

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

REPORT ON THE MEDICAL AUDIT OF

Alameda Alliance for Health

2021

Contract Number: 04-35399

Audit Period: June 1, 2019
Through
March 31, 2021

Report Issued: August 17, 2021

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I. INTRODUCTION

Alameda Alliance for Health (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 (W&I), section 14087.54. While it is a part of the county's health system, the Plan is an independent entity that is separate 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 March 31, 2021, the Plan had 281,637 members of which 249,410 (88.55 percent) were Medi-Cal members and 26,234 (9.31 percent) were Seniors and Persons with Disabilities (SPD) members, and 5,993 (2.13 percent) 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, 2019 through March 31, 2021. The onsite review was conducted from April 13, 2021 through April 23, 2021. The audit consisted of document review, verification studies, and interviews with Plan representatives.

An Exit Conference with the Plan was held on July 20, 2021. 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 DHCS' 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, 2018 through May 31, 2019) was issued on October 21, 2019. This audit examined documentation for contract compliance and assessed implementation of the Plan's 2019 Corrective Action Plan (CAP).

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

The summary of findings by category follows:

Category 1 – Utilization Management

Category 1 includes procedures and requirements for the Plan's UM program, including delegation of UM, prior authorization review and the appeal process.

The Plan is required to cover and ensure the provision of screening, preventive and medically necessary diagnostic, and treatment services for members under 21 years of age. The Plan is prohibited from imposing service limitations on any Early Periodic Screening, Diagnostic, and Treatment (EPSDT) benefit other than medical necessity. The Plan did not have appropriate processes to ensure that limitations on speech therapy services would not be imposed for members under 21 years old.

The Plan is required to review prior authorization for intravenous (IV) sedation and general anesthesia for dental services and ensure that qualified health care professionals supervise and review decisions. In addition, the Plan must ensure that anesthesia providers submit documentation outlining the patient's need for IV sedation or general anesthesia and ensure that dental providers meet the requirements for chart documentation. The Plan did not ensure that a qualified health care professional reviewed dental anesthesia prior authorization requests or related clinical data. The Plan did not ensure the use of appropriate criteria/guidelines when reviewing dental anesthesia requests.

The Plan is required to ensure that delegates are in compliance with all applicable Medi-Cal requirements, state and federal laws, and contractual requirements. Several systemic deficiencies were identified in functions delegated by the Plan. Some delegated prior authorizations were inappropriately denied, others were either not reviewed or decided by qualified health care professionals, and a few did not include all the required elements in the Notice of Action (NOA). Furthermore, the Plan did not obtain complete ownership and control disclosure information from its delegates. The Plan did not ensure its delegation agreements included all required provisions and did not have policies or procedures for imposing financial sanctions on its delegates.

Category 2 – Case Management and Coordination of Care

Category 2 includes requirements to provide Complex Case Management (CCM) and Health Risk Assessments (HRA) for SPD.

The Plan is required to administer a DHCS approved HRA survey within 45 days for SPD members deemed to be at a higher risk, and 105 days for those determined to be a lower risk. For the duration of the Covid-19 public health emergency, the HRA survey is to be administered within 135 days of enrollment, for high risk members, and within 195 days of enrollment, for low risk. The Plan did not conduct HRAs within the required timeframes for newly enrolled SPD members in 2019 and 2020.

The Plan is required to have procedures for monitoring the coordination of care provided to members and ensure the coordination of care for all medically necessary services delivered both within and outside the Plan's provider network. The Plan did not ensure coordination of care in certain cases where EPSDT services were medically necessary. The Plan did not consistently implement its CCM care plan procedures.

The Plan, in collaboration with the Primary Care Provider (PCP), is required to provide CCM services including the management of acute or chronic illness by a multidisciplinary case management team, development of care plans specific to individual needs, and updating these plans at least annually with member and PCP input. The Plan did not ensure the completion of Individualized Care Plans (ICP) for members enrolled in CCM and did not ensure the development of care plans in collaboration with the PCP. In addition, the Plan did not ensure that Interdisciplinary Team (IDT) assessments were included in updating of members' care plans and did not ensure that IDT meetings were documented in the Plan's information system timely.

The Plan is required to execute a Memorandum of Understanding (MOU) with the County Mental Health Plan (MHP) to delineate Plan and MHP responsibilities when covering mental health services. The Plan's MOU with the County MHP did not meet all the requirements specified in All Plan Letter (APL) 18-015 and did not specify policies, procedures, and reports to address QI requirements. The Plan did not conduct semi-annual calendar year reviews of referral and care coordination processes, generate semi-annual reports, or develop performance measures and QI initiatives during the audit period.

Category 3 – Access and Availability of Care

Category 3 includes requirements regarding member access to care, and the adjudication of claims for emergency services and Family Planning (FP) services, and provision of Non-Emergency Medical Transportation (NEMT) and Non-Medical Transportation (NMT).

The Plan is required to communicate, enforce, and monitor network providers' compliance with accessibility and availability requirements. The Plan is required to document when timeframes for appointments are shortened or extended by a health care professional, and maintain a QI system that includes mechanisms used to continuously review, evaluate, and improve access to and availability of services. The Plan did not monitor providers' compliance with the requirement to document when timeframes for appointments were shortened or extended, and did not adequately review, evaluate, and improve access to and availability of the first prenatal appointment.

The Plan is required to provide standing referrals to specialists. Standing referral determinations are required within three business days from the date of the request and the referral is required within four business days of the date the proposed treatment plan is submitted. The Plan did not ensure standing referral determinations and processing were made within the required timeframes.

The Plan is required to pay for emergency and family planning services received by members and shall not improperly deny those claims. The Plan is required to pay interest payments at the rate of 15 percent annually if an uncontested claim is not reimbursed within 45 working days after receipt. The Plan improperly denied emergency services claims and family planning claims, and did not pay interest for family planning claims processed late.

The Plan is required to provide medically appropriate NEMT services and to use a DHCS approved Physician Certification Statement (PCS) form to determine the appropriate level of service for Medi-Cal members. The Plan's network providers must be enrolled in the Medi-Cal program. The Plan did not ensure its transportation vendor's NEMT providers were enrolled in the Medi-Cal program. The Plan did not require PCS forms for NEMT services.

Category 4 – Member's Rights

Category 4 includes requirements to protect member's rights by properly handling grievances and reporting suspected security incidents of Protected Health Information (PHI).

The Plan is required to acknowledge standard grievances within five calendar days; and resolve, reach a final conclusion, within 30 calendar days. Exempt grievances are received over the phone excluding coverage disputes or health care service disputes, and are resolved by close of the next business day. The Plan improperly classified standard grievances as exempt grievances without conducting an investigation and improperly considered grievances resolved prior to sending resolution letters.

The Plan is required to resolve each grievance and provide notice as expeditiously as the member's health condition requires within state-established timeframes of five calendar days for written acknowledgement and 30 calendar days for resolution. If the Plan extends the timeframe, the Plan must make reasonable efforts to give the member prompt oral notice of the delay. The Plan did not send acknowledgement and resolution letters within the required timeframes and did not promptly notify members that expedited grievances would not be resolved within the required timeframe.

The Plan's medical director is required to resolve grievances related to medical quality of care. The Plan did not ensure that the medical director fully resolved quality of care grievances prior to sending resolution letters.

The Plan is required to make its written materials that are critical to obtaining services, such as fully translated member information including grievance and appeal acknowledgement and resolution letters, available in the prevalent non-English languages. The Plan did not send acknowledgement and resolution letters in threshold languages.

The Plan is required to report to DHCS within required timeframes of the discovery of any suspected security incident, intrusion, or unauthorized access, use, or disclosure of PHI or personal information. The Plan did not report suspected security incidents or unauthorized disclosures of PHI to DHCS within 24 hours, did not provide an updated investigation report within 72 hours, and did not submit a complete report of the investigation within ten working days of discovery.

Category 6 – Administrative and Organizational Capacity

Category 6 includes requirements to implement and maintain a compliance program to guard against fraud and abuse.

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

The Plan is required to annually report to DHCS recoveries of overpayments. The Plan did not conduct annual reporting of recoveries of overpayments to DHCS.

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 SPD, comply with federal and state laws, Medi-Cal regulations and guidelines, and the state Contract.

PROCEDURE

The onsite review was conducted from April 13, 2021 through April 23, 2021. 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: 23 medical prior authorization requests including six SPD cases, were reviewed for timeliness, consistent application of criteria, and appropriate review.

Appeal procedures: 15 prior authorization appeals including four SPD cases were reviewed for appropriate and timely adjudication.

