DHCS
CALIFORNIA DEPARTMENT OF
HEALTH CARE SERVICES
Michelle Baass | Director

November 3, 2023

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

RE: Department of Health Care Services Medical Audit

Dear Mr. Golfin:

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 4, 2022 through April 13, 2022. The audit covered the period of April 1, 2021 through March 31, 2022.

The items were evaluated and 4 of 15 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 2022 CAP with findings 3.8.1, 4.1.1, 4.1.2 and 4.1.3 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 2022 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
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Joshua Hunter, Lead Analyst
Audit Monitoring Unit
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**ATTACHMENT A**
**Corrective Action Plan Response Form**

**Plan:** Alameda Alliance for Health

**Review Period:** 04/01/2021 – 03/31/2022

**Audit Type:** Medical Audit and State Supported Services

**CAP Submitted:** 04/04/2022 – 04/13/2022

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.

| Finding Number and Summary | Action Taken | Supporting Documentation | Implementation Date* (*Short-Term, Long-Term) | DHCS Comments |
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| **1. Utilization Management** | | | | |
| **1.3.1 Acknowledgement Letters for Appeals**<br><br>The Plan did not send acknowledgement letters for standard appeals within the required timeframe of five calendar days. | The Daily Clerk Report is received daily by Grievance AND Appeals Clerks and Leadership. The report will be reviewed by the Grievance AND Appeals Leadership team to ensure acknowledgment letters are mailed timely.<br><br>The Plan provide training to the Grievance AND Appeals staff to review the regulatory requirements for mailing of acknowledgement letters. | 1.3.1 Clerk Report<br><br>1.3.1 Training.pdf<br><br>1.3.1 Training.pptx | Report: 10/1/2022<br><br>Training: 8/9/2022 | The following documentation supports the MCP's efforts to correct this finding:<br><br>**POLICIES AND PROCEDURES**<br><br>• 1.3.1_Clerk Ack Wrkflw (implemented 10/1/2022)<br>o Protocol document which describes a new internal monitoring process (a daily clerk report) in which the Daily Clerk Report is received by GANDA Clerks and Leadership five times [5] daily.<br>o The reports are regularly reviewed, at least daily, by GANDA Leadership to ensure compliance.<br>o GANDA Leadership prioritize and follow-up email Clerks regarding cases that have reached the 3-day mark; these cases often require research and are expedited to be sent out the same day if possible.<br><br>**TRAINING**<br><br>• 1.3.1_Training (PDF)<br>o Agenda for a GANDA Leadership meeting which included topics of standard and expedited appeals and grievances, acknowledgement and resolution letter requirements (including timeliness and content)<br>o An action item was created to resolve non-compliant cases before 8/3/22, allowing for over-time if needed.<br><br>• 1.3.1_Training (PowerPoint)<br>o Accompanying slides from 1.3.1_Training meeting wherein GANDA Leadership reviewed audit requirements.<br>o The Plan set an internal passing benchmark (95%) as a goal. |

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| | | | | • The Plan acknowledged that the root cause was understaffing during a period of high-volume cases. The Plan confirmed that additional staff were hired since then.<br>  ○ Two [2] new GANDA clerks and four [4] new GANDA coordinators were hired (hiring dates: 12/31/2021, 4/4/2022, 5/2/2022, 5/23/2022, 5/31/2022, 10/3/2022)<br><br>**MONITORING AND OVERSIGHT**<br><br>• 1.3.1_Clerk Ack Wrkflw (implemented 10/1/2022)<br>  ○ A new monitoring and oversight process involving GANDA Leadership and QA Specialists reviewing Clerks' cases daily<br>  ○ GANDA staff send emails following up with Clerks prompting research and if possible, requests the same day sending of an acknowledgement letter<br>  ○ If issues arise, the issue will be researched immediately in order to generate and send a letter before day 5<br>  ○ Please see details and elaboration above in PANDPs section<br><br>• 1.3.1_Daily Clerk Rpt<br>  ○ The Daily Clerk Report mentioned in the above workflow; contains a countdown indicating "# of days" for unresolved cases (Column J) in addition to other detailed metrics<br><br>• 1.3.1_ACK TAT<br>  ○ A log of 91 compliant acknowledgement letter cases ranging from August through October 2022, all of which were sent within five [5] days |

