

REPORT ON THE MEDICAL AUDIT OF ALAMEDA ALLIANCE FOR HEALTH CALENDAR YEAR 2025

**DHCS Audits and Investigations
Contract and Enrollment Review Division
San Diego Section**

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TABLE OF CONTENTS

- I. INTRODUCTION 3
- II. EXECUTIVE SUMMARY 4
- III. SCOPE/AUDIT PROCEDURES 7
- IV. COMPLIANCE AUDIT FINDINGS
 - Category 1 – Utilization Management Program 9
 - Category 2 – Population Health Management and Coordination of Care ...13
 - Category 4 – Grievances, Appeals, and Member Rights 17

I. INTRODUCTION

Alameda Alliance for Health (Plan) is a public, non-profit managed care health plan established by the Alameda County Board of Supervisors in 1994 under the California Welfare and Institutions Code, section 14087.54. The Plan operates as an independent entity within the county's health system, ensuring access to essential healthcare services while maintaining organizational autonomy.

The Plan was established to serve as the local initiative for Alameda County under the State Department of Health Services' strategy to expand Medi-Cal managed care. It received its initial license from the California Department of Corporations in September 1995 and entered into a Contract with the California Department of Health Care Services (DHCS) in November 1995. Operations subsequently began in January 1996.

Effective January 1, 2024, Alameda County transitioned from a two-plan Medi-Cal managed care model to a single-plan structure, designating the Plan as the exclusive Medi-Cal managed care provider.

As of June 30, 2026, the Plan had a total of 226,639 Medi-Cal members.

II. EXECUTIVE SUMMARY

This report presents the audit findings of the DHCS medical audit for the period of March 1, 2025, through December 31, 2025. The audit was conducted from March 2, 2026, through March 13, 2026. The audit consisted of documentation review, verification studies, and interviews with the Plan's representatives.

An Exit Conference with the Plan was held on August 25, 2026. The Plan was allowed 15 calendar days from the date of the Exit Conference to provide supplemental information addressing the draft audit findings. On September 10, 2026, the Plan submitted a response after the Exit Conference. The evaluation results of the Plan's response are reflected in this report.

The audit evaluated six categories of performance: Utilization Management (UM) Program, Population Health Management and Coordination of Care, Network and Access to Care, Grievances, Appeals, and Member Rights, Quality Improvement and Health Equity Transformation Program, and Plan Administration and Organization.

The prior DHCS medical audit for the period of June 1, 2024, through February 28, 2025, was issued on July 22, 2025. There were no deficiencies identified in the prior audit period.

However, an earlier DHCS medical audit for the period of June 1, 2023, through May 31, 2024, was issued on November 18, 2024. This audit examined the Plan's compliance with the DHCS Contract and assessed the implementation and effectiveness of the Plan's prior year 2024 Corrective Action Plan.

Findings denoted as repeat findings are uncorrected deficiencies substantially similar to those identified in the 2024 audit.

The summary of the findings by category is as follows:

Category 1 – Utilization Management Program

The Plan must ensure that decisions based on the medical necessity of proposed health care services are consistent with criteria or guidelines that are supported by clinical principles and processes. Finding 1.2.1: The Plan did not ensure that Prior Authorization (PA) decisions were based on medical necessity consistent with criteria or guidelines used.

The Plan must make an expedited authorization decision and provide its decision as expeditiously as the member's health condition requires, but no longer than 72 hours after the Plan's receipt of the request for services. Finding 1.2.2: The Plan did not process expedited authorization requests within 72 hours.

Category 2 – Population Health Management and Coordination of Care

The Plan must develop member-facing written material about Enhanced Care Management (ECM), which must explain that ECM participation is voluntary and can be discontinued at any time. The material must also describe the process by which the member may choose a different ECM Lead Care Manager or ECM provider. Finding 2.25.1: The Plan did not provide member-facing ECM written material that included all minimum required elements.

The Plan must ensure all members receive all seven ECM core service components, specifically comprehensive assessment and Care Management Plan (CMP). A comprehensive assessment and CMP must include identification of necessary clinical and non-clinical resources needed to assess member health status and inform the development of an individualized CMP. The Plan must also ensure that CMPs are reviewed, maintained, and updated under appropriate clinical oversight. Finding 2.25.2: The Plan did not ensure that comprehensive assessments and CMPs are completed, clinically reviewed, and properly documented.

Category 3 – Network and Access to Care

There were no findings noted for this category during the audit period.

Category 4 – Grievances, Appeals, and Member Rights

The Plan must ensure that its Grievance and Appeal System allows the member, provider, or authorized representative with the member's written consent, to file a grievance either orally or in writing. Finding 4.1.1: The Plan did not ensure the member's written consent was obtained for an authorized representative to file a grievance on the member's behalf.

