DHCS
CALIFORNIA DEPARTMENT OF
HEALTH CARE SERVICES
Michelle Baass | Director

October 31, 2023

Richard Golfin III, Chief Compliance Officer Via Email
Alameda Alliance for Health
1240 S. Loop Rd.
Alameda, CA 94502

RE: Department of Health Care Services Medical Audit

Dear Mr. Golfin III:

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 April 13, 2021 through April 23, 2021. The audit covered the period of June 1, 2019 through March 31, 2021.

The items were evaluated and 4 of 30 findings were repeat findings on the subsequent 2023 Medical Audit; therefore, DHCS will assess remediation for the 4 repeat findings in the 2023 Corrective Action Plan (CAP). As such, DHCS accepts and will provisionally close the 2021 CAP with findings 3.8.2, 4.1.3, 4.1.4 and 4.1.5 still needing remediation. The open findings are transferred to the 2023 CAP which has the same findings. The enclosed documents will serve as DHCS' final response to the MCP's 2021 CAP. 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 the DHCS from taking additional actions it deems necessary regarding 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 final CAP remediation document (final Attachment A) will be made available on the DHCS website and to the public upon request.

If you have any questions, please reach out to CAP Compliance personnel.

Sincerely,

[Signature on file]

Lyubov Poonka, Chief
Audit Monitoring Unit
Managed Care Quality and Monitoring Division
Department of Health Care Services

Enclosures: Attachment A (CAP Response Form)

cc: Stacy Nguyen, Chief
Managed Care Monitoring Branch
Managed Care Quality and Monitoring Division
Department of Health Care Services

Josh Hunter, Lead Analyst
Audit Monitoring Unit
Managed Care Quality and Monitoring Division
Department of Health Care Services

Lolita Aquino, Contract Manager
Medi-Cal Managed Care Division
Department of Health Care Services

ATTACHMENT A
Corrective Action Plan Response Form

Plan: Alameda Alliance for Health

Review Period: 06/01/2019 – 03/31/2021

Audit Type: Medical Audit and State Supported Services

CAP Submitted: 04/13/2021 – 04/23/2021

MCPs are required to provide a 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 that will reduce turnaround time for DHCS to complete its review. According to ADA requirement, 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, and 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. Implementation Documentation, and 4. Completion/Expected Completion Date. The MCP will be required to include 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 detail such as 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. For deficiencies that require short-term corrective action, implementation 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 completely remedy or operationalize, the MCP is to indicate that it has initiated remedial action and is on the way towards achieving an acceptable level of compliance. In those instances, the MCP will be required in addition to the above steps, to include the date when full compliance will be achieved. Policies and procedures submitted during the CAP process must still be sent to the MCP's Contract Manager for review and approval, as applicable in accordance with existing requirements.

Please note, 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 prior approval for an extended implementation effort is granted by DHCS.

DHCS will maintain close communication with the MCP throughout the CAP process and provide technical assistance to confirm the MCP provides sufficient documentation to correct deficiencies. Depending on the volume and complexity of deficiencies identified, DHCS may require the MCP to provide weekly updates, as applicable.

Deficiency Number and Finding	Action Taken	Supporting Documentation	Implementation Date* (*Short-Term, Long-Term)	DHCS Comments
1.2.1 Prior Authorization for Early Periodic Screening, Diagnostic, and Treatment (EPSDT) Services The Plan did not have appropriate processes to ensure that limitations on speech therapy services would not be imposed. In addition to using Medi-Cal guidelines, the Plan used MCG as its evidence-based criteria to make decisions. MCG criteria dictates the amount of visits that can be approved based on a diagnosis and therefore imposes limits.	1. The Plan developed workflow outlining standard review process for speech therapy Prior Authorization (PA) requests, ensuring that no limitations on speech therapy would be imposed on members under age 21. 2. The Plan will conduct a current staff training on standard process and include it in new staff training. 3. The Plan will revise 10748 Daily Auth Denial report to incorporate service type to capture PA requests for Speech Therapy. 4. The Plan will monitor PA requests for Speech Therapy on a quarterly basis. 5. The Plan will report results quarterly to UMC.	1. 1.2.1_1_2021 Speech Therapy Workflow	1. Completed 09/06/2021 2. 09/28/2021 3. 11/01/2021 4. 11/01/2021 5. Q4 2021	The following documentation supports the MCP's efforts to correct this finding: **POLICIES AND PROCEDURES** • Desktop Procedure, "Speech Therapy for Members Under 21 Years of Age Through EPSDT" outlining standard review process for speech therapy Prior Authorization (PA) requests, ensuring that no limitations on speech therapy would be imposed on members under age 21. **TRAINING** • Staff training, "Speech Therapy for Children" (09/29/21) sign-in sheet as evidence that MCP staff received training. The training materials address the updated Desktop Procedure, "Speech Therapy for Members Under 21 Years of Age Through EPSDT" ensuring that there are no service visit limitations for members under 21 years of age. **MONITORING AND OVERSIGHT** • Excel Spreadsheet, "Daily Auth Denials Report" (11/23/21) as evidence that the MCP has updated their Daily Auth Denial Report to incorporate service type to capture PA requests for Speech Therapy. • "Referral Management Utilization Activities Outpatient Services" (01/28/22) as evidence that the MCP is monitoring prior authorization requests for speech therapy on a quarterly basis and providing this report to the UM Committee. Tracking started on 11/23/21. The total volume for the fourth quarter is zero with zero services denied.

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				• "Speech Therapy Report" (03/08/22) and "Speech Therapy Report Template" as evidence that the MCP is monitoring prior authorization requests for speech therapy on a quarterly basis. In the report, the service type for speech therapy is captured as Rehab, and the MCP utilizes the date of birth for filter for children. **The corrective action plan for finding 1.2.1 is accepted.**
1.2.2 Dental Anesthesia Prior Authorizations The Plan did not ensure that a qualified health care professional reviewed dental anesthesia prior authorization requests which includes a review of clinical data. The Plan did not ensure the use of appropriate criteria/guidelines when reviewing dental anesthesia requests.	1. The Plan developed workflow outlining standard review process for dental anesthesia Prior Authorization (PA) requests. 2. The Plan will develop mitigation plan until auto auth programming is removed. 3. The Plan will conduct a staff training on the mitigation plan to identify and use standard UM review process for dental anesthesia (DA) and include it in new staff training. 4. The Plan's UM and IT teams will collaborate to remove DA requests from Auto Authorization programming in TruCare	1. 1.2.2_1_2021 Dental Anesthesia Workflow	1. Completed 09/06/2021 2. 09/28/2021 3. 09/28/2021 4. 11/15/2021	The following documentation supports the MCP's efforts to correct this finding: *The MCP has not denied any DA since its CAP launch and the Plan has been compliant with the DHCS interpretation with the UM workflow.* **POLICIES AND PROCEDURES** • Written response by the MCP (03/17/22) as evidence that the MCP has amended their workflows to address criteria #1-6 listed in the APL 15-012 after clinical review by a RN and sent to the MD if any of these 6 criteria were not met. **MONITORING AND OVERSIGHT** The MCP states that the following items if completed prior to referral were helpful, but were not required for the PA medical necessity review of dental anesthesia: • History (HPI was reviewed for comorbid conditions that impacted the criteria for DA #1-6 • Physical exam

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	(TC). 5. The Plan will develop a Tracking Report to capture and report on PA requests for Dental Anesthesia. 6. The Plan will monitor PA requests for Dental Anesthesia quarterly. 7. The Plan will report results quarterly to UMC. **03/17/22** - Amended Plan's Response "Plan Response: Per our communication with the state several weeks after launching of our CAP, we amended our workflows to address criteria #1-6 after clinical review by a RN and sent to the MD if any of these 6 criteria were not met. The following items if completed prior to referral were helpful but were not required for the PA medical necessity review of dental		5. 12/01/2021 6. 12/31/2021 7. Q1 2022	• Diagnosis • Treatment plan • Radiological reports and images • Evidence that the dental provider worked collaboratively with an anesthesia provider to determine if the member meets criteria for IV sedation or general anesthesia, and documentation of peri-operative care, inclusive of pre- operative, intra operative and post-operative care **The corrective action plan for finding 1.2.2 is accepted.**

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	anesthesia. The Plan would like to amend the original CAP response to reflect the current UM workflow changes which were adopted shortly after launch in 2021 and after DHCS guidance and feedback. • History (HPI was reviewed for comorbid conditions that impacted the criteria for DA #1-6 • Physical exam • Diagnosis • Treatment plan • Radiological reports and images • Evidence that the dental provider worked collaboratively with an anesthesia provider to determine if the member meets criteria for IV sedation or general anesthesia, and documentation of peri-operative care, inclusive of pre- operative, intra operative and post-operative care			

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	The Plan has not denied any DA since its CAP launch and the Plan has been compliant with the DHCS interpretation with the UM workflow.			
1.5.1 Inappropriate Denial of Medical Prior Authorizations The Plan did not ensure the delegate met standards set forth by the Plan and DHCS. The delegate inappropriately denied medical prior authorization requests.	1. The Plan will inform CHCN of DHCS findings about inappropriately denied medical prior authorization requests. 2. The Plan will re-educate delegates on requirements for standard UM processes, including application of appropriate criteria guidelines. 3. The Plan will audit CHCN denied cases for appropriateness of denial elements using annual audit tool. 4. The Plan will review denied cases at monthly CHCN meeting for education.		1. 10/08/2021 2. 10/12/2021 3. Q1 2022 4. 02/08/2022 and ongoing as needed	The following documentation supports the MCP's efforts to correct this deficiency: **POLICIES AND PROCEDURES** • Revised P&P, "UM-060: Delegation of Utilization Management" (03/17/22) which has been revised to include a review of standard and UM processes, review of appropriateness of denials, annual audit as well as focused auditing of UM processes as needed, tracking feedback and training indicated for any issues found within the last year's delegation reporting and prior year audit activities. • P&P, "CMP-019: Delegation Oversight", (11/23/21) as evidence that the Plan has an oversight process for contracted delegated entities. • P&P, "CMP-020: Corrective Action Plan (CAP)" (11/23/21), as evidence that the Plan has a CAP with its delegates once a contractual requirement is not met. **MONITORING AND OVERSIGHT** • AAH & CHCN monthly meetings (09/28/21, 10/26/21 and 12/28/21) which provide evidence of documented review between the Plan and delegate of discussion of overturned

