized Members and PCPs access to medical specialists. The case was not referred to the Medical Director for assessment of the specialist's, the PCP's or Member's concerns.

In the above cases, the Plan did not ensure satisfaction of the Contract's requirement that the Medical Director ensure Plan medical personnel follow medical protocols and rules of conduct.

RECOMMENDATIONS:

- 6.1.1 Develop processes for regular monitoring of Medical Directors' clinical decision making so that medical care provided consistently meets the standards for acceptable care.
- 6.1.2 Ensure that the Medical Director receives and investigates complaints in cases of significant physician deviation from rules of conduct and medical protocol.

❖ COMPLIANCE AUDIT FINDINGS (CAF) ❖

PLAN: Alameda Alliance for Health

AUDIT PERIOD: April 1, 2014 - March 31, 2015

DATE OF AUDIT: June 8, 2015 – June 18, 2015

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

SUMMARY OF FINDINGS:

6.3.1 The Plan did not conduct investigation and did not report to DHCS all suspected cases of fraud and/or abuse

The Plan is required to 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. *(Contract, A11, Exhibit E, Attachment 2, (26)(B)(4))*

Processing of suspected fraud and abuse cases reported to Plan by Members, Provider employee, and/or Plan employees were limited to documentation of case in an intake form and an entry in the Fraud, Waste, and Abuse (FWA) Incident Log. The Plan did not conduct further investigation to determine approximate dollars involved possible legal and administrative consequences applicable to the case, and other elements of the case. Thus, the cases were not reported to DHCS.

6.3.2 The Plan did not report to DHCS results of three preliminary investigations within 10 working days

The Plan is required to conduct, complete, and report to DHCS, the results of a preliminary investigation of the suspected fraud and/or abuse within 10 working days of the date the Plan first becomes aware of, or is on notice of, such activity. *(Contract, A11, Exhibit E, Attachment 2, (26)(B)(4))*

Three of 6 suspected fraud and/or abuse cases were reported to DHCS after 10 working days of the date the Plan first became aware of the incident.

❖ COMPLIANCE AUDIT FINDINGS (CAF) ❖

PLAN: Alameda Alliance for Health

AUDIT PERIOD: April 1, 2014 - March 31, 2015

DATE OF AUDIT: June 8, 2015 – June 18, 2015

6.3.3 The Plan did not ensure all affiliated Providers were not excluded from Medi-Cal/Medicare

The Plan 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 Medicare or Medi-Cal/Medicaid programs. (*Contract, A11, Exhibit E, Attachment 2, 26(B)(5)*)

The Plan tracked Medicaid/Medicare status of directly contracted Providers and Providers of one of its delegated entities through monthly monitoring. Other delegated entities' compliance with this requirement was monitored through an annual credentialing audit. However, the Plan did not track Medicaid/Medicare status of DME vendor Providers and Radiology vendor Providers which were not delegated for credentialing. Medicare status of out-of-network Providers submitting claims were checked by the claims auditing software vendor but not the Medicaid status. PBM also checked network pharmacies and prescribing Providers' OIG status but not whether they're on the Medi-Cal Suspended and Ineligible list.

6.3.4 The Plan did not notify Medi-Cal Managed Care Program/Program Integrity Unit of removing a suspended, excluded, or terminated Provider from its network

The Plan is required to notify the Medi-Cal Managed Care Program/Program Integrity Unit within 10 State working days of removing a suspended, excluded, or terminated Provider from its Provider network and confirm that the Provider is no longer receiving payments in connection with the Medicaid program. (*Contract, A11, Exhibit E, Attachment 2, (26)(B)(5)*)

During audit period, the Plan found a chiropractor in its Provider network listed on the Medi-Cal Suspended/Ineligible Provider List and whose license had been revoked by the CA Board of Chiropractic Examiners. However, the Plan failed to notify the Medi-Cal Managed Care Program/Program Integrity Unit about the terminated Provider. The Plan's policy for Ongoing Monitoring of Practitioners does not include procedures for reporting suspended, excluded, or terminated Providers to Medi-Cal Managed Care Program/Program Integrity Unity.