The Plan must provide a notice of resolution to the member as quickly as the member's health condition requires, not to exceed 72 hours from the date the member makes an oral or written request to the Plan for an expedited grievance. Finding 4.1.2: The Plan did not resolve expedited grievances within 72 hours.

The Plan must provide a notice of resolution to the member as quickly as the member's health condition requires, not to exceed 30 calendar days from the date the member makes an oral or written request to the Plan for a standard grievance. Finding 4.1.3: The Plan did not resolve standard grievances within 30 days.

The Plan must ensure the member, provider, or authorized representative acting on behalf of the member and with the member's written consent, may request an appeal. Finding 4.5.1: The Plan did not ensure the member's written consent was obtained for a provider or authorized representative to file an appeal on the member's behalf.

The Plan must resolve an expedited appeal as quickly as the member's health condition requires, but no later than 72 hours from the day the Plan receives the request for an expedited appeal. Finding 4.5.2: The Plan did not resolve expedited appeals within 72 hours.

The Plan must establish policies and procedures to ensure members receive all member information in a threshold language or alternative format of their choice. Finding 4.13.1: The Plan did not ensure that members received all grievance and appeal information in the threshold language of their choice.

Category 5 – Quality Improvement and Health Equity Transformation Program

There were no findings noted for this category during the audit period.

Category 6 – Plan Administration and Organization

There were no findings noted for this category during the audit period.

III. SCOPE/AUDIT PROCEDURES

SCOPE

The DHCS, Contract and Enrollment Review Division conducted the audit to ascertain that medical services provided to Plan members comply with federal and state laws, Medi-Cal regulations and guidelines, and the State Contract.

PROCEDURE

DHCS conducted an audit of the Plan from March 2, 2026, through March 13, 2026, for the audit period of March 1, 2025, through December 31, 2025. The audit included a review of the Plan's Contract with DHCS, policies and procedures for providing services, 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 the Plan's administrators and staff.

The following verification studies were conducted:

Category 1 – Utilization Management Program

PA Requests: Thirty PA requests were reviewed for timeliness, consistent application of criteria, appropriate review, and communication of results to members and providers.

Delegated PA Requests: Twenty-five PA requests were reviewed for appropriate and timely adjudication.

Category 2 – Population Health Management and Coordination of Care

ECM: Sixteen medical records were reviewed to evaluate the provision of ECM core service components.

Behavioral Health Treatment: Thirteen medical records were reviewed to evaluate treatment plans that included measurable goals, a transition plan, a crisis plan, and an exit plan.

Initial Health Appointment: Sixteen medical records were reviewed for timeliness and completeness of initial health appointment requirements.

Continuity of Care: Ten medical records were reviewed to evaluate timeliness, appropriate determination, and notification of continuity of care requests.

Category 3 – Network and Access to Care

Emergency Service Claims: Twenty-three records were reviewed for appropriate and timely adjudication.

Family Planning Claims: Twenty-one records were reviewed for appropriate and timely adjudication.

Category 4 – Grievances, Appeals, and Member Rights

Grievance Procedures: Thirty-seven standard grievances (25 Quality of Care (QOC) and 12 Quality of Service (QOS)), 8 expedited grievances, 5 exempt grievances, and 5 call inquiries were reviewed for timely resolution, response to the complainant, submission to the appropriate level for review, and translation in the member's preferred language (if applicable).

Appeals Procedures: Twenty-five medical appeals were reviewed for appropriate and timely adjudication.

Confidentiality Rights: Fifteen breach and security incidents were reviewed for processing and reporting requirements.

Category 5 – Quality Improvement and Health Equity Transformation Program

Quality Improvement: Ten potential quality issue cases were reviewed for timely evaluation and effective action taken to address improvements.

Category 6 – Plan Administration and Organization

Fraud and Abuse: Twelve suspected fraud and abuse cases were reviewed for processing and reporting requirements.

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

COMPLIANCE AUDIT FINDINGS

Category 1 – Utilization Management Program

1.2 Prior Authorization and Review Procedures

1.2.1 Medical Necessity Determination

The Plan must ensure that its UM Program includes a designated Medical Director or Clinical Director responsible for the UM process in accordance with the California Health and Safety Code section 1367.01, and qualified staff responsible for the UM Program. *(Contract, Exhibit A, Attachment III, 2.3 (A))*

The Plan shall have written policies and procedures establishing the process by which the Plan reviews and approves, modifies, delays, or denies, based in whole or in part on medical necessity, requests by providers of health care services. These policies and procedures ensure that decisions based on the medical necessity of proposed health care services are consistent with criteria or guidelines that are supported by clinical principles and processes. *(California Health and Safety Code section 1367.01 (b))*

The Plan's policy, *UM-001 Utilization Management Program* (revised September 17, 2025), states decisions to modify, deny or authorize a service that was requested will be made by a qualified health care professional with appropriate clinical expertise or who is competent to evaluate the specific clinical issues using appropriate clinical guidelines in treating the condition or disease. Qualified health care professionals do not have to be an expert in all conditions and may use other resources to make appropriate decisions.

