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

REPORT ON THE MEDICAL AUDIT OF

Alameda Alliance for Health

Contract Number:	04-35399
Audit Period:	June 1, 2018 Through May 31, 2019
Report Issued:	October 21, 2019

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I. INTRODUCTION

Alameda Alliance for Health (the Plan) is a public, non-profit managed care health plan with the objective to provide quality health care services to low income residents of Alameda County. The Alameda County Board of Supervisors established the Plan in 1994 in accordance with the Welfare and Institutions Code, Section 14087.54. While it is a part of the County's health system, the Plan is an independent entity that is separate and apart from the County.

The Plan was established to operate the Local Initiative for Alameda County under the State Department of Health Services' Strategic Plan for expanding Medi-Cal Managed Care. The Plan was initially licensed by the Department of Corporations in September 1995 and contracted with the California Department of Health Care Services (DHCS) in November 1995. The Plan began operations in January 1996 as the first Two-Plan Model health plan to be operational.

As of May 31, 2019, the Plan had 258,937 members of which 253,027 (97.72%) were Medi-Cal members and 5,910 (2.28%) were commercial members under the In-Home Supportive Services Program.

II. EXECUTIVE SUMMARY

This report presents the audit findings of the DHCS medical audit for the audit period of June 1, 2018 through May 31, 2019. The onsite review was conducted from June 10, 2019 through June 21, 2019. The audit consisted of document review, verification studies, and interviews with Plan representatives.

An Exit conference was held on September 18, 2019 with the Plan. The Plan was allowed 15 calendar days from the date of the Exit Conference to provide supplemental information addressing the draft audit report findings. The Plan submitted a response after the exit conference. The results of our evaluation of the Plan's response are reflected in this report.

The audit evaluated six categories of performance: Utilization Management (UM), Case Management and Coordination of Care, Access and Availability of Care, Member's Rights, Quality Improvement (QI), and Administrative and Organizational Capacity.

The prior DHCS medical audit (for the period of June 1, 2017 through May 31, 2018) was issued on December 21, 2018. This audit examined documentation for compliance and to determine to what extent the Plan has operationalized their corrective action plan (CAP).

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

The summary of the findings by category follows:

Category 1 – Utilization Management

Category 1 includes procedures and requirements for a Plan's Utilization Management (UM) program, including delegation of UM, prior authorization (PA) review and the appeal process.

The Plan is required to continuously monitor and evaluate delegated UM activities to ensure compliance and accountability of its delegates. The Plan did not continuously monitor and evaluate the functions of its' UM delegates and did not ensure receipt of all contractual and regulatory reports from its delegates during the audit period. The Plan's oversight of its delegate did not identify deficiencies related to its mild-to-moderate and behavioral health treatment services responsibilities.

The Plan is required to ensure that the UM program includes an established specialty referral system to track and monitor referrals requiring prior authorization. The system shall include authorized, denied, deferred, or modified referrals. The Plan did not track all approved PAs. The Plan's specialty referral tracking process did not include modified PAs and in-network approved services.

The Plan is required to ensure that its prior authorization, concurrent review and retrospective review be conducted by a qualified health care professional. The Plan denied retrospective service requests without review by a medical director if the provider submitted the request more than 30 days after the service delivery date, or if requests did not meet Plan-imposed conditions.

The Plan is required to send written notices to members that include a clear and concise explanation of the reasons for the Plan's decisions. The provider letter shall include the decision-maker's direct phone number. The Plan's notice of action (NOA) letters did not explain the reasons for the denial, were not concise, and did not include the decision makers' direct phone number or contained the incorrect number.

Category 2 – Case Management and Coordination of Care

Category 2 includes requirements to provide initial health assessments (IHA) to new members, Complex Case Management (CCM) and health risk assessments (HRA) for seniors and persons with disabilities (SPD).

The Plan is required to administer a DHCS approved HRA survey within 45 days for SPD members deemed to be at higher risk, and 105 days for those determined to be a lower risk. The Plan did not complete HRAs within the required timeframes.

The Plan is required to cover and ensure the provision of an IHA to each new member. An IHA consists of a comprehensive history and physical examination, preventive services, and the Individual Health Education Behavioral Assessment. The Plan did not ensure that all providers documented one of the required components of an IHA, United States Preventive Services Task Force (USPSTF) "A" & "B" recommended preventive services.

The Plan is required to maintain procedures for monitoring the coordination of care provided to members, including but not limited to all Medically Necessary services delivered both within and outside the Plan's provider network. The Plan did not implement its monitoring of the CCM program to address member needs.

Category 3 – Access and Availability of Care

Category 3 includes requirements regarding member access to care and pharmaceutical services and the adjudication of claims for emergency services (ER) and family planning (FP) services.

The Plan is required to take appropriate steps to ensure the accuracy of the information for each provider listed in the Plan's provider directory and shall, at least annually, review and update the entire directory. The Plan did not maintain an accurate provider directory.

The Plan is required to reimburse non-contracted ER and FP claims at no less than the Medi-Cal fee-for-service rate. Members may access ER and FP services through any provider. The Plan paid non-contracted family planning services at less than the Medi-Cal Fee-for-service rate. The Plan's Evidence of Coverage (EOC) incorrectly places age limitation on all family planning services.

The Plan is required to ensure the provision of drugs prescribed in emergency circumstances. The Plan did not monitor to ensure the provision of drugs prescribed in emergencies.

Category 4 – Member's Rights

Category 4 includes requirements to protect member's rights by properly handling of grievances and reporting of protected health information.

The Plan is required to ensure that the person making the final grievance decision be a qualified health care professional. The Plan did not document review and final resolution of clinical grievances by a qualified health care professional; a medical director did not resolve all clinical grievances.

The Plan is required to establish and maintain a grievance system that processes and resolves all member grievances and complaints. The Plan's grievance system did not capture all complaints and expressions of dissatisfaction reported by members. The Plan sent member resolution letters without completely resolving all complaints.

Category 5 – Quality Management

Category 5 includes requirements to deliver adequate quality of care to members and take effective action to address needed improvements in quality of care delivered by providers.

The Plan is required to conduct training for all providers within 10 working days after the Plan places a newly contracted provider on active status. The Plan did not ensure provider training was conducted within the required timeframe.

Category 6 – Administrative and Organizational Capacity

Category 6 includes requirements to implement and maintain a health education system and compliance program.

The Plan is required to establish an Anti-Fraud and Abuse Program in which there will be a compliance officer who is responsible for developing and implementing policies, procedures, and practices designed to ensure compliance. The Plan's compliance officer did not develop and implement fraud, waste, and abuse policies and procedures.

The Plan is required to conduct, complete, and report the results of a preliminary investigation of suspected fraud or abuse to DHCS within 10 working days of the date the Plan first becomes aware of such activity. The Plan did not conduct preliminary investigations of all suspected cases of fraud and abuse. The Plan did not investigate all suspected fraud and abuse incidents promptly.

III. SCOPE/AUDIT PROCEDURES

SCOPE

This audit was conducted by the DHCS Medical Review Branch to ascertain that medical services provided to Plan members, including seniors and persons with disabilities (SPD), comply with federal and state laws, Medi-Cal regulations and guidelines, and the state contract.

PROCEDURE

The onsite review was conducted from June 10, 2019 through June 21, 2019. The audit included a review of the Plan's policies for providing services, the procedures used to implement the policies, and verification studies of the implementation and effectiveness of the policies. Documents were reviewed and interviews were conducted with Plan administrators and staff.

The following verification studies were conducted:

Category 1 – Utilization Management

Prior authorization requests: 16 medical and 14 pharmacy prior authorization requests including 5 medical and 5 pharmacy seniors and person with disabilities (SPD) cases, were reviewed for timeliness, consistent application of criteria, and appropriate review.

Appeal procedures: 11 prior authorization appeals including 4 SPD cases were reviewed for appropriate and timely adjudication.

Delegated prior authorization requests: 15 service requests were reviewed for appropriate adjudication.

Category 2 – Case Management and Coordination of Care

Health Risk Assessment (HRA): 8 files were reviewed to confirm coordination of care and fulfillment of HRA requirements.

