CALIFORNIA DEPARTMENT OF HEALTH CARE SERVICES
Michelle Baass | Director

November 4, 2025

Marie Broadnax, Manager Regulatory Affairs and Compliance *Via E-mail*
Alameda Alliance for Health
1240 South Loop Rd.
Alameda, CA 94502

RE: Department of Health Care Services Medical Audit

Dear Ms. Broadnax:

The Department of Health Care Services (DHCS), Audits and Investigations Division, conducted an on-site Medical Audit of Alameda Alliance for Health, a Managed Care Plan (MCP), from June 17, 2024 through June 28, 2024. The audit covered the period from June 1, 2023, through May 31, 2024.

The items were evaluated, and DHCS accepted the MCP's submitted Corrective Action Plan (CAP). The CAP is hereby closed. The enclosed documents will serve as DHCS' final response to the MCP's CAP. The closure of this CAP does not halt any other processes in place between DHCS and the MCP regarding the deficiencies in the audit report or elsewhere, nor does it preclude DHCS from taking additional actions it deems necessary to address these deficiencies.

Please be advised that, in accordance with Health & Safety Code Section 1380(h) and the Public Records Act, the final audit report and the final CAP remediation document (Attachment A) will be made available on the DHCS website and to the public upon request.

If you have any questions, please contact CAP Compliance personnel.

Sincerely,

[Signature on file]
Lyubov Poonka, Chief
Audit Monitoring Unit
Process Compliance Section
DHCS - Managed Care Quality and Monitoring Division (MCQMD)

Enclosures: Attachment A (CAP Response Form)

cc: Kelli Mendenhall, Chief
Managed Care Monitoring Branch *Via E-mail*
DHCS - Managed Care Quality and Monitoring Division (MCQMD)

Grace McGeough, Chief *Via E-mail*
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Managed Care Monitoring Branch
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Joshua Hunter, Lead Analyst *Via E-mail*
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Aldo Flores, Unit Chief *Via E-mail*
Managed Care Contract Oversight Branch
DHCS – Managed Care Operations Division (MCOD)

Lolita Aquino, Contract Manager *Via E-mail*
Managed Care Contract Oversight Branch
DHCS – Managed Care Operations Division (MCOD)

ATTACHMENT A

Corrective Action Plan Response Form

Plan: Alameda Alliance For Health
Audit Type: Medical Audit
Review Period: 6/1/23 – 5/31/24
On-site Review: 6/17/24 – 6/28/24

MCPs are required to provide a Corrective Action Plan (CAP) and respond to all documented deficiencies included in the medical audit report within 30 calendar days unless an alternative timeframe is indicated in the CAP Request letter. MCPs are required to submit the CAP in Word format, which will reduce the turnaround time for DHCS to complete its review. According to ADA requirements, the document should be at least 12 pt.

The CAP submission must include a written statement identifying the deficiency and describing the plan of action taken to correct the deficiency, as well as the operational results of that action. The MCP shall directly address each deficiency component by completing the following columns provided for MCP response: 1. Finding Number and Summary, 2. Action Taken, 3. Supporting Documentation, and 4. Completion/Expected Completion Date. The MCP must include a project timeline with milestones in a separate document for each finding. Supporting documentation should accompany each Action Taken. If supporting documentation is missing, the MCP submission will not be accepted. For policies and other documentation that have been revised, please highlight the new relevant text and include additional details, such as the title of the document, page number, revision date, etc., in the column "Supporting Documentation" to assist DHCS in identifying any updates that were made by the plan. Implementing deficiencies requiring short-term corrective action should be completed within 30 calendar days. For deficiencies that may be reasonably determined to require long-term corrective action for a period longer than 30 days to remedy or operationalize completely, the MCP is to indicate that it has initiated remedial action and is on the way toward achieving an acceptable level of compliance. In those instances, the MCP must include the date when full compliance will be completed in addition to the above steps. Policies and procedures submitted during the CAP process must still be sent to the MCP's Contract Manager for review and approval, as applicable, according to existing requirements.

Please note that DHCS expects the plan to take swift action to implement improvement interventions as proposed in the CAP; therefore, DHCS encourages all remediation efforts to be in place no later than month 6 of the CAP unless DHCS grants prior approval for an extended implementation effort.

DHCS will communicate closely with the MCP throughout the CAP process and provide technical assistance to confirm that the MCP offers sufficient documentation to correct deficiencies. Depending on the number and complexity of deficiencies identified, DHCS may require the MCP to provide weekly updates.

1. Utilization Management

Finding Number and Summary	Action Taken	Supporting Documentation	Implementation Date * (*Short-Term, Long-Term)	DHCS Comments
1.2.1 Referral to Transplant Program Within 72 Hours The Plan did not directly refer an adult member to a transplant program for evaluation within 72 hours of the member's specialist identifying the member as a potential candidate for MOT.	1. The Plan's existing P&P references 72hr Major Organ Transport (MOT) TAT and is aligned with APL regulations (UM-071 Major Organ Transplant). 2. The Plan's Standard Operating Procedures (SOP) were updated to reflect the 72 hours MOT TAT, and all UM staff were re-trained on 6/20/2024. 3. The UM team instituted a formal internal review process to ensure all operating procedures align with P&Ps. A Standard Operating Procedures was developed, and staff were trained on the internal review process. 4. P&P Tracker developed to ensure at least annual and ad-hoc updates to P&Ps are monitored and aligned with regulatory guidance.	1. 1.2.1_UM-071 MOT P&P 2. 1.2.1_MOT SOP 1 1.2.1_MOT SOP 2 1.2.1_MOT SOP 3 1.2.1_MOT SOP 4 1.2.1_MOT Training 3. 1.2.1_SOP Maintain 4. 1.2.1_SOP P&P	1. N/A 2. 6/20/2024 3. 8/02/2024 4. 8/2/2024	The following documentation supports the MCP's efforts to correct this finding: **POLICIES AND PROCEDURES** » The MCP's Standard Operating Procedures was updated to reflect the 72-hour timeframe turnaround time for major organ transplants. (1.2.1_MOT SOP 1,1.2.1_MOT SOP 2, 1.2.1_MOT SOP 3, 1.2.1_MOT SOP 4) » Maintenance of Healthcare Services Policies & Procedures SOP and Maintaining Standard Operating Procedures SOP was developed to align policies and procedures with standard operating procedures. (1.2.1_SOP Maintain, 1.2.1_SOP P&P) **TRAINING** » Major Organ Transplant Training provided on 6/20/24 demonstrates the MCP has trained its staff and were trained on the 72 hour timeframe for MOT requests. (1.2.1_MOT Training) **MONITORING AND OVERSIGHT** » TAT Daily Operational Report is used to monitor compliance of the 72 hour timeframe. The report is run

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				four times a day and monitored by UM staff. (1.2.1_TAT report) **The corrective action for finding 1.2.1 is accepted.**
1.2.2 Centers of Excellence for Major Organ Transplants The Plan did not ensure that all MOT procedures were performed in a Medi-Cal approved COE transplant program. The Plan did not confirm that COEs were unable to perform a MOT surgery before arranging the MOT at a transplant program	1. On 6/27/2024 The Plan's Medical Directors were notified that Bone Marrow Transplant (BMT), and other regulatory Major Organ Transplants (MOT) are only managed in-network unless Continuity Of Care (COC) or related to urgent/emergent hospitalization. In addition, The Plan took the following actions: » On 6/27/2024 the MOT workflows were updated to include Chief Medical Officer (CMO) Denial oversight. » On 8/14/2024 The Plan conducted Delegate training for the new CHCN Medical Director and CHCN	1.2.2_UM-071 MOT P&P 1.2.2_MOT MD Train 1.2.2_MOT SOP 1 1.2.2_SOP Maintain 1.2.2_SOP P&P	1. 6/27/2024 2. 8/02/2024 3. 8/2/2024	The following documentation supports the MCP's efforts to correct this finding: **POLICIES AND PROCEDURES** » Policy UM-071 Major Organ and Bone Marrow Transplants was updated to ensure members receive major organ transplants at a Medi-Cal approved Center of Excellence. (1.2.2_UM-071 MOT P&P) » Major Organ Transplant Oversight and Monitoring Standard Operating Procedure outlines the process guidelines for oversight and monitoring of members in the continuum of care for major organ transplants. (1.2.2_MOT Tracker SOP) **TRAINING** » Major Organ and Bone Marrow Transplant Training from 8/14/24 demonstrates the MCP has trained delegates Medical and UM Directors on the requirement to ensure that all MOT procedures were performed in a Medi-Cal approved COE transplant program. (1.2.2_MOT MD Train)