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| | | | | • 1.3.1_Dec_Ack_TAT<br>  ○ A log of 55 compliant acknowledgement letter cases ranging from November through December 2022, all of which were went within five [5] days<br>  ○ The Plan further indicated that these internal audits are conducted monthly<br><br>**The corrective action plan for finding 1.3.1 is accepted.** |
| **1.3.2 State Fair Hearing Request**<br><br>The Plan did not comply with existing APLs to notify members receiving a NAR that upholds an adverse benefit determination that they have an additional 120 days in addition to the initial 120 days allowed to request a SFH. | Your Rights enclosure was updated to reflect enrollees have 240 days to request a State Fair Hearing<br><br>Policy AND Procedure GANDA-007 State Hearings has been updated to reflect the member has 240 calendar days to request a State Hearing. | 1.3.2 P&P State Fair.pdf<br><br>1.3.2 Your Rights.pdf | Your Rights anticipated date: 10/7/2022<br><br>Policy AND Procedure anticipated date: TBD (requires committee review and approval) | The following documentation supports the MCP's efforts to correct this finding:<br><br>**POLICIES AND PROCEDURES**<br><br>• 1.3.2 PANDP State Fair.pdf<br>  ○ The Plan submitted draft policy GANDA-007 State Fair Hearings – it newly reflects the compliant time frame to request a State Fair Hearing (SFH) of 240 days per the Public Health Emergency (page 1)<br><br>The Plan stated that they made note of the regulatory change back to 120 calendar days at the conclusion of the PHE and will update the policy to reflect the change<br><br>• 1.3.2_Your Rights.pdf<br>  ○ The Plan revised Your Rights attachment to reflect the extended timeframe of 240 calendar days, which is subject to the PHE<br><br>**MONITORING AND OVERSIGHT** |

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| | | | | The Plan has confirmed the corrected Your Rights has been updated in the system and is currently in use (10/7/2022). The enclosure was updated in the system, the old enclosure with 120 calendar days was removed and the updated Your Rights that reflect 240 days was added.<br><br>In addition, the Plan is ensuring that future updates are in place once the PHE is over:<br><br>• The Plan has an internal department which is updating the Your Rights enclosure which will reflect the 120 days allowed for a State Hearing once the Public Health Emergency is over<br><br>• The policy will be updated and reviewed and submitted to the committee for approval prior to the end of the PHE. Once approved, the Plan will provide the approved policy for review.<br><br>**The corrective action plan for finding 1.3.2 is accepted.** |
| **1.5.1 Ownership and Control Disclosure Review for Utilization Management (UM) Subcontractors**<br><br>The Plan did not ensure that its subcontractors submitted complete | The Alliance has made updates to its Provider Services Standard Operating Procedure (SOP) – Ownership and Control Disclosure Reviews for Delegates. This includes an additional layer of review from the Alliance Compliance Department | 1.5.1 KaiserEmail.pdf<br><br>1.5.1 Blank TempForm.xlsx<br><br>1.5.1 DeskProc 10.20.docx | SOP and tracking sheet were updated in October 2022.<br><br>DHCS finding will be presented to impacted | The following documentation supports the MCP's efforts to correct this finding:<br><br>**POLICIES AND PROCEDURES**<br><br>Provider Services Standard Operating Process (10/20/22)<br>Outlines general requirements, frequency (yearly), identifies delegates, process, including:<br>Disclosure forms are sent out to delegates each calendar year.<br>Plan has a two-step verification process conducted by Provider Relations and the Compliance Departments. |

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| ownership and control disclosure information. | when ownership and control forms are received from delegates.<br><br>The findings specifically mentioned two (2) forms:<br>• Kaiser who provided the Alliance with the email confirming that the form they submitted to the Alliance is the same form that Kaiser files with DHCS. According to Kaiser, DHCS confirmed acknowledgement of the form from Kaiser with no additional feedback.<br>• Community Health Center Network (CHCN) who does not have a sole owner and provided a list of their leadership team with the FEIN for each of the clinics.<br><br>The Alliance will notify the | 1.5.1 VendorDiscForm.pdf | delegates by the end of Q4 2022.<br><br>The Alliance will collect new forms starting Q1 2023. | **MONITORING AND OVERSIGHT**<br><br>The Plan has implemented a tracking log, including both first and second level reviews. Completed forms will be saved, tracked, and available upon request.<br><br>Delegate disclosure forms have been reviewed and found to be compliant with the requirements outlined in CFR 455.104.<br><br>**The corrective action plan for finding 1.5.1 is accepted.** |