Finding: The Plan did not ensure that PA decisions were based on medical necessity consistent with criteria or guidelines used.

A verification study showed that in 4 of 30 PA requests, the Plan did not ensure PA decisions were based on medical necessity for the requested service. Issues included misapplication or misinterpretation of Milliman Care Guidelines (MCG) and incorrect application of the Medi-Cal Provider Manual in the following ways:

- A member with shoulder pain requested biofeedback therapy, which is appropriate under MCG when 6-12 weeks of pain is indicated. Although the request was approved, the medical documentation did not indicate the specific duration of the member's pain.

- A member previously underwent breast surgery for atypical ductal hyperplasia, and follow-up imaging later confirmed that atypical ductal hyperplasia remained. The provider requested additional surgery; however, the request was denied under MCG which require evidence of a residual mass to approve further surgical intervention. In this case, the member has a precancerous breast condition that presents clinical complexity not fully addressed by the criteria used in the decision. This case should have been referred for review by a specialist with appropriate clinical expertise in treating the member's condition to ensure an accurate assessment of medical necessity.
- A member was admitted to the hospital for observation following a surgical procedure and the request was denied because the Plan applied guidelines intended for non-surgical admissions. The criteria used to make the decision did not include the member's specific condition or diagnosis.
- A member with radiation-induced jaw necrosis requested hyperbaric oxygen therapy, which is an appropriate adjunct treatment under the Medi-Cal Provider Manual. The Plan denied the request due to a misapplication of the Medi-Cal Provider Manual.

The Plan does not maintain routine or comprehensive monitoring processes to validate the correct application of medical necessity criteria. Oversight activities are limited to the annual Inter-Rater Reliability (IRR) review, in which physician reviewers complete five modules, with up to three attempts permitted, to achieve a passing score of 90 percent or higher. This review does not assess the full range of clinical determinations made throughout the year, and the 2025 IRR review, showing 100 percent scores for Medical Directors, did not identify any issues. Beyond the IRR, the Plan does not perform systematic review of Medical Director decisions, resulting in oversight gaps that impede timely identification and correction of misapplication of MCG criteria and Medi-Cal guidelines.

If medical necessity determinations are not based on the correct application of clinical criteria, PA decisions may be inappropriate. This can result in members being denied necessary services or receiving services that are not medically necessary, both of which increase the risk of member harm.

Recommendation: Implement policies and procedures to ensure PA decisions are based on medical necessity consistent with criteria or guidelines used.

1.2.2 Processing of Expedited Authorization Requests Within 72 Hours

The Plan must make an expedited authorization decision and provide its decision as expeditiously as the member's health condition requires, but no longer than 72 hours after the Plan's receipt of the request for services. (*Contract, Exhibit A, Attachment III, 2.3.2 (F)*)

For cases in which a provider indicates, or the Plan determines, that following the standard timeframe could seriously jeopardize the member's life or health or ability to attain, maintain, or regain maximum function, the Plan must make an expedited authorization decision. The Plan must provide notice as expeditiously as the member's health condition requires and no later than 72 hours after receipt of the request for service. (*Code of Federal Regulations (CFR), title 42, section 438.210 (d)(2)(i)*)

The Plan must maintain the necessary organization and level of staffing to implement and operate under the Contract and must ensure the following:

- Compliance with the Contract is a high priority, and that the Plan is committed to supplying any necessary resources to assure full performance of the Contract
- Adequate staffing in medical and other health services and fiscal and administrative capacity sufficient to effectively conduct Plan's business

(*Contract, Exhibit A, Attachment III, 1.1.4 (B) & (D)*)

The Plan's policy, *UM-051 Timelines of UM Decision Making and Notification* (revised December 18, 2024), states that the Plan processes expedited authorization requests within 72 hours of the request.

Finding: The Plan did not process expedited authorization requests within 72 hours.

In a verification study, 3 of 11 cases that met the criteria for expedited authorization requests were processed 9 to 16 days beyond the required 72 hour timeframe.

The Plan's staffing levels did not support consistent operation of its established policies and PA process. The Plan reported during an interview that increased authorization volumes, combined with the loss of a Medical Director and reduced clinical staffing, contributed to delays in completing expedited authorization reviews. Additionally, the 3 of 11 expedited authorization cases reviewed were received by the Plan in September, which aligns with the UM Committee Meeting Minutes dated October 31, 2025. The minutes reported a third-quarter timeliness rate of 64 percent, which is below the 95 percent goal, due to physician staffing shortages. As a result, the Plan was unable to

fully implement Plan policy UM-051 policy requiring expedited decisions within 72 hours.