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that is not a Medi-Cal approved COE.	Utilization Management Director. » On 8/1/2024 a copy of the current DHCS Centers Of Excellence list was distributed to staff. » The Plan updated policy UM-071 and submitted to Utilization Management Committee on 8/30/2024. » The Plan updated Standard Operating Procedures to include DHCS Center Of Excellence requirements. 2. The UM team instituted a formal internal review process to ensure all operating procedures align with P&Ps. A Standard Operating Procedures was developed, and staff were trained on the internal review process. 3. P&P Tracker developed to ensure at least annual and ad-hoc			» Outpatient Utilization Management Major Organ Physical Transplant Standard Operating procedure was updated to require Chief Medical Officer oversite on all physical transplants. (1.2.2_MOT SOP 1) **MONITORING AND OVERSIGHT** » Maintenance of Healthcare Services Policies and Procedures SOP and Maintaining Standard Operating Procedures was developed to instruct how to review, edit and submit a P&P for annual review and verify SOPs are up to date. (1.2.2_SOP Maintain, 1.2.2_SOP P&P) » MOT Tracker is used to track MOT procedures to verify they have been done in Medi-Cal approved. COE. (1.2.2_Sample MOT Tracker)_ **The corrective action for finding 1.2.2 is accepted.**

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	updates to P&Ps are monitored and aligned with regulatory guidance.			
1.3.1 Written Member Consent The Plan did not obtain members' written consent when providers requested appeals on behalf of members.	1. The Plan updated the G&A-008 Adverse Benefit Determination Appeal Process to meet the requirements of Member Written Consent in accordance with the Plan's DHCS contract. 2. The Plan updated the Adverse Benefit Determination Appeal Workflow and staff received training on 11/06/2024. 3. The G&A Department will begin to conduct monthly internal audits in January 2025 to ensure that the requirement for written member consent is being met	1. 1.3.1_G&A-008 ABD Appeal Process 2. 1.3.1_ABD Appeal Process Workflow 3. IA document (to follow)	1. 11/15/2024 2. 11/06/2024 3. 1/1/2025	The following documentation supports the MCP's efforts to correct this finding: **POLICIES AND PROCEDURES** » Policy G&A – 008 Adverse Benefit Determination Appeals Process was updated to require member written consent when provider files an appeal on their behalf. (1.3.1_G&A-008 ABD Appeal Process) **TRAINING** » Adverse Benefit Determination Appeal Process Workflow was updated to reflect the need to acquire member written consent for provider imitated appeals. Training on this workflow was provided on 11/6/24. (1.3.1_ABD Appeal Process Workflow_v1) **MONITORING AND OVERSIGHT** » January and February Internal Audit Reports demonstrate the MCP is auditing provider initiated appeals for the presence of member written consent. (1.3.1_Appeals Internal Audits_Jan 2025, 1.3.1_Appeals Internal Audits_Feb 2025) **The corrective action for finding 1.3.1 is accepted.**

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1.3.2 Appeals Letters: Nondiscrimination Notice and Language Assistance Taglines The Plan did not send NDN and LAT information that met the minimum requirements in APL 21-004 with member notifications for appeals.	1. The Plan ensured the current LAT and NDN were added to the Member's Rights package and updated in the G&A system. 2. The G&A Department in conjunction with the Compliance Department will review all enclosures on an annual basis to ensure compliance.	1. 1.3.2_MCAL Your Rights 1.3.2_IT CHANGEMANAGEMENT NOTIFICATION OF CR-04672-QualitySuite 2. To follow	1. 7/25/2024 2. 1/1/2025	The following documentation supports the MCP's efforts to correct this finding: **POLICIES AND PROCEDURES** » P&P, "CLS-003, Non-Discrimination, Language Assistance Services, and Effective Communication for Individuals with Disabilities (03/19/24) demonstrates the MCP has established policies and procedures related to NDN requirements for appeals. » Standard Operating Procedure, "Notice and Enclosure Guidance" (12/31/24) demonstrates the MCP is making certain all notices and enclosures, including those for AAH members, comply with DHCS requirements. » Standard Operation Procedure, "Quality Assurance Process" (03/03/25) which delineates the Plan's self-monitoring and internal audit procedures. » Updated Your Rights Package (07/25/24) demonstrates the MCP updated their NDN and LAT notices that were provided by DHCS. **TRAINING** » E-Mail, "IT Management Notification" (07/24/24) demonstrates the MCP generated an e-mail notification to

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				their G&A Department, providing proof that the updated NDN and LAT have been successfully incorporated into their G&A processing system. **MONITORING AND OVERSIGHT** » Report, "Appeals Internal Report" (January and February 2025) demonstrates that the MCP is monitoring whether member notifications for appeals contain the correct NDN and LAT information. **The corrective action plan for finding 1.3.2 is accepted.**
1.5.1 Overutilization of Subacute Level of Facility Care The Plan did not ensure that the delegate CHCN had mechanisms to detect overutilization of subacute level of facility care; the delegate	1. The Plan's existing Policy & Procedures support processes to monitor over/under utilization for nursing facility services (UM-060 Delegation Management and Oversight). 2. CHCN reports over/under-utilization measures in their quarterly HICE report. The Plan has instituted a Standardized Operating Procedure that delineates roles and responsibilities for reviewing delegate reports, including a formal	1. 1.5.1_UM-060 Del Mgt 2. 1.5.1_SOP Del Ovrst 3. AAH/CHCN Delegation Oversight Monthly Meeting Agenda: 1.5.1_ CHCN Agenda 12.19.24 4. Q4 2024 HICE report (to follow) CHCN's January Monthly internal UM audit report (to follow)	1. N/A 2. 10/1/2024 3. 12/19/2024 4. 3/1/2025	The following documentation supports the MCP's efforts to correct this finding: **POLICIES AND PROCEDURES** » Policy UM-060 Delegation of Utilization Management outlines annual delegation oversight activities/audits. Plan reviews delegated activities and assesses delegate performance. Delegates are required to report UM performance data on an established frequency (quarterly). The Plan reviews UM reports to demonstrate compliance standards are met. The delegate is required to submit monthly performance data results for outpatient and inpatient services. Oversight reports are reviewed by the

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inappropriately approved higher levels of subacute care for members who required lower levels of regular skilled nursing facility care.	sign-off process, to be used in conjunction with P&P UM-060. 3. The Plan will request CHCN include nursing facility utilization as part of their over/under utilization measures, reported in the Quarterly HICE report (auth volume by facility levels of care). The Plan will request CHCN include post-acute cases in their annual UM audit universe and monthly internal UM audit reports. Requests communicated to CHCN during AAH/CHCN Delegation Oversight Monthly Meeting. 4. The Plan will request CHCN include nursing facility utilization as part of their over/under utilization measures, reported in the next Quarterly HICE report (auth volume by facility levels of care), and will complete review of CHCN's over/under measures.	Report Review Attestations (to follow) 5. UMC meeting minutes (to follow)		Plan to measure performance against established benchmarks/goals. » Standard Operating Procedure – HCS Responsibilities: Delegation Oversight. The Plan's SOP clearly delineates the responsibilities and workflows for delegation oversight review. All delegates are required to submit reports to HCS for oversight and review. The SOP outlines the parties involved, their responsibilities and workflow to ensure proper sign-off. **MONITORING AND OVERSIGHT** » A system configuration error in Delegate (CHCN)'s authorization system was discovered during an internal focus audit that made it appear that subacute level of care was approved in lieu of lower levels of skilled care. This error was resolved effective 8/1/24. » CHCN conducts monthly internal UM audits. As part of the CAP, the Plan requested CHCN include post-acute cases in their monthly audits. The Plan has since completed a review of CHCN's audit results and noted adequate strategies to address the audit findings. (1.5.1 CHCN Internal Audit Nov. and AAH Review CHCN Internal Audit Nov.) » CHCN quarterly HICE reports include over and underutilization measures. The Plan requested CHCN