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

Category 2 – Case Management and Coordination of Care

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

CCM: Ten Plan CCM files were reviewed to confirm the performance of services.

California Children's Services (CCS): five medical records were reviewed for appropriate CCS identification, referral to the CCS program, and coordination of care for non- eligible CCS conditions.

Category 3 – Access and Availability of Care

Claims: 30 emergency services and 30 family planning claims were reviewed for appropriate and timely adjudication.

NMT: 30 claims were reviewed for timeliness and appropriate adjudication.

NEMT: 30 claims were reviewed for timeliness and appropriate adjudication. Contracted NEMT providers were reviewed for Medi-Cal enrollment.

Category 4 – Member's Rights

Grievance Procedures: 75 grievances, including 49 standard, 13 quality of care, ten exempt, and three expedited were reviewed for timely resolution, response to complainant, and submission to the appropriate level for review. Four 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: 15 new provider training records were reviewed for timely Medi-Cal managed care program training.

Potential Quality Issues (PQI): Six PQI cases were reviewed for timely evaluation and effective action taken to address needed improvements.

Category 6 – Administrative and Organizational Capacity

Fraud and Abuse: 11 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

1.2

PRIOR AUTHORIZATION REVIEW REQUIREMENTS

1.2.1 Prior Authorization for Early Periodic Screening, Diagnostic, and Treatment (EPSDT) Services

The Plan is required to cover and ensure the provision of screening, preventive and medically necessary diagnostic, and treatment services for members under 21 years of age, including services listed under 42 USC Section 1396d(r), and W&I Code section 14132(v), unless otherwise excluded under this Contract. (*Contract, Exhibit A, Attachment 10 (5)*).

EPSDT supplemental services requested as a result of EPSDT screening services are exempt from the benefit limitations. (*California Code of Regulations, Title 22, section 51340*).

Services that maintain (i.e., support, sustain, or prevent from worsening) the child's health condition are also covered under EPSDT because they ameliorate a condition. The common definition of ameliorate is to "make more tolerable." Additional services must be provided if determined to be medically necessary for an individual child. Medical necessity decisions are individualized, therefore, Plans are prohibited from imposing service limitations on any EPSDT benefit other than medical necessity. *APL 19-010 Requirements for Coverage of EPSDT Services for Medi-Cal Members under the Age of 21*).

In a written statement, the Plan stated that the EPSDT prior authorization process was described in its UM policy *UM-057 Authorization Service Requests* (revised 3/21/19) which it stated also governs speech therapy requests. It also stated that using the hierarchy of criteria, the Plan used the Medi-Cal guidelines for the speech therapy benefit, and then Milliman Care Guidelines (MCG) as its evidence-based criteria.

Finding: The Plan did not have appropriate processes to ensure that limitations on speech therapy services would not be imposed. In addition to using Medi-Cal guidelines, the Plan used MCG as its evidence-based criteria to make decisions. MCG criteria dictates the amount of visits that can be approved based on a diagnosis and therefore imposes limits.

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In interviews and a written statement, the Plan described its process for reviewing pediatric speech therapy prior authorizations. The Plan stated that it allowed coordinators to administratively approve the first ten visits. Additional visits were routed to the registered nurse for clinical review. The Plan used the Medi-Cal guidelines and the applicable MCG criteria set that provides further guidance to the medical necessity and guidance on generally expected number of visits for members with the same diagnosis. However, all requests were reviewed based on the member's presentation at the time of the requested service. If the request met the criteria for medical necessity, the nurse would approve the request. If the nurse was unable to approve the speech therapy request based on the Medi-Cal guidelines and MCG criteria, it was routed to the medical doctor for review and decision to deny or approve. The Plan's use of MCG criteria results in the imposition of service limitations on medically necessary speech therapy requests.

If benefit limitations are placed on EPSDT services such as speech therapy, there is a risk of delaying the correction or improvement of certain conditions, which in turn could result in poor health outcomes.

Recommendation: Revise and implement policies and procedures to ensure that service limitations are not placed on any EPSDT benefit including speech therapy.

1.2.2 Dental Anesthesia Prior Authorizations

The Plan may require prior authorization for medical services required in support of dental procedures. (*Contract, Exhibit A, Attachment 11 (15)*).

The Plan must ensure that qualified health care professionals supervise review decisions. (*Contract, Exhibit A, Attachment 5 (2)(C)*).

The Plan must provide prior authorization for IV sedation and general anesthesia for dental services and must assist providers and beneficiaries with the prior authorization process as a form of care coordination to avoid situations where services are unduly delayed. (*APL 15-012 Dental Services-Intravenous Sedation and General Anesthesia Coverage*).

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The Plan must ensure that anesthesia providers submit documentation outlining the patient's need for IV sedation or general anesthesia, and they must receive approval prior to delivering the requested sedation or anesthesia services. Additionally, the Plan must also ensure that dental providers meet the requirements for chart documentation, which includes a copy of a complete history and physical examination, diagnosis, treatment plan, radiological reports and images, the indication for IV sedation or general anesthesia, and documentation of perioperative care (preoperative, intraoperative and postoperative care) for the dental procedure pertinent to the request. (APL 15-012).

Plan policy *UM-024 Care Coordination-Dental Services* (revised 5/21/20) stated that the Plan would cover IV sedation and general anesthesia and associated facility charges for dental procedures rendered in a hospital or surgery center setting, when the clinical status or underlying medical condition of the member required general anesthesia. It did not describe the prior authorization process including who is responsible for reviewing these prior authorizations and what items should be reviewed prior to approval or denial of services.

Finding: The Plan did not ensure that a qualified health care professional reviewed dental anesthesia prior authorization requests which includes a review of clinical data. The Plan did not ensure the use of appropriate criteria/guidelines when reviewing dental anesthesia requests.

A verification study was done of 23 medical prior authorizations; four were requests for pediatric dental anesthesia. All were approved as follows:

- One case involved a three year old with developmental delay who required dental treatment under anesthesia. This case was reviewed and approved by a nurse. The criteria used was Anesthesiologist Services from the Evidence of Coverage (EOC) or member handbook which stated the Plan covers anesthesia services that are medically necessary when the member receives outpatient care.
- Another case involved a three year old with autism who required extensive dental treatment. This case was reviewed and approved by a coordinator. The criteria used was Anesthesiologist Services from the EOC.
- One request was for a five year old with asthma and a heart murmur who had multiple cavities who required dental treatment but was uncooperative. This case was reviewed and approved by a coordinator. The criteria used was Anesthesiologist Services from the EOC.

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- Another case involved a four year old with a possible heart problem based on the documentation submitted who was in pain requiring dental treatment. This case was reviewed and approved by a coordinator. The criteria used was Anesthesiologist Services from the EOC.
- In all four cases there was no evidence that a review of a complete history and physical exam, treatment plan, radiological reports and documentation of perioperative care was performed by a qualified health care professional prior to approval.

In interviews and a written statement received post onsite, the Plan described its process for reviewing dental anesthesia prior authorizations. The Plan stated that coordinators were allowed to approve dental anesthesia requests from in-network providers with specific diagnosis and procedure codes. All other services beyond the codes, or a request from an out-of-network provider went to the clinical team for review. The Plan stated it used the EOC as criteria to make these decisions.

If non-clinical staff and incorrect criteria are used to make medical determinations, there is a risk that members will be inappropriately approved or denied services. This could lead to poor health outcomes as well as over and underutilization.

Recommendation: Revise and implement policies and procedures to ensure that qualified health care professionals, and that appropriate criteria are used to make decisions on dental IV sedation and general anesthesia prior authorization requests.

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1.5

DELGATION OF UTILIZATION MANAGEMENT

1.5.1 Inappropriate Denial of Medical Prior Authorizations

The Plan is accountable for all QI functions and responsibilities (e.g. UM, credentialing and site review) that are delegated to subcontractors. The Plan shall maintain a system to ensure accountability for delegated QI activities that at a minimum ensures delegates meet standards set forth by the Plan and DHCS. (*Contract, Exhibit A, Attachment 4 (6)(A) and (B)(2)*).

The Plan maintains the responsibility of ensuring that delegates are and continue to be in compliance with all applicable Medi-Cal, state and federal laws, and contractual requirements. (*APL 17-004 Subcontractual Relationships and Delegation*)

The Plan shall develop, implement, and continuously update and improve, a UM program that ensures appropriate processes are used to review and approve the provision of medically necessary covered services. (*Contract, Exhibit A, Attachment 5(1)*)

The Plan shall ensure that there is a set of written criteria or guidelines for utilization review that is based on sound medical evidence, is consistently applied, regularly reviewed, and updated. (*Contract, Exhibit A, Attachment 5(2)(D)*)

Plan policy *UM-060 Delegation of Utilization Management* (revised 11/21/19) stated that delegates were required to have certain UM components and functions in adherence to DHCS, Department of Managed Health Care (DMHC), the Plan's standards, and that the delegated contractual agreement outlined the responsibilities for the delegate and the Plan.