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| | impacted delegates of the findings to receive forms that meet requirements by DHCS. | | | |
| **2. Case Management and Coordination of Care** | | | | |
| **2.1.1 Initial Health Assessment (IHA)**<br><br>The Plan did not document attempts to contact members and schedule the IHA. | The plan will continue to inform members of the IHA through the EOC, welcome letters to all new members, and videos.<br>• In addition, all members are eligible for a new member orientation (including a financial incentive).<br>• Information regarding the IHA will be included in the member newsletter.<br>• AAH will initiate a new phone campaign where all new members will receive a phone call encouraging the member to receive an IHA. This phone log will be appropriately | Proposed Phone Call Scripts (pending CANDA and DHCS approval) | Script: 1/31/2023<br><br>Report for Identification of new plan members: 1/31/2023<br><br>Workflows: 2/28/2023<br><br>Update PANDP: 2/28/2023<br><br>**Long Term:** Phone Call campaign; long term given need to create a script and ensure state approval | The following documentation supports the MCP's efforts to correct this finding:<br><br>**POLICIES AND PROCEDURES**<br><br>• Revised Policy, QI-124, "Initial Health Assessment" (Draft) outlines the Plan conducting IVR outreach calls to encourage new members to schedule an appointment with their PCP to complete an IHA.<br><br>In addition, the Plan trains their network providers and staff regarding documentation of the IHA or reasons IHAs were not completed, timelines for performing IHAs and procedures to assure that IHAs are scheduled, and members contacted about missed IHA appointments.<br><br>I**MPLEMENTATION**<br><br>• Hired Staff, a Clinical Quality Program Coordinator was hired April 17, 2022, who is responsible for IHA coordination and oversight.<br><br>• Robo Call Script, "IVR Outreach Call" (01/31/23) demonstrates the Plan will send automated calls to encourage members to schedule an IHA with their Primary Doctor. |

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| | documented.<br><br>(Please see attachment B for additional details) | | | • Workflow, “IHA Workflow” (2023) as evidence that the Plan has created a process in regard to Member Outreach, Provider Communication/Support, and Tracking/Monitoring as it relates to IHA contract requirements.<br><br>**MONITORING AND OVERSIGHT**<br><br>• Sample Report, “IHA Report” (12/22) demonstrates the Plan will capture members name, mailing address, IHA report date, IHA due date, call one attempt with date and time, disposition of call one, call two attempts with date and time, and disposition of call two.<br><br>• Report, “Fulfillment Report” (01/22 – 12/22) demonstrates the Plan has a monthly tracking method for mailing member ID Cards and Orientation Packets with a reminder to schedule an initial health assessment.<br><br>• Report, “Member Orientation Service Request” demonstrates the Plan attempts to reach out to members monthly to complete new member orientation, which includes communication about scheduling the initial health assessment.<br><br>• Review, “QI Review: Initial Health Assessment” demonstrates the Plan will randomly select 30 files annually to monitor IHA completion.<br><br>• Report, “IHA Report” (Q1 – Q4 2022) demonstrates the Plan is reporting and sharing IHA rates and goals at committee meeting with providers.<br><br>• Audit Tool, Revised, “Interim Monitoring Facility Site Review Form” (03/07/23) demonstrates the Plan has a tool to audit providers on |

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| | | | | regularly scheduled basis to confirm providers are documenting outreach efforts in contacting members and scheduling IHA's. In addition, a CAP will be issued to providers who are non-compliant.<br><br>• Presentation, "Member Orientation Presentation" demonstrates the Plan shares with members the importance of scheduling their IHA.<br><br>• Test, "Member Orientation Pre-Test and Post-Test" demonstrates if members fully understand the IHA process via member orientation presentation. The members who completed the post-test knew when to get their IHA after completing the member education class.<br><br>• Incentive Program, "Member Incentive Program" which has been designed to assist members to understand their benefits and the importance of completing an IHA.<br><br>**The correction action plan for finding 2.1.1 is accepted.** |
| **2.5.1 Memorandum of Understanding (MOU) with the County Mental Health Plan (MHP)**<br><br>The Plan's MOU with the county MHP did not include the responsibility for the review of disputes | The Alliance has made several updates to the MOU and incorporated APL 18-015, as well as APL 21-013 Dispute Resolution Process Between Mental Health Plans and Medi-Cal Managed Care Health Plans. The Alliance has had a series of meetings with Alameda County Behavioral | 2.5.1 CountyEmail_09.15.msg<br><br>2.5.1CountyEmail_09.20msg<br><br>2.5.1MeetNotes 0131.pdf<br><br>2.5.1 MeetNotes 08.22.pdf | December 2022 | **MOU UPDATE:**<br><br>• APLs 18-009 and 18-015 relating to Memorandum of Understanding (MOU) requirements are both being retired.<br><br>• APL 23-029 Memorandum of Understanding Requirements for Medi-Cal Managed Care Plans and Third Party Entities was released on 10/11/23.<br><br>• The APL clarifies the intent of MOU requirements and contains templates with general provisions and templates tailored for certain programs. |