Initial Health Assessment (IHA): 10 medical records including 5 SPD records were reviewed to confirm coordination of care and fulfillment of IHA requirements.

Complex Case Management (CCM): 10 Plan CCM files were reviewed to confirm the performance of services.

Category 3 – Access and Availability of Care

Appointment availability verification: 28 providers of routine, urgent, specialty, and prenatal care from the Plan's directory were reviewed. The first next available appointments were used to measure access to care.

Claims: 20 emergency services and 20 family planning claims were reviewed for appropriate and timely adjudication.

Category 4 – Member's Rights

Grievance procedures: 69 grievances, including 47 standard, 9 quality of care, 10 exempt, and 3 expedited were reviewed for timely resolution, response to complainant, and submission to the appropriate level for review. 20 grievances were for SPD members.

Confidentiality rights: 20 Health Insurance Portability and Accountability Act (HIPAA) cases were reviewed for appropriate reporting and processing.

Category 5 – Quality Management

New provider training: 20 new provider training records were reviewed for timely Medi-Cal managed care program training.

Category 6 – Administrative and Organizational Capacity

Fraud and abuse: 12 fraud and abuse cases were reviewed for appropriate reporting and processing.

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

❖ COMPLIANCE AUDIT FINDINGS (CAF) ❖

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CATEGORY 1 - UTILIZATION MANAGEMENT

1.1	UTILIZATION MANAGEMENT PROGRAM REFERRAL TRACKING SYSTEM / DELEGATION OF UM MEDICAL DIRECTOR AND MEDICAL DECISIONS

1.1.1 Oversight of Delegated Mild-to-Moderate Mental Health Services

The Plan is required to ensure subcontractor meets standards set forth by the Plan and DHCS. (*Contract, Exhibit A, Attachment 4(6)(B)(2)*)

A beneficiary may seek and obtain a mental health assessment at any time directly from a licensed mental health provider without requiring a referral or prior authorization (PA). (*Title 42, CFR, Section 438.910(d)(1) and (2);* and *All Plan Letter 17-018*)

Plan policy *CMP-019, Delegation Oversight* stated its purpose was to ensure Plan members received care across all lines of business in accordance with all contract requirements and any applicable government standards.

The Plan delegated utilization management of mental health services; responsibilities included approving and arranging treatment for mild-to-moderate mental health conditions. The delegate's 2019 Quality Program Description stated it did not provide actual health care to patients, but organized a network of providers who delivered mental health care to members.

Finding: The Plan did not ensure a delegate complied with all contractual and regulatory requirements. The delegate required a screening and a referral for an initial visit with a mental health provider.

Documentation, including medical record review showed the delegate screened members for mild-to-moderate mental health conditions instead of allowing them to contact network mental health providers directly for an initial evaluation for mental health care. The delegate's policy, screening tools, and delegate interviews described the process for obtaining treatment for mild-to-moderate mental health conditions as follows:

- Plan members seeking mental health care called the delegate.
- Licensed clinician telephonic screeners used a standard questionnaire to decide if members qualified for referral to mental health providers.

- The process did not meet DHCS' requirement that the Plan not require a referral and screening, and allow members to self-refer to a mental health provider for a mental health screening and possible treatment.

In interviews, the Plan did not consider the delegate's screening for mild-to-moderate mental health to be out of compliance.

Oversight of a delegate that allows non-compliant processes may lead to impaired delivery of needed health care services to members.

Recommendation: Revise Plan policies and implement processes to ensure the delegate complies with contractual and regulatory requirements.

1.1.2 Oversight of Delegated Behavioral Health Treatment (BHT) Services

The Plan is required to ensure subcontractor meets standards set forth by the Plan and DHCS. (*Contract, Exhibit A, Attachment 4(6)(B)(2)*)

The Plan is required to ensure there is a set of written criteria for utilization review that is consistently applied. (*Contract, Exhibit A, Attachment 5(2)(C)*)

Plan policy *CMP-019, Delegation Oversight* stated its purpose was to ensure Plan members received care across all lines of business in accordance with all contract requirements and any applicable government standards.

The Plan delegated utilization management of behavioral health services. Delegated responsibilities included approving and arranging treatment for BHT services for members. The purpose of BHT is to improve behavior in conditions such as autism spectrum disorder. A BHT provider must develop a behavioral treatment plan, and can review and/or modify the plan, if medically necessary, during reassessment periods, usually every 6 months.

Finding: The Plan did not ensure a delegate complied with all contractual and regulatory requirements. The delegate did not consistently apply criteria for approving BHT.

Documentation, including medical record review, showed deficiencies in the delegate's UM processes. The delegate denied delivery of or reduced requested hours for BHT services after misapplication of criteria:

- In multiple cases, the delegate's psychiatrist downgraded requested hours for BHT at the 6-month reassessment. The reviewer stated the member was progressing using fewer hours. The delegate's criteria did not include parameters for decreasing requested hours.

- In a request for initial services, the delegate modified the requested amount of treatment stating behaviors were not severe enough. The member's case met applied behavioral health criteria used in the case. The criteria did not include parameters for decreasing initially requested hours or describe determining "severity" of behaviors.

- In a separate but similar case, the reviewer decreased requested hours stating there was not enough information to approve the amount of provider-requested hours, though the request for new services met the criteria applied to the case.

- In another case, the delegate denied continuing BHT exclusively in a school setting. The reviewer cited APL18-006, which does not require denial of services delivered exclusively in the school setting.

The Plan's annual oversight audit of its mental health delegate reviewed approved prior authorizations for requested services. The Plan's audit did not review modified or denied service requests. An appeal of a modified request for BHT services resolved by the Plan showed it used the delegate's rationale to uphold a decision for less than the requested number of services.

Oversight of a delegate that allows non-compliant processes may lead to impaired delivery of needed health care services to members.

Recommendation: Revise Plan policies and implement processes to ensure the delegate complies with contractual and regulatory requirements.

1.1.3 Ownership and Control Disclosure Reviews

The Plan is required to comply with Title 42, Code of Federal Regulations (CFR) 455.104. (*Contract, Exhibit A, Attachment 1(2)(B)*)

The Plan must require each disclosing entity to disclose certain information, including the name, address, date of birth, and social security number of each person or other tax identification number of each corporation with an ownership or control interest in the disclosing entity. (*Title 42, CFR, Section 455.104*)

The Plan is required to collect and review their subcontractors' ownership and control disclosure information as set forth in 42 CFR Section 455.104. The Plan must make the subcontractors' ownership and control disclosure information available, and upon request, this information is subject to audit by DHCS. (*All Plan Letter 17-004*)

Plan policy *CMP-024, Subcontracting Relationships and Delegation* stated the Plan required subcontracts to provide written disclosure of information on subcontractor's ownership and controls for the Plan's review. If a subcontractor were found to be out of compliance with the requirements or if disclosure revealed any potential violation(s) of the ownership and control requirements, the Plan would inform the DHCS Contract Manager within three business days of discovery.

Finding: The Plan did not review ownership and control disclosure information for their Utilization Management (UM) delegates.

Review of Plan disclosure forms revealed the following deficiencies:

- Four disclosure forms did not contain all owners or individuals with control interest
- Four disclosure forms did not contain social security numbers or tax identification numbers of all owners and individuals with control interest.
- Three disclosure forms did not contain dates of birth for all owners and individuals with control interest
- One disclosure form did not contain addresses for all owners and individuals with control interest
- Two disclosure forms did not contain any ownership or control interest information

This was finding 1.5.1 Ownership and Control Disclosure Reviews in the prior year's audit. The Plan did not collect and review delegates' ownership and control disclosures. As a corrective action, the Plan collected delegates' disclosure forms. In an interview, the Plan stated it reviewed all disclosure forms; however, DHCS's current review shows that the forms were incomplete.

When the Plan does not collect and review ownership and control disclosure information of its UM delegates, they cannot ensure that the delegates owners and controlling interest individuals are eligible for program participation.