Plan policy *UM-001 Utilization Management* (revised 9/17/20) stated that the Plan and its delegates would maintain evidence-based criteria and a hierarchal criteria process for approving, modifying, deferring, and denying requested services. In its hierarchal criteria process, regulatory contractual requirements was first. Further, it stated that criteria were applied in conjunction with considering individual needs such as age, co-morbidities, complications, progress of treatment, psychosocial situations, and home environment.

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A review of the delegate's policy *UM04 Medical Necessity Criteria* (revised 7/22/20) showed that they followed the same process as the Plan when applying criteria to a given member during the prior authorization review process.

Finding: The Plan did not ensure the delegate met standards set forth by the Plan and DHCS. The delegate inappropriately denied medical prior authorization requests.

A verification study of prior authorization appeals showed that in four of six cases where the initial prior authorization review was done by the delegate the following was determined:

- For one member with stage four metastatic lung cancer the delegate denied an outpatient visit with their long time specialist due to the provider being out-of-network. However, in this case the visit should have been approved for transition of care to the delegate's contracted network. The member had been with this specialist since 2017.
- For another member the delegate denied a visit with a podiatrist due to not meeting the criteria of functional impairment. However, this patient had chronic foot pain and a history of multiple surgeries of the foot as well. Furthermore, MCG criteria was used rather than Medi-Cal criteria. The podiatry benefit had been reinstated by the time the delegate received this request.
- In another case, a 42 year old member with a strong family history of breast and ovarian cancer was denied genetic counseling and breast cancer gene (BRCA) testing stating that Medi-Cal only covered genetic counseling and testing if a member was pregnant or the doctor thought the unborn child may have Down syndrome. However, Medi-Cal covered genetic counseling and BRCA testing under preventative care and molecular pathology.
- For another member the delegate denied acupuncture visits due to not meeting Medi-Cal criteria which they stated as "severe, persistent chronic pain resulting from a generally recognized medical condition." This patient had fibromyalgia and therefore did meet the criteria.

The Joint Operations Committee, that included members from the Plan and the delegate met quarterly. Meeting minutes did not show a discussion of applying relevant criteria or appropriateness of denials. The Plan and delegate also met monthly. Agendas submitted by the Plan did not reveal any discussions regarding inappropriately denied prior authorizations by the delegate. The Plan audited its delegate in October 2019 and July 2020 but there were no deficiencies identified in the review area of appropriateness of denials.

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If appropriate processes with a set of correct criteria and guidelines are not in place, there is a risk that members will be inappropriately denied services, which could lead to poor health outcomes.

Recommendation: Revise and implement policies and procedures to ensure delegates use correct criteria to make decisions on prior authorization requests.

1.5.2 Review of Behavioral Health Prior Authorizations

The Plan is accountable for all QI functions and responsibilities (e.g. UM, Credentialing and Site Review) that are delegated to subcontractors. The Plan shall maintain a system to ensure accountability for delegated QI activities that at a minimum ensures delegates meet standards set forth by the Plan and DHCS. (*Contract, Exhibit A, Attachment 4 (6)(A) and (B)(2)*).

The Plan maintains the responsibility of ensuring that delegates are, and continue to be, in compliance with all applicable Medi-Cal, state and federal laws, and contractual requirements. (*APL 17-004 Subcontractual Relationships and Delegation*)

The Plan shall ensure that decisions to deny or to authorize an amount, duration, or scope that is less than requested shall be made by a qualified health care professional with appropriate clinical expertise in treating the medical or behavioral health condition and disease. (*Contract, Exhibit A, Attachment 5(2)(C)*)

NOA letters to the provider shall contain the name and direct telephone number or extension of the decision maker. (*Health and Safety Code section 1367.01(h)(4) and APL 17-006 Grievance and Appeal Requirements and Revised Notice Templates and "Your Rights" Attachments*)

Plan policy *UM-060 Delegation of Utilization Management* (revised 11/21/19) stated that delegates were required to have certain UM components and functions in adherence to DHCS, DMHC, the Plan's standards, and that the delegated contractual agreement outlined the responsibilities for the delegates and the Plan.

Plan policy *UM-001 Utilization Management* (revised 9/17/20) stated that decisions to modify, deny or authorize an amount, duration or scope of a service that is less than what was requested would be made by a qualified health care professional with appropriate clinical expertise or who is competent to evaluate the specific clinical issues using appropriate clinical guidelines in treating the condition or disease.

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Plan policy *UM-054 Notice of Action* (revised 11/21/19) stated that members and requesting practitioners were provided with written notifications of UM decisions. These included NOA letters for denials, modifications, and deferrals/delays. The NOA informed the member of an adverse benefit determination. NOA requirements included, for written notification to the provider, the name and direct telephone number or extension of the decision maker.

Finding: The Plan did not ensure the delegate met standards set forth by the Plan and DHCS. The Delegate did not ensure that requests to see out-of-network providers were reviewed and decisions were made by a qualified health care professional. It did not include the decision-maker's name in the NOA.

A verification study of prior authorization appeals showed that in three of three behavioral health requests, administrative denials were issued for out-of-network provider requests. An administrative denial is a denial made by a non-clinical staff member of the Plan, such as a coordinator in these cases.

- One case involved a 54 year old patient with post-traumatic stress disorder and obsessive compulsive disorder seeking treatment with an out-of-network provider.
- Another case involved a 27 year old with generalized anxiety disorder who had been seeing their therapist since 2019 but the therapist switched to a private practice and was no longer in-network but the member wanted to continue seeing them.
- One other case involved a 40 year old who requested to see a specific provider who specialized in dialectical behavior therapy. Per the member, there were no other providers in the Plan's network that offered these services.
- For all three cases the NOAs did not include the decision-maker's name.

In a written statement, the Plan stated that the administrative denials were issued to redirect the member in-network as there was an established network of providers who met the requested needs. A review of the delegate's process indicated administrative denials did not require a physician review. There was no medical necessity review completed during the initial determination of these cases.

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The Plan conducted a case file audit of its delegate in August 2019 and October 2020, which included a review of the following areas: appropriate professionals, timeliness of UM decisions, and clinical information. There was only one finding for timeliness in one case in the 2019 audit but no findings in 2020. Appropriateness of denials, denial notices, and the components of the NOA letters were not evaluated.

The Joint Operations Committee, that included members from the Plan and the delegate met quarterly. Meeting minutes did not show a discussion regarding specific issues of appropriate professionals, appropriateness of denials and NOA components.

A qualified health care professional making a decision on requests for health care services is ultimately responsible for the member and therefore documentation of reasons for decisions in clinical charts is imperative. A review of medical necessity must be clear and it must be from the qualified health care professional.

Recommendation: Revise and implement policies and procedures to ensure that delegates require a qualified health care professional with appropriate clinical expertise in treating the medical or behavioral health condition and disease to make decisions to deny or to authorize an amount, duration, or scope that is less than requested. Ensure NOA letters include the decision-maker's name and contact information.

1.5.3 Ownership and Control Disclosure Reviews

The Plan is required to comply with *Title 42, Code of Federal Regulations (CFR) section 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. The Plan is also required to disclose the name, address, date of birth, and social security number of any managing employee of the disclosing entity. (*Title 42, CFR, Section 455.104*)

The Plan is required to collect and review their delegates' ownership and control disclosure information as set forth in *42 CFR Section 455.104. (APL 17-004)*

Plan policy *CMP-024 Subcontracting Relationships and Delegation* (revised 11/11/19), stated the Plan required delegates to provide written disclosure of information on delegates' ownership and controls. The Plan collected and reviewed the delegates' ownership and control disclosure information as set forth in *42 CFR section 455.104.*

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Finding: The Plan did not obtain complete ownership and control disclosure from its delegates.

A review of 2020 and 2021 delegates' disclosure forms revealed the following deficiencies:

- One disclosure form did not contain the address and tax identification number of the corporation.
- Two disclosure forms did not contain the names of the delegated entities' managing employees in leadership position such as directors and executives.