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	The Plan will request CHCN include post-acute cases in their next monthly internal UM audit reports and will complete review of audit outcomes. 5. The Plan will report CHCN's over/under utilization measures and audit outcomes at UMC (upon receipt of reports).			include nursing facility utilization in its over and underutilization measures. HICE quarterly reports address the following categories: Over and Under Utilization Workplan goals Planned Activities Key Findings and Analysis Actions and Interventions » CHCN has mechanisms in place to detect over-utilization in subacute level facilities. CHCN submits monthly authorization utilization volume reports (1.5.1 CHCN Auth Vol.) which include descriptions of the level of care correlated with the revenue codes (1.5.1 CHCN Feb Auth Util). » The Plan has processes in place to confirm delegates have adequate knowledge of current revenue codes for each level of care by sharing all newly issued DHCS guidance, including billing instructions related to revenue codes and collects attestations from their delegates. » The Plan confirmed that current revenue codes have been shared with CHCN, along with the DHCS APLs 24-009 Skilled Nursing Facilities – Long Term Care Benefit

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				Standardization and Transition of Members to Managed Care and 24-010 Subacute Care Facilities – Long Term Care Benefit Standardization and Transition of Members to Managed Care and the Plan has received signed attestations indicating all related revenue codes have been implemented. **The corrective action plan for finding 1.5.1 is accepted.**
1.5.2 Early and Periodic Screening, Diagnostic, and Treatment Services The Plan did not ensure that the delegate, CHCN, provided medically necessary EPSDT services, care coordination, and appointment scheduling assistance to	1. The Plan will obtain CHCN's new Policy & Procedures specific to EPSDT care coordination. The Plan will obtain CHCN's new operational procedures specific to EPSDT care coordination. The Plan will request CHCN identify EPSDT cases in their monthly internal Case Management (CM) audit reports. The Plan will request CHCN identify EPSDT cases in their annual UM audit universe and monthly internal Utilization Management (UM) audit reports (for EPSDT cases, auditor	1. AAH/CHCN Delegation Oversight Monthly Meeting Agenda: 1.5.2_CHCN Agenda 12.19.24 2. CHCN's January Monthly internal CM and UM audit report (to follow) Report Review Attestations (to follow) 3. UMC meeting minutes (to follow)	1. 12/19/24 2. 3/01/2025 3. 3/1/2025	The following documentation supports the MCP's efforts to correct this finding: **POLICIES AND PROCEDURES** » Plan policy, *UM-060 Delegation of Utilization Management* (approved 3/19/2024), stated the Plan conducts an annual delegation audit for UM, which includes review of policies and procedures for coordination of care. » Plan document, *2024 AAH Case Management Program Description* (approved 4/19/2024), stated the Plan provides oversight of delegated care coordination activities through an annual delegation audit of case management and review of delegates' reports. » To address their Delegate's lack of policies for the provision of EPSDT services, CHCN (Delegate) Policy UM11 EPSDT Services (1/22/25) establishes guidelines around EPSDT

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members under the age of 21.	will evaluate whether members are receiving appropriate EPSDT services, care coordination and appointment scheduling, as needed). Request communicated to CHCN during The Plan/CHCN Delegation Oversight Monthly Meeting. 2. The Plan will request CHCN identify EPSDT cases in their next monthly internal CM and UM audit reports and will complete review of audit outcomes. 3. The Plan will report CHCN's CM and UM audit outcomes at UMC (upon receipt of reports).			services for individuals 21 years of age and younger. Policy addresses the provision of medically necessary EPSDT services, care coordination, case management, and appointment scheduling assistance for members (page 1 (B) and page 2 (C)(D) and (E). **MONITORING AND OVERSIGHT** » CHCN EPSDT Review Workflow (5/15/25). Provides guidance on the review of Early and Periodic Screening, Diagnostic and Treatment (EPSDT) Services and referral to basic case management for assistance with coordinating the member's care. If authorization is approved under EPSDT, a daily referral report of EPSDT authorizations is processed and referrals to EPSDT care coordination and follow up with members. » CHCN is pending a system configuration update to fully implement. There is ongoing collaboration between IT and the Analytics team to capture EPSDT reviews and referrals and to automate sending referrals for care coordination. Full implementation is expected by 5/28/25. » The Plan has worked with CHCN to revise their internal audit tool to include EPSDT audit elements. Audit categories include: Clinical Decision Making

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				Timeliness Member/Provider Notification Care Coordination Activities **The corrective action plan for finding 1.5.2 is accepted.**

2. Case Management and Coordination of Care

Finding Number and Summary	Action Taken	Supporting Documentation	Implementation Date * (*Short-Term, Long-Term)	DHCS Comments
2.1.1 Provision of Blood Lead Screening The Plan did not ensure that blood lead screening tests were conducted for members up to six years of age.	1. The Plan updated Policy QI-125 to include a requirement for providers to follow up on lab orders. Policy QI-125 will be approved in Quality Committee by 2/30/2025 and the Administrative Oversight Committee by 4/30/2025 2. Funding for point-of-care testing units was provided in January 2024 to the CHCN network. These units aim to eliminate the need for members to make an additional visit to the lab. 3. The Plan has conducted member outreach, and member Incentive; members were offered a gift card to complete their services at the lab. 4. The Plan continues monitoring of HEDIS lead screening rates. 5. The Plan has conducted provider education through webinars, 1:1 meetings, CLPP training 1) Healthcare Services All-Staff	1. 2.1.1_QI-125 BLS Policy_Draft, pg 2 2. 2.1.1_Lead Screening Rates_MY24 2.1.1_CHCN Minutes (page 4) 3. 2.1.1_Member Incentive_LSD_2024 4. 2.1.1_Lead Screening Rates_MY243 5. 2.1.1_W30 Webinar_051723 (slide 35) 2.1.1_W30 Webinar_020724 (slide 24) 2.1.1_QI_LSC_DEV (Measure Highlight tool) 2.1.1_RootsTraining (slide 15,16)	1. 2/14/2025 2. 1/1/2024 3. 7/31/2024 4. 1/1/2024 5. 2/7/2024 6. 7/31/2024 7. 1/1/2024 8. 1/1/2024	The following documentation supports the MCP's efforts to correct this finding: **POLICIES AND PROCEDURES** » Updated P&P, "QI-125: Blood Lead Screening for Children" which has been amended to include that the MCP will ensure its contracted providers, delegates, and subcontractors comply with blood lead screening and reporting requirements by monitoring encounter data submissions and periodic medical record review of assessments. (QI-125 BLS Policy, Page 3). » Meeting Minutes, "AAH QI and CHCN DDQI Quarterly Meeting" (06/18/24) in which the MCP has provided the point-of-care testing units on January 2024 to the CHCN network. These units aim to eliminate the need for members to make an additional visit to the lab. (CHCN Minutes). » Excel Spreadsheet, "Member Incentive Lead Screening" (December 2024) to demonstrate that the MCP has conducted member outreach to complete blood lead screening tests and provided member incentive. Members were offered a gift card to complete their blood lead screening test services at the lab. (Member Incentive LSD 2024).