This is a repeat of prior year finding 1.5.1 - Ownership and Control Disclosure Reviews.

Recommendation: Implement policies and procedures to ensure review and completion of delegates' ownership and control disclosure information.

1.1.4 Monitoring and oversight of UM Delegates

The Plan is accountable for all quality improvement functions and responsibilities (e.g. Utilization Management) that are delegated to subcontractors. (*Contract, Exhibit A, Attachment 4(6)(A)*)

The Plan is required to include in their subcontract agreements delegate reporting requirements. (*Contract, Exhibit A, Attachment 4(6)(A)(3)*)

The Plan is required to maintain a system to ensure accountability for delegated quality improvement activities that at a minimum, includes the continuous monitoring, evaluation and approval of the delegated functions. (*Contract, Exhibit A, Attachment 4(6)(B)*)

Plan policy *CMP-019, Delegation Oversight* stated the delegate shall submit all contractual and regulatory reports to the Compliance Department, in a format acceptable to the Alliance in accordance to their delegation agreement. The Compliance Department will review the reports and forward to the applicable operational department for feedback, recommendations, and any Corrective Action Plan (CAP) if applicable.

Finding: The Plan did not continuously monitor and evaluate the functions of its' UM delegates. The Plan did not ensure receipt of all contractual and regulatory reports during the audit period. Delegate contracts required monthly and quarterly reporting of UM data.

The Plan did not receive all required reports from 5 of 7 UM delegates during the audit period.

- One delegate did not provide two 2019 monthly UM Turnaround Time Reports
- One delegate did not provide a 2018 UM Program Evaluation
- One delegate did not provide a 2018 UM Evaluation Report

- One delegate did not provide monthly reports: 1 authorization report, 1 determination report, 2 turnaround time reports, and 9 denied case reports

- One delegate did not have any reports tracked

In response to the prior year's audit finding (1.5.3 Monitoring and Oversight of UM Delegates) that the Plan did not continuously monitor and evaluate the functions of its UM delegates as contractually agreed, the Plan updated its delegation reporting tracking log to document all UM delegation reporting. However, the tracking log showed required reports were not received or tracked. The Plan's tracking log of its delegates' required reports was not consistent with the delegates' contracts; some reports were listed as quarterly when the contract only required annual submission.
The Plan stated that for most of 2018, staffing shortages limited the amount of review and oversight of delegate reports.

Without continuous monitoring and oversight, the Plan cannot ensure that the delegates meet standards set forth by the Plan and DHCS.

This is a repeat of prior year finding 1.5.3 - Monitoring and Oversight of UM Delegates.

Recommendation: Implement policies and procedures to ensure receipt of delegated UM activity reports and adherence to delegates' contract reporting requirements.

1.1.5 Delegate Behavioral Health Treatment (BHT) NOA Letters

The Plan is required to follow Health and Safety Code (H&S Code) 1367.01 in notifying members of a decision to deny, defer or modify requests for PA. (*Contract, Exhibit A, Attachment 13(8)(A)*)

The Plan is required to provide information about how to file grievances and obtain a state fair hearing (SFH) in these member notices. (*H&S Code 1367.01(h)(4)*)

The Plan is required to send Notice of Action (NOA) letters informing members of adverse benefit determinations. Letters must include a clear and concise explanation of the reasons for the decision; a description of the specific criteria used; and explicitly state how the case does not meet the criteria. Members have 60 days to file an appeal after an adverse PA decision and 120 days to file a state fair hearing after an appeal decision. Members can file a grievance at any time. Member rights NOA letter attachments shall follow the DHCS format. (*All Plan Letter 17-006*)

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Plan policy *CMP-019, Delegation Oversight* stated that on an annual basis the Compliance Department would conduct an on-site audit to assess compliance with the Plan's criteria and all applicable state and federal regulations.

Finding: The Plan's oversight of its delegate did not identify unclear NOA letters, and incorrect appeal and SFH information.

A verification study revealed 8 of 15 NOA letters for BHT services contained outdated appeal and SFH information, and unclear and inaccurate information:

- All eight letters informed members of a 90-day instead of a 60-day filing timeframe for appeals and a 90-day instead of 120-day filing timeframe for SFH.

- Three of eight NOA letters evaluated for content contained inaccuracies including stating the delegate used "Continued Stay Criteria" (criteria for evaluating the need to continue treatment) though two requests were for new services, and a third request was denied on the basis of DHCS criteria.

- Seven of eight letters contained high-level language ("Progress on acquisition goals is between 60-85% in addition to decreased rates of behaviors over the reporting period").

- Seven of eight letters did not explicitly state how the case did not meet criteria. Letters stated services were denied because the member had improved on fewer hours of treatment; however, that requirement was not in criteria used to resolve the cases.

- The delegate did not supply provider NOA letters demonstrating that it provided a direct contact number for the requesting provider to contact the decision maker.

The Plan's 2018 annual audit of the delegate only reviewed approval letters. Therefore, the Plan did not review "Your Rights" attachments or NOA letters, which are sent for adverse benefit decisions.

Unclear NOA letters with incorrect member rights information may lead to poor healthcare choices by members.

Recommendation: Implement policies and procedures to ensure delegates' NOA letters and attachments meet current regulatory requirements.

1.1.6 Referral Tracking

The Plan is required to ensure that the UM program includes an established specialty referral system to track and monitor referrals requiring prior authorization (PA). The system shall include authorized, denied, deferred, or modified referrals, and the timeliness of the referrals. This specialty referral system should include non-contracting providers. (*Contract, Exhibit A, Attachment 5(1)(F)*)

Plan policy *UM-050, Tracking and Monitoring of Services Prior Authorized* stated the Plan maintained a system to track and monitor referrals requiring prior authorization that included authorized, denied, deferred, or modified referrals, and the timeliness of the referrals. This specialty referral system included non-contracting providers. Services requiring PA included out of network specialist referrals, podiatry and second opinions.

Finding: The Plan did not track all approved PAs; the specialty referral tracking process did not include modified PAs and in-network approved services.

The Plan implemented a tracking system as of April 2019 that included sending member notices when the member had not received an approved service timely. However, the Plan only included out-of-network open authorizations in this tracking system.

The Plan's specialty referral tracking system did not include monitoring of PAs with modified (partially approved, partially denied) decisions, as it counted these cases as denials; this was confirmed in the Plan's November 2018 Joint Operations Meeting minutes. Reporting modifications as denials is not consistent with the contract.

In an interview, the Plan did not report that it planned to expand the PA tracking to include all open authorizations.

This was finding 1.3.1 Prior Authorization Referral Tracking in the prior year's audit. The Plan responded to last year's finding that it did not have a tracking process for open authorizations by developing and implementing a tracking policy and report, and notifying providers of the new process.

Not tracking all open authorizations could result in missed opportunities to detect and correct underutilization of services.

This is a repeat of prior year finding 1.3.1 - Prior Authorization Referral Tracking.

Recommendation: Revise Plan processes to ensure tracking of all open PAs to completion.

1.2	PRIOR AUTHORIZATION REVIEW REQUIREMENTS

1.2.1 Retrospective Prior Authorizations (PA)

The Plan is required to ensure that its pre-authorization, concurrent review and retrospective review procedures include the following requirement: qualified health care professionals supervise review decisions, including service reductions, and a qualified physician will review all denials based on medical necessity. (*Contract, Exhibit A, Attachment 5(2)(A)*)

Plan policy *UM-001, Utilization Management* stated qualified physicians and pharmacists with unrestricted licenses supervised UM decisions and signed all denials based on medical necessity.

Finding: The Plan denied retrospective service requests without review by a medical director if the provider submitted the request more than 30 days after the service delivery date, or if requests did not meet Plan-imposed conditions. The Plan's contract did not specify submission timeframes or other conditions that, if not met, allowed eliminating medical necessity review of retrospective requests for covered services.

A review of PA data showed non-qualified Plan staff denied retrospective cases for administrative reasons other than non-eligibility for membership.