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| between the Plan and the MHP. | Health (ACBH) to review redline changes to the MOU. ACBH is currently under review of the redline changes and will notify the Alliance when they can move forward with signing the MOU. ACBH MOU vetting process includes County Board of Supervisor (BOS) approval. Therefore, the Alliance is hoping to execute the MOU by the end of 2022. | | | • 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.<br><br>**This finding is closed due to previously issued guidance from DHCS and the pending updates to the APL and MOU requirements.** |
| **3. Access and Availability of Care** | | | | |
| **3.1.1 Extending Timeframes for Obtaining Appointments**<br><br>The Plan did not monitor the network providers' compliance with requirements for when appointments were extended. | 1. Provider Manual Edits<br>2. Quarterly Provider Packet Information<br>3. Discussion with AAH Provider Reps who visit PCPs<br>4. Provider Fax Blasts<br>5. Edits to the Provider Education Document<br><br>1. Edit PANDP and Quality of Access Workflow<br><br>2. All cases are reviewed by | 3.1.1 ProvManual.pdf<br><br>3.1.1_Q2_ProvPack.pdf<br><br>3.1.1_Q3_ProvPack.pdf<br><br>3.1.1_TimelyAccess.pdf | Q2 2022<br>Q4 2022 | The following additional documentation supports the MCP's efforts to correct this finding:<br><br>**POLICIES AND PROCEDURES**<br><br>• QI-114 - Monitoring of Access and Availability (AANDA) Standards<br>  ○ The Plan submitted a revised PANDP directing AANDA staff to review medical records (available through Grievances and Appeals) to ensure that a longer waiting time will not have a detrimental impact on members' health<br><br>• QI-105: Facility Site Reviews, Medical Record Reviews, and Physical Accessibility Review Surveys<br>  ○ The Plan revised their FSR PANDP to ensure physicians monitor missed, canceled, and rescheduled appointments through periodic full |

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| | a QI Nurse. If a case is determined to be related to access, QI / AANDA staff will review data for ED / Inpatient Stays as a result of delay in appointment. If the member does have an ED / IP Claim, the QI RN will then work the case up as a PQI / Quality of Care. This will be reviewed by the Medical Director and follow the PQI process. Finally, all QOA cases with available MRs will be reviewed to ensure the appropriate provider documentation. | 3.1.1_PQI_Workflow.pdf<br><br>3.1.1_QI-114.pdf | | scope, focused, and interim monitoring of FSR/MRR evaluations (page 4)<br><br>**MONITORING AND OVERSIGHT**<br><br>• FSR Process and PQI Grievance Processes (AAH_Narrative, page 2)<br>  ○ 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)<br><br>• QI-114 - Monitoring of Access and Availability (AANDA) Standards<br>  ○ If improper documentation is found, AANDA staff will ensure appropriate provider education (page 5)<br>  ○ (a) Based on results of the PAAS, QI staff will provide re-education on appointment availability standards and issue CAPs accordingly (page 3)<br>  ○ (b) The PANDP also commits the Plan to randomly evaluate cases for appropriate documentation regarding members' appointment extensions on a semi-annual basis<br>  ○ AANDA staff will also:<br>  ○ (c) checking claims data, to ensure that members were not admitted or sent to an Emergency Department; when applicable, the case is escalated to the QI RN Supervisor<br>  ○ (d) conduct confirmatory to providers to assess timely compliance; all outreach is tracked and trended for internal performance improvement and issuance of CAPs as needed (see CS Log)<br><br>• CS Log (a part of the Access-Related PQI QOA Workflow) |

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| | | | | ○ 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.<br><br>• Access AND Availability Sub-Committee AND Internal Quality Committee - Quarterly Review (see AAH_Narrative, page 3)<br>○ The two committees meet quarterly to review PQI and Grievance trends to enforcing compliance once providers are found to be non-compliant<br>○ Root cause analyses and internal CAPs may be issued accordingly<br><br>• Non-Compliance CAP Letter - Provider Appointment Availability Survey (PAAS)<br>○ The Plan implemented a more targeted CAP process for providers found non-compliant in this requirement by creating this letter following substandard PAAS results<br>○ The letter template highlights Timely Access Standards and the specific timely access/extended timeframes requirements<br><br>**TRAINING**<br><br>• Provider Manuals and Packets<br>○ 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<br>○ Generally, the Plan educates the provider network through fax blasts, communication with Provider Relations, Facility Site Review education, and inclusion within CAPs issued to non-responsive AND non-compliant providers |