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				appealed cases. • Audit Report, “2021 Annual Delegation Audit” (02/08/22) demonstrates the MCP is monitoring delegates performance and case workload for appropriate of prior authorization denials. • During the annual delegation audit, the MCP Compliance Auditor reviewed a total of 15 denied prior authorizations for appropriate denial. Twelve cases were found in compliance and three cases non-compliant. The delegate received a passing score of 80%. • Audit Plan, “2021 DHCS Annual Audit Finding 1.5.1 (Inappropriate denial of medical prior authorizations) Delegate Audit Plan (02/22) which includes a description of its plan for reviewing and auditing cases. • Audit Tools, “CHCN UM File Audit” and “Utilization Management Audit” (2021) as evidence in which the Plan will perform monitoring of its delegate. The audit tool includes the Plan’s review of the delegate’s appropriateness of denial and UM denial system controls. • A Letter to CHCN from AAH, (12/17/21) confirming the dates of the audit to be performed 02/08/22 – 2/11/22. Audit Period is 06/1/20 – 06/30/21. • JOM Meeting Minutes, (10/13/21) which provides evidence of documented review and discussion of the 2021 DHCS Medical Audit finding 1.5.1 Inappropriate Denial of Medical Prior Authorizations. • Meeting Agenda, “AAH-CHCN MD Meeting” (09/28/21, 10/26/21 and 12/28/21) as evidence the Plan is meeting with CHCN in

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				regard to overturned appealed cases. • Meeting Agenda, "UM Festival, UM Meeting with CHCN" (09/14/21, 10/12/21 and 01/11/22) as evidence the Plan is meeting with CHCN on a monthly basis regarding appealed case reviews. **TRAINING** • Delegate Training, "2021 DHCS Medical Audit Findings letter to CHCN" (10/8/21), "DHCS CAP Remediation Meeting Agenda" (10/12/21), "CHCN Session" (10/12/21), "Delegate Audit Plan" (02/22) and "Summary of CHCN Training – Feedback Q4 2021" (Q4, 2021) as evidence that the Plan has provided training to CHCN in regard to inappropriate denial of medical prior authorizations. **The corrective action plan for finding 1.5.1 is accepted.**
1.5.2 Review of Behavioral Health Prior Authorizations The Plan did not ensure the delegate met standards set forth by the Plan and DHCS. The Delegate did not ensure that requests to see out-of-network providers were reviewed and decisions were made	1. The Plan will inform Delegate of DHCS findings about qualified health care professional did not always make decisions to deny or only authorized an amount, duration, or scope that was less than requested, and the lack of name and contact information on the NOA of the decision-maker 2. The Plan will re-educate delegates on standard UM		1. 10/08/2021 2. 10/30/2021	The following documentation supports the MCP's efforts to correct this deficiency: **POLICIES AND PROCEDURES** • Delegate P&P, College Health IPA, "Clinical Coverage and Access to Utilization Management Staff" (01/26/21) which states, "All adverse medical necessity decisions regardless of time of day or night are made by CHIPA contracted PA's. • P&P, "CMP-019: Delegation Oversight", (11/23/21) as evidence that the Plan has an oversight process for contracted delegated entities.

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by a qualified health care professional. It did not include the decision-maker's name in the NOA.	requirement that only qualified health care professionals make decisions to deny or authorize an amount, duration, or scope that is less than requested, including out of network requests, and on the requirement to have the decision-makers' name and contact information on the NOA. 3. The Plan will audit delegate's cases during the annual audit to ensure that only qualified health care professionals make decisions on denials and authorizations of the amount, duration, and scope less than requested, and contact information for the decision maker.		3. January 2022	**MONITORING AND OVERSIGHT** • Audit Report, "Annual Delegation Audit" (02/08/22) demonstrates the MCP is compliant in regard to a physician, or other healthcare professional has appropriately reviewed medical denials of care based on medical necessity. In addition, the MCP's Compliance Auditor reviewed a total of 32 Practitioner Review of Medical Healthcare Denials. All 32 cases were found in compliance. • Audit Tool, "21 BHT File Audit Tool" (12/17/21) as evidence the MCP is compliant in regard to a physician, or other healthcare professional has appropriately reviewed medical denials of care based on medical necessity. • Letter, "2021 Beacon Delegation Audit Request Letter" (12/06/21) which notifies Beacon of the annual audit of 01/18/22 – 01/20/22. Review period is 07/01/20 -06/30/21. This audit will verify Beacon is in compliance with its contractual obligations. • Delegate Overview, "2021 DHCS Medical Audit Findings letter to Beacon" (10/8/21), "Beacon WebEx Meeting invite" (10/28/21) as evidence that the Plan has had a meeting to discuss the cases found to be non-compliant. **TRAINING** • An email between Beacon (Delegate) and the Plan (11/19/21) which includes an acknowledgement from the delegate in regard to this finding and confirms the decision makers name will be included in the NOA and will be compliant by December 31, 2021.

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				• In addition, Beacon acknowledges the three cases were reviewed as benefit determination instead of a medical necessity review. Beacon verifies all adverse determinations are issued as a medical necessity determination by a MD or Phd/PsyD and will be compliant by December 31, 2021. • JOM Meeting Minutes between AAH and Beacon, (11/18/21) which provides evidence of documented discussion of Physicians making referrals to BHT services and that they should be in ABA. In addition, UM program includes making certain that goals are medically necessary, ensuring Beacon's not authorizing services that are not medically necessary. **The corrective action plan for finding 1.5.2 is accepted.**
1.5.3 Ownership and Control Disclosure Reviews The Plan did not obtain complete ownership and control disclosure from its delegates.	1. The Plan has updated its documentation, Provider Services Standard Operating Procedure – Ownership and Control Disclosure Reviews for Delegates, to include collecting required disclosures from the managing employees, or board of directors and senior management team in cases where the entity is a non-profit with no majority ownership and/or owned by physician shareholders.	1. 1.5.3_1_Provider Services Standard Operating Procedure (SOP) – Ownership and Control Disclosure Reviews for Delegates (Redlined and Clean version)	1. 09/14/2021	The following documentation supports the MCP's efforts to correct this finding: **POLICIES AND PROCEDURES** • Provider Services Standard Operating Process (10/20/22) Outlines general requirements, frequency (yearly), identifies delegates, process, including: • Disclosure forms are sent out to delegates each calendar year. Plan has a two-step verification process conducted by Provider Relations and the Compliance Departments. **MONITORING AND OVERSIGHT** • The Plan has implemented a tracking log, including both first and second level reviews. Completed forms will be saved, tracked,

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				and available upon request. • Delegate disclosure forms have been reviewed and found to be compliant with the requirements outlined in CFR 455.104. **The corrective action plan for finding 1.5.3 is accepted.**
1.5.4 Written Agreement Requirements for Audit and Inspection of UM Delegates The Plan did not ensure the written agreements with its delegates included the requirement to allow specified departments, agencies, and officials to audit, inspect, and evaluate the Plan's facilities, records, and systems related to good and services provided to Medi-Cal members.	1. The Plan is adding the Comptroller General in the Behavioral Health contract, Amendment 7. 2. The Plan is currently working with its delegate, CFMG on a new contract and delegation agreement which will include the provision and requirement to allow governmental and specified agencies and officials to audit records and systems. 3. The Plan will conduct a review of all of its delegated agreements and update the agreements to ensure that all of the language requirements are included.		1. 10/15/2021 2. 12/31/2021 3. 12/31/2021	The following documentation supports the MCP's efforts to correct this deficiency: **POLICIES AND PROCEDURES** • Amended Delegated Agreement "Amendment 7, Administrative Services Agreement between AAH, and Beacon Health" (12/17/21) includes the requirement to allow specified departments, agencies, and officials to audit, inspect, and evaluate the Plan's facilities, records, and systems related to good and services provided to Medi-Cal members. • Delegated Agreement between, Community Health Center Network and Alameda Alliance for Health (04/27/18) includes the requirement to allow specified departments, agencies, and officials to audit, inspect, and evaluate the Plan's facilities, records, and systems related to good and services provided to Medi-Cal members. • Drafted Amended Delegated Agreement, "Medical Service Agreement between AAH and Children First Medical Group (IPA)" (02/22) includes the requirement to allow specified departments, agencies, and officials to audit, inspect, and evaluate the Plan's facilities, records, and systems related to good and services provided to Medi-Cal members. 08/15/22 –

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				Per MCP, at the end of August 2022, the final delegation agreement will be executed once the rate component is finalized. • Amended Delegated Agreement between Kaiser Foundation Health Plan, Inc. and Alameda Alliance for Health (03/22 per email dated 02/17/22) 08/15/22 – Per written response, "The Alliance has been in contact with Kaiser and informed them that the contract needs to be amended with the reference to CMS. Both parties have agreed to amend the base agreement by September 30, 2022." • These delegated agreements demonstrate the MCP is compliant in regard to the MCP's delegated agreements included the requirement to allow specified departments, agencies, and officials to audit, inspect, and evaluate the Plan's facilities, records, and systems related to good and services provided to Medi-Cal members. • P&P, "CMP-019: Delegation Oversight", (11/23/21) as evidence that the Plan has an oversight process for contracted delegated entities. **MONITORING AND OVERSIGHT** • Technical assistance was provided to the Plan explaining that CMS is a federal agency and not a state agency. The Plan will verify this information is shared with their staff and the appropriate update is made to the delegated agreements. • Written statement, (08/15/22) Per MCP written statement, "The Plan will conduct a review of its delegated agreements and update the agreements to confirm that all the language requirements are included." In addition, "The delegate's written