Delays in processing expedited authorization requests beyond the 72 hour requirement jeopardize the member's timely access to medically necessary care and may result in potential member harm.

Recommendation: Implement policies and procedures to ensure expedited authorization requests are processed within 72 hours.

COMPLIANCE AUDIT FINDINGS

Category 2 – Population Health Management and Coordination of Care

2.25 Enhanced Care Management

2.25.1 Member-Facing Written Materials

The Plan must develop member-facing written material about ECM for use across its network of ECM providers. The written material must be submitted for DHCS review and approval prior to use. This material must explain that ECM participation is voluntary and can be discontinued at any time. The material must also describe the process by which the member may choose a different ECM Lead Care Manager or ECM provider.

(Contract, Exhibit A, Attachment III, 4.4.1 (K)(3) & (K)(5))

The Plan's policy, *CM-018 CalAIM Enhanced Care Management Member Notification* (approved September 17, 2025), states that members are notified of the ECM benefit through standard communication venues, such as the Member Handbook/Evidence of Coverage, Plan website, and Member Portal. Notification includes, but is not limited to, explanation that participation is voluntary, and members may discontinue participation at any time. Members may change their ECM provider by contacting the Plan's Member Services.

Finding: The Plan did not provide member-facing ECM written material that included all minimum required elements.

The audit found no member-facing written material demonstrating that members were informed that ECM is voluntary, can be discontinued at any time, or showing how to change their ECM Lead Care Manager or ECM provider. A review of the Plan policy CM-018 showed that although the policy lists general member notification methods and mentions voluntary participation and changing of ECM providers, it does not describe the process for changing an ECM Lead Care Manager. Additionally, the Plan did not implement the policy's stated notification procedures.

The Plan lacks adequate oversight to ensure that materials are created, reviewed, or submitted. In an interview, the Plan acknowledged a lapse in the development and distribution of the necessary ECM member-facing materials. While some ECM policies were reviewed by the Plan's Quality Improvement Health Equity Committee and final

approval was assigned to the Administrative Oversight Committee, the audit found no evidence of consistent follow through to verify implementation or review of ECM member materials.

Without written materials explaining that ECM participation is voluntary and may be discontinued at any time, members may not understand their right to decline or leave the program. Similarly, without clear instructions on how to change their ECM Lead Care Manager or ECM provider, members may be unable to access a Lead Care Manager or provider that best meets their needs.

Recommendation: Revise and implement policies and procedures to ensure the provision of member facing ECM written materials.

2.25.2 Comprehensive Assessment and Care Management Plan

The Plan must ensure all members receive a comprehensive assessment and CMP, as further defined in All Plan Letters (APL). (*Contract, Exhibit A, Attachment III, 4.4.11 (B)*)

The comprehensive assessment and CMP must include, but are not limited to, the following:

- Identifying necessary clinical and non-clinical resources that may be needed to appropriately assess member health status and gaps in care, and may be needed to inform the development of an individualized CMP.
- Developing a comprehensive, individualized, person-centered CMP with input from the members and their family members, legal guardians, authorized representatives, caregivers, and other authorized support persons, as appropriate, to assess strengths, risks, needs, goals, and preferences. Additionally, to make recommendations for service needs.
- Incorporating into the members' CMP identified needs and strategies to address the needs, including, but not limited to, physical and developmental health, mental health, dementia, substance use disorders, long term services and supports, oral health, palliative care, necessary community-based and social services, and housing.
- Ensuring the CMP is reviewed, maintained, and updated under appropriate clinical oversight.

(*APL 23-032, Enhanced Care Management Requirements*)

The Plan's policy, *CM-011 Enhanced Care Management – Care Management & Transitions of Care* (approved September 17, 2025), states that the Health Action Plan

(HAP) is a combination of the ECM assessment and the resultant care plan. Assessment information will include but is not limited to physical health, mental health, substance use disorder, community-based services, palliative care, trauma-informed care needs, housing and other social determinants of health and utilization. The policy also states a clinician at the ECM provider reviews the HAP.

The Plan's policy, *CM-013 Enhanced Care Management – Oversight, Monitoring, and Controls* (approved April 16, 2025), states that 12 percent of the ECM provider universe will be reviewed for evidence of required ECM care management services, including evidence of HAP completion.

The Plan's policy, *CM-016 Enhanced Care Management – Staffing* (approved April 16, 2025), describes the Plan's ECM team member credentials and roles. The clinical consultant may be a primary care physician, specialist physician, psychiatrist, psychologist, pharmacist, registered nurse, advanced practice nurse, nutritionist, licensed clinical social worker, or other behavioral or health care professional. Their role includes review and inform the HAP.

Finding: The Plan did not ensure that comprehensive assessments and CMPs are completed, clinically reviewed, and properly documented.