6.3.5 The Plan did not conduct monitoring and auditing of all delegated entities' compliance with the Plan's Anti-Fraud and Abuse Program

The Plan is required to include a provision for internal monitoring and auditing in its Compliance Plan. (*Contract, A11, Exhibit E, Attachment 2, 26(B)(3)*) (*42, CFR, §436.608(b)(6)*)

There was no oversight monitoring of delegated entities' Fraud, Waste, and Abuse measures. One delegated entity's compliance with the Plan's Fraud, Waste and Abuse Program was audited by the Plan. The Plan's Anti-Fraud and Abuse Program did not include procedures to ensure delegated entities' have procedures in place that are consistent with the Plan's.

RECOMMENDATIONS:

- 6.3.1 Investigate all suspected fraud and abuse reported to the Plan.
- 6.3.2 Report to DHCS results of preliminary investigation of suspected fraud and abuse within 10 working days of the date Plan first becomes aware of such activity.
- 6.3.3 Ensure all affiliated Providers including subcontractors and out-of-network Providers (billing, rendering, and prescribing Providers) are not excluded from Medicare/Medicaid.
- 6.3.4 Notify Medical Managed Care Program/Program Integrity Unit within 10 working days of removing a suspended, excluded, or terminated Provider from the Plan's network.
- 6.3.5 Conduct oversight monitoring of all delegated entities' Fraud, Waste, and Abuse measures.

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

Alameda Alliance for Health

Contract Number: 03-75793
State Supported Services

Audit Period: April 1, 2014
Through
March 31, 2015

Report Issued: November 13, 2015

TABLE OF CONTENTS

I. INTRODUCTION1

II. COMPLIANCE AUDIT FINDINGS2

INTRODUCTION

This report presents the audit findings of 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 from June 8, 2015 through June 18, 2015. The audit period was April 1, 2014 through March 31, 2015 and consisted of document review, verification studies, and interviews with Plan personnel.

20 state supported services claims were reviewed for appropriate and timely adjudication.

❖ COMPLIANCE AUDIT FINDINGS (CAF) ❖

PLAN: Alameda Alliance for Health

AUDIT PERIOD: April 1, 2014 – March 31, 2015

DATE OF AUDIT: June 8, 2015 – June 18, 2015

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:

SSS.1 The Plan did not process state supported services claims within 45 working days

The Plan is required to reimburse each complete claim, or portion thereof, whether in state or out of state, as soon as practical, but no later than 45 working days after the date of receipt of the complete claim. (CCR, 28, § 1300.71(g))

During the audit period, the Plan did not meet claim processing times as specified in the Plan's Family Planning and Sensitive Services Policy, and Provider Dispute Resolution Policy. (Contract, A11, Exhibit A, Attachment 8, 5(A))(Health and Safety Code, § 1371.35)

- 8 of 20 state supported services sample claims were processed beyond 45 working days

SSS.2 The Plan did not redirect state supported services claims received in error to the appropriate entity within 10 working days

The Plan is required to maintain sufficient claims processing/tracking/payments systems capability to: comply with applicable State and Federal law, regulations and Contract requirements. (Contract, A11, Exhibit A, Attachment 8(5)(D))

The Plan's Claims Processing Policy establishes that the Plan and its delegated providers must redirect or deny claims that are not their financial responsibility within 10 working days.

The Plan did not have sufficient claims processing systems capability in place to completely process misdirected claims timely. The Plan's process for identifying misdirected claims was not integrated into their claims processing system. Misdirected claims had to be manually pulled out of the Plan's processed claims' database before they were forwarded thus misdirected claims were not forwarded timely.