In a written response, the Plan stated that one delegate was a non-profit corporation with no ownership; therefore, the Plan did not collect ownership disclosures. However, the Plan did not collect the required disclosures for delegates' managing employees. Also, another delegate provided a letter to the Plan which stated the delegate was a professional corporation owned by physician shareholders who govern the entity along with the Senior Management Team. The entity's Board of Directors was composed of representative equal shareholders. The Plan did not collect the required disclosures from the Board of Directors and the Senior Management Team.

As a corrective action to the 2019 audit finding, 1.1.3 Ownership and Control Disclosure Reviews, the Plan developed the standard operating procedure for Ownership and Control Disclosure Reviews for delegates, Vendor Disclosure of Ownership Form, and Vendor Disclosure of Ownership tracking log to collect the required information as described in *Title 42, CFR section 455.104*. However, the current audit found that these corrective actions did not resolve the deficiency.

This is a repeat finding.

When the Plan does not collect the complete required ownership and control disclosure information of all delegates, it cannot ensure that the delegates' owners and controlling interest individuals are eligible for program participation.

Recommendation: Implement policies and procedures to ensure complete collection of all delegates' ownership and control disclosure information including delegates' managing employees.

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1.5.4 Written Agreement Requirements for Audit and Inspection of UM Delegates

The Plan is required to include in its delegates' agreements a provision to make all of its premises, facilities, equipment, books, and records, contracts, computer and other electronic systems available for the purpose of an audit, inspection, evaluation, examination or copying, including but not limited to access requirements and state's right to monitor, and be inspected by DHCS, Center of Medicare and Medicaid Services (CMS), the Department of Health and Human Services (DHHS) Inspector General, the Comptroller General, Department of Justice (DOJ), and DMHC, or their designees. (*Contract, Exhibit A, Attachment 6 (14)(B)(8)(a)*)

Plan policy *CMP-024 Subcontracting Relationships and Delegation (revised 11/11/19)*, stated the Plan's written agreement with delegates included requirements to allow DHCS, CMS, DHHS Inspector General, the Comptroller General, DOJ, and DMHC, or their designees, to audit, inspect, and evaluate information related to Medi-Cal members.

Finding: The Plan did not ensure the written agreements with its delegates included the requirement to allow specified departments, agencies, and officials to audit, inspect, and evaluate the Plan's facilities, records, and systems related to good and services provided to Medi-Cal members.

A review of the delegates' written agreements revealed the lack of the requirements to allow for audit, inspection and evaluation in the following agreements:

- Three did not include the DHHS Inspector General.
- Two did not include the CMS, or their designees.
- One did not include the Comptroller General.

The Plan provided the pages in the written agreements where the requirement was addressed, however, a review of these pages did not show the required information.

When the Plan does not include the required information in the delegates' written agreements, the Plan cannot ensure its delegated entities and delegates will comply with all applicable requirements under the contract.

Recommendation: Implement policies and procedures to ensure all required information is included in the delegates' written agreements.

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1.5.5 Imposition of Financial Sanctions

The Plan shall comply with all existing final Policy Letters and APLs issued by Managed Care Quality and Monitoring Division (MCQMD) and Managed Care Operations Division. (*Contract, Exhibit E, Attachment 2 (1)(D)*)

The Plan is required to maintain policies and procedures for imposing corrective action and financial sanctions on delegates upon discovery of noncompliance with the subcontract or other Medi-Cal requirements. (*APL 17-004*)

Plan policy *CMP-024 Subcontracting Relationships and Delegation* (revised 11/11/19), stated the Plan has policies and procedures for imposing corrective action and financial sanctions on delegates upon discovery of non-compliance with the subcontract or other Medi-Cal requirements. However, this policy did not describe the process of imposing financial sanctions.

Plan policy *CMP-020 Corrective Action Plan (CAP)* (revised 11/11/19), stated the Compliance Department conducted annual audits for all delegated entities. The audit included a review of policies and procedures, reporting, and case file review. If the Plan found any non-compliant areas or deficiencies in the audit review or in routine reporting, the Plan would develop and issue a CAP to the delegated entity to correct those deficiencies. However, the policy did not mention procedures for imposing financial sanctions on its delegates upon discovery of non-compliance.

Finding: The Plan did not have policies and procedures for imposing financial sanctions on its delegate and delegated entities.

During the interviews, when asked about the policies and procedures of imposing corrective action and financial sanctions, the Plan referred to policy *CMP-020* as described above.

When the Plan does not have policies and procedures to impose financial sanctions on non-compliant delegates, the Plan cannot ensure that current and future delegates will comply with contract requirements.

Recommendation: Develop and implement policies and procedures for imposing financial sanctions on delegated entities.

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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
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2.1.1 Health Risk Assessment (HRA) Completion Time Frames

The Plan is required to administer the DHCS approved HRA survey within 45 days for SPD members deemed to be at a higher health risk, and 105 days for those determined to be a lower health risk based on the results of the health risk stratification. The health risk stratification and assessment shall be done in accordance with W&I Code sections 14182 (c)(11) to (13) and APL 17-013. (*Contract, Exhibit A, Attachment 10(4)*)

For the duration of the public health emergency, the Plan must conduct an HRA survey to comprehensively assess each newly enrolled SPD member’s current health risk as follows (*APL 20-011 Governor’s Executive Order N-55-20 In Response to Covid-19*):

- Within 135 days of enrollment, for those identified as higher risk through the Plan’s risk stratification process; or
- Within 195 days of enrollment, for those identified as lower risk.

Plan policy *CM-008 SPD Health Risk Assessment – Stratification and Process* (revised 4/16/19) stated the Plan performs a HRA survey within the required timeframe: 45 days of enrollment for those identified as higher risk, 105 days of enrollment for those identified as lower risk.

Finding: The Plan did not conduct HRAs within the required timeframes for newly enrolled SPD members in 2019 and 2020.

A verification study of ten samples revealed:

- In one record, the member received HRA beyond the 105 calendar days for low risk stratification level from newly enrolled SPD date in 2019.
- In one other record, the member received the HRA beyond the 135 day calendar days for high risk stratification level from newly enrolled SPD date in 2020.

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In interviews and written correspondence, the Plan confirmed that HRA completion did not consistently follow the Plan's policy and standard practice. The Plan stated there were many causes such as staff training on workflow, documentation, monitoring, and reporting.

In response to the 2019 finding 2.1.1 HRA Completion, the Plan developed the HRA desktop procedure to include details about the HRA timeline and telephonic process. The Plan also used a HRA tracking log with due date and risk level to ensure HRA timeliness requirements were met, however, the verification study continued to show noncompliance with meeting the time frames.

This is a repeat finding.

When the Plan does not conduct HRAs timely, this may lead to delays in identifying the members' needs.

Recommendation: Implement policies and procedures to assess each newly enrolled SPD member's current health risks within the required time frames.

2.1.2 Coordination of Care for EPSDT

The Plan is required to have 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. (*Contract, Exhibit A, Attachment 11(1)*).

The Plan must ensure the provision of coordination of care for all medically necessary EPSDT services delivered both within and outside the Plan's provider network. The Plan must also ensure coordination of carved-out and linked services and referral to appropriate community resources and other agencies. (*APL 19-010 Requirements for Coverage of EPSDT Services for Medi-Cal Members under the Age of 21*).

Plan policy *UM-018 Targeted Case Management and Early Periodic Screening, Diagnosis and Treatment (EPSDT)* (revised 9/17/20) stated that the Plan was required to provide all necessary case management services for members accessing EPSDT supplemental services including coordination of care between all practitioners (PCPs, specialists, other EPSDT providers).

Finding: The Plan did not ensure coordination of care in certain cases where EPSDT services were medically necessary.

❖ COMPLIANCE AUDIT FINDINGS (CAF) ❖

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A verification study showed that two of five prior authorization requests for pediatric speech therapy were retrospective requests which were denied for untimely notification. There was no evidence of coordination of care for these two denied retrospective requests:

- One case involved an 18 year old with delayed expressive language and social language skills secondary to autism spectrum disorder. The family had a limited support system. The speech therapist instructed the member to follow up with Regional Center to have patient reconnect with services. There was no documentation that the Plan followed up with the member and family to assist with coordination of care.
- Another case involved a three year old with a speech and language evaluation that demonstrated they scored below normal limits in the following: language comprehension, language expression, gestural and social skills. The speech therapist referred them to occupational therapy and recommended assessment by the school district and speech therapy through the school district. There was no documentation that the Plan followed up with the member and family to assist with coordination of care.

In a written statement, the Plan stated that for one case the member would have benefitted from coordination of care to ensure the referral to the Regional Center was completed. For the other case, they stated there was no indication that there was a need to provide care coordination for speech therapy but that it was noted that there were conditions in the medical record that indicated the need for a referral for EPSDT evaluation.