In a verification study, 3 of 16 medical records did not include the required comprehensive assessment and CMP components to inform the development of the CMP.

- In one case, a member at risk for avoidable emergency room utilization had an assessment that did not address the member's physical health, which resulted in a CMP that lacked strategies to reduce emergency room use. Additionally, there was no evidence of CMP clinical oversight, as the documentation lacked any ECM staff review or signature demonstrating clinical involvement.
- In a second case, a medically complex member had an assessment that did not address their physical or developmental health, and a CMP was not developed to address their needs.
- In a third case, the assessment identified a housing need, but the Plan did not develop a CMP, which resulted in a missed opportunity for referral to community housing supports to address the member's need.

An additional 5 of 16 medical records lacked documentation showing clinical oversight of the CMP. Although ECM staff completed the CMPs, their roles (such as registered nurse, community health worker, or licensed clinical social worker) were inconsistently

documented, which prevented confirmation of staff qualifications and clinical involvement. Furthermore, there was no supporting evidence, such as medical record notes, showing that a clinician reviewed, maintained, or updated the CMP as required.

The Plan did not ensure comprehensive assessment and CMPs are completed, clinically reviewed, and properly documented. While the Plan relies on its ECM audit tool and participation in Interdisciplinary Team (IDT) meetings to demonstrate compliance, the audit found that the Plan's ECM audit tool does not include fields to document CMP clinical review or approval, and the Plan's IDT minutes did not contain documentation related to CMP review, updates, or clinical decision-making. The audit also found that while the Plan's policies identify responsibilities for monitoring ECM provider performance, including conducting chart audits, the policies however do not clearly define pathways for elevating audit findings beyond the ECM Department. Therefore, audit results, IDT summaries, and ECM performance data were not disseminated to the Quality Improvement Health Equity Committee or other committees charged with organizational oversight.

When assessments are not comprehensive and CMPs lack clinical oversight, members may receive care plans that do not fully address their needs. This can lead to missed interventions, delays in accessing appropriate services, and potentially avoidable health deterioration or unnecessary use of higher level care.

Recommendation: Develop and implement procedures to ensure that comprehensive assessments and CMPs are completed, clinically reviewed, and properly documented.

COMPLIANCE AUDIT FINDINGS

Category 4 – Grievances, Appeals, and Member Rights

4.1 Grievance and Appeal Program Requirements

4.1.1 Written Consent for Grievances Filed on a Member's Behalf

The Plan must ensure that its Grievance and Appeal System allows the member, provider, or authorized representative with the member's written consent, to file a grievance, or request an appeal with the Plan either orally or in writing. (*Contract, Exhibit A, Attachment III, 4.6.1 (A)*)

The Plan's policy, *G&A-001 Grievance and Appeals System Description* (revised December 18, 2024), states that grievance and appeals may be filed either orally or in writing by the member or an authorized representative.

Finding: The Plan did not ensure the member's written consent was obtained for an authorized representative to file a grievance on the member's behalf.

A verification study showed that the Plan processed three of seven QOC standard grievances submitted on a member's behalf without the member's written consent or documentation of an Authorization of Representation (AOR) letter. In all three instances, the member gave verbal consent to process the grievance; however, the audit found no further attempts to obtain written consent.

The absence of clear policy requirements contributed to the Plan's inability to ensure written consent was obtained and documented. Although Plan policy G&A-001 permits grievances to be filed by the member or an authorized representative, it does not establish procedures for obtaining written consent or require a letter of AOR when grievances are submitted on a member's behalf. In an interview, the Plan acknowledged that it could not confirm whether a valid authorization letter was on file. In a subsequent written statement, the Plan explained that staff relied on verbal consent and made no further attempts to obtain written consent.

If the Plan processes a grievance filed on behalf of a member without receiving the member's written consent, it can jeopardize the member's autonomy and potentially compromise their Protected Health Information. This could result in medical care decisions being made without their authorization and unauthorized access to their medical records.

Recommendation: Revise and implement policies and procedures to obtain member's written consent for an authorized representative filing a grievance on behalf of a member.

4.1.2 Resolution of Expedited Grievances Within 72 Hours

The Plan must provide a notice of resolution to the member as quickly as the member's health condition requires, not to exceed 72 hours from the date the member makes an oral or written request to the Plan for an expedited grievance or appeal. (*Contract, Exhibit A, Attachment III, 4.6.1 (B)*)

The Plan must maintain the necessary organization and level of staffing to implement and operate under the Contract and must ensure the following:

- Compliance with the Contract is a high priority, and that the Plan is committed to supplying any necessary resources to assure full performance of the Contract
- Adequate staffing in medical and other health services and fiscal and administrative capacity sufficient to effectively conduct Plan's business

(*Contract, Exhibit A, Attachment III, 1.1.4 (B) & (D)*)

The Plan's policy, *G&A-005 Expedited Review of Urgent Grievance and Appeals* (revised December 18, 2024), states that the Plan ensures that grievance and appeals for cases involving an imminent and serious threat to the health of the patient, including, but not limited to, severe pain, potential loss of limb, or major bodily function are reviewed expeditiously and resolved within 72 hours or sooner, if the medical condition requires.