- 10 of 10 state supported services sample claims identified as misdirected claims were not forwarded to appropriate delegated provider within 10 working days

SSS.3 **The Plan did not implement its established Abortion Claims Processing Guidelines consistently**

The Plan is required to maintain procedures for prepayment and post payment claims review and sufficient claims processing/tracking/payment systems capability. (*Contract, A11, Exhibit A, Attachment 8, 5(C-D)*)

The Plan's processing of state supported services claims was not consistent with its Abortion Processing Guidelines.

- 5 of 20 state supported services sample claims were denied as misdirected claims because they were services performed for a delegated entity's members. The Plan's Abortion Processing Guidelines specify that the Plan was responsible for all abortion claims for members of a specific delegated entity yet the Plan erroneously denied abortion claims for those members.
- 2 of 20 state supported services sample claims were initially denied as misdirected claims and later adjusted after provider disputed the claim. These claims were professional services provided to a delegated entity's members. The Plan's Abortion Processing Guidelines specify that the Plan was only responsible for facility, drugs, and supplies for the delegated entity's members. Professional fees were the delegated entity's responsibility and were supposed to be denied by the Plan.
- 3 of 5 state supported services samples claims for code X7726 were denied as either "Not a Covered Benefit" or "No Allowance for Procedure". Abortion Claims Processing Guidelines specifies that abortion services include code X7726. Throughout the audit period, the Plan paid at least 69 claims for code X7726.

SSS.4 **The Plan did not identify all reasons for denial of a claim in its written notification to provider**

The Plan may contest or deny a claim by notifying provider in writing that the claim is contested or denied. The notice that a claim is denied shall identify the portion of the claim that is denied and the specific reasons for the denial. (*Health and Safety Code, §1371*)

The Plan's method of denial written notification was through the Remittance Advice sent to providers. The current claim processing system used by the Plan can only include the first reason on a Remittance Advice as the Denial Reason. Therefore when there are multiple reasons associated with a claim denial, the provider is only made aware of the primary reason, while all other reasons are not communicated.

- 5 of 5 state supported services samples claims for code X7726 were denied with only one reason indicated in Remittance Advice. According to the Director of Claims, a deny reason of "Not a Covered Benefit" or "No Allowance for Procedure" means the code billed is not on the Plan's benefit list and/or the claim needs to be billed using the appropriate/updated code. The Plan failed to notify the provider of all specific reasons for the denial. The Plan left it to the provider to interpret the denial reason instead of providing all applicable reasons that will enable the provider to rectify the claim appropriately.

SSS.5 **The Plan did not ensure information regarding state supported services distributed by delegated entities' to providers is in accordance with the Plan's policies and procedures**

The Plan is governed by the laws of the State of California. (*Hyde Contract, Exhibit E(2)(A)*) A minor may consent to an abortion without parental consent and without court permission. (*American Academy of Pediatrics v. Lungren (1997) 16 Cal, 4th 307*)

The Provider Manual of the Plan's primary delegated entity states that only adult and adolescent Medi-Cal members have the right to timely access to confidential and sensitive services without authorization from providers in network or out-of-network. An adolescent was considered between the ages of 12 and 18. This was contrary to the Plan's Provider Manual which indicated an abortion as one of the Minor Consent Services (confidential services available to Medi-Cal members under age 18 without parental approval).

Additionally, the Provider Manual of another delegated entity contained no information to indicate that no prior authorization was required for state supported services provided by an out-of-network provider. That delegated entity's Provider Manual states that all services provided out-of-network require prior authorization.

RECOMMENDATIONS:

SSS.1 Process all claims within 45 working days.

SSS.2 Forward misdirected claims to responsible party within 10 working days.

SSS.3 Implement Abortion Claims Processing Guidelines consistently.

SSS.4 Include all denial reasons for denied/contested claims in written notifications to providers.

SSS.5 Ensure all informing materials of delegated entities clearly state that minors of any age may consent to obtain abortion services and that no prior authorization is required for abortion services obtained out-of-network.