Plan policy *UM-001, Utilization Management* stated the Plan did not accept retrospective requests that did not meet certain requirements. This included post service requests for covered benefits not previously authorized and

- Not submitted within 30 days of service delivery
- Not involving member eligibility issues
- Not for inpatient services where the facility was unable to confirm member enrollment
- That were not post stabilization cases

In an interview, the Plan confirmed it allowed administrative denial of retrospective service requests by non-clinical Plan staff. The Plan reported challenges with multiple providers who exclusively submitted post service authorization requests in large volumes for services requiring PA.

The Plan responded to the previous year's audit finding (1.2.3 Retrospective Reviews) that it denied retrospective service requests without documentation of a qualified health care professional's review by updating its policy, and ensuring its provider communications accurately described the retrospective review process. However, the practice of not having a medical director review retrospective PAs that involved medical necessity continued.

Resolution of retrospective reviews in a manner that conflicts with contractual and regulatory requirements, including denial without a medical director review when medically necessary, may negatively affect providers' payments and their future willingness to provide services to Plan members.

This is a repeat of prior year finding 1.2.3 - Retrospective Reviews.

Recommendation: Revise policies and procedures to ensure a medical director reviews all medical necessity denials for services requiring PA, including denials for service requests received retrospectively.

1.2.2 Appropriate Processes for Approving Service Requests

The Plan's UM program is required to ensure it uses appropriate processes to review and approve the provision of medically necessary covered services. (*Contract, Exhibit A, Attachment 5(1)*)

The responsibilities of the Plan's Medical Director shall include ensuring that qualified medical personnel render medical decisions. *(Contract, Exhibit A, Attachment 1 (6) (A) (1)).*

According to B&P Code Section 2859, and the California Board of Licensed Vocational Nursing (LVN) and Psychiatric Technicians, LVNs are "dependent" practitioners directed by a physician or registered nurse (RN), who may perform only manual duties and basic data collection. While the dependent practitioner may collect basic explicitly defined data, he or she may not evaluate or analyze the data, and must not independently review any medical record. *(PL 14-004)*

Plan policy *UM-057, Authorization Service Request* stated LVNs approved PA requests using UM Committee approved criteria.

Finding: The Plan did not ensure it used appropriate processes to review and approve medically necessary covered services when it did not ensure that qualified medical personnel rendered medical decisions. Dependent practitioners reviewed, assessed and approved requests for continued hospital stays.

The Plan's Clinical Services Organizational Chart 2019 listed two dependent practitioners as Inpatient UM nurses who reviewed requests for continued hospital stays. The position of Inpatient UM Manager who directly supervised the practitioners was unfilled in the organizational chart.

A verification study of four of four inpatient reviews showed dependent practitioners performed the following activities:

- Independently selected criteria for continued hospital stay requests.
- Summarized case details.
- Determined whether cases met criteria for continued hospitalization or not.

In an interview, the Plan stated RNs and Medical Directors supervised dependent practitioners, but that they did not provide patient specific instructions to these individuals for UM reviews, and did not review all their cases.

UM processes that allow dependent practitioners to make UM decisions may result in health care decisions that adversely affect members.

Recommendation: Revise policies and procedures to ensure qualified medical personnel make medical decisions.

1.2.3 Notice of Action Letters

The Plan is required to notify members of decisions to deny, modify or defer PA requests as specified in HSC Section 1367.01. (*Contract, Exhibit A, Attachment 13(8)(A)*)

The notification shall clearly and concisely explain the reasons for the Plan's decision, and describe the criteria used. The provider letter shall include the decision-maker's direct phone number so that the requesting provider can easily contact him/her. (*H&S Code 1367.01(h)(4)*)

Plan policy *UM-054, Notice of Action* stated NOA letters would include "a clear and concise explanation of the reasons for the PA decision. The specific reasons for the denial shall be in easily understandable language and include the clinical reasons for a decision regarding medical necessity."

Plan policy *RX-011, Decision and Notification Requirements* stated NOAs would include clear and concise reasons for denials, the medication, amount, and requested duration of treatment denied, and criteria used to make the decision.

Finding: The Plan's notice of action (NOA) letters did not follow specifications in Health and Safety Code Section 1367.01. Provider letters in medical cases did not include the decision makers' direct phone number or contained the incorrect number. Letters did not explain the reasons for the denial. Pharmacy NOAs were not concise.

A verification study of 16 medical PAs and 14 pharmacy PAs showed deficiencies in the Plan's NOA letters:

- Five pharmacy letters were redundant and unnecessarily long.
- One pharmacy letter was unclear about whether the Plan denied the medication because it was not a covered benefit or was not medically necessary.
- Seven medical provider NOAs did not contain the decision maker's telephone number.
- Two medical NOAs did not give the clinical reasons for the denials, stating the Plan did not have enough information to decide without specifying the needed information.
- One medical letter was addressed to the incorrect provider.
- One medical letter was not translated into a threshold language.

The Plan's response to last year's audit finding (1.2.5 Member Notice of Action Letters) regarding deficient medical and pharmacy NOA letters included staff training, new NOA writing processes, NOA audit tools, and internal auditing for compliant letters. The Plan updated its NOA policy and reported that it continued to train staff on this issue. However, documentation showed continued deficiencies in NOA letters.

Unclear and unconcise NOA letters with incorrect information may leave members and providers poorly informed about PA decisions regarding needed services.

This is a repeat of prior year finding 1.2.5 - Member Notice of Action Letters.

Recommendation: Implement processes to ensure compliant NOA letters.

1.2.4 Provider Notification of PA Processes

The Plan is required to communicate to health care practitioners the procedures and services that require PA and ensure that all contracting health care practitioners are aware of the procedures and timeframes necessary to obtain prior authorization for these services. (*Contract, Exhibit A, Attachment 5(1)(E)*)

Plan policy *UM-057, Authorization Service Request* stated the plan would inform all contracted health care practitioners of the services requiring authorization and of authorization procedures and timeframes.

Finding: The Plan did not ensure that all contracting practitioners were aware of the procedures for orthotic items; the Plan provided inaccurate information about authorization requirements for orthotic items.

The Plan's Referral and Prior Authorization (PA) Grid informed providers that orthotics, such as shoe inserts, were only available to diabetic Medi-Cal members. The latter is not consistent with Medi-Cal criteria. The Plan reported it used Medi-Cal criteria for orthotics and considered requests for orthotics for non-diabetic members.

The Plan responded to last year's audit finding (1.2.7 Provider Notification of PA Processes) that it inaccurately informed providers of the podiatry benefit by reporting that it updated its PA grid and provider training presentation.

Misinformation regarding covered benefits may prevent providers from requesting medically necessary covered benefits.

Recommendation: Revise provider PA authorization information; ensure authorization requirements are accurate.

1.3	PRIOR AUTHORIZATION APPEAL PROCESS

1.3.1 Appeal Resolution Letters

The Plan is required to follow government regulations in sending appeal notification letters. If the Plan upholds its original decision on appeal, the Notice of Appeal Resolution (NAR) shall include the reasons and criteria used for the determination. For overturned decisions, the NAR shall explain the reason for the decision clearly and concisely. (*All Plan Letter 17-006*)

Plan policy *G&A-008, Adverse Benefit Determination Appeals Process* described appeal notification letters that met regulatory requirements.

Finding: The Plan's appeal notification letters did not comply with contractual regulations. NAR letters were not clear or concise, and contained inaccurate information.

A verification study of 11 appeals showed deficient NAR letters:

- Three of 11 letters contained inaccurate information that resulted in unclear appeal decisions. In one case, the letter stated the Plan denied a medication and included that same medication as an alternative treatment.

- Four of 11 letters contained information that made the letter unnecessarily long and confusing.

In an interview, the Plan reported Medical Directors contributed to the writing of appeal letters. In each case, they included information about the decisions that led to the appeal in order to inform members completely about the Plan's determinations.

Without clear information about Plan appeal processes and decisions, members may be confused and unable to make informed decisions about their health care.

Recommendation: Implement processes to ensure appeal letters that accurately, clearly and concisely convey the Plan's appeal decisions and members' rights.