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	meeting, 2) Provider webinar (live) and video (posted on Alliance website) and Measure Highlight tools. 6. The Plan previously conducted annual IHA audits to review provider charts for completion of preventive screenings. The frequency of these audits has now increased to twice a year. Additionally, during Facility Site Reviews (FSRs), charts are monitored for lead screening compliance. 7. Monitoring of HEDIS lead screening rates and IHA Audit Results. 8. Review lead screening rate and IHA results at Quality Improvement Health Equity Committee.	2.1.1_WestOakTraining (slide 4, 8) 2.1.1_CLPP Narrative 2.1.1_LeadTrng_ppt 9.12.2024 6. 2.1.1_IHA Audit Q3 2024.pptx 2.1.1_MMR Tool Effective July 1, 2022 7. 2.1.1_11.15 QIHEC Meeting Minutes (Lead Screening Rates) 2.1.1_IHA Audit Q3 2024 (QIHEC Presentation) 8. 2.1.1_11.15 QIHEC Meeting Minutes (Lead Screening Rates) 2.1.1_IHA Audit Q3 2024 (QIHEC Presentation)		**TRAINING** » PowerPoint Slides, "Measure Highlight: Well-Visits in the First 30 Months of Life (W30), Well-Child Measure Highlight, ROOTS Pediatric Training, West Oakland Pediatric Training, The Prevention of Childhood Lead Poisoning: Early Identification is Key" (2024) to demonstrate that the MCP has conducted provider education through webinars. (W30 Webinar, Roots Training, West Oak Training, Lead Training). **MONITORING AND OVERSIGHT** » Excel Spreadsheet, "Initial Health Assessment Audit" (Quarter 3, 2024) to demonstrate that the MCP has implemented a monitoring process to track documentation of blood lead screening tests results or member refusal in the medical records. An audit is conducted for Blood Lead Screening, and charts are reviewed for evidence of discussion, orders/refusal, and results. When evidence of lead screening is not found, the Plan sends education letters to providers indicating the discrepancy. The frequency of these audits has now increased to twice a year. (IHA Audit_Q3 2024). **The corrective action plan for finding 2.1.1 is accepted.**

Finding Number and Summary	Action Taken	Supporting Documentation	Implementation Date * (*Short-Term, Long-Term)	DHCS Comments
2.3.1 Provision of Behavioral Health Treatment Services The Plan did not ensure the provision of BHT services in accordance with approved BHT plans for members under the age of 21.	1. The Plan's existing policies support BHT services in accordance with BHT plans for members under the age of 21. The Plan insourced BHT services on 4/1/23 with the goal of increasing member access to care. The Plan has a dedicated team of care coordinators and BCBAs to support access to care. The Plan continues to explore opportunities to improve access to BHT care. This includes interventions to enhance the network and incentivize agencies to prioritize AAH members for services. The Plan continues to authorize out-of-network services whenever possible. 2. The Plan authorizes care within the required timeframes as requests are received. To monitor this issue, The Plan has established a metric to track the number of authorized hours to bill	1. 2.3.1 2023 AAH CAP Closeout 2.3.1 Att B 2023 AAH Final 2. 2.3.1_BHTABA Cred Prov	1. 4/1/2023 2. 4/1/2023 5/10/2024 Ongoing	The following documentation supports the MCP's efforts to correct this finding: **POLICIES AND PROCEDURES** » Plan Policy, "BH-004 Behavioral Health Therapies: Applied Behavioral Analysis" (4/10/2024), stated that for members under the age of 21, the Plan has primary responsibility for medically necessary BHT services provided across environments including community-based settings, on-site at schools, or during virtual school sessions in coordination with the local education agency. The Plan verifies that BHT services are provided and supervised in accordance with a Plan-approved behavioral treatment plan that is developed by a BHT service provider who meets the requirements in California's Medicaid State Plan. The Plan is required to ensure that treatment plans include a plan for the delivery of BHT services in a home or community-based setting, including clinics. BHT intervention services that are provided in schools, in the home, or other community settings, must be clinically indicated, medically necessary, and delivered in the most appropriate setting for the direct benefit of the member. BHT service hours delivered across the settings, including during school, must be proportionate to the member's medical need for BHT services in each setting. (2024-2025 AAH Medical Audit Report, Page 25)

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	services. This functions as an indicator of the need for additional provider resources. This is a continuous process that started 5/10/2024. The Plan has ongoing efforts to onboard and contract additional BHT/ABA providers as additional resources are necessary. 2.3.1_BHTABA Cred Prov reflects the cumulative count of credentialed providers for the period from 2022 to 2024.			» Standard Operating Procedure "BHT/ABA Utilization Provider Monitoring & Oversight" (5/10/24) outlines the process for monitoring and oversight of providers' utilization. The report is reviewed and analyzed monthly to assess provider performance and identify trends or gaps in care. (2.3.1 BHT ABA Prov Util M&O SOP) **TRAINING** » PowerPoint Training, "BHT-ABA Forms Training" (4/30/25, 5/7/25), and BH provider attendance list as evidence the MCP has conducted provider training on submitting online treatment plans for BHT/ABA. The training material also addressed reporting barriers and disruption in members' care to MCP. (2.3.1 BHT-ABA Forms Training, Slide 41; 2.3.1_Attendees) **MONITORING AND OVERSIGHT** » Table, "BHT/ABA Providers" demonstrates the MCP effort to address BHT staff shortage by increasing the number of ABA providers from 291 in 2022 to 1,107 in 2024. The MCP insourced BHT services on 4/1/2023. (2.3.1 BHTABA Cred Prov, Attachment B December Submission) » Internal Audit Report, "BHT Audit Q4 2024" demonstrates the MCP is conducting quarterly internal audits of treatment

Finding Number and Summary	Action Taken	Supporting Documentation	Implementation Date * (*Short-Term, Long-Term)	DHCS Comments
				review documentation. Eight files were reviewed and were found 100% compliant. (2.3.1 BHT Audit Q4 2024) » Report, "BHT ABA Provider Utilization" demonstrates the MCP is monitoring total utilization of BHT/ABA providers. The data shows that providers with the highest success rate in completing authorized hours achieve 46.3% and with an overall average of 29.3%. (2.3.1 BHT ABA Prov Util Rep) » Report, "BHT Member Utilization" demonstrates the MCP monitors members monthly authorized services by comparing the number of authorized hours of BHT/ABA to the number of hours delivered based on claims data. (2.3.1 BHT Mbr Util Rep) » The Plan provided meeting minutes (3/28/25) which provide evidence of documented review and discussion of BHT utilization report. (2.3.1_BH Util Report). **The corrective action plan for finding 2.3.1 is accepted.**
2.3.2 Timely Access to Behavioral Health Treatment Services The Plan did not arrange and coordinate BHT	The Plan established an EPSDT Policy & Procedure. The Plan established care coordination guidelines for staff providing care coordination with expectations. The Plan has a dedicated team of care coordinators and BCBAs to support	1. 2.3.2_QI-135 EPSDT 2.3.2 BHN Daily Workload 2.3.2 BHN Daily Workload	1. 12/19/2023 8/1/2024 8/1/2024 8/1/2024 3/31/2025	The following documentation supports the MCP's efforts to correct this finding: **POLICIES AND PROCEDURES** » Plan Policy, "QI-135: EPSDT (Medi-CAL for Kids & Teens) (approved 12/19/23) stated that the Plan will cover and ensure the provision by network providers of exams, screening, diagnostic testing, and treatment for preventative

Finding Number and Summary	Action Taken	Supporting Documentation	Implementation Date * (*Short-Term, Long-Term)	DHCS Comments
services for members under the age of 21 within 60 calendar days.	access to care. The Plan has increased staffing to better support member access to care. 1. BH Navigators are required to conduct monthly follow-up with parents or guardians to inform them of the status of Mental Health (MH), Behavioral Health Treatment (BHT), or Comprehensive Diagnostic Evaluation (CDE) referrals. This process ensures timely communication and continuity of care for families. 2. The post training email is evidence that mandatory training was provided to the BH navigators with written standard work. 3. The Plan has developed a report that is being refined currently. However, this report will be utilized in an ongoing manner to monitor compliance with current case management protocols and DHCS requirements. The implementation is	2. 2.3.2 Post Training Email 3. Report in progress to follow 4. Report in progress to follow	3/31/2025	and all medically necessary services for members under the age of 21 in accordance with the EPSDT program benefit. The policy also stated that the services to be provided must meet the criteria of timely access to all medically necessary services and that appropriate diagnostic and treatment services are initiated as soon as possible, but no later than 60 calendar days following either a preventive screening or other visit that identifies a need for follow-up. (2024-2025 AAH Medical Audit Report, page 28) » Standard Operating Procedure, "BHT Caregiver Update Internal Monitoring Process" (5/12/25) was developed to make certain consistent and timely follow-up on caregiver update activities by BH Navigators through weekly reviews by BH Leadership. (2.3.2 BHT Caregiver Update SOP) **TRAINING** » Workload, "Behavioral Health Navigator Daily Expectations" was developed to make certain staff provide timely care coordination for BHT services. Training on this workload was provided on 7/26/24. (2.3.2 BHN Daily Workload, 2.3.2 Post Training Email) **MONITORING AND OVERSIGHT** » Sample report "BHT Caregiver Update Report" as evidence the MCP is conducting weekly reviews to confirm that