Finding: The Plan did not resolve expedited grievances within 72 hours.

In a verification study, three of five expedited QOC grievances were resolved 7 to 11 days beyond the 72 hour timeframe; and one of three expedited QOS grievances was resolved 28 days beyond the 72 hour timeframe.

The Plan's staffing levels did not align with the workload required to operate and fully implement its established policies and resolution process. In a written statement, the Plan explained that the Grievance and Appeal Coordinator was unable to resolve the grievance within the required 72 hours and continued working the case beyond that timeframe. The issue stemmed from a staffing shortage in the Grievance and Appeals Department during the audit period, which increased caseloads and contributed to delays in resolving expedited grievances. Meeting minutes from the Plan's Administrative Oversight Committee from April through December 2025 further

confirmed that the Plan's Grievance and Appeals Department faced challenges managing high case volumes alongside ongoing staff shortages, which contributed to missed expedited grievance criteria.

When the Plan does not resolve an expedited grievance within 72 hours, members may experience delays in accessing urgent health care that is needed, which could result in worsening medical conditions or increased risk of hospitalization.

Recommendation: Implement policies and procedures to resolve expedited grievances within 72 hours.

4.1.3 Resolution of Standard Grievances Within 30 Days

The Plan must provide a notice of resolution to the member as quickly as the member's health condition requires, not to exceed 30 calendar days from the date the member makes an oral or written request to the Plan for a standard grievance or appeal.

(Contract, Exhibit A, Attachment III, 4.6.1 (B))

The Plan must comply with the State's established timeframe of 30 calendar days for grievance resolution. *(APL 21-011, Grievance and Appeal Requirements, Notice and "Your Rights" Templates)*

The Plan must maintain the necessary organization and level of staffing to implement and operate under the Contract and must ensure the following:

- Compliance with the Contract is a high priority, and that the Plan is committed to supplying any necessary resources to assure full performance of the Contract
- Adequate staffing in medical and other health services and fiscal and administrative capacity sufficient to effectively conduct Plan's business

(Contract, Exhibit A, Attachment III, 1.1.4 (B) & (D))

The Plan's policy, *G&A-001 Grievance and Appeals System Description* (revised December 18, 2024), states the Plan has a written Grievance and Appeals System. This system outlines procedures to receive, review, and resolve grievances and appeals within 30 calendar days from when they are received by the Plan or its delegated entities responsible for handling member grievances and appeals.

Finding: The Plan did not resolve standard grievances within 30 days.

In a verification study, 18 of 25 standard QOC grievances were resolved 1 to 38 days beyond the 30 day timeframe; and 2 of 12 standard QOS grievances were resolved 2 to

29 days beyond the 30 day timeframe. In all instances, the Plan sent members an out-of-compliance letter, which notified them of the delay, explained that the grievance could not be resolved within 30 days, and provided an estimated resolution date.

The Plan's staffing constraints resulted in delays in grievance processing and hindered full implementation of its established policies and resolution process. In a written statement, the Plan reported that the two QOS grievances were resolved untimely because staffing constraints increased the Grievance and Appeals Coordinator's caseload beyond what could be handled within the required 30 day timeframe.

The Plan further explained that all 18 delayed QOC grievances were untimely due to delays in requesting necessary medical records from providers, a delay also attributed to staffing constraints. Unlike QOS concerns, QOC issues require Medical Director involvement and a complete clinical picture, including comprehensive documentation from providers. The Plan's slowed initiation of request for additional information postponed receipt of needed records, which in turn delayed clinical review and grievance resolution.

Ultimately, the Plan's Grievance and Appeals Department experienced a staffing shortage during the audit period, leading to elevated caseloads and delays in sending provider response requests. Meeting minutes from the Plan's Board of Governors further confirmed that the Plan's Grievance and Appeals Department faced challenges managing high case volumes alongside ongoing staff shortages.

When the Plan does not resolve a standard grievance within 30 days, members may not have sufficient information to make informed decisions about their health care, which could result in delayed care and potential member harm.

Recommendation: Implement policies and procedures to ensure standard grievances are resolved within 30 days.