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				agreement is a document maintained and updated by the Plan and thus there is no need to do a delegate review. The Plan instead did an internal review and retrained staff to verify the documents are updated to reflect the contractual requirements." **TRAINING** • PowerPoint Training, "2021 DHCS CAP Finding 1.5.4, Written Agreement Requirements" and Staff Attendance Sheet (08/12/22) as evidence the MCP has conducted training for Compliance Staff. The training materials addressed the requirement to allow specified departments (DHS, CMS, DHHS, Inspector General, Comptroller General, DOJ, and DMHC) and agencies and officials to audit, inspect, and evaluate the Plan's facilities, records and systems related to good and services provided to Medi-Cal members. **The corrective action plan for finding 1.5.4 is accepted.**
1.5.5 Imposition of Financial Sanctions The Plan did not have policies and procedures for imposing financial sanctions on its delegate and delegated entities.	1. The Plan has created a new Policy, CMP-030 Financial Sanctions. This Policy describes the standards by which the Plan may impose sanctions against Delegated Entities (DE) for non-compliance or failure to comply with Corrective Actions Plan (CAP) deficiencies, or for breach of any material term, covenant or condition of an	1. 1.5.5_1_CMP-030 Financial Sanctions_DRAFT	1. 12/01/2021	The following documentation supports the MCP's efforts to correct this deficiency: **POLICIES AND PROCEDURES** • Newly Created P&P, "CMP-030: Financial Sanctions", (11/23/21) which has been created to describe the procedures by which the Plan may impose sanctions against Delegated Entities for non-compliance or failure to comply with Corrective Action Plan. • An email (01/26/22) which states, "CMP-030 Sanction and Escalation was reviewed approved at the November 23, 2021 Compliance Committee meeting. As part of the review and

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	agreement and/or for failure to comply with applicable federal or state statutes, regulations, and rules. This policy is scheduled to be reviewed and approved at the Compliance Committee on November 23, 2021.			approval process, CMP-30 was presented to the Committee Members prior to the vote for approval. Committee members who attended that meeting included the AAH Senior Leadership Team and Plan Directors. CMP-030 is available to Alliance staff via a shared platform that Staff have access to". • An email (03/07/22) which describes why there are no meeting minutes nor any reports in regard to imposing financial sanctions to its delegate or delegated entities. The Plan has stated, "Since there have been no DEs, providers or vendors been brought before committee for review, there are no reports to provide". **The corrective action plan for finding 1.5.5 is accepted.**
2.1.1 Health Risk Assessment (HRA) Completion Time Frames The Plan did not conduct HRAs within the required timeframes for newly enrolled SPD members in 2019 and 2020.	1. The Plan revised the HRA process to track all incoming HRAs via a Log, documenting date of receipt. 2. The Plan revised current process for HRAs received past due to be entered into the system of record TruCare (TC) during the month of receipt. 2.a. The Plan updated workflows. 3. The Plan re-trained staff on	1.a. 2.1.1_1a_HRA Workflow 1.b. 2.1.1_1b_ HRA Mail Tracking Log – Redacted 2.a. 2.1.1_2_HRA Workflow 3. 2.1.1_3_Traini	1. Completed January 2021 2. Completed April 2021 2.a. Completed 09/15/2021 3. 09/17/2021	The following documentation supports the MCP's efforts to correct this finding: **POLICIES AND PROCEDURES** • The MCP revised its Workflow that documents date of receipt, verifies due dates, confirms if translation is required, etc. The MCP documents that the day a HRA is received from the member, outreach is performed via telephone, with automated calls for lower risk members and plan staff calls for higher risk members. Tracking prioritizes HRA by due date and reviews are conducted weekly to verify accuracy. The MCP revised its process to track incoming HRAs through the use of a tracking log. An example was provided. A workflow was submitted which details the process to enter HRAs that are past due into their TruCare system during the month of receipt. Additionally, the MCP trained its staff on 9/17/21. • Revised HRA Workflow that tracks incoming HRAs by documenting by date of receipt in tracking log.

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	the HRA process. 4. The Plan will monitor the Log weekly to ensure adherence to the new process. 5. The Plan will report outcomes up to UMC quarterly.	ng Materials and Sign-In Sheet 9.17.21	4. 10/01/2021 5. Q4 2021	• HRA tracking log used to track HRA completion. • HRA process training materials and sing-in sheet. • HRA tracking log review results with data from September 24 through October 25 serves as evidence that the tracking log is being used to monitor adherence to the new process. **The corrective action plan for finding 2.1.1 is accepted.**
2.1.2 Coordination of Care for EPSDT The Plan did not ensure coordination of care in certain cases where EPSDT services were medically necessary.	1. The Plan will develop training on EPSDT PA requests to identify and refer members who need coordination of their care. 2. The Plan will provide training to UM and CM staff. 3. The Plan will create a reporting system to capture referrals to CM and the provision of care coordination. 4. The Plan will report outcomes at UMC on a quarterly basis.		1. 10/15/2021 2. 10/21/2021 3. 10/31/2021 4. Q4 2021	The following documentation supports the MCP's efforts to correct this finding: **TRAINING** • EPSDT Coordination of Care Training and attendance sheet demonstrates has trained its staff on EPSDT PA requests and identifying and referring members who need coordination of their care. The training specifically covered the areas of non-compliance from the audit report. (Slides 19 & 20) **MONITORING AND OVERSIGHT** • EPSDT Care Coordination Tracking Template is used to capture and track EPSDT referrals. The spreadsheet demonstrates the MCP has a process in place for monitoring regular contact to the member, duration and activities. The log now includes tracking multiple attempts of follow-up with the member/family which would lead the plan staff to determine if a referral went through.

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				The corrective action plan for finding 2.1.1 is accepted.
2.2.1 Complex Case Management Individualized Care Plan The Plan did not ensure the completion of ICPs for members enrolled in CCM.	1. The Plan revised its CCM ICP workflow and added the requirement that all staff complete ICPs for all members in CCM. 2. The Plan re-trained staff to complete ICPs for all members in CCM. 3. The Plan will revise its CM Aging Report to capture completion of ICPs for daily management and reporting outcomes. 4. The Plan will develop a monitoring workflow. 5. The Plan will routinely monitor completion of the ICPs. 6. The Plan will report outcomes at UMC quarterly.	1. 2.2.1_1_Complex CM Workflow 2. 2.2.1 - 2.2.3 - Training Materials and Sign-In Sheet 9.16.21	1. Completed 09/15/2021 2. Retraining completed on 09/16/2021 3. 10/01/2021 4. 10/01/2021 5. 10/01/2021 6. Q4 2021	*DHCS Comment: The MCP revised its CCM workflow to add the requirement that all staff complete ICPs for all members in CCM. The MCP trained its staff on 9/16/21, materials were provided. The MCP revised its aging report to capture completion of ICPs. The MCP also created a monitoring workflow with an explanation of their monitoring instructions for the aging.* The following documentation supports the MCP's efforts to correct this finding: **POLICIES AND PROCEDURES** • Updated CCM ICP workflow requires the completion of ICPs for all members in CCMCMDM Nurses training PowerPoint instructs staff on completing ICPs. • The Plan revised its CCM ICP workflow and added the requirement that all staff complete ICPs for all members in CCM. • The Plan developed a monitoring workflow. **MONITORING AND OVERSIGHT** • Revised CM Ageing Report from 9/24/21 • Complex Case Management Monitoring Workflow requires the monitoring of cases by reviewing the Aging Report weekly to confirm Care Plan is complete within 7 days of Complex

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				Assessment completion. • Monitoring of CM 2021 spreadsheet confirmation of MCP's monitoring of ICP Completion along with monitoring method instructions. • The Plan revised its CM Aging Report to capture completion of ICPs for daily management and reporting outcomes. Revised CM Ageing Report from 9/24/21. • The Plan will routinely monitor completion of the ICPs. Monitoring of CM 2021 spreadsheet confirmation of MCP's monitoring of ICP Completion along with monitoring method instructions. • The Plan will report outcomes at UMC quarterly. **TRAINING** • The Plan re-trained staff to complete ICPs for all members in CCM. CMDM Nurses training PowerPoint instructs staff on completing ICPs. **The corrective action plan for finding 2.2.1 is accepted.**
2.2.2 Individualized Care Plan Development The Plan did not ensure development of care plans in collaboration with the	1. The Plan re-trained staff on policy regarding developing care plans in collaboration with PCP. 2. The Plan will revise its CM Aging Report to capture the date the letter regarding	1. 2.2.1 - 2.2.3 - Training Materials and Sign-In Sheet 9.16.21	1. Completed 09/16/2021 2. 10/01/2021	The following documentation supports the MCP's efforts to correct this finding: **POLICIES AND PROCEDURES** • Revised CM Aging Report from 9/24/21 to capture the date letter regarding care plan sent to PCP.

Deficiency Number and Finding	Action Taken	Supporting Documentation	Implementation Date* (*Short-Term, Long-Term)	DHCS Comments
PCP.	Care Plans was sent to the PCP. 3. The Plan will monitor, on an ongoing basis, the CM Aging Report to ensure CP letters are being sent to PCPs. 4. The Plan will report outcomes to UMC quarterly.		3. 10/01/2021 4. Q4 2021	**MONITORING AND OVERSIGHT** • Monitoring of CM 2021 spreadsheet is confirmation that MCP is monitoring the date the care plan letter is sent to PCP. • The Plan affirmed its monitoring efforts, on an ongoing basis. Monitoring of CM 2021 spreadsheet is confirmation that MCP is monitoring the date the care plan letter is sent to PCP. • The Plan will report outcomes to UMC quarterly. **TRAINING** • The MCP conducted staff training relating to policies and procedures and revised their case management aging report to document when the letter was sent to the PCP and assist with the monitoring process. • CMDM Nurses training PowerPoint instructs staff on care plans and PCP collaboration. • The Plan re-trained staff on policy regarding developing care plans in collaboration with PCP. **The corrective action plan for finding 2.2.2 is accepted.**