Finding Number and Summary	Action Taken	Supporting Documentation	Implementation Date * (*Short-Term, Long-Term)	DHCS Comments
	scheduled for the end of the first quarter of 2025. 4. Pending the report, the internal self-monitoring and auditing process is as follows: » BH leadership team will conduct biweekly reviews to confirm that follow-ups are performed consistently and on schedule. » During the review: » Identify overdue follow ups. » Provide reminders or guidance to BH Navigators as needed. » If BH Navigator consistently fails to make follow-up calls: » Feedback loops will be established to address any barriers encountered during follow-ups and			follow-ups are performed consistently and on schedule. (2.3.2_Caregiver Update Report) **The corrective action plan for finding 2.3.2 is accepted.**

Finding Number and Summary	Action Taken	Supporting Documentation	Implementation Date * (*Short-Term, Long-Term)	DHCS Comments
	adjust the protocol accordingly. » BH Navigators will undergo mandatory training to reinforce the importance of consistent monthly follow-ups, effective communication with parents, and accurate documentation.			
2.4.1 Notice of Action Letters for Continuity of Care Requests The Plan did not ensure that NOA letters for COC requests that were sent to members contained a clear explanation of the reason for the denial decision.	1. The Plan's existing Policy & Procedure supports processes to ensure Notice Of Actions (NOA) contain clear explanations of denial reasons (UM-054 Notice of Action). 2. NOAs drafted and cleared by Patient Education on 7/12/2024. The Plan trained Medical Directors during authorization meeting on 8/14/2024. The Plan productionalized COC NOAs on 8/14/2024 and all	1. 2.4.1_UM-054 NOA 2. 2.4.1_MD Mtg Min 2.4.1_SOP COC 3. UMC meeting minutes (to follow)	1. N/A 2. 8/14/2024 3. 2/1/2025	The following documentation supports the MCP's efforts to correct this finding: **TRAINING** » Medical Director Training from 8/14/24 demonstrates the MCP trained appropriate staff on the new COC NOA templates. (2.4.1_MD Mtg Min) » COC Standard Operating Procedure instructs staff on the use of the new single letter COC NOA. (2.4.1_SOP COC) » Example of COC NOA Denial Letter demonstrates the MCP's single COC NOA is in use. (2.4.1_CoC NOA) **MONITORING AND OVERSIGHT**

Finding Number and Summary	Action Taken	Supporting Documentation	Implementation Date * (*Short-Term, Long-Term)	DHCS Comments
	impacted staff were notified via email. Standard Operating Procedure updated to reflect utilization of new CoC NOA in a single letter. 3. The Plan will include CoC denial notices in the monthly operational NOA audits (reported quarterly at UMC).			» Sample UM Audit from 4/1/24-6/30/24 and COC Audit Tool demonstrate the MCP has two audit tools that are used to monitor for the appropriate processing of COC requests including the monitoring of NOAs. Policy UM 54 Notice of Action and policy UM-059 Continuity of Care for Medi-Cal Beneficiaries Who Transition into Medi-Cal Managed Care speak to oversight & monitoring procedures, including the auditing process. (2.4.1_Sample UM Audit, 2.4.1_CoC audit tool, 2.4.1_NOA P&P, 2.4.1_COC P&P) **The corrective action for finding 2.4.1 is accepted.**

3. Access and Availability of Care

Finding Number and Summary	Action Taken	Supporting Documentation	Implementation Date * (*Short-Term, Long-Term)	DHCS Comments
3.1.1 Appointment Waitlist Timeliness The Plan did not ensure members were able to obtain medically necessary appointments within established timely access standards.	1. The Plan worked with AHS to close their Highland panel in September, preventing additional wait listed members. (9/1/2024). The Plan met with AHS related to access in an On-going manner during Joint Operating Meetings (JOM) and AAH/AHS Access Meetings. AHS actively outreached to members on the wait list. Progress reports were reviewed at AAH/AHS Access meetings. In September, AHS brought in two new providers to support with Highland wait list. In review of grievances data, the number of grievances declined for timely access at Highland. The Plan has implemented QI initiatives to improve access to care, including pay for performance (P4P), extended office hours	1. 3.1.1_7.15_AccessDis 3.1.1_8.19.2024_AccessDis 3.1.1_9.10.2024_AccessDis 3.1.1_10.21.2024_AccessDis	1. 7/1/2024-Ongoing	The following documentation supports the MCP's efforts to correct this finding: **POLICIES AND PROCEDURES** » Plan policy "QI-114 Monitoring of Access and Availability Standards" demonstrates how the Plan monitors for established timely access standards. The Plan monitors through Confirmatory Surveys. The survey verifies provider compliance with appointment availability standards. (Procedure, Access & Availability Reports, 13. Confirmatory Surveys, page 7) **TRAINING** » Various meeting materials "Alliance/Alameda Health System (AHS) Discussion on Access to Care" demonstrates the Plan's monthly meetings with the Plan's medical group reviewing & addressing access-related concerns. (See 3.1.1 AccessDis) **MONITORING AND OVERSIGHT** » Plan policy "QI-114 Monitoring of Access and Availability Standards" demonstrates how the Plan monitors for established timely access standards. The Plan monitors through Confirmatory Surveys. The survey verifies provider compliance with appointment availability standards. The

Finding Number and Summary	Action Taken	Supporting Documentation	Implementation Date * (*Short-Term, Long-Term)	DHCS Comments
	incentives and provider recruitment/retention incentives (AAH provider grant live as of 6/1/2024).			Plan staff will outreach to providers found to be non-compliant or non-responsive to inform them of the survey results, provide re-education, and/or issue corrective action plans (CAPs) accordingly. (Procedure, Access & Availability Reports, 13. Confirmatory Surveys, page 7) » Plan report "AHS Outreach Log" demonstrates how the Plan staff conducts live Confirmatory Surveys on a daily basis to provider's office to assess timely access compliance. (See 3.1.1_AHS OutreachLog) **The corrective action plan for finding 3.1.1 is accepted.**
3.1.2 Monitoring In-Office Wait Times for Specialty and Behavioral Health Services The Plan did not monitor in-office wait time for specialists and behavioral health providers.	1. The Plan added in-office wait times measure to CG-CAHPS survey for BH providers on 5/6/2024. The finalized report was presented at the Access & Availability Committee in September. Specialist providers will be added to the CG-CAHPS survey starting on 1/21/2025. QI-114 Monitoring of Access and Availability Standards was revised to include monitoring of in-office	1. 3.1.2_CG_CAPHS folder 3.1.2_QI 114_A&A MON 3.1.2_A&A 9.4.24 Min	1. 5/6/2024 1/21/2025	The following documentation supports the MCP's efforts to correct this finding: **POLICIES AND PROCEDURES** » Updated P&P, "QI-114: Monitoring of Access and Availability Standards" (03/06/2024), which has been amended to include monitoring of in-office wait times for specialists and behavioral health providers through quarterly CG-CAHPS survey. (3.1.2 QI 114 A&A MON, Page 5) **MONITORING AND OVERSIGHT** » The Plan provided meeting minutes (09/04/2024) and sample report "CG-CAHPS: In Office Wait Time" which provide evidence of documented review and discussion of

Finding Number and Summary	Action Taken	Supporting Documentation	Implementation Date * (*Short-Term, Long-Term)	DHCS Comments
	wait times for specialist and behavioral health providers.			results of behavioral health providers in-office wait time for Q2 2024 at Access and Availability Committee. Behavioral health providers received an average 94% compliance rate, and all delegate providers scored above the 80% compliance threshold. (3.1.2 A&A 9.4.24 Min, Page 7; Q2 2024 BH In-Office Wait Time) » Monitoring of specialist providers for in-office wait times was added to the CG-CAHPS survey on 01/21/2025. The final report is expected to be completed by 06/30/2025. (Attachment B February Submission) **The corrective action plan for finding 3.1.2 is accepted.**
3.1.3 Monitoring Telephone Calls for Specialty and Behavioral Health Services The Plan did not monitor wait times for specialty and behavioral health providers to	1. The Plan added telephone wait times measure to CG-CAHPS survey for BH providers on 5/6/2024. The finalized report was presented at the Access & Availability Committee in September. Specialist providers will be added to the CG-CAHPS survey starting on 1/21/2025.	1. 3.1.2_CG_CAPHS folder 3.1.2_QI 114_A&A MON 3.1.3_A&A 9.4.24 Min	1. 5/6/2024 1/21/2025	The following documentation supports the MCP's efforts to correct this finding: **POLICIES AND PROCEDURES** » Updated P&P, "QI-114: Monitoring of Access and Availability Standards" (03/06/2024), which has been amended to include monitoring of call answer and wait return times for specialists and behavioral health providers through quarterly CG-CAHPS survey. (3.1.3 QI 114 A&A MON, Page 5) **MONITORING AND OVERSIGHT**