If care coordination for EPSDT services is not provided, there is a risk of delaying the correction or improvement of certain conditions, which in turn could result in poor health outcomes.

Recommendation: Revise and implement policies and procedures to ensure the provision of coordination of care for all medically necessary EPSDT services even when these requests are denied retrospectively for untimely notification.

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2.2 COMPLEX CASE MANAGEMENT

2.2.1 Complex Case Management Individualized Care Plan

CCM Services are provided by the Plan, in collaboration with the PCP, and shall include, at a minimum: Development of care plans specific to individual needs, and updating of these plans at least annually with member and PCP input. (*Contract, Exhibit A, Attachment 11(1)*)

Plan policy *CM-002, Complex Case Management Plan Development and Management* (revised 4/16/19) stated the Plan will develop an ICP based on an analysis of the general assessment and specialty assessments, as applicable, and in collaboration with the member and/or their representative, and care providers. The care plan is completed within 30 calendar days of CCM enrollment. The care plan, and all associated documentation and correspondence, is documented in the Plan's clinical information system. The Plan's CCM policies did not specify how the Plan would ensure and monitor the completion of ICPs for its CCM members.

Finding: The Plan did not ensure the completion of ICPs for members enrolled in CCM.

A verification study of ten CCM files revealed two cases did not have care plans. These cases were discussed in IDT rounds; however, the care plans were not developed. In an interview, the Plan could not provide a reason why care plans were not developed for these members.

ICPs for higher risk members are essential for effective health care management. These members need additional help and guidance to manage their high risk health care needs. The lack of care plans may lead to poor health outcomes due to unidentified problems, undefined interventions to address problems, and lack of evaluation to check progress towards measurable goals.

Recommendation: Revise and implement policies and procedures to ensure and monitor the completion of ICPs for CCM members.

2.2.2 Individualized Care Plan Development

CCM services are provided by the Plan, in collaboration with the PCP, and shall include, at a minimum: Development of care plans specific to individual needs, and updating of these plans at least annually with member and PCP input. (*Contract, Exhibit A, Attachment 11(1)*)

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Plan policy *CM-002 Complex Case Management Plan Development and Management* (revised 4/16/19) stated the Plan would send a draft of the care plan to the provider with a request to review and provide input into the final care plan.

Finding: The Plan did not ensure development of care plans in collaboration with the PCP.

A verification study of ten CCM files revealed four cases did not have letters inviting the PCPs to participate in the member's care plan development. In a written response, the Plan stated it was unable to locate the PCP notification letter of the member's CCM status for these cases.

When the Plan does not offer PCPs the opportunity to review and contribute to the members' care plan, members may not receive relevant and health and human service needs.

Recommendation: Implement policies and procedures to ensure the development of care plans in collaboration with the PCP.

2.2.3 Complex Case Management Activities and Duration

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 CCM 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* (revised 4/16/19) stated the Plan would contact the member monthly, at a minimum, or more frequently based on the needs of the member and the referrals made. Cases that remained open after 90 days required case rounds review with care team members. The Plan would close cases within 90 days of care plan development unless otherwise extended at case rounds.

Finding: The Plan did not conduct periodic evaluations to ensure the provision of CCM based on the member's medical needs. The Plan did not implement procedures for monitoring time frame standards or maintaining monthly contact with members.

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A verification study of ten CCM cases revealed the following:

- One case was open for more than 150 days without any activity for more than five weeks.
- Another case was open for more than 90 days while two IDT rounds did not provide any recommendation for case extension.

In an interview, the Plan could not provide additional information regarding the cases above.

Inconsistent implementation of policies to periodically evaluate CCM members can lead to delay reassessment and identification of possible impending needs, or improvements in the care for CCM members.

Recommendation: Implement policies and procedures to ensure provision and monitoring of coordination of care for CCM members.

2.2.4 Timely Charting of Interdisciplinary Team Rounds Notes

CCM services are provided by the Plan, in collaboration with the PCP, and shall include, at a minimum: Management of acute or chronic illness, including emotional and social support issues by a multidisciplinary case management team; intense coordination of resources to ensure the member regains optimal health or improved functionality; and updating of care plans. (*Contract, Exhibit A, Attachment 11(1)*)

Plan policy *CM-002 Complex Case Management Plan Development and Management* (revised 4/16/19) stated the Plan would conduct case meetings with care team members to ensure that the best thinking and specialized expertise is available in care plan decisions. The Plan would coordinate with care providers on progress towards or lack thereof with the care plan. The Plan would continually update and evaluate the care plan based on members' needs and used information from ongoing screenings and assessments. The care plan, and all associated documentation and correspondence, would be documented in the Plan's clinical information system.

Finding: The Plan did not ensure that IDT assessments were included in the updating of members' care plans. The Plan did not ensure timely documentation of the IDT meeting notes.

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A verification study of ten CCM cases revealed the following:

- In three cases, the IDT meeting notes were created later in the information system. In two of these cases, the IDT meeting notes were as late as two months after the meeting date.

In interviews and in written responses, the Plan stated it began a new IDT process in January of 2020. The Plan acknowledged that IDT meeting notes were not being documented timely and made adjustments to notify Plan staff to enter IDT notes into the system within one week.

When the members care plans are not updated with timely documentation of IDT meeting notes, the delay and incomplete documentation could affect case management decisions, resulting in missed opportunities for members to receive care they need.

Recommendation: Revise and implement policies and procedures to ensure timely documentation of IDT meeting notes to use in updating care plans.

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2.5

MENTAL HEALTH AND SUBSTANCE ABUSE

2.5.1 Memorandum of Understanding with the County Mental Health Plan

The Plan is required to execute a MOU with the MHP as stipulated in the contract. (*Contract, Attachment 11, (6) (B)*)

The Plan is responsible for updating, amending, or replacing existing MOUs with MHPs to delineate Plan and MHPs responsibilities when covering mental health services. (*APL 18-015 Memorandum of Understanding Requirements for Medi-Cal Managed Care Plans*)

For MHPs, Title 9, CCR, Chapter 11, Medi-Cal Specialty Mental Health Services Regulations (*Attachment 1*) outlines MOU requirements including, but not limited to:

- Section 1810.370, MOUs with Medi-Cal Managed Care Plans.
- Section 1810.415, Coordination of Physical and Mental Health Care.
- Section 1850.505, Request for Resolution.

APL 18-015 outlines the MOU elements including, but not limited to:

- Oversight Responsibilities of the MCP and MHP
- Care Coordination
- Information Exchange
- Reporting and QI Requirements
- Dispute Resolution

The required elements are described in greater detail in attachment 1 and attachment 2 of the APL.

Finding: The Plan's MOU with the county MHP did not meet all the requirements specified in APL 18-015.

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The MOU did not include the following elements:

- Points of contact for each party responsible for managing the MOU, overseeing QI, and resolving disputes. The only identified point of contact within the MOU was the Chief at MCQMD.
- The Plan's obligation to provide procedures for obtaining authorization of prescribed drugs and laboratory services.
- The MHP's obligation to designate a process or entity to receive notices of actions, denials, or deferrals from the Plan and to provide any information requested in the deferral notice as necessary for a medical necessity determination by the Plan.
- All of the referral options for physical health care based treatment.
- The required timeframes for notification and retrieval of documentation for request of dispute resolution. Upon receipt of a request for resolution, the department receiving the request shall notify the other party within seven calendar days. The other party shall submit the requested documentation within 21 calendar days from notification.
- A policy or procedure for exchange of member information. In a written response, the Plan referred to page seven and eight of the MOU. These pages did not contain specific policies, protocols, or procedures for the information exchange. Upon request of such policy and procedure, the Plan provided two policies from its mild-to-moderate mental health delegate. These policies did not include information regarding the exchange of member PHI and did not specify the agreed upon roles and responsibilities of the Plan and the MHP.
- The representatives of the Medi-Cal oversight team responsible for program oversight, QI, dispute resolution, and ongoing management of the MOU.
- The multidisciplinary clinical team oversight process for clinical operations: screening, assessment, referrals, care management, care coordination, and exchange of medical information. Instead, the MOU stated the mild-to-moderate mental health delegate staff and other Plan operational staff will confer with the MHP to resolve operational, administrative, and policy issues.