❖ COMPLIANCE AUDIT FINDINGS (CAF) ❖
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CATEGORY 2 – CASE MANAGEMENT AND COORDINATION OF CARE

2.1	**BASIC CASE MANAGEMENT** **CALIFORNIA CHILDREN'S SERVICES (CCS)** **EARLY INTERVENTION/DEVELOPMENTAL DISABILITIES** **INITIAL HEALTH ASSESSMENT**

2.1.1 Health Risk Assessment

The Plan is required to administer a DHCS approved health risk assessment survey within 45 days for Senior and Persons with Disabilities (SPD) members deemed to be at higher risk, and 105 days for those determined to be a lower risk. (*Contract, Exhibit A, Attachment 10(4)*)

Plan policy *CM-008, SPD Health Risk Assessment – Stratification and Process* stated the Plan performs a Health Risk Assessment (HRA) survey for members within 45 days of enrollment for those identified as higher risk and within 105 days of enrollment for those identified as lower risk.

Finding: The Plan did not follow the specified timeframes required for completion of the HRAs for newly enrolled SPD members. The Plan did not ensure that HRAs were completed within 45 calendar days of enrollment for those identified by the risk stratification mechanism as higher risk, and within 105 calendar days of enrollment for those identified as lower risk.

A verification study revealed 7 of 8 new SPD member HRA files did not have the HRA completed within the required timeframes:

- For six high-risk members, the Plan completed HRAs between 70 and 216 calendar days after their enrollment dates.

- For one low-risk member, the Plan completed the HRA 121 calendar days after their enrollment date.

In interviews, the Plan expressed the need for improvement and acknowledged staffing shortages that contributed to challenges in meeting the required timeframes.

Delays in conducting health risk assessments may result in adverse healthcare outcomes for SPD members.

Recommendation: Implement policies and procedures to ensure the completion of health risk assessments within the required timeframes.

2.1.2 Required Component of an Initial Health Assessment (IHA)

The Plan must cover and ensure the provision of an Initial Health Assessment to each new member within 120 days of enrollment. An IHA consists of a comprehensive history and physical examination, preventive services, and an Individual Health Education Behavioral Assessment. (*Contract, Exhibit A, Attachment 10(3)(A), (5)(A)(2), and Policy Letter 08-003*)

The Plan is required to ensure that the latest edition of the Guide to Clinical Preventive Services published by the U.S. Preventive Services Task Force (USPSTF) is used to determine the provision of clinical preventive services to asymptomatic, healthy adult Members [age 21 or older]. All preventive services identified as USPSTF "A" and "B" recommendations must be provided. (*Contract A17, Exhibit A, Attachment 10(6)(B)(1*))

Status of current USPSTF "A" and "B" recommended services must be documented. (*Policy Letter 08-003*)

According to Plan policy *QM-124, Initial Health Assessment (IHA)/Health Information Form/ Member Evaluation Tool (HIF/MET)*, an IHA is a comprehensive assessment that is completed during a member's initial encounter(s) with his/her Primary Care Physician (PCP). An IHA consists of a comprehensive history and exam, diagnosis and plan of care, preventive services and the Individual Health Education Behavioral Assessment (IHEBA). The Plan adheres to the current edition of the Guide to Clinical Preventive Services of the U.S. Preventive Services Task Force, in particular the Grade "A" and "B" recommendations. Plan providers must document the status of current recommended services.

Finding: The Plan did not ensure that all providers documented all required components of an IHA. Preventive services identified as USPSTF "A" and "B" recommended services were not provided, or status of these recommended services was not documented.

A verification study of 10 member medical records was conducted. Preventive services identified as USPSTF "A" and "B" recommended services were missing screenings for colorectal in 6 records, hepatitis C in 7 records, HIV in 6 records, and lung cancer in 5 records. Status of these recommended services was not documented.

The Plan's resources for providers to provide preventive services to members were not consistent with the current edition of the Guide to Clinical Preventive Services published by the USPSTF. The Plan's New Provider Orientation Packet and New Provider Orientation presentation did not include USPSTF "A" and "B" recommended preventive services.

As of March 2019, quality meeting minutes stated the Plan adopted the most current version of the USPSTF preventive guidelines. In addition, the Plan's provider website provided a link to the USPSTF recommendations and reproduced the current set of USPSTF "A" and "B" recommended services. However, the Provider Manual only guided providers to the Guide to Clinical Preventive Services dated 2014. Providers received inconsistent information instead of clear guidance that they were required to provide the most current USPSTF "A" and "B" services.

During onsite clinic visits, four providers were interviewed and all confirmed that the Plan did not provide training on the required components of an IHA including USPSTF "A" and "B" preventive health services or documentation of the status of these services. Providers stated they used their own knowledge in the provision of preventive services to members.

Preventive services are important to assess and reduce member's risks for diseases and to identify and prevent illnesses. Inconsistent information about preventive care services may lead to missed contractually required service provision and poor member health outcomes.

Recommendation: Implement policies and procedures and revise provider-informing materials to require provision of required components of an IHA, particularly USPSTF "A" and "B" recommended preventive services. Document status of these recommended services.

2.2	COMPLEX CASE MANAGEMENT

2.2.1 Complex Case Management (CCM) Program

The Plan is required to maintain procedures for monitoring the coordination of care provided to members, including but not limited to all Medically Necessary services delivered both within and outside the Plan's provider network. These services are provided through either basic or complex case management activities based on the medical needs of the member. (*Contract, Exhibit A, Attachment 11(1)*)

Plan policy *CM-002, Complex Case Management Plan Development and Management* stated cases that remain open after 90 days require review at Case Rounds. Cases where the Case Manager deems multi-disciplinary assistance is needed can be referred at any time to weekly Case Rounds. Members of the care team conducted case rounds.

Finding: The Plan did not implement its monitoring of the CCM program to address member needs. The Plan did not close its CCM cases after 90 days, or present them at Case Rounds as stated in its policy.

A verification study of 10 CCM cases revealed seven cases remained open for more than 90 days after development of the care plans. Three of the 7 cases did not have documentation of Case Round reviews.

This was finding 2.5.1 Monitoring of Complex Case Management Program in the prior two DHCS audits. The Plan's corrective action included implementation of a daily Aging Report to monitor timeframes for CCM case closure and ongoing assessment of member care. According the to the Plan, each case manager is responsible for reviewing and presenting their own cases over 90 days at case rounds. A review shows the Plan did not implement its CAP and close or present all cases over 90 days at case rounds.

The lack of monitoring may delay reassessment and identification of possible impending needs, or improvements in the care for CCM members.

This is a repeat of prior year finding 2.5.1 - Monitoring of Complex Case Management Program.

Recommendation: Revise and implement procedures to monitor the provision of CCM services.

CATEGORY 3 – ACCESS AND AVAILABILITY OF CARE

3.1	APPOINTMENT PROCEDURES AND MONITORING WAIT TIMES

3.1.1 Provider Directory Accuracy

The Plan is required to distribute a provider directory that includes the following information: name, provider number, and telephone number of each Service Location. In the case of a medical group/foundation or independent practice association, the medical group name, provider number, address and telephone number shall appear for each physician provider. (*Contract, Exhibit A, Attachment 13(4)(D)(4)*)

The Plan is required to ensure the accuracy of the provider directory information by updating the online directory at least weekly or more frequently and when informed of and upon confirmation by the Plan of any information that affects the content or accuracy of the provider directory. Plans shall at least annually review and update the entire provider directory for each product offered. (*H&S Code 1367.27*)

Finding: The Plan did not maintain an accurate provider directory.

DHCS conducted an appointment availability verification study that included 51 providers. This study measured the Plan's average member wait times to obtain an appointment and verified the accuracy of the Plan's provider directory information.

The verification study identified the following deficiencies related to the Plan's provider directory:

- One PCP was in the provider's appointment system but was not available for scheduling.
- Three specialist telephone numbers were incorrect.
- Three OB/GYN telephone numbers were for providers that did not work at the location listed.
- Three OB/GYN telephone numbers were incorrect.
- The provider directory listed one OB/GYN as accepting new members, but the provider stopped accepting new members as of January 2018.