Deficiency Number and Finding	Action Taken	Supporting Documentation	Implementation Date* (*Short-Term, Long-Term)	DHCS Comments
2.2.3 Complex Case Management Activities and Duration The Plan did not conduct periodic evaluations to ensure the provision of CCM based on the member's medical needs. The Plan did not implement procedures for monitoring time frame standards or maintaining monthly contact with members.	1. The Plan developed a workflow to maintain regular contact with members and ensure that the continuation of CCM is based on medical needs by using the Complex Criteria Checklist. 2. The Plan conducted staff training. 3. The Plan will revise its CM Aging Report to capture provision of CCM and maintaining monthly contact with member. 4. The Plan will monitor, on an ongoing basis, the CM Aging Report. 5. The Plan will report outcomes quarterly to UMC.	1.a. 2.2.3_1_ Complex CM Workflow 1.b. 2.2.3_1b_ Complex Case Management Criteria 2. 2.2.1 - 2.2.3 – Training Materials and Sign-In Sheet 9.16.21	1. Completed 09/15/2021 2. Completed 09/16/2021 3. 10/01/2021 4. 10/01/2021 5. Q4 2021	The following documentation supports the MCP's efforts to correct this finding: **POLICIES AND PROCEDURES** • CCM workflow requires the maintenance of regular contact with the member and continuation of CCM based on medical needs through the use of complex case criteria checklist. **MONITORING AND OVERSIGHT** • Revised CM Aging Report from 9/24/21 is used to verify member contact by verifying each case. • MCP's written response (1/5/22) clarifies the MCP's CM Aging report monitoring process. The MCP validates the member comments in the ageing report by comparing them to TruCare on a monthly basis. • Monitoring of CM 2021 spreadsheet demonstrates the MCP has a process in place for monitoring regular contact to the member, duration and activities. **TRAINING** • Staff training on the use of the complex criteria check list every three months if case remains open. **The corrective action plan for finding 2.2.3 is accepted.**

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2.2.4 Timely Charting of Interdisciplinary Team Rounds Notes The Plan did not ensure that IDT assessments were included in the updating of members' care plans. The Plan did not ensure timely documentation of the IDT meeting notes.	1. The Plan created an additional column in the Complex Case Log to monitor timely entry of IDT Round note into system of record. 2. The Plan will develop a workflow for staff to include the IDT note in the updated care plans. 3. The Plan will develop a monitoring workflow. Monitoring will be done on a bi-weekly basis. 4. The Plan conducted a staff training on the process. 5. The Plan will use Complex Case Log to monitor adherence to procedure. 6. The Plan will report outcomes quarterly to UMC.	1. 2.2.4_1_Complex Case Log 2021 Redacted 4. 2.2.1 - 2.2.3 - Training Materials and Sign-In Sheet 9.16.21	1. Completed 05/01/2020 2. 10/01/2021 3. 10/11/2021 4. Completed 09/16/2021 5. 10/11/2021 6. Q1 2022	The following documentation supports the MCP's efforts to correct this finding: **POLICIES AND PROCEDURES** • Complex case log was updated to include a column with IDT Round notes. It will be monitored to verify that the IDT notes are placed in TruCare. **MONITORING AND OVERSIGHT** • Complex Case Management Workflow was updated to require the incorporation IDT notes in the care plan. The MCP has incorporated a verification procedure (see CCM log) to monitor timely documentation of IDT notes. The MCP will allow only 7 days and then the person will be notified via email if they haven't. • Complex Case Log is monitored to verify IDT notes are placed in TruCare. • Complex Case Monitoring Log is used to monitor timely documentation of IDT notes. **TRAINING** • Staff training from 9/16/21 included a segment on timely documentation of IDT notes. *DHCS Comment: The Plan modified its workflow to include presenting at IDT round, IDT notes are to be incorporated into the Care Plan. The Plan monitors timely documentation of IDT notes through its modified Complex Case Log which now has a column*

Deficiency Number and Finding	Action Taken	Supporting Documentation	Implementation Date* (*Short-Term, Long-Term)	DHCS Comments
				for verifying entry of IDT notes into their system of record (TruCare). Plan monitors adherence to procedure on a biweekly basis with the use of a monitoring log which was provided. Staff was trained on this process during their 9/16/21 meeting. **The corrective action plan for finding 2.2.4 is accepted.**
2.5.1 Memorandum of Understanding with the County Mental Health Plan The Plan's MOU with the county MHP did not meet all the requirements specified in APL 18-015.	1. The Plan will conduct annual meetings with the County to ensure that the MOU is being updated (when appropriate). 1.a. The Plan will develop meeting minutes to demonstrate topic of discussions. The Plan will submit meeting minutes to DHCS. 2. The Plan's internal departments will work together to ensure clinical and quality components that are not present be updated in the MOU to reflect the requirements in APL-018.		1. 01/01/2022 2. 01/01/2022	The following documentation supports the MCP's efforts to correct this deficiency: **TRAINING** • Meeting Agenda, "Virtual Alameda Alliance and Alameda County Behavioral Health Joint Operations Q1 2022 Meeting" (01/31/22) which provides evidence of documented review and discussion of the MOU and requirements for APL18-015. **POLICIES AND PROCEDURES** • The drafted MOU was sent to County Behavioral Health on 12/17/21 in preparation of 01/31/22 JOM meeting. • MOU, "DRAFTED Memorandum of Understanding between Alameda Alliance for Health and Alameda County Behavioral Health Care Services" includes reporting and quality improvement requirements of APL-18-015. **MONITORING AND OVERSIGHT** • Tracker, "Alliance Behavioral Health MOU Tracker", (created 12/21) as evidence that the Plan will capture any yearly updates as a result of new APL's or other regulatory requirements of changes.

Deficiency Number and Finding	Action Taken	Supporting Documentation	Implementation Date* (*Short-Term, Long-Term)	DHCS Comments
				• Bi-Monthly Meeting, “ACBH and AAH” (01/13/22) as evidence of discussion of care coordination, members stepping up and down, and QI metrics. • PowerPoint Presentation, “Mild-to-Moderate MH and Autism Spectrum Disorder Services” (01/13/22) was presented at the 01/13/22 bi-monthly meeting. **MOU Update:** • APLs 18-009 and 18-015 relating to Memorandum of Understanding (MOU) requirements are both being retired. • APL 23-029 Memorandum of Understanding Requirements for Medi-Cal Managed Care Plans and Third Party Entities was released on 10/11/23. • The APL clarifies the intent of MOU requirements and contains templates with general provisions and templates tailored for certain programs. • MCPs will be required to make a good faith effort to execute MOUs with other parties by 1/1/24, 7/1/24, or 1/1/25 as outlined in the APL. **The corrective action plan for finding 2.5.1 is accepted.**
2.5.2 MOU Quality Improvement Requirements The Plan’s MOU with the county MHP did	1. The Plan will establish a cross-functional workgroup to develop specific P&Ps and QI performance metrics, in addition to referral and care		1. 12/01/2021	The following documentation supports the MCP’s efforts to correct this deficiency: **POLICIES AND PROCEDURES** • DRAFTED P&P, QI-136: “Behavioral Health Quality Improvement

Deficiency Number and Finding	Action Taken	Supporting Documentation	Implementation Date* (*Short-Term, Long-Term)	DHCS Comments
not specify policies, procedures, and reports to address QIs requirements specified in APL 18-015. The Plan did not conduct semi-annual calendar year reviews of referral and care coordination processes, generate semi-annual reports, or develop performance measures and QI initiatives during the audit period	coordination reports.			Oversight and Care Coordination", establishes the appropriate structure and mechanism to perform oversight of behavioral health Quality Management and Utilization Management activities to demonstrate compliance with MOU and regulatory requirements. **MONITORING AND OVERSIGHT** • Matrix, "AAH and ACBHS Semi-Annual Reporting Matrix, provides semi-annual reporting requirements. • Meeting Agenda, "Virtual Alameda Alliance and Alameda County Behavioral Health Joint Operations Q1 2022 Meeting" (01/31/22) which provides evidence of documented review and discussion of the MOU requirements for APL18-015, and collaboration to define the QI reporting metrics/future reporting review and schedule. In addition, the January 2020 – December 2021 PQI Dashboard will be presented. • An email (01/28/22) which includes a description of the Plan's process for monitoring to evaluate referral and coordination of care processes for members across both entities. In addition, outcomes of the ongoing performance metrics will be used to develop QI initiatives between AAH and ACBH regarding referrals and coordination of care for medical/physical and mental health needs across settings. **IMPLEMENTATION** • MOU, "DRAFTED Memorandum of Understanding between Alameda Alliance for Health and Alameda County Behavioral Health Care Services" includes reporting and quality

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				improvement requirements of APL-18-015, page 16 of MOU. • An email (01/28/22) which states, "At the AAH-ACBH meetings the Plan will coordinate with the county to develop semi-Annual calendar year reviews of referral and care coordination process. **MOU UPDATE** • APLs 18-009 and 18-015 relating to Memorandum of Understanding (MOU) requirements are both being retired. • APL 23-029 Memorandum of Understanding Requirements for Medi-Cal Managed Care Plans and Third Party Entities was released on 10/11/23. • The APL clarifies the intent of MOU requirements and contains templates with general provisions and templates tailored for certain programs. • MCPs will be required to make a good faith effort to execute MOUs with other parties by 1/1/24, 7/1/24, or 1/1/25 as outlined in the APL. **The corrective action plan for finding 2.5.2 is accepted.**
3.1.1 Extending Timeframes for Obtaining Appointments The Plan did not enforce and monitor	1. The Plan revised P&P QI-107 to include appointment extension language and will be submitted to committee for approval.	1. 3.1.1_3.1.2_QI-107 Appointment Access and Availability Standards_Extending Appt.	1. 10/01/2021	The following documentation supports the MCP's efforts to correct this finding: **POLICIES AND PROCEDURES** • QI-114 - Monitoring of Access and Availability (A&A) Standards ○ The Plan submitted a revised P&P directing A&A staff to review medical records (available through Grievances and