Finding Number and Summary	Action Taken	Supporting Documentation	Implementation Date * (*Short-Term, Long-Term)	DHCS Comments
answer and return telephone calls.	QI-114 Monitoring of Access and Availability Standards was revised to include monitoring of telephone wait times for specialist and behavioral health providers.			» The Plan provided meeting minutes (09/04/2024) and sample reports "CG-CAHPS: Call Return Time (Telephone Monitoring)" and "CG-CAHPS Time To Answer Call," which provide evidence of documented review and discussion of the results of behavioral health providers' telephone wait times measure for Q2 2024 at Access and Availability Committee. (3.1.3 A&A 9.4.24 Min, Page 7; Q2 2024 BH Call Return Time, Q2 2024 BH Time to Answer Call) » Monitoring telephone calls for specialist providers was added to the CG-CAHPS survey on 01/21/2025. The final report is expected to be completed by 06/30/2025. (Attachment B February Submission) **The corrective action plan for finding 3.1.3 is accepted.**

4. Member's Rights

Finding Number and Summary	Action Taken	Supporting Documentation	Implementation Date * (*Short-Term, Long-Term)	DHCS Comments
4.1.1 Grievances Involving Clinical Issues The Plan did not ensure that a person with clinical expertise in treating a member's condition made the resolution decision for grievances involving clinical issues.	1. The Plan's Policy & Procedures were reviewed on 7/10/2024, and no deficiencies were found. 2. The G&A Department will begin to conduct monthly internal audits in January 2025 to ensure that the requirement for grievances involving clinical issues is being met.	1. 4.1.1_G&A Meeting Agenda_7.10.24 4.1.1_Grievance Timeline 2. IA document (to follow)	1. 7/10/2024 2. 1/25/2025	The following documentation supports the MCP's efforts to correct this finding: **POLICIES AND PROCEDURES** » Standard Operation Procedure, "Quality Assurance Process" (03/03/25) which delineates the Plan's self-monitoring and internal audit procedures. » Updated Timeline, "Graphic Grievance Timeline" (04/25) specifies the contract requirement that grievance decisions involving clinical issues must be made by someone with clinical expertise in treating the member's condition." **TRAINING** » Staff Training, "Grievance System Staff Training" (02/12/25) demonstrates the MCP provided a training to their Grievance Staff to guarantee that a person with clinical expertise in treating a member's condition is responsible for making resolution decisions for grievances involving clinical issues. **MONITORING AND OVERSIGHT** » Internal Audit, "Quality Assurance Focused Internal Audit" (02/2025) demonstrates the MCP has implemented a monitoring process to track that a person with clinical expertise in treating a member's condition makes the

Finding Number and Summary	Action Taken	Supporting Documentation	Implementation Date * (*Short-Term, Long-Term)	DHCS Comments
				resolution decision. 88 Cases were pulled for review. Of the 88 cases audited, 13 cases had a clinical element to review. 10 of the 13 Cases with clinical element were reviewed by a person with clinical expertise in treating a member's condition. The remaining 75 did not have a clinical element to review. » Teams Meeting, "G&A Team Bi-Weekly Meeting" (03/19/25) demonstrates the MCP is sharing the audit findings with the G&A Supervisor to facilitate staff retraining and coaching. **The corrective action plan for finding 4.1.1 is accepted.**
4.1.2 Resolution of Grievances The Plan did not completely resolve the members' grievances.	1. The Plan's Policy & Procedures were reviewed, and no deficiencies were found. 2. The Plan Grievance & Appeal Staff reviewed the DHCS Audit Findings on 07/10/2024, and the QA Grievance Audit Tool was reviewed to outline the future monitoring process to ensure that all grievances are resolved prior to being closed. 3. The G&A Department will begin to conduct monthly internal audits	1. NA 2. 4.1.2_ G&A Audit Tool 3. To follow	1. NA 2. 7/10/2024 3. 1/1/2025	The following documentation supports the MCP's efforts to correct this finding: **POLICIES AND PROCEDURES** » Standard Operation Procedure, "Quality Assurance Process" (03/03/25) which delineates the Plan's self-monitoring and internal audit procedures for grievances. **TRAINING** » Meeting, "Grievance and Appeal Meeting Agenda" (07/12/24) demonstrates the Plan presented the findings from the DHCS audit, emphasizing the importance of capturing all issues in the grievance investigation conducted by the MCP.

Finding Number and Summary	Action Taken	Supporting Documentation	Implementation Date * (*Short-Term, Long-Term)	DHCS Comments
	in January 2025 to ensure that the requirement for resolution of grievances is being met.			» Staff Training, "Grievance System Staff Training" (02/12/25) demonstrates the MCP provided a training to their Grievance Staff to make certain that member's grievances are completely resolved. » Teams Meeting, "G&A Team Bi-Weekly Meeting" (03/19/25) demonstrates the MCP is sharing the audit findings with the G&A Supervisor to facilitate staff retraining and coaching. **MONITORING AND OVERSIGHT** » Audit Tool, "Grievance and Appeal Audit Tool" (12/2024) was developed to analyze and verify data to make certain full compliance with contractual requirements. » Internal Audit, "Quality Assurance Focused Internal Audit" (02/2025) demonstrates that the Plan has conducted a focused audit to make certain that all member grievances are fully resolved. » Internal Audit, "Quality Assurance Focused Internal Audit" (03/2025) demonstrates the MCP makes certain that all grievances are fully resolved. » Report, "Grievance and Appeal Report" (Q4–2024) as evidence the MCP is conducting quarterly reviews to track and trend all grievances resolved to identify opportunities for quality improvement.

Finding Number and Summary	Action Taken	Supporting Documentation	Implementation Date * (*Short-Term, Long-Term)	DHCS Comments
				The corrective action plan for finding 4.1.2 is accepted.
4.1.3 Clear and Concise Resolution Letters The Plan's written resolution did not contain a clear and concise explanation of the Plan's decision.	1. The Plan's Policy & Procedures were reviewed, and no deficiencies were found. 2. The Plan Grievance & Appeal Staff reviewed the DHCS Audit Findings on 07/10/2024, and the QA Grievance Audit Tool was reviewed to outline the future monitoring process to ensure that all grievances have clear and concise resolution letters prior to being closed. 3. The G&A Department will begin to conduct monthly internal audits in January 2025 to ensure that the requirement for Clear and Concise Resolution Letters is being met.	1. NA 2. 4.1.3_ G&A Audit Tool 3. To follow	1. NA 2. 7/10/2024 3. 1/1/2025	The following documentation supports the MCP's efforts to correct this finding: **POLICIES AND PROCEDURES** » Standard Operation Procedure, "Quality Assurance Process" (03/03/25) which delineates the Plan's self-monitoring and internal audit procedures. **TRAINING** » Staff Training, "Grievance System Staff Training" (02/12/25) demonstrates the MCP provided a training to their Grievance Staff to guarantee that written resolution letters contain a clear and concise explanation of the Plan's decision. **MONITORING AND OVERSIGHT** » Report, "Grievance and Appeals Report – Medi-Cal" (Q4 2024) as evidence the MCP is conducting quarterly reviews to track and trend all grievances resolved to identify opportunities for quality improvement. » Internal Audit, "Quality Assurance Focused Internal Audit" (02/2025) demonstrates the MCP's commitment to monitoring grievance resolution letters to confirm they