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As a corrective action for the prior year's audit finding 3.1.2 Provider Directory Accuracy, the Plan revised its monitoring procedures to verify 10 providers per week to update and maintain an accurate provider directory. However, the verification study revealed continued deficiencies in the Plan's provider directory.
Inaccurate information on the provider directory may lead to barriers for members' access to care.

This is a repeat of prior year finding 3.1.2 - Provider Directory Accuracy.

Recommendation: Develop and implement policies and procedures to update provider directory to reflect accurate information.

3.3 EMERGENCY SERVICES AND FAMILY PLANNING CLAIMS

3.3.1 Family Planning Claims

The Plan is required to reimburse non-contracting family planning providers at no less than the appropriate Medi-Cal FFS rate. (*Contract, Exhibit A, Attachment 8(9)*)

The Plan shall not improperly deny, adjust or contest a claim. (*CCR, Title 28, Section 1300.71(d)(1)*)

Plan policy *CLM-010, Family Planning and Sensitive Services Claims Processing* stated the Plan's claims department would ensure family planning claims do not require prior authorization, in- and out-of-network.

Finding: The Plan paid non-contracted family planning services at less than the Medi-Cal Fee-For-Service rate. The Plan's claim system misclassified non-contracted family services as non-billable. The Plan is required to pay all covered family planning services regardless if these services are contracted with the Plan.

A verification study of 20 family planning claims found four claims denied as non-billable services.

The Plan utilized a contract to adjudicate claims submitted by a provider. The Plan contracted with a provider for family planning services; however, not all family planning services were listed in the contract. The claims system was configured to deny any family planning service not specifically listed in the contract. This configuration resulted in the denial of four family planning claims, service code 87806, HIV Testing, because the service code was not listed in the contract. Any family planning claims not listed in the contract should have been treated as non-contracted family planning claims and paid at no less than the Medi-Cal Fee-For-Service rate as these are covered benefits.

Inappropriate denials and reimbursements of family planning claims may limit members' access to care and discourage providers from participating with the health plan if not properly reimbursed.

Recommendation: Implement policies and procedures and configure the claims system to ensure appropriate adjudication of all family planning claims.

3.3.2 Minor Consent Services

The Plan is required to ensure the provision of Minor Consent Services for children under the age of 18. The Plan is required to inform members of the availability of these services. Minors do not need parental consent to access services family planning services at any age, and sexually transmitted disease (STD) services in children 12 years of age or older. (*Contract, Exhibit A, Attachment 9(9)(D)*)

Minors can consent to family planning services at any age. Minors can consent to STD services at 12 years of age or older. (*CCR, Title 22, Section 50063.5*)

Plan policy *CLM-010, Family Planning and Sensitive Services Claims Processing* stated parental consent is not required for minors 12 years or older to obtain medical care related to the diagnosis and treatment of STDs. The Plan's policies and procedures do not address parental consent or member age limitations for family planning services.

Finding: The Plan did not inform members of the correct minor consent provision for family planning services in its Evidence of Coverage (EOC).

The Plan's EOC informs members they may access minor consent services without consent from their parents or guardians for family planning (minors 12 years of age or older). The Plan's EOC incorrectly places age limitation on all family planning services; the Contract only restricts STD testing to minors 12 years of age or older. Minors are allowed to access all other family planning services at any age.

When the Plan places age restrictions on family planning services, this may create barriers to members accessing care, and may cause members to avoid seeking care for lack of parental or guardian consent.

Recommendation: Revise the Evidence of Coverage document to ensure member notification of the correct provisions for all minor consent services.

3.4 ACCESS TO PHARMACEUTICAL SERVICES

3.4.1 Monitoring of the Provision of Drugs Prescribed in Emergency Situations

The Plan is required to ensure the provision of drugs prescribed in emergency circumstances in amounts sufficient to last until the Member can reasonably be expected to have the prescription filled. (*Contract, Exhibit A, Attachment 10(8)(G)(1) and CCR, Title 22, Section 53854(1), (2), & (3)*)

Plan policy *RX-009, Emergency Supply Provision* addresses overutilization of emergency supply drugs. The Plan's monitoring policy does not address the provision of sufficient amounts of drugs prescribed in emergency situations.

Finding: The Plan did not monitor the provision of drugs prescribed in emergency situations.

The Plan stated it monitored drugs prescribed in emergency situations by reviewing pharmacy data for overutilization. The data did not include any member specific information and did not evaluate whether members who did not have a corresponding paid claim had access to an emergency drug supply after an emergency room discharge. The reports monitored overutilization and abuse but did not ensure adequate access to emergency supply of drugs.

As a corrective action plan to the prior audit deficiency (3.6.1 Emergency Provision of Drugs) of not monitoring the provision of drugs prescribed in emergency situations, the Plan revised policy *RX-009*. The revised policy did not address the prior year deficiency. The Plan did not revise its processes and only included its vendor as an alternate responsible party for monitoring overutilization of paid emergency drug supplies.

When the Plan does not monitor whether members have access to an emergency supply of drugs prescribed in emergency situations, the Plan cannot determine whether members lacked access to medically necessary drugs.

This is a repeat of prior year finding 3.6.1 - Emergency Provision of Drugs.

Recommendation: Develop and implement a system to monitor and ensure the provision of prescribed drugs in emergency situations.

CATEGORY 4 – MEMBER'S RIGHTS

4.1	GRIEVANCE SYSTEM

4.1.1 Clinical Grievance Resolution

The Plan is required to ensure that the person making the final decision for the proposed resolution of a grievance shall be a health care professional with clinical expertise in treating a beneficiary's condition or disease for any grievance involving clinical issues. (*All Plan Letter 17-006*)

Plan policy G*&A-003, Grievance Receipt, Review and Resolution* stated the person making the final decision for grievance involving clinical issues would be a treating health-care professional.

Finding: The Plan did not document review and final resolution of clinical grievances by a qualified health care professional.

A verification study showed non-compliant processing of grievances involving clinical issues:

- In six of 9 grievances, a medical director did not resolve the cases.

The Plan responded to last year's audit finding 4.1.1 Review of Quality of Care Grievances by updating its grievance procedures to include medical director review for quality of care grievances. The new procedure stated a clinical nurse would send cases to a medical director after their review; the medical director would resolve the case prior to sending resolution letters. However, documentation received did not demonstrate medical director reviews for all clinical grievances.

Inappropriate grievance resolution may lead to missed opportunities to improve the quality of clinical care.

This is a repeat of prior year finding 4.1.1 - Review of Quality of Care Grievances.

Recommendation: Implement policies and procedures to ensure a health care professional with clinical expertise in treating a beneficiary's condition or disease resolves grievances involving clinical issues.

4.1.2 Capturing All Expressions of Dissatisfaction as Grievances

The Plan is required to implement and maintain a Member Grievance System in accordance with Title 22 CCR Section 53858. (*Contract, Exhibit A, Attachment 14(1)*)

The Plan is required to establish a grievance system. A Grievance means a written or oral expression of dissatisfaction regarding the plan and/or provider. Where the plan is unable to distinguish between a grievance and an inquiry, it shall be considered a grievance. (*CCR, Title 22, Section 1300.68(a)(1)*)

Plan policy *G&A-001, Grievance and Appeals System Description* stated a member does not need to use the term 'Grievance' for a complaint to be captured as an expression of dissatisfaction and, therefore, a Grievance.

Finding: The Plan's grievance system did not capture all complaints and expressions of dissatisfaction reported by members.

A review of 47 grievances found that for three, not all complaints or issues were fully captured.

- In one case, a member complained about:

  1. A prescription not being ready when the pharmacy called the member to pick up their medication
  2. A pharmacy losing their prescription
  3. A pharmacist's rudeness
  4. Long wait times to pick up medications

  The Plan's resolution letter only addressed and resolved the member's complaint of the pharmacy losing their medication. The Plan did not capture or address any of the member's other three complaints.