Deficiency Number and Finding	Action Taken	Supporting Documentation	Implementation Date* (*Short-Term, Long-Term)	DHCS Comments
providers' compliance with the requirement to document when timeframes for appointments were extended.	2. The Plan revised Timely Access Standards Provider Communication Sheet and will be submitted to committee for approval.	Timeframes_11_19_21 2. 3.1.1_2_Timely Access Standards_09172021 clean 3. 3.1.1_2021-Q1-Provider-Packet_web 4. 3.1.1_2021-Q2-3-Provider-Packet-for-web 5. 3.1.1_ExtendTimeframes Obtaining Appt 6. 3.1.1_February Capacity 2022 7. 3.1.1_Provider Manual 2022 8. 3.1.1_Provider Manual November 2021 9. 3.1.1_Q4-Provider-Packet_website	2. 10/01/2021	Appeals) to confirm that a longer waiting time will not have a detrimental impact on members' health • QI-105: Facility Site Reviews, Medical Record Reviews, and Physical Accessibility Review Surveys o The Plan revised their FSR P&P to confirm physicians monitor missed, canceled, and rescheduled appointments through periodic full scope, focused, and interim monitoring of FSR/MRR evaluations (page 4) **MONITORING AND OVERSIGHT** • FSR Process and PQI Grievance Processes (AAH_Narrative, page 2) o The Plan's first line of proactive monitoring providers' adherence to medical record documentation requirements is through their every-three-year FSR and PQI/Grievance process; CAPs are issued to providers as needed (page 4 of QI-114) • QI-114 - Monitoring of Access and Availability (A&A) Standards o If improper documentation is found, A&A staff will provide appropriate provider education (page 5) o (a) Based on results of the PAAS, QI staff will provide re-education on appointment availability standards and issue CAPs accordingly (page 3) o (b) The P&P also commits the Plan to randomly evaluate cases for appropriate documentation regarding members' appointment extensions on a semi-annual basis o A&A staff will also: o (c) checking claims data, to verify that members were not admitted or sent to an Emergency Department; when applicable, the case is escalated to the QI RN Supervisor o (d) conduct confirmatory to providers to assess timely

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				compliance; all outreach is tracked and trended for internal performance improvement and issuance of CAPs as needed (see CS Log)
				
				• CS Log (a part of the Access-Related PQI QOA Workflow)
				  ○ The Plan submitted a record of confirmatory survey calls to providers as a form of oversight, following up with trended data and non-compliant providers' offices.
				
				• Access & Availability Sub-Committee & Internal Quality Committee - Quarterly Review (see AAH_Narrative, page 3)
				  ○ The two committees meet quarterly to review PQI and Grievance trends to enforcing compliance once providers are found to be non-compliant.
				  ○ Root cause analyses and internal CAPs may be issued accordingly.
				
				• Non-Compliance CAP Letter - Provider Appointment Availability Survey (PAAS)
				  ○ The Plan implemented a more targeted CAP process for providers found non-compliant in this requirement by creating this letter following substandard PAAS results
				  ○ The letter template highlights Timely Access Standards and the specific timely access/extended timeframes requirements
				
				TRAINING
				
				• Provider Manuals and Packets
				  ○ The Plan revised and sent communications to remind network providers that extended wait times are acceptable if there are no detrimental effects on members' health
				  ○ Generally, the Plan educates the provider network through fax blasts, communication with Provider Relations, Facility Site Review education, and inclusion within CAPs issued to

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				non-responsive & non-compliant providers o The following documents demonstrate an effort to reiterate and communicate timely access requirements: o "ProvManual" (Page 24), "Q2_ProvPack" & "Q3_ProvPack (sections: Timely Access Standards, Page 19 and Page 3, respectively), "TimelyAccess" (Page 1) (See supporting documentation from 2022 CAP) **The corrective action plan for finding 3.1.1 is accepted.**
3.1.2 Monitoring Access to the First Prenatal Appointment The Plan did not continuously review, evaluate and improve access to and availability of the first prenatal appointment.	1. The Plan revised P&P QI-107 to indicate current Access Standards for First Prenatal Appointment from 2 weeks from date of request to 10 days for PCP OB/GYN and 15 days from request for OB/GYN Specialty Care. P&P will be submitted to committee for approval. 2. The Plan revised Timely Access Standards Provider Communications Sheet. 3. The Plan will be implementing a tracking and trending report of First Prenatal PQIs.	1. 3.1.2_1_QI-107 Appointment Access and Availability Standards_Revised Draft 2. 3.1.2_2_Timely Access Standards_09172021 clean 3. 3.1.2_3_First Prenatal Visit PQI Tracking Trending Log	1. 10/15/2021 2. 10/15/2021 3. 10/15/2021	The following documentation supports the MCP's efforts to correct this finding: **POLICIES AND PROCEDURES** • P&P QI-107, Appointment Access and Availability Standards (Rev.11/18/21): o The policy was updated to comply with the requirement of 10 business days from 2 weeks. • Timely Access Standards: o The Plan's submitted P&P includes revisions around the requirements regarding access & availability of the first prenatal appointment from 2 weeks to 10 business days. **TRAINING** • Various Final Signed Copies of Meeting Minutes: o Each copy of provided meeting minutes from the Plan confirms that monitoring reports/surveys are reviewed & evaluated by the appropriate committees to improve access to & availability of the first prenatal appointment. • QOA PQI Referrals Q1 2021-Q4 2021:

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				○ The Plan demonstrates a high-level overview of access-related PQI referrals specifically to access categories & provider types for Q1 – Q4 2021. ○ The report confirms that the Plan has sent out CAPs for contracted providers & delegates found to be non-compliant. **MONITORING AND OVERSIGHT** • P&P QI-114, Monitoring of Access and Availability Standards: ○ This policy details the Plan's monitoring & oversight process of contracted providers & delegates. (Page 1, Policy Statement) ○ The Plan clearly details the CAP process when a deficiency is found. (Page 7, CAPs) • FirstPrenatalVisit PQI TrackingTrendingLog_Q1 -Q4 2021: ○ The log encompasses the tracking & trending of various referrals with PQIs identified for Q1 – Q4 2021. ○ This log identifies the status, the outcome, any notes of outreach made by the Plan, & various other components that provide a clear picture of how the Plan is best resolving any QOA issues regarding first prenatal appointments. **The corrective action plan for finding 3.1.2 is accepted.**
3.4.1 Standing Referrals The Plan did not ensure standing referral determinations and processing were	1. The Plan will develop a standing referral workflow. 2. The Plan will update the AAH system of record for UM and CM, TruCare (TC) to add user define field in order to identify standing	1. 3.4.1 standing referral process flow 2. 3.4.1 Standing Referrals_Q4_ 2021 3. 3.4.1_ Standing	1. 10/28/2021 2. 11/29/2021	The following documentation supports the MCP's efforts to correct this finding: **POLICIES AND PROCEDURES** • "P&P Standing Referral Process" demonstrates The policy has been revised & updated to reflect the correct timeframes regarding standing referrals. The policy outlines the following:

Deficiency Number and Finding	Action Taken	Supporting Documentation	Implementation Date* (*Short-Term, Long-Term)	DHCS Comments
made within the required timeframes.	referral status to ensure correct TAT, which would include a reportable field for monthly reporting 3. The Plan will revise TruCare (TC) to capture timeframes for processing Standing Referrals. 4. The Plan will revise Authorization Aging report for day to day management and to report on timeframes for Standing Referrals. 5. The Plan will conduct staff training on standard work for Standing Referrals. 6. The Plan will monitor Standing Referral timeframes with the daily Authorization Aging report. 7. The Plan will report results quarterly to UMC.	Referral Process P&P 4. 3.4.1_3_TruCare indicator to capture timeframes for processing standing referrals 5. 3.4.1_4_ standing referrals identified on aging report 6. 3.4.1_5 _sign in sheet for standing referral staff training 11-16-21	4. 11/29/2021 5. 12/31/2021 6. 01/31/2022 7. 02/28/2022 8. Q2 2022	○ Policy language has been revised to 3 business days from the day of receipt. ○ The authorization duration may be given up to 1 year but is ultimately determined by MD reviewer. ○ Language added regarding the initial requests from a PCP for specialist/specialty center, for 3 or more office visits, service type updated to Standing Referral. • Standing Referral Process Workflow demonstrates a visual representation of the aforementioned standing referral P&P. The workflow outlines the following: ○ The language has been revised to 3 business days from the day of receipt. ○ The authorization duration may be given up to 1 year but is ultimately determined by MD reviewer. ○ Language added regarding the initial requests from a PCP for specialist/specialty center, for 3 or more office visits, service type updated to Standing Referral. ○ The P&P is directly linked in the workflow of which provides more detail of the Standing Referral Process. **TRAINING** • Standing Referrals_Q4_2021: ○ The PowerPoint slides demonstrate the Plan has provided staff with a re-education of Standing Referrals. ○ The training including the criteria & requirements for Standing Referrals. • Standing Referral Staff Training 11-16-21: ○ Provides the names of staff that were in attendance for the standing referral training, ensuring training was completed for

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				the re-education. • TruCare indicator to capture timeframes for processing standing referrals: o The Plan provided a screenshot ensuring it has included an indicator to capture the timeframe a standing referral was received to demonstrate determinations & processing are made within the required timeframes. **OVERSIGHT AND MONITORING** • Standing Referrals Identified on Aging Report: o The sample report demonstrates the Plan has included standing referrals on the Daily Aging Report – an issue that was identified in the report being the Plan was not capturing standing referral requests in its daily aging report, acknowledging the lack of tracking mechanism for standing referrals to be a gap in care. **The corrective action plan for finding 3.4.1 is accepted.**

Deficiency Number and Finding	Action Taken	Supporting Documentation	Implementation Date* (*Short-Term, Long-Term)	DHCS Comments
3.6.1 Denial of Claims The Plan improperly denied emergency services claims and family planning claims.	1. The Plan updated its monitoring report criteria to include a denial code (code:0630) which would allow us to identify claims prior to finalizing adjudication.	1. 3.6.1_1_ 04025_Emergency Services_Denied Claims_2021-09-16-14-02-05	1. 03/26/2021	The following documentation supports the MCP's efforts to correct this finding: **MONITORING AND OVERSIGHT** • The MCP updated its monitoring report criteria to include a denial code (code:0630) which would allow the MCP to identify claims prior to finalizing adjudication. • MCP conducts weekly audits to verify claims are not improperly denied. A majority were overturned on review of provider disputes or through the MCP's weekly audit. • MCP updates its claim system annually for enhancement and corrections. Error Code 630 was added to identify emergency claims improperly denied. The error code that was added is 630 and it appears in the report. The MCP also has attached an image of the claim in the Excel Spreadsheet showing that the MCP used the report to override the error message 630. • An Excel Spreadsheet, "Emergency Services Denied Claims" that includes the weekly report the MCP uses to identify emergency room claims that are denied for authorization issues. This helps verify the MCP does not ultimately deny these claims. **The corrective action plan for finding 3.6.1 is accepted.**