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| | | | | ○ The following documents demonstrate an effort to reiterate and communicate timely access requirements:<br>○ "ProvManual" (Page 24), "Q2_ProvPack" AND "Q3_ProvPack (sections: Timely Access Standards, Page 19 and Page 3, respectively), "TimelyAccess" (Page 1)<br><br>**The corrective action plan for finding 3.1.1 is accepted.** |
| **3.6.1 Denial of Emergency Services Claims**<br><br>The Plan improperly denied emergency services claims. | Case #7 – The Plan agrees that claim #875287269 was denied incorrectly for missing/invalid DX code due to an OCR lift issue on the DX Pointer by our vendor, DocuStream, who converts our paper claims to electronic versions. The claim was subsequently paid on 8/11/2021. The vendor was notified of the finding on 5/19/2022 and asked to review their internal process to ensure that codes on claims are captured correctly. They acknowledged they reviewed their internal processes and stated that poor claim image may have cause the issue, but they | 3.6.1 ER10paid1.5.22.pdf<br><br>3.6.1_Confirm Email.pdf<br><br>3.6.1_DHCS Case 10.xlsx<br><br>3.6.1_ER Case 10.pdf | Verbal communication on 5/19/2022, with a confirming email on 10/11/2022 with resolutions | The following documentation supports the MCP's efforts to correct this finding:<br><br>**POLICIES AND PROCEDURES**<br><br>• The MCP updated P&P CLM-003, "Emergency Services Claims Processing" (09/13/22) which includes a weekly focused audit that will be performed to ensure that claims for emergency services are not denied for lack of an authorization, medical necessity, or OCR lift issues on paper claims.<br><br>**MONITORING AND OVERSIGHT**<br><br>• Weekly Report, "Focus Audit" (06/2021-10/2022) which is a weekly report that the MCP uses to track and review all the ER claims denied at the header level. This process is done weekly by the Claim Specialists and any claims found to be incorrectly denied are adjusted for the next run. Out of 54 claims audited, the MCP had an 80% compliance rate of claims being properly adjudicated. |

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| | will increase the resolution to help ensure better results in the future.<br><br>Case #20 – The Plan agrees that claim # 491938409 was denied incorrectly for an invalid date of service due to an OCR lift issue by our vender, DocuStream, who converts our paper claims to electronic versions. The vender was notified of the issue on 5/19/2022 and asked to review their internal process to ensure that dates on clams are captured correctly. They acknowledged they reviewed their internal processes and stated that poor claim image may have cause the issue, but they will increase the resolution to help ensure better results in the future. In addition, an edit was enhanced to | | Verbal communication on 5/19/2022, with a confirming email on 10/11/2022 with resolutions<br><br>Re-training for this finding occurred on 8/2/2022, see attached agenda and sign-in sheet. | • Revised Workflow, HS-039 ER, "Emergency ER/AAH CLM", (12/5/22) which describes steps taken by the Processor when a claim is received for emergency services. The MCP confirms Processors understand when to deny at the header level vs. the line level.<br><br>**TRAINING**<br><br>• Meeting, "Mandatory Huddle", (12/5/22) this meeting was with the Processors to discuss the updated HS-039 workflow for ER claims. Especially around the denying claims at the Header vs. The Line Level. Attestations included.<br><br>• Verbal (05/09/22) and followed up with an Email, (10/11/22) the MCP communicated with its Vendor, DocuStream to notify them of the finding and asked them to review their internal process to verify that codes on claims are captured correctly. They acknowledged they reviewed their internal processes and stated that poor claim image may have caused the issue, but they will increase the resolution to help achieve better results in the future.<br><br>**The corrective action plan for finding 3.6.1 is accepted.** |

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| | ensure that the date range is order is correct.<br><br>Case#10 – the Plan agrees that claim #6938877008 was not manually process by the Claims Processor correctly. The claim was paid subsequently on 1/5/2022 correctly. The Claims Processor was shown the claim finding for review along with the correct workflow document that shows the correct process to help ensure moving forward this does not occur again. This workflow was also reviewed by the Claim Processor team overall on 8/2/2022. | | | |

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| **3.8.1 Physician Certification Statement (PCS) Forms**<br><br>The Plan did not use PCS forms for NEMT services. | 1. The Plan will educate providers on PCS requirements.<br>2. Refine PCS workflows to meet all regulatory requirements.<br>3. The Plan will conduct staff trainings on process workflow changes.<br>4. The Plan will ensure that the transportation vendor trains their staff on PCS process workflow changes. Vendor will provide training materials and sign sheets.<br>5. The Plan will develop reports on PCS form outcomes using both transportation vendor information and the Plan's process to obtain PCS forms.<br>6. The Plan will monitor process workflows from the vendor and the Plan to obtain missing PCS forms.<br>7. The Plan will analyze trends in provider practices and provide feedback to | | 1. 2022 Q4<br><br>2. 2023 Q1<br><br>3. 2023 Q1<br><br>4. 2023 Q1<br><br>5. 2023 Q1<br><br>6. 2023 Q1<br><br>7. 2023 Q1<br><br>8. 2023 Q2<br><br>9. 2023 Q2 | DHCS has identified that the finding 3.8.1 was a repeat finding on the subsequent 2023 Medical Audit; therefore, DHCS will assess remediation for the finding 3.8.1 in the 2023 Corrective Action Plan (CAP). |