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- For care coordination, an identified point of contact from each party who will initiate, provide, and maintain ongoing care coordination, a notification process between the Plan and MHP to arrange for follow-up services within 24 hours of admission and discharge, a transition of care plan for members transitioning to or from the Plan or MHP, the frequency of regular meetings between the Plan and the MHP, and the protocols for members enrolled in the Health Homes Programs.
- For reporting and QI, the frequency of regular meetings between the Plan and the MHP to review referral and the care coordination process and to monitor member engagement and utilization. The MOU also did not specify policies, procedures and reports to address QI requirements for mental health services including a semi-annual calendar year review and semi-annual reports for quality findings.

The term of the MOU began on August 1, 2019 and renews each June 1st annually. As stated in the MOU, the Plan and the county MHP agree to review the MOU yearly. The Plan stated they meet with the county MHP the first Friday of every two months. However, the Plan did not have meeting minutes for its meetings with the county MHP to indicate when the MOU was reviewed or updated.

If the Plan does not take responsibility for updating, amending, or replacing the existing MOU with the county MHP, the Plan and MHP staff may not be aware of their roles and responsibilities when covering mental health services.

Recommendation: Revise the MOU to specify the information required in Attachments 1 and 2 of APL 18-015.

2.5.2 MOU Quality Improvement Requirements

The Plan is required to execute a MOU with the MHP as stipulated in the Contract. (*Contract, Attachment 11, (6) (B)*)

The Plan is responsible for updating, amending, or replacing existing MOUs with MHPs to delineate Plan and MHPs responsibilities when covering mental health services. (*APL 18-015*)

The MOU shall specify policies, procedures, and reports to address QI requirements for mental health services including, but not limited to (*Attachment 2*):

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- No less than a semi-annual calendar year review of referral and care coordination processes to improve quality of care; and at least semi-annual reports summarizing quality findings, as determined in collaboration with DHCS. Reports summarizing findings of the review must address the systemic strengths and barriers to effective collaboration between the MCP and MHP
- Performance measures and QI initiatives to be determined in collaboration with DHCS.

Finding: The Plan's MOU with the county MHP did not specify policies, procedures, and reports to address QIs requirements specified in APL 18-015. The Plan did not conduct semi-annual calendar year reviews of referral and care coordination processes, generate semi-annual reports, or develop performance measures and QI initiatives during the audit period.

The MOU stated the Plan coordinates with the county to perform analyses and evaluation, at least annually, of the effectiveness of the care management program to identify actions to implement and improve the quality of care and delivery of services.

Upon request for documentation of semi-annual year reviews and semi-annual reports for the audit period, the Plan provided Joint Operations meeting slides with the mild-to-moderate mental health delegate for one meeting during the third quarter of 2020. There were no reports that summarized findings or addressed systemic strengths and barriers to effective collaboration between the Plan and the MHP. Upon request for performance measures and QI initiatives, the Plan provided the mild-to-moderate mental health delegate's Quality Program Annual Evaluation for 2019 which did not include this information.

If the Plan does not conduct semi-annual reviews, generate semi-annual reports, and develop performance measures and quality initiatives, the Plan may miss opportunities for QI for some of its most vulnerable members.

Recommendation: Develop and implement policies and procedures for the QI requirements as specified in *Attachment 2 of APL 18-015*.

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CATEGORY 3 – ACCESS AND AVAILABILITY OF CARE

3.1	APPOINTMENT PROCEDURES AND MONITORING WAITING TIMES
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3.1.1 Extending Timeframes for Obtaining Appointments

The Plan shall ensure the provision of acceptable accessibility standards in accordance with Title 28 CCR Section 1300.67.2.2. The Plan shall communicate, enforce, and monitor network providers' compliance with these requirements. (*Contract, Exhibit A, Attachment 9 (4)*)

The Plan is required to ensure timeframes for appointments are shortened or extended as clinically appropriate by a qualified health care professional. If the timeframe is extended, it must be documented within the member's medical record that a longer timeframe will not have a detrimental impact on the member's health. (*Contract, Exhibit A, Attachment 9 (4) (C)*)

Plan policy *QI-114 Monitoring of Access and Availability Standards* (revised 3/19/20) stated the Plan would perform ongoing monitoring of its direct and delegate provider network including PCPs, behavioral health providers and specialists.

Finding: The Plan did not enforce and monitor providers' compliance with the requirement to document when timeframes for appointments were extended.

During the interview, the Plan was asked how they determined compliance with the documentation requirement and they stated this could potentially be captured through grievances but a formal process was not in place.

The policy did not include information about the provider's ability to shorten or extend appointment timeframes or the documentation and monitoring of extended timeframes. The new provider orientation material stated that preventive and periodic follow up care may be scheduled in advance and the applicable waiting time for a particular appointment may be extended if the healthcare professional determined and noted in the relevant record that a longer waiting time would not have a detrimental impact on the health of the member. Other Plan materials including the provider manual and provider newsletters, did not include this information. Plan's access and availability surveys did not monitor for documentation of extended timeframes.

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If the Plan does not enforce and monitor standards for providers to extend appointment timeframes, then there may be delays in members' access to care resulting in poor health outcomes.

Recommendation: Revise and implement policies and procedures to ensure and monitor documentation of extended appointment timeframes.

3.1.2 Monitoring Access to the First Prenatal Appointment

The Plan is required to communicate, enforce and monitor network provider's compliance with the first prenatal visits. The Plan is required to ensure the first prenatal visits for a pregnant member will be available within two weeks upon request. (*Contract, Exhibit A, Attachment 9 (3) (B)*)

The Plan is required to implement and maintain a written description of its quality improvement system that shall include a description of the mechanisms used to continuously review, evaluate, and improve access to and availability of services. The description shall include methods to ensure members are able to obtain appointments within established standards. (*Contract, Exhibit A, Attachment 4 (7) (G)*)

The Plan's 2020 Quality Improvement (QI) Program Description stated the QI program would collaborate with the Provider Relations Department to monitor access and availability of care including member wait times and access to practitioners for routine, urgent, emergency and preventive, specialty, and after-hours care. Access to medical care would be ensured by monitoring compliance with timely access standards for office appointments and appointment availability.

Plan policy *QI-114 Monitoring of Access and Availability Standards* (revised 3/19/20) stated the Plan would annually conduct a survey of its OB/GYN provider network to ensure provider compliance with the DHCS two week first prenatal visit standard.

Finding: The Plan did not continuously review, evaluate and improve access to and availability of the first prenatal appointment.

During the audit period, the Plan conducted two surveys for the first prenatal visit. Both surveys did not meet the Plan's goal to have 75 percent of providers indicate first prenatal appointment availability within two weeks. The samples used in the prenatal surveys were not sufficient to calculate an accurate compliance rate. In 2019, there were 84 providers surveyed, however, only 40 percent of those were used in determining the compliance rate. The remaining providers were either ineligible, refused to participate, or answered not applicable. In an effort to improve the next survey, the

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Plan re-educated providers, issued CAPs and shared the list of ineligible providers with the Provider Services department. In 2020, 135 providers were surveyed. The percentage of surveyed providers with useful responses decreased to 34 percent. The Plan again had ineligible providers included in the survey as well as providers who refused to participate or answered not applicable.

If the Plan does not continuously review, evaluate, and improve access to and availability of the first prenatal appointment, the Plan may not capture providers' availability accurately which may lead to increased wait time to schedule an appointment.

Recommendation: Revise and implement policies and procedures to ensure the Plan continuously reviews, evaluates and improves access and availability for the first prenatal appointment.

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3.4

SPECIALISTS AND SPECIALTY SERVICES

3.4.1 Standing Referrals

The Plan is required to provide standing referrals to specialists. Determinations for standing referrals shall be made within three business days from the date the request is made by the member or the member's PCP. Once a determination is made, the referral shall be made within four business days of the date the proposed treatment plan, if any, is submitted to the Plan's Medical Director or the Medical Director's designee. (*Contract, Exhibit A, Attachment 9 (6) (C)*)

Plan policy *UM-056 Standing Referrals* (revised 5/21/20) stated authorization determinations for specialty services shall be processed in accordance with the Plan's and/or its delegated entity's policies and procedures for referral management and within required timeframes for standing referrals, as described in this policy and applicable regulations. The policy included the contractual timeframes. The UM department would conduct internal monitoring on a routine basis through reviews of quarterly reports of authorizations and claims for non-network specialty referrals and standing referrals.

Finding: The Plan did not ensure standing referral determinations and processing were made within the required timeframes.

The Plan did not capture standing referrals requests in its daily aging report. The Plan also acknowledged the lack of tracking mechanism for standing referrals to be a gap in care.

If the Plan does not ensure standing referrals are determined and processed within the required timeframes, then member care may be delayed.

Recommendation: Revise and implement policies and procedure to ensure timely standing referral determination and processing.