Deficiency Number and Finding	Action Taken	Supporting Documentation	Implementation Date* (*Short-Term, Long-Term)	DHCS Comments
3.6.2 Interest Payment The Plan did not pay interest for family planning claims not completely reimbursed within 45 working days of receipt.	1. The Plan reviewed the issue thru Claims Processor & Specialist training to ensure staff understands the issue that resulted in no interest. The trainings were completed in May 2021.	1. 3.6.2 _1_ HS-039 Emergency	1. May 2021	The following documentation supports the MCP's efforts to correct this finding: **POLICIES AND PROCEDURES** • Updated Workflow, "HS-039: Emergency" that now includes overriding the error code 630. This was presented to the entire Claims Department on May 10, 2021 (3.6.2_1_HS-039 Emergency, Page 1). **IMPLEMENTATION** • Screen shot, "HealthSuite" as evidence that the MCP's claims adjudication system is set to automatically add interest to Family Planning claims paid more than 45 business days from the claims received date. The screen shot is a Family Planning claim that shows the received date, paid date, and the auto generated interest amount (3.6.2_2e_ HealthSuite screenshot). **TRAINING** • Sign-off sheets, "Claim Level I Training (ER/Timely)" and Outlook Meeting Notices (May 2021) as evidence that the MCP staff received training. The subject of paying interest was covered in both of these trainings to confirm that no Processor manually turns off the ability to automatically calculate interest by the system (3.6.2_(2a)(2b)_Sign off sheet Claim level I JM_FAS 05.10.21, 3.6.2_2c_5.3.2021 Timely Filing Training, 3.6.2_2d_5.21.2021_JM_FAL Training). **MONITORING AND OVERSIGHT**

Deficiency Number and Finding	Action Taken	Supporting Documentation	Implementation Date* (*Short-Term, Long-Term)	DHCS Comments
				• Excel Spreadsheet, "HS Claims Interest Monitoring Report" (10/30/21 – 3/11/22) as evidence that the MCP is generating weekly interest monitoring reports to confirm accurate interest is paid and to review for high dollar interest amounts (HSClaims_InterestMonitoringReport_10-30-21_3-11-22). **The corrective action plan for finding 3.6.2 is accepted.**
3.8.1 NEMT providers Medi-Cal Enrollment Status The Plan did not ensure its transportation broker's NEMT providers were enrolled in the Medi-Cal program.	1. The Plan notified its transportation broker that remaining unenrolled NEMT providers need to complete PAVE application by 12/01/2021. 2. The Plan will audit transportation broker providers to ensure drivers are enrolled in the Medi-Cal program. This was last completed August 27, 2021. Monitoring will be conducted on an annual basis.	1. 3.8.1_1_ModivCare_NEMT provider enrollment 2. 3.8.1_2a_20210823 Future Medical DHCS Emergency Letter 3. 3.8.1_2b_20210825 Alameda Alliance ModivCare Transportation Provider Roster Template 8-18	1. 12/01/2021 2. 09/01/2022 (audit and monitoring)	The following documentation supports the MCP's efforts to correct this finding: **POLICIES AND PROCEDURES** • Updated P&P "UM-016 Transportation Guidelines" demonstrates the Plan will be tracking that transportation brokers are complying with all requirements set forth in APL 22-008, occurring no less than quarterly, including but not limited to Enrollment Status. The P&P also demonstrates the Plan has a corrective action process in place & will impose on its transportation brokers & providers should non-compliance be identified through monitoring activities. [AAH Monitoring & Oversight, Page 7] **MONITORING AND OVERSIGHT** • P&P "UM-016" demonstrates the Plan monitors & oversees transportation through verification of broker/provider roster, ensuring its transportation broker's NEMT providers are enrolled in the Medi-Cal program, occurring no less than quarterly. [Transportation Brokers, Page 5 & 7] • AAH Transportation Roster "NMT_NEMT_Roster" demonstrates the Plan is tracking enrollment of transportation providers. The roster reflects the Plan's monthly notes of checking status for

Deficiency Number and Finding	Action Taken	Supporting Documentation	Implementation Date* (*Short-Term, Long-Term)	DHCS Comments
				providers through the open data portal that are currently pending. **The corrective action plan for finding 3.8.1 is accepted.**
3.8.2 Physician Certification Statement Form Requirement The Plan did not require PCS forms for NEMT services.	1. The Plan will require transportation vendor to provide ongoing reports on rates of obtaining PCS forms from providers: 2. The Plan will analyze trends in provider practices on a quarterly basis. 3. The Plan will educate providers on PCS requirements and provide data on their performance: 3.a. Provider newsletter 3.b. Individual office contacts 4. The Plan will finalize process workflow to obtain missing PCS forms. 5. The Plan will conduct staff trainings on process workflow. 6. The Plan will provide a		1. 10/28/2021 2. Q4 2021 3.a. Q4 Provider Newsletter 3.b. Q1 2022 4. 10/16/2021 5. 11/30/2021 6. 12/31/2021	DHCS has identified that finding 3.8.2 was a repeat finding on the subsequent 2022 and 2023 Medical Audits; therefore, DHCS will assess full remediation for the finding 3.8.2 in the superseding 2023 Corrective Action Plan (CAP). The open finding is transferred to the subsequent CAP which has the same finding.

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	quarterly report to UMC.			
4.1.1 Review of Quality of Care (QOC) Grievances The Plan did not ensure that the medical director fully resolved QOC grievances prior to sending resolution letters.	1. The Plan updated G&A-003 Grievance and Appeals Receipt, Review and Resolution to include the process for the medical director's review and resolution of all levels of quality of care grievances prior to sending a resolution letter to members. The policy will be reviewed at the Health Care Quality Committee on November 18, 2021 and the Compliance Committee Meeting on November 23, 2021. 2. The Plan will provide training to the medical directors to review G&A-003 Grievance and Appeals Receipt, Review and Resolution by November 30, 2021.	1. 4.1.1_1_GA-003 Grievance Receipt Review and Resolution_092221_DRAFT	1. 11/18/2021 2. 11/30/2021	The following documentation supports the MCP's efforts to correct this finding: **POLICIES AND PROCEDURES** • Policy GA-003 was updated to include the requirement that medical director must resolve grievances related to quality of care. (Page 2) **TRAINING** • Medical Director Review Workflow for Quality of Care Grievances describes the specific steps the Medical Director takes to review a QOC grievance. Process implemented as of 2/1/22. • Grievance system MD training demonstrates the MCP has trained staff on the necessity of MD review of QOC grievances prior to resolution. **MONITORING AND OVERSIGHT** • Q1 2022 Internal G&A Audit results demonstrates the MCP's auditing for Medical director review of QOC grievances is now active. **The corrective action plan for finding 4.1.1 is accepted.**

Deficiency Number and Finding	Action Taken	Supporting Documentation	Implementation Date* (*Short-Term, Long-Term)	DHCS Comments
4.1.2 Grievance Classification and Processing The Plan did not consistently implement its procedure for processing grievances. The Plan considered member's grievances resolved and classified as exempt without conducting investigation.	1. The Plan is updating its policy and procedures for processing Exempt Grievances to reflect its current process. The policy MBR-0024 will be reviewed at the Compliance Committee Meeting on November 23, 2021. 2. The Plan will provide staff training by November 30, 2021.	1. 4.1.2_1_MBR-0024 Exempt Grievances_P&P_clean	1. 11/23/2021 2. 11/30/2021	The following documentation supports the MCP's efforts to correct this finding: **POLICIES AND PROCEDURES** • Training Manual 2021 Unit 5 G&A contains section on proper classification of exempt grievances. **MONITORING AND OVERSIGHT** • MBR – 0024 "Exempt Grievances" commits the MCP to the monitoring activities: o The exempt grievance report is monitored monthly and analyzed to identify trends of complaints and areas needing further review. o Exempt grievances are reviewed daily by the Member Services Supervisor and/or designee in the QualitySuite and coded appropriately for reporting purposes. o The QA Specialist reviews a random sample of call recordings to verify that exempt grievances are logged accurately and resolved in a timely manner. o The G&A Unit will track and trend exempt grievances, grievances, and appeals by provider type, specialty type, delegates, specific-provider/provider groups and reporting monitoring activities to the Access & Availability Committee, Compliance Committee, Ongoing Monitoring Workgroup, and Health Care Quality Committee as applicable. • Misclassified Trend Report tracks the misclassified calls by month and by agent. Demonstrates MCP is actively monitoring. • Q3 2021 G&A Report demonstrates the MCP conducts on going monitoring of its G&A program including the classification of

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				exempt grievance. The MCP's compliance rate for exempt grievances was 99.6% for Q3 2021. **TRAINING** • MSD G&A training roster and agenda from 11/19/21 and G&A Cheat Sheet demonstrates the MCP is training its staff on the appropriate classifications and processing of member grievances. **The corrective action plan for finding 4.1.2 is accepted.**
4.1.3 Grievance Notification and Letter Timeframes The Plan did not send acknowledgement and resolution letters within the required timeframes. The Plan did not promptly notify the members that expedited grievances would not be resolved within the required timeframe.	1. The Plan provided training to the Grievance and Appeals staff to review G&A-003 Grievance and Appeals Receipt, Review and Resolution and G&A-005 Expedited Review of Urgent Grievances. The staff attested that they understood the requirements and will ensure that acknowledgement and resolution letters are sent within the required timeframes, and to also notify members when expedited grievances would not be resolved within the required timeframe.	1.a. 4.1.3-4.1.5_1a_Grievance System Training 1.b. 4.1.3-4.1.5_1b_Grievance System Training_Sign-In Sheet	1. 09/21/2021	DHCS has identified that finding 4.1.3 was a repeat finding on the subsequent 2022 and 2023 Medical Audits; therefore, DHCS will assess full remediation for finding 4.1.3 in the superseding 2023 Corrective Action Plan (CAP). The open finding is transferred to the subsequent CAP which has the same finding.