- In another case, a member complained about:

  1. Cancellation of appointments
  2. Physician talking over the member
  3. Physician's refusal to provide sleep study results
  4. Lack of communication/instructions from staff
  5. Rude receptionist and being kicked out of the provider's office

  The Plan's resolution letter did not address the member's complaint of the physician's refusal to provide the member's sleep study results.

When grievances are not captured by the Plan, member complaints may not be addressed, investigated and resolved appropriately.

Recommendation: Implement policies and procedures to capture all expressions of dissatisfaction.

4.1.3 Capturing All Grievances Filed Through Providers

The Plan is required to implement and maintain a Member Grievance System in accordance with Title 22 CCR Section 53858. (*Contract, Exhibit A, Attachment 14(1)*)

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

Plan policy *G&A-001, Grievance and Appeals System Description* stated a member does not need to use the term 'Grievance' for a complaint to be captured as an expression of dissatisfaction and, therefore, a Grievance.

Finding: The Plan's grievance system did not capture all complaints and expressions of dissatisfaction filed through Plan providers.

Interviews with four providers revealed they processed grievances internally and did not forward complaints to the Plan. The Plan did not delegate grievance functions to these providers. The Plan's delegation agreement with these providers stated that all member grievances received must be forwarded to the Plan. The Plan's policies do not address grievances filed through its provider network.

This was finding 4.1.4 Capturing All Grievances in the prior audit. As a corrective action, the Plan stated it provided training to the prior year's identified provider groups to ensure that they forwarded all expressions of dissatisfaction to the Plan. However, the corrective action did not resolve the prior year's deficiency.

When grievances are not processed by the Plan, member complaints may not be addressed, investigated and resolved appropriately. Additionally, the Plan would not be aware of any potential issues within its provider network.

This is a repeat of prior year finding 4.1.4 - Capturing All Grievances.

Recommendation: Develop and implement processes to capture all expressions of dissatisfaction filed through network providers.

4.1.4 Grievance Resolution/Grievance Process

Contractor is required to implement and maintain a Member Grievance System in accordance with CCR, Title 22, Section 53858 and Title 28, Section 1300.68. (*Contract, Exhibit A, Attachment 14(1)*)

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

Resolved means that the grievance has reached a final conclusion with respect to the enrollee's submitted grievance, and there are no pending enrollee appeals within the Plan's grievance system, including entities with delegated authority. (*CCR, Title 28, Section 1300.68(a)(4)*)

Plan policy G&A-001 Grievance and Appeals System Description stated the Plan ensures 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, and there are no pending enrollee appeals within the Plan's grievance system, including entities with delegated authority.

Finding: The Plan sent member resolution letters without completely resolving all complaints.

A review of 47 grievances found that 18 were not fully resolved.

- In two cases, members complained the Plan's mental health delegate was unable to provide mental health services. Plan's resolution letter stated, the delegate would continue to make efforts to search for a mental health provider for the members. The Plan closed the grievance prior to resolving the members' complaint.

- In one case, a member complained about the cancellation of appointments, a physician talking over the member, the lack of communication/instructions from staff, and a rude receptionist and being kicked out of the provider's office. The Plan's resolution letter did not address any of the member's complaints. The Plan stated the member's concerns were further reviewed; the results could not be shared with the member due to privacy laws. However, none of the member's complaints involve physician reviews which are subject to privacy laws.

- In one case, a member complaint about being retaliated against for filing a previous grievance, wanting to know why they were discharged, and a named administrator's rudeness towards the member. The Plan's resolution letter did not address two of the member's complaints and the third complaint was inaccurate. The Plan stated that there was no administrator by the name the member provided; however, the Plan's notes showed the grievance coordinator spoke with an individual at the provider's office with the same name.

- In another case, a member requested a reimbursement for the insulin supplies from out of network provider that was paid out of pocket for three months. The resolution letter only addressed reimbursement for one of the three months requested.

This was finding 4.1.2 Grievance Resolutions / Grievance Process in the prior two audits. As a corrective action, the Plan stated it updated its grievance checklist to include a process for resolving all complaints within 30 days. However, the grievance checklist did not have any updates related to the resolution of all member grievances. The Plan's corrective action did not address the prior year's finding.

If grievances are not fully resolved, this may lead to adverse health outcomes for members.

This is a repeat of prior year finding 4.1.2 - Grievance Resolutions / Grievance Process.

Recommendation: Implement policies and procedures to ensure all complaints are resolved prior to sending a resolution letter to members.

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CATEGORY 5 – QUALITY MANAGEMENT

5.1	QUALITY IMPROVEMENT SYSTEM DELEGATION OF QUALITY IMPROVEMENT ACTIVITIES

5.1.1 Quality Improvement System (QIS) Written Description

The Plan is required to implement and maintain a written description of its QIS that shall include the following: Qualifications of staff responsible for quality improvement studies and activities, including education, experience and training. (*Contract, Exhibit A, Attachment 4(7)(C)*)

Plan policy *QI-101, Quality Improvement Program* stated its QI Program Description (QIPD) would include qualifications of staff responsible for QI studies and activities.

Finding: The Plan's QI Program did not include qualifications of staff responsible for quality improvement studies and activities, including education, experience and training.

The Plan's 2019 QIPD described multiple QI positions as unfilled, and therefore did not include staff education, experience and training. However, the QIPD contained a QI organizational chart with the following filled positions:

- CMO
- Quality Improvement Supervisor
- Health Education Manager
- Quality Programs Coordinator
- Senior QI Nurse Specialist
- Quality Review Nurse
- Health programs Coordinator
- Health Education Specialist
- Quality Improvement Project specialist

The QIPD did not list the above individuals' qualifications, which was inconsistent with Plan policy.

Listing the credentials of staff responsible for QI confirms/supports the Plan's commitment to ensure the provision of high value health care services through the employment of qualified individuals.

Recommendation: Implement policies and procedures to include qualifications of staff responsible for QI studies and activities in the QIPD.

5.2	PROVIDER QUALIFICATIONS

5.2.1 Provider Training Requirements

The Plan is required to ensure that all providers receive training regarding the Medi-Cal managed care services, policies, procedures, and any modifications to existing services, policies or procedures. The Plan is required to conduct training for all providers within 10 working days after the Plan places a newly contracted provider on active status. (*Contract, Exhibit A, Attachment 7(5)(A)*)

Plan policy *PRV-001, New Provider Orientation* stated within 10 business days of the newly contracted provider's effective date, the assigned provider relations representative conducts a provider orientation by scheduling an appointment with the contracted provider. The newly contracted provider acknowledges receipt of the training and materials by signing an attestation through a digital signature process, acknowledging receipt of the training and materials. The Provider Services Department will ensure provider orientations occur by monitoring the list of newly contracted providers against a provider orientation log.

Finding: The Plan did not ensure provider training was conducted within 10 working days.

Review of the Plan's new provider training records found the following deficiencies:

- A verification study found 13 of 20 newly contracted providers did not receive training within the 10 working day requirement. These providers received training between 13 and 265 days after they became active with the Plan. One of the providers was listed as completing training but the Plan did not have a signed attestation of completion.

- The provider orientation log, which tracks timely completion of new provider training, showed 9 providers did not receive training.

- Comparison of the provider orientation log and newly contracted provider list found 8 new providers were not included on the orientation log and did not receive training.

This was finding 5.2.1 Completion of Provider Training in the prior year audit. As part of its corrective action plan, the Plan stated it would conduct staff training; however, the Plan did not provide documentation of staff training. The Plan's corrective action plan did not address the prior year's deficiency.

In an interview, Plan staff acknowledged lack of compliance with some network providers in conducting provider training within 10 working days.

When new provider training is not completed and documented, the Plan cannot ensure providers operate in full compliance with the Contract.

This is a repeat of prior year finding 5.2.1 - Completion of Provider Training.

Recommendation: Implement policies and procedures to ensure providers receive new provider training within 10 working days after being placed on active status.