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3.6

EMERGENCY SERVICES AND FAMILY PLANNING CLAIMS

3.6.1 Denial of Claims

The Plan shall not apply prior authorization requirements to emergency services and FP services. (*Contract, Exhibit A, Attachment 5 (2)(H)*)

Members have the right to access family planning services through any family planning provider without prior authorization. Members of childbearing age may access the family planning services from out-of-network family planning providers. (*Contract, Exhibit A, Attachment 9 (9)(A)(2)*)

The Plan is required to pay for emergency services received by a member from non-contracting providers. (*Contract, Exhibit A, Attachment 8 (13)(C)*)

The Plan shall not improperly deny or contest a claim or portion thereof. For each claim that is denied or contested, the Plan shall provide an accurate and clear written explanation of the specific reasons. (*California Code of Regulations., title 28, section 1300.71 (d) (1) and (h)*)

Plan policy *CLM-007 Family Planning Services Post-Pay Claims Audit* (revised 4/18/19) stated the Plan would ensure that family planning services claims are not denied for lack of an authorization or medical necessity.

Plan policy *CLM-010 Family Planning and Sensitive Services Claims Processing* (revised 6/30/20) stated the Plan would process claims or any portion of a claim for family planning and sensitive services, whether in-network or out-of-network, as soon as practical, but no later than 45 working days after receipt. The Plan would reimburse in-network providers based on their Contract and out-of-network providers at the prevailing Medi-Cal rate based on the service provided.

Plan policy *CLM-003 Emergency Services Claims Processing* (revised 6/30/20) stated emergency services claims from participating and non-participating providers for services rendered to members assigned to a delegated entity would be forwarded to the delegated entity. The policy also stated emergency services claims do not require prior authorization or clinical review by the Plan.

Finding: The Plan improperly denied emergency services claims and family planning claims.

❖ COMPLIANCE AUDIT FINDINGS (CAF) ❖

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A verification study found 12 of 30 FP claims and two of 30 ER claims were improperly denied as follows:

- Three FP claims were denied due to lack of authorization and submitted by out-of-network providers. Two claims were later corrected after provider disputed them while the other claim was adjusted after the Plan discovered the error in its internal audit.
- Four FP claims were denied based on missing or incorrect modifiers. However, the Plan found they were incorrectly denied during its review.
- Four FP claims were denied as misdirected claims and were forwarded to the delegated entity. Based on the *Division of Financial Responsibility* between the Plan and the delegated entity, FP services provided out-of-network were the Plan's responsibility.
- One FP claim was denied because the drug code was invalid. When the Plan reviewed the provider dispute, it determined that the drug code was valid.
- One ER claim was denied because the member's primary insurance paid greater than the allowed amount. However, the primary insurance remittance advice showed the provider was paid less than Medi-Cal rate.
- One ER claim was denied as a misdirected claim and was forwarded to a delegated entity. Although the member was assigned to a delegated entity, ER services provided out-of-network were the Plan's responsibility.

During the interview, the Plan stated it conducted an internal audit every week to ensure claims were not improperly denied. In addition, the Plan updated its claim system annually for enhancement and corrections. However, there were still claims denied improperly.

When the Plan denies payment for covered services, providers may be discouraged from treating members; members' access to care may be limited.

Recommendation: Revise and implement policies and procedures to ensure emergency and family planning service claims are appropriately adjudicated.

❖ COMPLIANCE AUDIT FINDINGS (CAF) ❖

PLAN: Alameda Alliance For Health

AUDIT PERIOD: June 1, 2019 through March 31, 2021

DATE OF AUDIT: April 13, 2021 through April 23, 2021

3.6.2 Interest Payment

The Plan shall comply with *Health and Safety Code Sections 1371 through 1371.36*. The Plan shall be subject to any remedies, including interest payments provided for in these sections, if it fails to meet the standards specified in these sections. (*Contract, Exhibit A, Attachment 8 (A)(5)*)

If an uncontested claim is not reimbursed within 45 working days after receipt, interest shall accrue at the rate of 15 percent annually beginning with the first calendar day after the 45 working day period. The Plan shall automatically include in its payment of the claim all interest that has accrued without requiring to submit a request for the interest amount. (*Health and Safety Code section 1371*) (*Cal. Code Regs., Title 28, section 1300.71(i)(2)*)

Plan policy *CLM-006 Claims Late Interest and Penalties* (revised 4/18/19) stated that a complete claim, or portion thereof, that is neither contested nor denied, if not reimbursed to the provider within 45 working days after receipt, the Plan would automatically pay interest beginning with the first calendar day after the 45th working day. Late payments on complete claims shall automatically include interest at the rate of 15% annually for the period of time that the payment is late.

Plan policy *CLM-001 Claims Processing* (revised 6/30/20) stated that an interest penalty must automatically be paid on any claim not paid within the required timeframe or that were identified as underpaid, beginning with the first day after the 45-working day required timeframe has elapsed. Interest must be paid for the period of the time that the payment is late or portion underpaid, at 15% annually, per claim.

Finding: The Plan did not pay interest for family planning claims not completely reimbursed within 45 working days of receipt.

A verification study of family planning claims found two were not paid interest despite being processed over 45 working days. During the Plan's weekly internal audit, these claims were determined improperly denied. The Plan subsequently corrected the claim and paid the providers but did not pay interest on the claims.

In a written response, the Plan stated it bypassed the interest because of APL 019-013 Proposition 56 Hyde Reimbursement Requirements for Specified Services. However, these improperly denied sample claims were not subject to APL 019-013 payment rate increases. The Plan incorrectly treated the family planning claims as state-supported services claims which resulted in no interest payment.

❖ COMPLIANCE AUDIT FINDINGS (CAF) ❖

PLAN: Alameda Alliance For Health

AUDIT PERIOD: June 1, 2019 through March 31, 2021

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Insufficient interest payments on family planning claims may cause harm to a provider's practice and limit members' access to care.

Recommendation: Implement policies and procedures to pay interest for family planning claims processed over 45 working days from receipt.

❖ COMPLIANCE AUDIT FINDINGS (CAF) ❖

PLAN: Alameda Alliance For Health

AUDIT PERIOD: June 1, 2019 through March 31, 2021

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3.8

NON-EMERGENCY MEDICAL TRANSPORTATION AND NON-MEDICAL TRANSPORTATION

3.8.1 NEMT providers Medi-Cal Enrollment Status

All Policy Letters and APLs issued by DHCS subsequent to the effective date and during the term of this Contract shall provide clarification of Plan’s obligations pursuant to this Contract, may include instructions to the Plan regarding implementation of mandated obligations pursuant to changes in state or federal statutes or regulations, or pursuant to judicial interpretation. *(Contract, Exhibit E, Attachment 2 (1)(D))*

All of the Plan’s network providers must enroll in the Medi-Cal program. The Plan has the option to develop and implement a managed care provider screening and enrollment process that meets the requirement of this APL, or they may direct their network providers to enroll through the DHCS. *(APL 17-019 Provider Credentialing / Recredentialing and Screening / Enrollment.)*

The Plan is required to provide medically appropriate NEMT services when the member’s medical and physical condition is such that transport by ordinary means of public or private conveyance is medically contraindicated and transportation is required for obtaining medically necessary services. The Plan is required to provide NEMT for members who cannot reasonably ambulate or are unable to stand or walk without assistance, including those using a walker or crutches. The Plan shall also ensure door-to-door assistance for all members receiving NEMT services. *(APL 17-010 Non-Emergency Medical and Non-Medical Transportation Services.)*

Plan policy *CRE-002 Credentialing and Recredentialing of Individual Practitioners* (revised 7/21/20) stated that providers who successfully enroll through the Medi-Cal FFS enrollment process are eligible to contract with the Plan. The Plan and providers may confirm Medi-Cal FFS enrollment by accessing the open data portal, California Health and Human Services. Monthly monitoring for screening and enrollment activities are to be performed by the Plan.

Finding: The Plan did not ensure its transportation broker’s NEMT providers were enrolled in the Medi-Cal program.

A review of the verification study showed that 14 of 30 trips were completed by seven providers that were not enrolled in the Medi-Cal program.

❖ COMPLIANCE AUDIT FINDINGS (CAF) ❖

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During interviews, the Plan stated that providers were required to be enrolled in Medi-Cal but it had not review the broker's transportation network during the audit period. The last time the Plan discussed the vendor's compliance with *APL 17-010* was in the June 2017 to December 2017 workgroup meetings with its transportation broker. The Plan did not have a process in place to ensure NEMT providers are enrolled in the Medi-Cal program.