4.5 Appeal Process

4.5.1 Written Consent for Appeals Filed on a Member's Behalf

The member, provider, or authorized representative acting on behalf of the member and with the member's written consent, may request an appeal. (*Contract, Exhibit A, Attachment III, 4.6.5 (A)*)

The Plan must maintain the necessary organization and level of staffing to implement and operate under the Contract and must ensure the following:

- Compliance with the Contract is a high priority, and that the Plan is committed to supplying any necessary resources to assure full performance of the Contract
- Adequate staffing in medical and other health services and fiscal and administrative capacity sufficient to effectively conduct Plan's business

(Contract, Exhibit A, Attachment III, 1.1.4 (B) & (D))

The Plan's policy, *G&A-008 Adverse Benefit Determination Appeals Process* (revised November 15, 2024), states that an appeal submitted on a member's behalf must have a current AOR on file before the appeal can be processed. The Plan will make reasonable efforts to obtain written consent from the member if a provider files the appeal on their behalf. If written consent is not obtained, the case will be closed as a grievance, and the member will be informed of the reason why the appeal cannot be processed.

Finding: The Plan did not ensure the member's written consent was obtained for a provider or authorized representative to file an appeal on the member's behalf.

This is a repeat of the 2024 prior year finding – 1.3.1 Written Consent for Appeals.

In response to the 2024 prior year finding, the Plan revised its policy G&A-008, updated its Appeals Process Workflow, and initiated monthly internal audits beginning in January 2025. However, a verification study showed that the Plan processed 3 of 10 appeals submitted by a provider on a member's behalf without the member's written consent on file.

While the Plan updated its process to obtain member written consent, staffing shortages prevented full operation and implementation of its monitoring and oversight mechanisms. The Plan reported that a significant increase in appeal volume exceeded available staffing capacity, resulting in processing backlogs. These backlogs led to missed procedural steps, including verification of written consent, and contributed to inconsistent compliance when appeals were submitted on behalf of members. In addition, the Plan stated that although internal audits were completed in January and February 2025, no further audits occurred because staff were redirected to manage the increased appeal workload. As a result, the Plan's limited staffing hindered its ability to consistently enforce compliance, identify ongoing issues, and implement timely corrective actions.

If the Plan processes an appeal filed on behalf of a member without receiving the member's written consent, it can jeopardize the member's autonomy and potentially compromise their Protected Health Information. This could result in medical care

decisions being made without their authorization and unauthorized access to their medical records.

Recommendation: Implement policies and procedures to obtain member's written consent for a provider or authorized representative filing an appeal on behalf of a member.

4.5.2 Resolution of Expedited Appeals Within 72 Hours

The Plan must resolve an expedited appeal as quickly as the member's health condition requires, but no later than 72 hours from the day the Plan receives the request for an expedited appeal. (*Contract, Exhibit A, Attachment III, 4.6.6 (C)*)

For expedited resolution of an appeal and notice to members, the Plan must establish a timeframe that is no longer than 72 hours after the Plan receives the appeal. (*42 CFR, section 438.408 (b)(3)*)

The Plan must maintain the necessary organization and level of staffing to implement and operate under the Contract and must ensure the following:

- Compliance with the Contract is a high priority, and that the Plan is committed to supplying any necessary resources to assure full performance of the Contract
- Adequate staffing in medical and other health services and fiscal and administrative capacity sufficient to effectively conduct Plan's business

(*Contract, Exhibit A, Attachment III, 1.1.4 (B) & (D)*)

The Plan's policy, *G&A-008 Adverse Benefit Determination Appeals Process* (revised November 15, 2024), states that the Plan makes expedited appeal decisions and notifies members and providers as expeditiously as the medical condition requires, but no later than 72 hours after the request.

Finding: The Plan did not resolve expedited appeals within 72 hours.

In a verification study, five of six expedited appeals were resolved 4 to 10 days beyond the 72 hour timeframe.

The Plan's staffing levels did not align with the workload required to operate and fully implement its established policies and resolution process. In an interview, the Plan explained that issues began to emerge as caseloads increased, including a rise in Community Supports appeals. This increase, coupled with staff shortages in the Grievance and Appeals Department during the audit period, resulted in higher caseloads

and contributed to delays in resolving expedited appeals. Meeting minutes from the Plan's Administrative Oversight Committee from April through December 2025 further confirmed that the Plan's Grievance and Appeals Department experienced ongoing challenges managing high case volumes amid continued staff shortages, which contributed to missed expedited appeal criteria.

When the Plan does not resolve an expedited appeal within 72 hours, members may experience delays in accessing urgent health care needed, which could result in worsening medical conditions or increased risk of hospitalization.

Recommendation: Implement policies and procedures to resolve expedited grievances within 72 hours.