Deficiency Number and Finding	Action Taken	Supporting Documentation	Implementation Date* (*Short-Term, Long-Term)	DHCS Comments
4.1.4 Grievance Letters in Threshold Languages The Plan did not send acknowledgement and resolution letters in threshold languages.	1. The Plan provided training to the Grievance and Appeals staff to review G&A-001 Grievance and Appeals System Description and CLS-003 Language Assistance Services. The staff attested that they understood the requirements and will ensure that acknowledgement and resolution letters are sent to members in their threshold languages.	1.a. 4.1.3-4.1.5_1a_Grievance System Training 1.b. 4.1.3-4.1.5_1b_Grievance System Training_Sign-In Sheet	1. 09/21/2021	DHCS has identified that finding 4.1.4 was a repeat finding on the subsequent 2022 and 2023 Medical Audits; therefore, DHCS will assess full remediation for finding 4.1.4 in the superseding 2023 Corrective Action Plan (CAP). The open finding is transferred to the subsequent CAP which has the same finding.
4.1.5 Grievance Resolution / Grievance Process The Plan did not consistently resolve grievances prior to sending resolution letters.	1. The Plan provided training to the Grievance and Appeals staff to review G&A-001 Grievance and Appeals System Description. The staff attested that they understood the requirements and will ensure that grievances are fully resolved prior to sending resolution letters.	1.a. 4.1.3-4.1.5_1a_Grievance System Training 1.b. 4.1.3-4.1.5_1b_Grievance System Training_Sign-In Sheet	1. 09/21/2021	Finding 4.1.5 was a repeat finding 4.1.4 on 2022 medical audit. The following documentation supports the MCP's efforts to correct this finding. (Supporting documentation from 2022 CAP, finding 4.1.4) **Policy** • Plan policy *G&A-001 Grievance and Appeals System Description* (revised 1/21/21) stated the Plan verifies that each issue is addressed and resolved when a complainant presents with multiple issues. Resolved means that the grievance has reached a final conclusion with respect to the enrollee's submitted grievance. (2022 Medical Audit Report CAF, 4.1.4) **Training** • Training agenda and PowerPoint from 8/9/22 demonstrate the MCP has provided additional training to the Grievance & Appeals staff ensuring the resolution letter clearly addresses all of the member's concerns.

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				Monitoring • Narrative from 10/7/22 and SG Checklist demonstrated the MCP has a process in place for the QA Specialist review all letters for the addressing of all the member's concerns prior to sending. • The MCP's real time review of grievances involves the Quality Assurance Specialist. The Quality Assurance Specialist will review the case and if the resolution letter is not addressing all the member's concerns or has grammatical errors, the letter will be emailed back to the Coordinator for updating. Once updated, the letter is emailed back to the Quality Assurance Specialist for review again. If there are no other updates needed the letter is emailed back to the Coordinator advising the case can be closed. • The MCP has created a review checklist to be used during real time review beginning on 1/16/23. • Weekly QAS Case Review demonstrates the MCP monitors for resolution of all grievances prior to mailing resolution letter. **The corrective action plan for finding 4.1.5 is accepted.**
4.3.1 Reporting of Health Insurance Portability and Accountability Act (HIPAA) Incidents and Disclosures The Plan did not report suspected security incidents or	1. To address staffing needs, the Plan has streamlined its Compliance Department and now has a dedicated staff member who focuses on Privacy. This FTE was hired on February 22, 2021. 2. The Plan reviewed and updated CMP-013 HIPAA	1. 4.3.1_1_Compliance Org Chart 2. 4.3.1_2_CMP-013 HIPAA	1. 02/22/2021 2. 11/30/2021	The following documentation supports the MCP's efforts to correct this finding: • "Compliance Org Chart," to address staffing needs, the Plan has streamlined its Compliance Department and now has a dedicated staff member who focuses on Privacy. This FTE was hired on February 22, 2021 (4.3.1_1_Compliance Org Chart). **POLICIES AND PROCEDURES**

Deficiency Number and Finding	Action Taken	Supporting Documentation	Implementation Date* (*Short-Term, Long-Term)	DHCS Comments
unauthorized disclosures of PHI to DHCS within 24 hours of discovery, did not provide an updated investigation report within 72 hours, and did not submit a complete report of the investigation within ten working days.	Privacy Reporting to reflect the 24hr, 72hr and 10-day reporting requirements. This policy is scheduled to be reviewed and approved at the Compliance Committee on November 23, 2021.	Privacy Reporting_Draft		• Updated P&P, "CMP-013: HIPAA Privacy Reporting" to reflect the 24hr, 72hr and 10-day reporting requirements. This policy is scheduled to be reviewed and approved at the Compliance Committee on November 23, 2021 (4.3.1_2_CMP-013 HIPAA Privacy Reporting_Draft, Page 2). **TRAINING** • PowerPoint training, "2021 HIPAA Privacy Overview" (July 2021 – December 2021) and "FWA/HIPAA Training by Department" calendar as evidence that MCP staff received training on privacy requirements and privacy protocol. The training explains the reporting timelines of suspected security incidents or unauthorized disclosures of PHI to DHCS within 24 hours of discovery, provide an updated investigation report within 72 hours, and submit a complete report of the investigation within ten working days 2021 (HIPAA Privacy Overview – Departmental, Slide 24, and Schedule - Department Training). **MONITORING AND OVERSIGHT** • Excel Spreadsheet, "2021 HIPAA Incident Tracking Log" as evidence that the MCP has a tool to track the timely reporting of suspected security incidents or unauthorized disclosures of PHI to DHCS within 24 hours of discovery, providing an updated investigation report within 72 hours, and submitting a complete report of the investigation within ten working days (2021 HIPAA Privacy Incident Log). • An email (04/05/22) which includes a description of the MCP's improvements to infrastructure and workflow and training efforts.

Deficiency Number and Finding	Action Taken	Supporting Documentation	Implementation Date* (*Short-Term, Long-Term)	DHCS Comments
				A separate compliance team was developed to address Privacy matters only. A dedicated Privacy Resource was hired, the Privacy Compliance Specialist. The MCP developed a dedicated Privacy Email to triage and immediate address privacy related questions and referrals. The MCP instituted the Privacy & Security Joint Taskforce/Workgroup to oversee and develop corporate direction and strategy. The MCP instituted the release of periodic work-from-home MEMOs to reiterate Privacy Rules and best practices for a remote workforce. Beginning July 2021 and ending in February 2022, HIPAA Privacy training was delivered to each Department at the MCP. The training covered the Plan reporting timelines for suspected Privacy incidents. A training was also provided at an all staff, company-wide meeting in July 2021. New employee Onboarding Training includes suspected incident reporting timelines (2021 DHCS CAP deliverable for finding 4.3.1 additional Q 4_5_22, Page 1). **The corrective action plan for finding 4.3.1 is accepted.**
6.2.1 Fraud and Abuse Reporting The Plan did not conduct and report preliminary investigations of all suspected cases of fraud and abuse to DHCS within ten working days.	1. The Plan has a dedicated staff member in the Special Investigations Unit (SIU) to focus on Fraud, Waste and Abuse FWA cases. This FTE was hired on June 25, 2021. 2. The plan updated CMP-002 to reflect reporting requirements. This policy is scheduled to be re-approved at the Compliance Committee on Nov 23, 2021.	1. 6.2.1_1_Compliance Org Chart 2. 6.2.1_2_CMP 002 Fraud, Waste, and Abuse_DRAFT	1. 06/25/2021 2. 12/01/2021	The following documentation supports the MCP's efforts to correct this finding: **POLICIES AND PROCEDURES** • "Audits & Oversight Department Organization Chart" as evidence that the MCP has hired on 6/25/2021 a dedicated staff member in the Special Investigations Unit (SIU) to focus on Fraud, Waste and Abuse FWA cases. • Updated P&P, "CMP-002: Fraud, Waste, and Abuse" (11/12/21) that states that the Compliance Department will submit the confidential DHCS Complaint Form (MC609) to DHCS Program Integrity Unit with the required reporting information along with the preliminary investigation summary and supporting

Deficiency Number and Finding	Action Taken	Supporting Documentation	Implementation Date* (*Short-Term, Long-Term)	DHCS Comments
				documents; supporting document may include, but not limited to: enrollee confirmation, provider confirmation, and a claims screenshot (page 3). **TRAINING** • PowerPoint training, "Fraud, Waste, & Abuse (FWA) and HIPAA Overview" (07/28/21) as evidence that MCP staff received training. The training included information on the requirement that the MCP is required to notify DHCS of any potential FWA incident reported within 10 working days from the date of first discovery (slide 13). **MONITORING AND OVERSIGHT** • Excel Spreadsheet, "2021 FWA Incident Log" as evidence that the MCP is tracking FWA investigations. The FWA Incident Log includes a column where it tracks the Initial Reporting TAT (10 working days). • "FWA Tracker" (February 2023 – May 2023) to demonstrate that the root cause was remediated. The root cause was that the MCP's other internal departments failed to notify the Compliance Department within a timely manner of the discovery leading to a further delay in reporting to DHCS. The FWA Tracker shows that the MCP is compliant with the turnaround timeline of initial reporting to the Compliance Department. (Feb23-May23_FWA). • "FWA Incidents" (April 2022 – January 2023) to demonstrate that the MCP has a monitoring tool in place to track the reporting of preliminary investigations of all suspected cases of fraud and abuse to DHCS within 10 working days of the Plan receiving notification of the incident. The following categories monitored are as follows: Date of the Incident, Date Received by AAH, Date