Finding Number and Summary	Action Taken	Supporting Documentation	Implementation Date * (*Short-Term, Long-Term)	DHCS Comments
				provide a clear and concise explanation of the MCP's decision. This internal audit had a review of 88 grievance cases, 77 provided clear and concise letters. The 11 cases that did not provide a clear and concise grievance resolution letter, are sent to the supervisor to retrain or coach accordingly. » Teams Meeting, "G&A Team Bi-Weekly Meeting" (03/19/25) demonstrates the MCP is sharing the audit findings with the G&A Supervisor to facilitate staff retraining and coaching. » Meeting, "Alameda Alliance for Health Board of Governors – April 2025 Activities" (05/09/25) demonstrates the MCP held a meeting with their Board of Governors to discuss that standard grievance cases missed the 95% regulatory resolution target. **The corrective action plan for finding 4.1.3 is accepted.**
4.1.4 Grievance Letters: Non-Discrimination Notice and Language Assistance Tagline	1. The Plans Policy & Procedures were reviewed, and no deficiencies were found. Current LAT and NDN were added to the Member's Rights package and updated in the G&A system.	1. 4.1.4_MCAL Your Rights 4.1.4_IT CHANGEMANAGEMENT NOTIFICATION OF CR-04672-QualitySuite 2. To follow	1. 7/25/2024 2. 1/1/2025	The following documentation supports the MCP's efforts to correct this finding: **POLICIES AND PROCEDURES** » Standard Operation Procedure, "Quality Assurance Process" (03/03/25) which delineates the Plan's self-monitoring and internal audit procedures.

Finding Number and Summary	Action Taken	Supporting Documentation	Implementation Date * (*Short-Term, Long-Term)	DHCS Comments
The Plan did not include updated NDN and LAT information with grievance acknowledgement and resolution letters.	2. The G&A Department in conjunction with the Compliance Department will review all enclosures on an annual basis to ensure compliance.			» Email, "IT Change Management Notification" (07/24/24) demonstrates the MCP notified their Grievance Department about the updated NDN and LAT notices in the Grievance and Appeals Processing System. » Updated, "Your Rights Package" (07/25/24) demonstrates that the MCP updated their "Your Rights" package to include the current Non-Discrimination and Language Assistance tagline provided by DHCS. **TRAINING** » Email, "IT Change Management Notification" (07/24/24) demonstrates the MCP notified their Grievance Department about the updated NDN and LAT notices in the Grievance and Appeals Processing System. **MONITORING AND OVERSIGHT** » Report, "Grievance and Appeals Report – Medi-Cal" (Q4 2024) as evidence the MCP is conducting quarterly reviews to track and trend all grievances resolved to identify opportunities for quality improvement. » Internal Audit, "Quality Assurance Focused Internal Audit" (02/25) demonstrates the MCP's commitment to monitoring grievance acknowledgement and resolution letters to confirm they provide NDN and LAT information. This internal audit had a review of 88 grievance cases, all 88-

Finding Number and Summary	Action Taken	Supporting Documentation	Implementation Date * (*Short-Term, Long-Term)	DHCS Comments
				grievance acknowledgement and resolution letters did include the NDN and LAT information. » Teams Meeting, "G&A Team Bi-Weekly Meeting" (03/19/25) demonstrates the MCP is sharing the audit findings with the G&A Supervisor to facilitate staff retraining and coaching. » Meeting, "Alameda Alliance for Health Board of Governors – April 2025 Activities" (05/09/25) demonstrates the MCP held a meeting with their Board of Governors to discuss that standard grievance cases missed the 95% regulatory resolution target. **The corrective action plan for finding 4.1.4 is accepted.**
4.2.1 Monitoring of Linguistic Performance The Plan did not assess the performance of the vendors' staff that provided linguistic services such as interpreter services.	1. The Plan has completed updates of Policy and Procedure (P&P) CLS-011-CLS Program Monitoring to include additional language on monitoring information collected and reporting. See Section 2: Multilingual Staff and Vendor Language. The Plan anticipates approval date of the updated draft by Alliance	1. 4.2.1_Plcy-CLS011 (DRAFT P&P) 2. 4.2.1_CyraCom CNT-RL (DRAFT Contract) Redlined vendor contracts for Hanna Interpreting and Propio. (to follow) 4.2.1_LinguisticAssessTplt (Created)	1. 3/31/2025 2. 03/31/2025 01/31/2025 3/31/2025 3. 3/31/2025 4/30/2025	The following documentation supports the MCP's efforts to correct this finding: **POLICIES AND PROCEDURES** » Updated Policy and Procedure CLS-011 "Compliance Monitoring of Cultural and Linguistic Services Program" has been updated to include additional language on monitoring information collected and reported. The revisions address the gap that contributed to the audit finding. Updated P&Ps were submitted to and approved by Alliance Administrative Oversight Committee (AOC) on

Finding Number and Summary	Action Taken	Supporting Documentation	Implementation Date * (*Short-Term, Long-Term)	DHCS Comments
	Administrative Oversight Committee (AOC) for 3/31/2025. Please refer to current language in Policy and Procedure (P&P) CLS-011-CLS Program Monitoring language regarding oversight infrastructure. See Section 4: CL Monitoring Reporting Structure 2. The Plan anticipates that updates to vendor contracts to include reporting requirements for vendor interpreter qualifications and cadence will be implemented by 3/31/2025. The Plan anticipates implementation of monthly vendor interpreter qualifications reporting by 1/31/2025. The Plan anticipates implementation of a monthly attestation of monthly vendor interpreter qualifications review by 1/31/2025.	Monthly interpreter qualifications reports (to follow) 4.2.1_IntrRvwAttestDFT (DRAFT Attestation Template). Completed attestations of monthly vender interpreter qualifications review (to follow) 3. JOM Minutes for CyraCom, Hanna Interpreting and Propio. (to follow) CLSS Meeting Minutes (to follow)		3/31/2025. (4.2.1_Plcy-CLS011_Draft, Section 2. Multilingual Staff and Vendor Language Capacity, page 5) **MONITORING AND OVERSIGHT** » Interpreter Linguistic Reports were submitted by vendors CyraCom, Hanna and Propio with current report dated March 2025 for CyraCom, Hanna and Propio (see 4.2.1_CyraCmILA_3.25, 4.2.1_HannaILA_3.25 and 4.2.1_PropioILA_3.25). These reports are submitted monthly to the Plan. » Interpreter Qualification Report Review Attestation Form as evidence that the Plan has implemented a monthly attestation process for the review of vendor interpreter qualifications. (See form 4.2.1_IntrRvwAttestDFT and sample 4.2.1_IntRwAtt_1.25, 2.25 and 3.25) » The Plan created a Linguistic Assessment Template for use in tracking, assessing and evaluating accuracy and proficiency of interpreters. (4.2.1_LinguisticAssessTplt) » The Plan conducts quarterly Joint Operations Meetings where concerns regarding vendor interpreter qualifications are reviewed and addressed. (4.2.1_PropJOMMin_4.25) **The corrective action plan for finding 4.2.1 is accepted.**

Finding Number and Summary	Action Taken	Supporting Documentation	Implementation Date * (*Short-Term, Long-Term)	DHCS Comments
	3. The Plan will review and address concerns with vendor interpreter qualifications at Quarterly Vendor Joint Operations Meeting (JOM) by 3/31/2025. The Plan will report and address concerns with vendor interpreter qualifications at Quarterly Cultural and Linguistic Services Subcommittee (CLSS) meetings by 4/30/2025.			
4.3.1 Notification to DHCS The Plan did not notify the DHCS within 24 hours upon discovery of any suspected security incident, unauthorized access, use or	1. The Plan updated CMP-013 "HIPAA Privacy Reporting" in September 2024 to include verbiage addressing the gap that contributed to the audit finding: "Referrals must be made immediately upon discovery, and no later than 24 hours after." Additional updates included a Corrective Action section to address late referrals: "Corrective actions will be taken for delayed referrals,	1. 4.3.1_CMP-013 2. 4.3.1_SOP July Clean 4.3.1_SOP July Redline 4.3.1_SOP Dec 3. 4.3.1_HS Audit SOP 4.3.1_HS Audit Results 4. Internal audit reports to follow Meeting minutes to follow	9/18/2024 12/13/2024 7/15/2024 12/31 2025	The following documentation supports the MCP's efforts to correct this finding: **POLICIES AND PROCEDURES** » The Plan revised HIPAA Privacy Reporting, Policy Number CMP-013, approved 9/18/24, to include the language that referrals must be made immediately upon discovery and no later than 24 hours after discovery of any suspected breach or security incident. The Plan also included language to address late referrals with corrective action. (4.3.1_CMP-013, page 1)