4.13 Member Information

4.13.1 Requirements for Providing Accessible Member Information

The Plan must establish policies and procedures to ensure members receive all member information in a threshold language or alternative format of their choice as required by 42 CFR, section 438.10, and the California Welfare and Institutions Code, section 14029.91. (*Contract, Exhibit A, Attachment III, 5.1.3 (F)(3)*)

The written notice of appeal resolution must meet all language and accessibility standards, including translation, font, and format requirements, as set forth in *APL 25-005, Standards for Determining Threshold Languages, Nondiscrimination Requirements, and Language Assistance Services*, federal and state law, and all requirements in the Contract. (*APL 21-011, Grievance and Appeal Requirements, Notice and "Your Rights" Templates*)

The Plan's policy, *G&A-001 Grievance and Appeals System Description* (revised December 18, 2024), states that all members with limited English proficiency or with a visual or other communicative impairment have access to and can fully participate in the grievance and appeals system through translations of grievance and appeals procedures, forms, and Plan responses to grievance and appeals.

Finding: The Plan did not ensure that members received all grievance and appeal information in the threshold language of their choice.

A verification study showed the following deficiencies:

- Four of 10 QOC grievances did not have translated acknowledgement and resolution letters, out-of-compliance letters, and/or non-discrimination notices to the member's preferred language.
- Four of 12 QOS grievances did not have fully translated "your rights" and/or non-discrimination notices included in the acknowledgement and resolution letters to the member's preferred language.
- Six of nine appeals did not have translated non-discrimination notices to the member's preferred language.

The Plan does not have an effective oversight mechanism to ensure that all grievance and appeal information is translated into the member's threshold language. Although the Grievance and Appeals Department utilizes a daily aging report to identify cases requiring translation, the report did not flag any issues. As a result, letters not translated were sent to members without being identified. During an interview, the Plan noted that only resolution letters go through quality review. However, acknowledgement letters, "your rights" and non-discrimination notices are automatically generated and are not checked for quality. Additionally, the Plan's quality assurance team was reassigned to process cases, resulting in the absence of personnel to review translated letters. Consequently, notifications were inadvertently sent in English rather than the member's preferred language, reflecting the Plan's lack of adequate oversight controls.

When members do not receive grievance and appeal-related information in their preferred language, they may be unable to understand their rights, the outcome of their grievance or appeal, or the next steps available to them.

Recommendation: Implement policies and procedures to ensure that members receive all grievance and appeal information in the threshold language of their choice.

REPORT ON THE MEDICAL AUDIT OF ALAMEDA ALLIANCE FOR HEALTH CALENDAR YEAR 2025

**DHCS Audits and Investigations
Contract and Enrollment Review Division
San Diego Section**

Contract Number: 23-30244

Contract Type: State Supported Services

Audit Period: March 1, 2025 — December 31, 2025

Dates of Audit: March 2, 2026 — March 13, 2026

Report Issued: October 15, 2026

TABLE OF CONTENTS

I. INTRODUCTION 3

II. COMPLIANCE AUDIT FINDINGS 4

I. INTRODUCTION

This report presents the results of the audit of Alameda Alliance for Health (Plan) compliance and implementation of the State Supported Services contract number 23-30244 with the State of California. The State Supported Services Contract covers abortion services with the Plan.

The audit covered the period of March 1, 2025, through December 31, 2025. The audit was conducted from March 2, 2026, through March 13, 2026, which consisted of a document review and verification study with the Plan administration and staff.

An Exit Conference with the Plan was held on August 25, 2026. No deficiencies were noted during the review of the State Supported Services Contract.

COMPLIANCE AUDIT FINDINGS

State Supported Services

The Plan is required to provide, or arrange to provide, to eligible members the following services: Current Procedural Coding System codes 59840 through 59857 and Centers for Medicare and Medicaid Services Common Procedure Coding System codes X1516, X1518, X7724, X7726, and Z0336. (*State Supported Services Contract, Exhibit A, 1.2.1*)

The Plan's policy, *CLM-011 Private Services (Abortion Services) Claims Processing* (approved November 19, 2025), states that the Plan will reimburse claims or any portion of any claim for abortion services received on or before December 31, 2025, whether in-plan or out-of-plan, as soon as practical, but no later than 45 working days after the receipt of the claim, unless the Plan contests the claim or a portion of the claim. Furthermore, the Plan ensures that abortion service claims for Medi-Cal members will not require prior authorization or clinical review by Plan staff when performed on an outpatient basis.

The Plan's Member Handbook informs members about minor consent services where members under the age of 18 can receive abortion services without a parent or guardian's permission. Furthermore, members are informed of their rights to obtain outpatient abortion services at any Medi-Cal provider without a referral or prior authorization from the Plan.

Additionally, the Plan communicates members' rights to providers through the Provider Manual, which states that members are entitled to timely, convenient, and confidential access to abortion services. These services can be obtained within and outside of the Plan's provider network without a referral or prior authorization. Providers are instructed to make every effort to assist members who are seeking abortion services, which includes providing timely and appropriate counseling, education, information, and referral.

A verification study of 16 State Supported Service claims was conducted to determine the appropriate process and timely adjudication of claims. No deficiencies were noted during the audit period.

Recommendation: None.