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| | providers regarding PCS form requirements<br>8. The plan will evaluate whether to continue having the transportation vendor manage the PCS forms or take the direct management of PCS forms back into the Plan.<br>9. The Plan will provide a quarterly report to UM Committee | | | |
| **4. Member Rights** | | | | |
| **4.1.1 Grievance Acknowledgement and Resolution Letter Timeframes**<br><br>The Plan did not send acknowledgement and resolution letters within the required timeframes. | The G & A Department Leadership and Quality Assurance Specialist will reference the daily reports to ensure the acknowledgment and resolution letters are sent timely<br><br>The Plan provide training to the Grievance & Appeals staff to review the regulatory requirements for mailing of acknowledgement and resolution letters. | 4.1.1_Training .pdf<br><br>4.1.1_Training .pptx<br><br>4.1.1_Meet_090 8202 2.pdf<br><br>4.1.1_Aging Report | Review reports: 10/1/2022<br><br>Training: 8/9/2022 and 9/8/2022<br><br>Internal audits: Q3 2022 | DHCS has identified that the finding 4.1.1 was a repeat finding on the subsequent 2023 Medical Audit; therefore, DHCS will assess remediation for the finding 4.1.1 in the 2023 Corrective Action Plan (CAP). |

| Finding Number and Summary | Action Taken | Supporting Documentation | Implementation Date* (*Short-Term, Long-Term) | DHCS Comments |
|---|---|---|---|---|
| | The Quality Assurance Specialist will audit 5 appeals cases and 5 grievances cases per Grievance & Appeals Coordinator per month. | | | |
| **4.1.2 Grievance Letter in Threshold Languages**<br><br>The Plan did not send acknowledgement and resolution letters in threshold languages. | Updated our system of record to capture the dates the resolution letter was submitted for translation and the date it was mailed to the member<br><br>The Plan provide training to the Grievance & Appeals staff on the updates made to the system of record.<br><br>The Quality Assurance Specialist will audit 5 appeals cases and 5 grievances cases per Grievance & Appeals Coordinator per month. | 4.1.2_MeetAgenda. pdf<br><br>4.1.2_TransUpdate. pdf | System updated: 9/15/2022<br><br>Training to the team: 9/20/2022<br><br>Q3 2022 | DHCS has identified that the finding 4.1.2 was a repeat finding on the subsequent 2023 Medical Audit; therefore, DHCS will assess remediation for the finding 4.1.2 in the 2023 Corrective Action Plan (CAP). |

| Finding Number and Summary | Action Taken | Supporting Documentation | Implementation Date* (*Short-Term, Long-Term) | DHCS Comments |
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| **4.1.3 Grievance Extension Letter Timeframes**<br><br>The Plan was not compliant with grievance extension letter timeframes; in some cases, it did not send extension letters for grievances that were not resolved within 30 calendar days and in other cases it did not resolve grievances by the estimated completion date specified in the extension letter. | The Plan provide training to the Grievance & Appeals staff on the system updates to capture extension letters.<br><br>The Quality Assurance Specialist will audit 5 appeals cases and 5 grievances cases per Grievance & Appeals Coordinator per month.<br><br>Updated Policy & Procedure G&A- 003: Grievance and Appeals, Receipt, Review and Resolution | 4.1.3_MeetAgenda. pdf<br><br>4.1.3_Ext Letters.pdf | 9/15/2022<br><br>9/20/2022 | DHCS has identified that the finding 4.1.3 was a repeat finding on the subsequent 2023 Medical Audit; therefore, DHCS will assess remediation for the finding 4.1.3 in the 2023 Corrective Action Plan (CAP). |
| **5. Quality Management** | | | | |
| **4.1.4 Grievance Investigation and Resolution**<br><br>The Plan did not thoroughly investigate and resolve | The Alliance will review resolution letters prior to mailing to the member.<br><br>The Alliance provided training to the Grievance & Appeals staff to ensure the | 4.1.4_Training.pdf<br><br>4.1.1_Training .pptx | Letter review: 10/1/2022<br><br>Training date: 8/9/2022 | The following documentation supports the MCP's efforts to correct this finding:<br><br>**POLICIES AND PROCEDURES**<br><br>• Plan policy *G&A-001 Grievance and Appeals System Description* (revised 1/21/21) stated the Plan ensures that each issue is addressed and |