Finding Number and Summary	Action Taken	Supporting Documentation	Implementation Date * (*Short-Term, Long-Term)	DHCS Comments
disclosure of PHI or PI.	including but not limited to education, training, and / or Corrective Action Plans (CAP)." CMP-013 also states, "The Alliance will investigate the incident and submit an Initial Privacy Incident Report (PIR) to DHCS within 24 hours of discovery of a breach, suspected breach or security incident." 2. Verbiage of "Privacy Incident Investigation and Reporting Procedure" updated to: » Formalize education and corrective action for late referrals. » Implement new monitoring process to address the gap in referrals from G&A and internally within Compliance that contributed to the audit finding: "The Privacy Office will monitor the Compliance inbox, Compliance hotline,			» The Plan also included a section on timely reporting to DHCS, stating that the incident will be investigated, and an Initial Privacy Incident Report (PIR) will be submitted to DHCS within 24 hours of discovery of a breach, suspected breach or security incident. (4.3.1_CMP-013, page 2) **TRAINING** » The Plan updated desktop procedure "PRIVACY INCIDENT INVESTIGATION & REPORTING DESKTOP PROCEDURE" to include that the Plan's Privacy Office will monitor, and check daily, the Compliance Inbox, Compliance Hotline, Privacy Compliance Inbox, and HEALTHSuite system for referral of any HIPAA Privacy reporting incidents. (4.3.1_SOP July Redline) » The Plan's Privacy Department implemented a training schedule which addresses topics on timely reporting requirements. (4.3.1 dept trng sched) **MONITORING AND OVERSIGHT** » "HealthSuite Privacy Referral Audit" SOP demonstrates that procedures are in place for the Privacy Office to conduct weekly audits of HEALTHSuite referrals to verify privacy concerns reported by members are appropriately categorized by the Member Services Department. (4.3.1_HS Audit SOP)

Finding Number and Summary	Action Taken	Supporting Documentation	Implementation Date * (*Short-Term, Long-Term)	DHCS Comments
	Privacy Compliance Inbox, and HEALTHSuite system for referral of any HIPAA Privacy reporting incidents. Each will be checked daily at minimum." 3. The Privacy Office is conducting weekly audits of HEALTHSuite referrals to ensure privacy concerns reported by members are appropriately categorized by the Member Services Department. Appropriate categorization will enable timely reporting of privacy incidents. 4. The Plan will include review of the internal audit results at the Compliance Committee meetings.			» Sample audit reports are submitted as evidence that the Plan is conducting regular weekly internal audit reports. The audit reports are reviewed and discussed at the Compliance Committee Meetings. (4.3.1_HS Audit Result Jan and 4.3.1_HS Audit Results Feb 2025). **The corrective action plan for finding 4.3.1 is accepted.**

5. Quality Management

Finding Number and Summary	Action Taken	Supporting Documentation	Implementation Date * (*Short-Term, Long-Term)	DHCS Comments
5.3.1 Notification of Provider Terminations The Plan did not meet the DHCS reporting and member notification requirements for provider terminations.	1. The Plan will review and update the following impacted P&Ps as needed: PRV-005 & CRE-002 In addition, the Plan will provide an advisory to delegates and/or providers that delegated for credentialing functions about timely reporting requirements. 2. The Plan will update P&Ps pertaining to provider termination and member notification: PRV-005 & CRE-002 The Plan conducts monthly review of the exclusion and suspension lists and this is an ongoing process that will support the identification and reporting of adverse provider termination. There are no changes to the Plan's provider notice templates and member notice templates.	1. To follow 2. To follow 5.3.1_Mon Template 5.3.1_ProvTerm Ltr 3. 5.3.1 Adv Term Log-DRAFT 5.3.1_Mon Template To follow 4. IA Results to follow 5. 5.3.1 Cred Attestation form template Meeting minutes to follow Meeting minutes to follow	1. 3/31/2025 2. 3/31/2025 3. 1/31/2025 Ongoing 9/30/2025 4. 9/30/2025 5. 3/31/2025 6/30/2025 12/31/2025	The following documentation supports the MCP's efforts to correct this finding: **POLICIES AND PROCEDURES** » Plan Policy and Procedure, PRV-005, Provider Terminations (approved 9/19/2023), already contained information and language stating that providers and delegates are required to notify the Plan at least 60-days prior to the effective date of the termination as outlined in the provider's contract. The Plan's Provider Services Department works collaboratively with various Plan departments to send member notices and then reports the information to the Compliance Department for notification to DHCS. Additionally, the Policy states that the Plan will follow all protocols for notification to DHCS when a termination is determined to be significant and will notify DHCS at least 60-days prior to the effective date of the contract termination, or immediately upon learning and obtaining details of the termination. (5.3.1_PRV-005, Provider Terminations Policy) **TRAINING** » The Plan notified providers and delegates responsible for credentialing functions about the importance of timely adverse termination reporting requirements. (5.3.1_AAH_Provider Notices, email dated 2/7/2025)

Finding Number and Summary	Action Taken	Supporting Documentation	Implementation Date * (*Short-Term, Long-Term)	DHCS Comments
	The Plan's provider manual will be updated in Q1 2025. 3. The Plan will develop a log that will track Provider terminations, provider notification, and member notification including date of reports received and submitted to DHCS and date members were notified; see: 5.3.1 Adv Term Log-DRAFT The Plan is providing the monthly exclusion/suspension list review as evidence of continuous monitoring. The Plan will develop a reporting template/instruction for Providers/Delegate/Subcontractor for reporting adverse terminations to the Plan. 4. In addition, the Plan has an internal audit process managed by the Compliance Internal Audit team. The Internal Audit team will include a review of this item in their Internal Audit Plan.			» The Plan provided PowerPoint Reminder notification to providers and delegates responsible for credentialing functions about timely termination reporting requirements. (5.3.1_DHCS APL 21-003 Provider Terminations PP) » Additionally, the Plan included the notification information with Teledoc at the Q1 2025 Joint Operations Meeting (JOM) Meeting Agenda on 2/4/2025. (5.3.1_Teladoc JOM_Q12025) **MONITORING AND OVERSIGHT** » A sample tracking log titled "Adverse Action Termination Log" was submitted as evidence that the Plan developed a standardized reporting template. This template includes instructions for providers and delegates on how to complete and use the log when reporting adverse terminations. The log contains columns for "Date Notified", "Name of Provider", "Action Type" and "Reason for Termination", among other vital information. The log was distributed to providers and delegates on 2/7/2025. (5.3.1_Potential Prov Term) » The Plan conducts monthly reviews of exclusion and/or suspension lists and has submitted documentation to demonstrate ongoing monitoring efforts. (5.3.1_2024 Ongoing Monitoring Q2 APR to JUN; and 5.3.1_2024 Ongoing Monitoring Q3 JUL to SEP; and 5.3.1_2024 Ongoing Monitoring Q4 OCT to DEC)

Finding Number and Summary	Action Taken	Supporting Documentation	Implementation Date * (*Short-Term, Long-Term)	DHCS Comments
	The Plan will provide results of internal audit review when it becomes available. 5. The Plan will Review the quarterly HICE Credentialing report and confirm against the adverse termination log to determine if provider suspended/termed for quality of care has been reported during the month of termination. During this review, if providers are identified as having been suspended or terminated due to quality of care, the Plan will confirm submission of the 805 report to DHCS. The Plan will include review of the reports/logs during Subcontractor_Delegation Oversight Committee meetings. The Plan will include review of the Internal Audit results at the Compliance Committee meetings.			**The corrective action plan for finding 5.3.1 is accepted.**

*Attachment A must be signed by the MCP's compliance officer and the executive officer(s) responsible for the area(s) subject to the CAP.

Submitted by Plan: Alameda Alliance for Health **Date:** 12/23/2024

Reviewed and approved by:

[Signature on file].

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Matthew Woodruff

Chief Executive Officer

[Signature on file].

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Richard Golfin III, FACHE, JD, MBA

Chief Compliance & Privacy Officer