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CATEGORY 6 – ADMINISTRATIVE AND ORGANIZATIONAL CAPACITY

6.2	FRAUD AND ABUSE

6.2.1 Fraud and Abuse Reporting

The Plan is required to report to DHCS all cases of suspected fraud or abuse where there is reason to believe that an incident of fraud and/or abuse has occurred by subcontractors, members, providers, or employees. The Plan shall conduct, complete, and report the results of a preliminary investigation of the suspected fraud or abuse to DHCS within 10 working days of the date the Plan first becomes aware of, or is on notice of, such activity. (*Contract, Exhibit E, Attachment 2(26)(B)(4)*)

Plan policy, *CMP-002 Fraud, Waste, and Abuse* stated that the compliance department will report all suspected fraud, waste, and abuse (FWA) incidents to DHCS within 10 working days of the date the Alliance becomes first aware or notified of the suspected activity. The compliance department will submit the confidential complaint form with the required reporting information along with the preliminary investigation summary.

Finding: The Plan did not conduct and report preliminary investigations of all suspected cases of fraud and abuse to DHCS within 10 working days.

A verification study revealed the Plan did not conduct a preliminary investigation in 7 of 12 of cases reported to DHCS, for example:

- In one case, the plan reported to DHCS its Compliance Department received a report about a member stating they had never been to a named pharmacy for medications. The report to DHCS did not include any preliminary investigation details and stated “the case is currently under investigation.”

- In another case, the Plan reported to DHCS a member received a notice of action letter for Intensive Care Unit (ICU) services and approval for surgery. The member alleged to not have been in the ICU and did not receive surgery. The report to DHCS did not include any preliminary investigation details and stated “the case is under investigation.”

This was finding 6.3.1 Fraud and Abuse Reporting in the prior two audits. As part of the corrective action, the Plan updated its desktop procedure *Fraud, Waste, and Abuse (FWA) Investigations* to require the Compliance Auditor to report FWA cases to DHCS within 10 working days from the date the incident was reported to the Compliance Department. The Plan's corrective action does not address the prior audits deficiency to report and conduct preliminary investigations.

If the Plan does not conduct preliminary investigations into suspected incidents, it could delay the detection and later prevention of actual fraud, waste, and abuse.

This is a repeat of prior year finding 6.3.1 - Fraud and Abuse Reporting.

Recommendation: Implement policies and procedures to conduct and report preliminary investigations of all suspected cases of fraud and abuse.

6.2.2 Fraud and Abuse Investigation

The Plan is required to establish a mandatory compliance plan designed to guard against fraud and abuse. The Plan is required to establish policies and procedures for identifying, investigating and providing a prompt response against fraud and/or abuse, and provide for the development of corrective action initiatives. (*Contract, Exhibit E, Attachment 2(26)(B)(1)*)

Plan policy *CMP-002, Fraud, Waste, and Abuse* identified the mechanisms of how the Plan identified, investigated, and provided prompt responses against fraud and/or abuse.

The Plan's FWA Investigation Desktop procedure stated that the Compliance Auditor would immediately investigate the FWA incident and gather all pertinent information from the reporting department or person.

Finding: The Plan did not investigate all suspected fraud and abuse incidents promptly. The Plan did not conduct a preliminary or follow-up investigation of 4 of 12 suspected fraud and abuse cases until two to six months after it became aware of the incidents.

This was prior audit finding 6.3.2 Fraud and Abuse Investigation. As a corrective action, the Plan updated its FWA Investigations desktop procedure to require a complete investigation form for all case files. The verification study found that the Plan did include complete investigation forms; however, the investigations were not conducted promptly. The Plan's corrective action plan did not address conducting prompt investigations.

If the Plan does not conduct prompt investigations of suspected incidents, it could delay the detection and later prevention of actual fraud, waste, and abuse.

This is a repeat of prior year finding 6.3.2 - Fraud and Abuse Investigation.

Recommendation: Revise and implement policies and procedures to promptly investigate all fraud and abuse incidents.

6.2.3 Compliance Officer

The Plan is required to meet the requirements set forth in 42 CFR 438.608 and establish an Anti-Fraud and Abuse Program in which there will be a compliance officer and a compliance committee for all fraud and/or abuse issues, and who shall be accountable to senior management. (*Contract, Exhibit E, Attachment 2(B)(1)*)

The Compliance Officer is responsible for developing and implementing policies, procedures, and practices designed to ensure compliance with the requirements of the contract. (*Title 42, CFR, Section 438.608(a)(1)(ii)*)

Plan policy *CMP-001, Compliance Program* stated the compliance officer is responsible for updating, revising, and evaluating the effectiveness of the compliance program annually. The compliance officer monitors the compliance program and identifies areas that require modification.

The Plan's compliance officer did not develop and implement fraud, waste, and abuse policies and procedures.

An internal Plan memo showed the Plan designated the head of another department as Chief Compliance Officer in September 2018. The memo and a job description stipulated that the appointed Compliance Officer conducted oversight of the compliance program but did not describe development or implementation of the compliance program.

Compliance meeting minutes shows that the individual attended meetings but did not approve compliance policies and procedures, 2019 Anti-Fraud Program, and the Code of Conduct. In an interview, the Plan stated the development and implementation of compliance policies and processes were the responsibility of the Compliance Director who reports to the Compliance Officer.

Without the Compliance Officer's participation in the development and implementation of the FWA policies and procedures, the Plan cannot ensure the appropriate individual monitors the compliance program and identifies areas that require modification.

Recommendation: Develop and implement policies and procedures to ensure the compliance officer develops and implements processes as required by the contract.

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

REPORT ON THE MEDICAL AUDIT OF

Alameda Alliance for Health

Contract Number: 03-75793
State Supported Services

Audit Period: June 1, 2018
Through
May 31, 2019

Report Issued: October 21, 2019

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I. INTRODUCTION

This report presents the audit findings of the Alameda Alliance for Health (the Plan) State Supported Services contract No. 03-75793. The State Supported Services contract covers contracted abortion services with the Plan.

The on-site review was conducted from June 10, 2019 through June 21, 2019. The audit period is June 1, 2018 through May 31, 2019 and consisted of document review, verification study, and interviews with Plan personnel.

An Exit conference was held on September 18, 2019 with the Plan. The Plan was allowed 15 calendar days from the date of the Exit Conference to provide supplemental information addressing the draft audit report findings. The Plan submitted a response after the exit conference. The results of our evaluation of the Plan's response are reflected in this report.

Twenty State Supported Services claims were reviewed for appropriate and timely adjudication.

❖ COMPLIANCE AUDIT FINDINGS (CAF) ❖

PLAN: Alameda Alliance for Health

AUDIT PERIOD: June 1, 2018 through May 31, 2019
DATE OF AUDIT: June 10, 2019 through June 20, 2019

STATE SUPPORTED SERVICES CONTRACT REQUIREMENTS

Abortion
Contractor agrees to provide, or arrange to provide, to eligible Members the following State Supported Services:
Current Procedural Coding System Codes*: 59840 through 59857
HCFA Common Procedure Coding System Codes*: X1516, X1518, X7724, X7726, Z0336

**These codes are subject to change upon the Department of Health Services' (DHS') implementation of the Health Insurance Portability and Accountability Act of 1996 (HIPAA) electronic transaction and code sets provisions. Such changes shall not require an amendment to this Contract.*
State Supported Services Contract Exhibit A.1

SSS.1 Misdirected Claims

The Plan is required to within ten (10) working days of receipt of a claim forward the claim to the appropriate capitated provider. (*CCR, Title 28, Section 1300.70(b)(2)(B)*)

Plan policy *CLM-001, Claims Processing* stated misdirected claims must be forwarded to the appropriate financially responsible entity within ten working days of receipt.

Finding: The Plan did not forward all misdirected claims within 10 working days.

A verification study found the Plan did not forward 4 of 20 abortion service claims that were the responsibility of a delegate entity. The Plan stated these claims were not forwarded due to a system configuration issue that prevented forwarding of the claims to the delegated entity.

When the Plan does not forward all misdirected claims to the appropriate entity, providers may be discouraged from participating with the Plan if not properly reimbursed.

Recommendation: Implement policies and procedures and configure the claims system to ensure appropriate forwarding of misdirected claims within the required timeframe.