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| grievances prior to sending resolution letters. | resolution letter clearly addresses all of the member's concerns<br><br>The Quality Assurance Specialist will audit 5 appeals cases and 5 grievances cases per Grievance & Appeals Coordinator per month. | | Internal audits: Q3 2022 | 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)<br><br>**TRAINING**<br><br>• 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.<br><br>**MONITORING**<br><br>• 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.<br><br>• 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.<br><br>• The MCP has created a review checklist to be used during real time review beginning on 1/16/23. |

| Finding Number and Summary | Action Taken | Supporting Documentation | Implementation Date* (*Short-Term, Long-Term) | DHCS Comments |
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| | | | | • Weekly QAS Case Review demonstrates the MCP monitors for resolution of all grievances prior to mailing resolution letter.<br><br>**The corrective action for finding 4.1.4 has been accepted** |
| **4.3.1 Reporting of HIPAA Incidents and Disclosures**<br><br>The Plan did not report suspected security incidents or unauthorized disclosures of PHI to DHCS within the required timeframes. | The Plan has created an interdepartmental team to work in collaboration to develop a reporting process for timely submissions of possible HIPAA and FWA incidents to Compliance. Six points of entry for possible incidents have been identified.<br><br>The team is utilizing technological improvements as well as developing staff training to be able to identify HIPAA and FWA incidents and the method for<br>immediate reporting to compliance. | | 12/31/2022 | The following documentation supports the MCP's efforts to correct this finding:<br><br>**POLICIES AND PROCEDURES**<br><br>• P&P, "CMP-013: HIPAA Privacy and Reporting" which reflects the 24 hours, 72 hours, and 10-day reporting requirements to DHCS.<br><br>• 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. Written response from the MCP (03/10/23), in which the MCP has developed an automated process to assist with identifying possible Privacy incidents and FWA allegations in order to report them to the compliance department with minimal human intervention. The MCP finalized the technological improvements for timely referral of suspected HIPAA incidents to Compliance Dept. from within the Plan in December 2022. Compliance Dept. is responsible for sending to DHCS. (4.3.1_Narrative Response).<br><br>**TRAINING**<br><br>• Training Schedule "Point of Entry Training" and PowerPoint Training, "How to Recognize and Report HIPAA and FWA Incidents" (01/01/23) |

| Finding Number and Summary | Action Taken | Supporting Documentation | Implementation Date* (*Short-Term, Long-Term) | DHCS Comments |
|---|---|---|---|---|
| | | | | which demonstrates that the MCP conducted refresher training to staff regarding reporting suspected security incidents or unauthorized disclosures of PHI to DHCS within the required timeframes (PoE Training).<br><br>• Training Schedule (January 2023) which demonstrates that MCP staff were trained on how to use the new reporting process to Compliance utilizing a semi-automated process for immediate reporting during intake of a possible Privacy incident. (4.3.1_Narrative Response).<br><br>**MONITORING**<br><br>• HIPAA Track" (April 2022 – January 2023) which demonstrates that the MCP has a self-monitoring process to track the reporting of suspected security incidents or unauthorized disclosures of PHI to DHCS within the required timeframes. The following categories monitored are as follows: Date PIR Submitted to DHCS (24hr), Updated Reporting to DHCS (72hr), Updated Reporting to DHCS (close or 10-day) (4.3.1_April22-Jan23_HIPAA).<br><br>**The corrective action plan for finding 4.3.1 is accepted.** |
| **4.3.2 Notification of Privacy Incident Reports (PIR)**<br><br>The Plan did not notify the DHCS Program Contract | Due to human error reporting to the three (3) entities at DHCS; DHCS Program Contract Manager, the DHCS Privacy Officer and the DHCS Information Security | 4.3.2_CMP-013 HIPAA.pdf | 11/23/2022 | The following documentation supports the MCP's efforts to correct this finding:<br><br>**POLICY AND PROCEDURES**<br><br>• Updated P&P, "CMP-013: HIPAA Privacy reporting" (12/16/22) in which the MCP has included the email address for possible HIPAA incidents to |