Deficiency Number and Finding	Action Taken	Supporting Documentation	Implementation Date* (*Short-Term, Long-Term)	DHCS Comments
				Received by Compliance, Initial Reporting TAT (10 Working Days), Updated Reporting to DHCS (Every 2 weeks), Reporting & Close Out Due Date to DHCS (90 Cal Days). (April22-Jan23_FWA). The MCP demonstrated that self-monitoring procedures are in place to prevent future non-compliance. **The corrective action plan for finding 6.2.1 is accepted.**
6.2.2 Annual Overpayment Reporting The Plan did not report recoveries of overpayments to DHCS annually.	1. The Plan has updated CMP-002, Fraud, Waste and Abuse to meet reporting requirements. This policy is scheduled to be reviewed and approved at the Compliance Committee on Nov 23, 2021.	1. 6.2.2_1_CMP-002 Fraud, Waste, and Abuse_DRAFT	1. 12/01/2021	The following documentation supports the MCP's efforts to correct this finding: **POLICIES AND PROCEDURES** • Updated P&P, "CMP-002 Fraud, Waste, and Abuse" Abuse to meet reporting requirements. This policy is scheduled to be reviewed and approved at the Compliance Committee on Nov 23, 2021. • P&P states that, "The Alliance Special Investigations Unit (SIU) reports FWA incidents to the regulatory agencies within the required timeframes and reports recoveries of overpayments to DHCS on an annual basis." • P&P states that, "Recoveries of overpayments are reported to DHCS on an annual basis. Recoveries will be reported no later than the last business day of January of the new calendar year and will reflect overpayments collected during the prior calendar year." **MONITORING AND OVERSIGHT**

Deficiency Number and Finding	Action Taken	Supporting Documentation	Implementation Date* (*Short-Term, Long-Term)	DHCS Comments
				• "Fraud Reporting Workflow," which explains the MCP's process for reporting and investigating fraud, waste, and abuse incidents. The MCP logs the initial report into the incident reporting log. The MCP's Compliance Investigator will review the incident, request additional information, and will interview those involved in the case. A report is filed with DHCS within 10 working days of the date the incident was reported. The MCP's Compliance Investigator will take actions with appropriate staff until a resolution is obtained and will be documented in the FWA reporting log. **IMPLEMENTATION** • Screenshots of various upload confirmations (February 2021 – January 2022) to the DHCS Secure File Transfer Protocol/E-Transfer site. The upload confirmations serve as evidence that the MCP has implemented policies and procedures to annually report overpayment recoveries to DHCS. **The corrective action plan for finding 6.2.2 is accepted.**
SSS.1 Payment Distribution Timeframe The Plan did not distribute payments for State Supported Services claims within 90 calendar days as described in APL 19-013.	1. The Plan made changes to the claims system on 2/17/2021 and re-adjudicated all the previous claims paid incorrectly to pay the balance to the Prop 56 rate.	1. SSS.1-SSS.2_Abortion Rate Increase Claims 04.01.2021_current	1. 02/17/2021	The following documentation supports the MCP's efforts to correct this finding: **POLICIES AND PROCEDURES** • Written response by the MCP (01/11/22) which states that the claims system is set up to price these services at the Prop 56 rate and will follow the interest programming that states any claim paid after 45 working days incur interest automatically. Therefore, the Plan no longer tracks any of these to the 90-day threshold.

Deficiency Number and Finding	Action Taken	Supporting Documentation	Implementation Date* (*Short-Term, Long-Term)	DHCS Comments
				• The MCP also states that no training was needed, since the claims system pays these claims automatically the Plan no longer pends these claims for manual review. However, there was a system issue for the claims related to the findings that caused these to be misdirected to the MCP's delegated groups since they were out-of-area (OOA). This system configuration was corrected, and the claims no longer misdirect due to OOA, the Plan's claims system automatically processes these claims for payment. **MONITORING AND OVERSIGHT** • Excel Spreadsheet, "Interest Monitoring Report" (February 2022) as evidence that the MCP is monitoring claims payment. The MCP reviews this report at least monthly by a cross-functional workgroup consisting of Claims, Healthcare Services (UM) and IT staff to review for trends and identify root cause and resolution related to identified errors. This workgroup would identify interest issues within a reasonable timeframe since it meets bi-weekly. • Excel Spreadsheet, "Claims TAT by Check-Run Report" (3/4/22) as evidence that the MCP is monitoring claims payment. The MCP reviews this report weekly after the check-run is complete. It lists all claims TAT that are over 60 days old on the check-run and if any interest incurred. The interest is incurred at 63 days and older. Since this is reviewed weekly, any interest issues would be caught within a week. • Excel Spreadsheet, "Abortion Rate Increase Claims 04.01.2021 – Current" as evidence that the MCP made changes to the claims system on 2/17/2021 and re-adjudicated all the previous claims paid incorrectly to pay the balance to the Prop 56 rate. This report shows that that MCP paying all our SSS services at

Deficiency Number and Finding	Action Taken	Supporting Documentation	Implementation Date* (*Short-Term, Long-Term)	DHCS Comments
				the higher rates. This report also shows an “Interest Amount” column to track the amount of interest paid. **The corrective action plan for finding SSS.1 is accepted.**
SSS.2 Interest Payment The Plan did not pay interest for State Supported Services claims processed beyond the 90 calendar day timeframe specified in *APL 19-013*.	1. The Plan made changes to the claims system on 2/17/2021 and re-adjudicated all the previous claims paid incorrectly to pay the balance to the Prop 56 rate. The claim system was also updated to pay interest at the normal timeline of claims adjudicated after 45 work days from the received date.	1. SSS.1-SSS.2_Abortion Rate Increase Claims 04.01.2021_current	02/17/2021	The following documentation supports the MCP’s efforts to correct this finding: **POLICIES AND PROCEDURES** • Excel Spreadsheet, “Abortion Rate Increase Claims 04.01.2021 – Current” as evidence that the MCP made changes to the claims system on 2/17/2021 and re-adjudicated all the previous claims paid incorrectly to pay the balance to the Prop 56 rate. This report shows that that MCP paying all our SSS services at the higher rates. This report also shows an “Interest Amount” column to track the amount of interest paid. • Written response by the MCP (01/11/22) which states that the claims system is set up to price these services at the Prop 56 rate and will follow the interest programming that states any claim paid after 45 working days incur interest automatically. Therefore, the Plan no longer tracks any of these to the 90-day threshold. • The MCP also states that no training was needed, since the claims system pays these claims automatically the Plan no longer pends these claims for manual review. However, there was a system issue for the claims related to the findings that caused these to be misdirected to the MCP’s delegated groups since they were out-of-area (OOA). This system configuration was corrected, and the claims no longer misdirect due to OOA, the Plan’s claims system automatically processes these claims

Deficiency Number and Finding	Action Taken	Supporting Documentation	Implementation Date* (*Short-Term, Long-Term)	DHCS Comments
				for payment. **MONITORING AND OVERSIGHT** • Excel Spreadsheet, “Interest Monitoring Report” (February 2022) as evidence that the MCP is monitoring claims payment. The MCP reviews this report at least monthly by a cross-functional workgroup consisting of Claims, Healthcare Services (UM) and IT staff to review for trends and identify root cause and resolution related to identified errors. This workgroup would identify interest issues within a reasonable timeframe since it meets bi-weekly. • Excel Spreadsheet, “Claims TAT by Check-Run Report” (3/4/22) as evidence that the MCP is monitoring claims payment. The MCP reviews this report weekly after the check-run is complete. It lists all claims TAT that are over 60 days old on the check-run and if any interest incurred. The interest is incurred at 63 days and older. Since this is reviewed weekly, any interest issues would be caught within a week. **The corrective action plan for finding SSS.2 is accepted.**
SSS.3 Denial of Claims The Plan improperly denied State Supported Services claims.	1. As of 8/7/2020 the Plan reconfigured the system to no longer re-suspend CHCN Non-Emergency Out of Area processed claims. In addition, the Claims workflow has been updated to accommodate the system change.	1. SSS.3_OOA Claims	2. 08/07/2020	The following documentation supports the MCP’s efforts to correct this finding: **POLICIES AND PROCEDURE** • Written response by the MCP (01/11/22) which states that the MCP’s claims system configuration that was changed, not the workflow. The system was recently updated to not misdirect these claims for Out of Area (OOA) to the MCP’s Delegated Groups. Prior to that the system was reconfigured to pay these

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				SSS services at the Prop 56 rates automatically as a part of the normal claims adjudication process. This includes to pay interest if they are paid after 45 working days. • The MCP also states that the Out of Area (OOA) claims now go into the MCP's claims system for processing and are paid automatically at the Prop 56 rates. Since the claims process automatically, there was no need to train claims processors on how to handle these claims manually. **MONITORING AND OVERSIGHT** • Excel Spreadsheet, "OOA Claims" as evidence that as of 8/7/2020 the MCP reconfigured the system to no longer re-suspend CHCN Non-Emergency Out of Area processed claims. • From Excel Spreadsheet, "OOA Claims": This report shows claims that had out-of-area (OOA) services that the MCP monitors for denials to confirm that none are for misdirection to a delegated group other than Kaiser (mssg 8199). All those listed under the Denied Delegate Group were denied for misdirection to Kaiser (see clm mssg column for codes 8199). The tab for ALW_SUS_DN does show claims with the mssg for misdirection for CHCN (mssg 8201) or CFMG (8198), but all were paid except one which was actually denied for duplicate (mssg 1385). • Excel Spreadsheet, "Interest Monitoring Report" (February 2022) as evidence that the MCP is monitoring claims payment. The MCP reviews this report at least monthly by a cross-functional

Deficiency Number and Finding	Action Taken	Supporting Documentation	Implementation Date* (*Short-Term, Long-Term)	DHCS Comments
				workgroup consisting of Claims, Healthcare Services (UM) and IT staff to review for trends and identify root cause and resolution related to identified errors. This workgroup would identify interest issues within a reasonable timeframe since it meets bi-weekly. • Excel Spreadsheet, “Claims TAT by Check-Run Report” (3/4/22) as evidence that the MCP is monitoring claims payment. The MCP reviews this report weekly after the check-run is complete. It lists all claims TAT that are over 60 days old on the check-run and if any interest incurred. The interest is incurred at 63 days and older. Since this is reviewed weekly, any interest issues would be caught within a week. **The corrective action plan for finding SSS.3 is accepted.**

Submitted by: Scott Coffin **Date: September 23, 2021**

Title: Chief Executive Officer