| Finding Number and Summary | Action Taken | Supporting Documentation | Implementation Date* (*Short-Term, Long-Term) | DHCS Comments |
|---|---|---|---|---|
| Manager and DHCS ISO of suspected security incidents or unauthorized disclosure of PHI or PI. | Officer was not completed for all possible HIPAA incidents.<br><br>Reporting Policy CMP-013 has been updated to reflect the current reporting email address for possible HIPAA incidents to DHCS incidents@dhcs.ca.gov . This change was reviewed and approved by the Compliance Committee on 11/23/2021. | | | DHCS, the webpage link to the DHCS Privacy Incident Reporting Portal, and the telephone number to the DHCS EITS Service Desk. The MCP Privacy Department is utilizing the online reporting portal that has been established by DHCS for suspected Privacy incidents. (CMP-013 HIPAA, Page 1).<br><br>**TRAINING**<br><br>• PowerPoint Training, "How to Report HIPAA Incidents to DHCS" (01/01/23) which demonstrates that the MCP conducted refresher training to staff to notify the DHCS Program Contract Manager, the DHCS Privacy Officer and the DHCS Information Security Officer for the following: within 24 hours of the discovery of any suspected security incident, intrusion or unauthorized access, use or disclosure of PHI or PI, an updated Privacy Incident Report within 72 hours of discovery, and a complete report of the investigation within 10 working days of discovery.(Rpt_HIPAA_Incidents_Train).<br><br>**MONITORING**<br><br>• "HIPAA Track" (April 2022 – January 2023) which demonstrates that the MCP has a self-monitoring process to track the reporting of suspected security incidents or unauthorized disclosures of PHI to DHCS within the required timeframes. The following categories monitored are as follows: Date PIR Submitted to DHCS (24hr), Updated Reporting to DHCS (72hr), Updated Reporting to DHCS (close or 10-day). (4.3.1_April22-Jan23_HIPAA).<br><br>**The corrective action plan for finding 4.3.2 is accepted.** |

| Finding Number and Summary | Action Taken | Supporting Documentation | Implementation Date* (*Short-Term, Long-Term) | DHCS Comments |
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| | | | | |
| **6. Administrative and Organizational Capacity** | | | | |
| **6.2.1 Fraud and Abuse Reporting**<br><br>The Plan did not report preliminary investigations of all suspected cases of fraud and abuse to DHCS within ten working days of the Plan receiving notification of the incident. | The Plan has created an interdepartmental team working in collaboration to develop a reporting process for timely submissions of possible HIPAA and FWA incidents to Compliance.<br>Six points of entry for possible incidents have been identified.<br>The team is utilizing technological improvements as well as developing staff training to be able to identify a possible incident for immediate reporting to compliance.<br>At the initiation of the Reporting Process Enhancement, the FWA Specialist will conduct | | 12/31/2022 | The following documentation supports the MCP's efforts to correct this finding:<br><br>**POLICIES AND PROCEDURES**<br><br>• P&P, "CMP-002: Fraud, Waste, and Abuse" which reflects that the MCP's Compliance Department will report all suspected FWA incidents to DHCS within 10 working days of the date the Plan becomes first aware or notified of the suspected activity.<br><br>• 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. Written response from the MCP (03/10/23), in which the MCP has developed an automated process to assist with identifying possible Privacy incidents and FWA allegations in order to report them to the compliance department with minimal human intervention. The MCP finalized the technological improvements for timely referral of suspected HIPAA incidents to Compliance Dept. from within the Plan in December 2022. Compliance Dept. is responsible for sending to DHCS. (6.2.1_Narrative Response).<br><br>**TRAINING** |

| Finding Number and Summary | Action Taken | Supporting Documentation | Implementation Date* (*Short-Term, Long-Term) | DHCS Comments |
|---|---|---|---|---|
| | training designed for each department identified as a point of entry.<br>The FWA Specialist will be responsible to track and monitor all privacy related referrals to the compliance department for timeliness. | | | • Training Schedule "Point of Entry Training" and PowerPoint Training, "How to Recognize and Report HIPAA and FWA Incidents" (01/01/23) which demonstrates that the MCP conducted refresher training to staff regarding the reporting of preliminary investigation of all suspected cases of fraud and abuse to DHCS within 10 working days of the Plan receiving notification of the incident. (How_To_Recognize_Training).<br><br>**MONITORING**<br><br>• "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).<br><br>• "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 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). |

| Finding Number and Summary | Action Taken | Supporting Documentation | Implementation Date* (*Short-Term, Long-Term) | DHCS Comments |
|---|---|---|---|---|
| | | | | The MCP demonstrated that self-monitoring procedures are in place to prevent future non-compliance.<br><br>**The corrective action plan for finding 6.2.1 is accepted.** |
| **SSS. State Supported Services** | | | | |
| No deficiencies were identified in this audit. | | | | |

**Submitted by Plan:** Scott Coffin [Original signature on file] **Date:** 10/25/22
**Title:** Chief Executive Officer
Alameda Alliance for Health