If transportation providers are not enrolled with Medi-Cal, there may be a risk that drivers and vehicles may not meet safety requirements, which may result in members receiving inadequate or unsafe transportation.

Recommendation: Develop and implement policies and procedures to ensure that new and existing NEMT providers meet the enrollment requirements.

3.8.2 Physician Certification Statement Form Requirement

Plans and transportation brokers must use a DHCS approved PCS form to determine the appropriate level of service for Medi-Cal members. Once the member's treating physician prescribes the form of transportation, the Plan cannot modify the authorization. In order to ensure consistency amongst all Plans, all NEMT PCS forms must include, at a minimum, the following: function limitations justification, dates of service needed, modes of transportation needed, and certification statement. Each Plan must have a mechanism to capture and submit data from the PCS form to DHCS. Members can request a PCS form from their physician by telephone, electronically, in person, or by another method established by the Plan. (*APL 17-010*)

Plan policy *UM-016 Transportation Guidelines* (revised 9/6/18) stated the Plan must use the DHCS approved PCS form with requests for transportation services. The PCS form would collect data regarding the member's functional limitations, prescribed dates of service, and prescribed mode of transportation. The completed PCS form must be submitted to the Plan's transportation broker for coordination of services. The PCS form must be completed before NEMT services can be prescribed and provided to the member. PCS form includes the certification statement (prescribing physician's statement certifying that medical necessity was used to determine the type of transportation being requested). The signed PCS form with the required fields will be considered completed.

Finding: The Plan did not require PCS forms for NEMT services.

A verification study found that in ten of 30 samples, a PCS form was not completed at the time of the trip.

❖ COMPLIANCE AUDIT FINDINGS (CAF) ❖

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During the interview, the Plan stated it was standard practice for its transportation broker to make three follow up attempts with providers for the PCS form. If the Plan was not able to reach the provider, the transportation services would still be provided without a PCS form and physician certification. The Plan informs its providers of the PCS form requirements through the provider manual, provider orientation packet, and quarterly provider packet.

Without the PCS form, Medi-Cal members may be subject to inadequate assistance and transportation methods, and unsafe transportation conditions.

Recommendation: Revise and implement policies and procedures to ensure that the completed PCS form is received from providers before transportation.

❖ COMPLIANCE AUDIT FINDINGS (CAF) ❖

PLAN: Alameda Alliance For Health

AUDIT PERIOD: June 1, 2019 through March 31, 2021

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CATEGORY 4 – MEMBER’S RIGHTS

4.1 GRIEVANCE SYSTEM

4.1.1 Review of Quality of Care (QOC) Grievances

The Plan’s Medical Director is required to resolve grievances related to medical quality of care. 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. If the Plan has multiple internal levels of grievance resolution or appeal, all levels must be completed within 30 calendar days of the Plan’s receipt of the grievance. (*Contract, Exhibit A, Attachment 1(6)(E)*) (*Cal. Code of Regs., Title 28, § 1300.68(a)(4)(A)*)

Plan Policy *G&A-003 Grievance and Appeals Receipt, Review and Resolution* (revised 11/21/20) stated that all grievances related to medical QOC issues were immediately submitted to a medical director for action. The policy did not describe the procedures a medical director would follow for complete resolution of QOC grievances.

Finding: The Plan did not ensure that the medical director fully resolved QOC grievances prior to sending resolution letters.

A verification study showed that in 12 of 13 QOC grievances a medical director did not review all relevant information necessary to resolve the grievances. In these cases, there was a note from a medical director stating they would request a provider response and medical records and refer to QI for PQI investigation. There was no summary of the case with the medical director’s input and documentation that they had at least reviewed the provider response.

During interviews and in follow up written statements, the Plan stated that in order to consider a QOC grievance resolved a medical director would need to at least review the provider response and medical records. If these documents were not available, however, they depended on internal sources such as customer service call logs, UM or pharmacy history, and case management notes to assist them with closing the grievance. If a medical director identified a PQI, the case was closed and routed to the QI department for further investigation.

If pertinent medical records and provider responses are not reviewed, this could lead to incomplete resolution of grievances which may result in missed opportunities to improve the quality of clinical care.

❖ COMPLIANCE AUDIT FINDINGS (CAF) ❖

PLAN: Alameda Alliance For Health

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Recommendation: Revise and implement policies and procedures to ensure that all levels of quality of care grievances are resolved by the medical director prior to sending a resolution letter to members.

4.1.2 Grievance Classification and Processing

The Plan is required to implement and maintain procedures as described for grievances and the expedited review of grievances required under *CCR, Title 28, sections 1300.68 and 1300.68.01* and *CCR, Title 22, section 53858*. (*Contract, Exhibit A, Attachment 14(2)*).

Grievances received over the telephone that are not coverage disputes, disputed health care services involving medical necessity or experimental or investigational treatment, and that are resolved by the close of the next business day, are exempt from the requirement to send a written acknowledgment and response (*Cal. Code Regs., Title 28, § 1300.68 (d)(8)*).

Plan policy *MBR-0024 Exempt Grievances* (revised 7/16/20) defined an exempt grievance as complaint that is not coverage disputes, disputed health care services involving medical necessity, or experimental or investigational treatment and that are resolved by the close of the next business day following receipt. Member Services staff would investigate the complaint and provide a resolution to the member or authorized representative within the close of the next business day. If the complaint could not be resolved within the close of the next business day, the complaint would be forwarded to the G&A unit to process as a standard grievance.

Finding: The Plan did not consistently implement its procedure for processing grievances. The Plan considered member's grievances resolved and classified as exempt without conducting investigation.

A verification study of ten exempt grievances found four were not properly classified, processed, and resolved.

- In one case, the member complained that their PCP refused to prescribe a medication refill and was very rude to them. The Plan's resolution was to assist the member in changing PCP. The Plan did not perform any investigation to review the complaint.
- In the second case, the member was dissatisfied with the services provided by their PCP. The Plan's action to resolve the member's complaint was to change the member's PCP but it did not conduct an investigation to validate the member's complaint.

❖ COMPLIANCE AUDIT FINDINGS (CAF) ❖

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- In the third case, the member complained about an ancillary provider because they refused to schedule a second ultrasound appointment which according to their PCP was medically necessary. The member also complained about the lack of appointment availability. The Plan closed the case as an exempt grievance after the member stated that their PCP referred them to a different ancillary provider. The Plan did not perform an investigation of the original ancillary provider.
- In the fourth case, the member complained that their PCP cancelled three scheduled appointments upon arrival. The Plan resolved the member's complaint by changing the member's PCP. The Plan did not perform an investigation to review the complaint.

During the interview, the Plan stated that these cases were opportunities for Member Services to improve the grievance process.

By inappropriately classifying grievances as exempt, grievances are not fully investigated and resolved, and members may not be able to exercise their rights.

Recommendation: Implement policies and procedures to ensure grievances are appropriately classified, processed and resolved.

4.1.3 Grievance Notification and Letter Timeframes

The Plan shall follow grievance and appeal requirements, and use all notice templates included in APL 17-006 Grievance and Appeal Requirements and Revised Notice Templates and "Your Rights" attachments. The Plan shall ensure that the requirements are met through its grievance and appeal system. The Plan is required to implement and maintain procedures as described for grievances and the expedited review of grievances required under *42 CFR 438.408*. (*Contract, Exhibit A, Attachment 14(1)(2)*)

The Plan must resolve each grievance and provide notice, as expeditiously as the member's health condition requires, within state-established timeframes. If the Plan extends the timeframe not at the request of the member, the Plan must make reasonable efforts to give the member prompt oral notice of the delay. (*42 CFR 438.408 (a)(c)(2)(i)*)

❖ COMPLIANCE AUDIT FINDINGS (CAF) ❖

PLAN: Alameda Alliance For Health

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The Plan shall provide written acknowledgment to the beneficiary that is dated and postmarked within five calendar days of receipt of the grievance. The Plan shall comply with the state's established timeframe of 30 calendar days for grievance resolution. Federal regulations require the Plan to make reasonable efforts to provide oral notice to the beneficiary of the resolution. The Plan shall apply this requirement of oral notice for expedited grievances. (*APL 17-006*)

Plan policy *G&A-003 Grievance and Appeals Receipt, Review and Resolution* (revised 11/21/20) stated the Plan would provide a written acknowledgement dated and postmarked within five calendar days of receipt. The Plan would provide a written resolution within thirty calendar days of receipt.

Plan policy *G&A-005 Expedited Review of Urgent Grievances* (revised 5/21/20) stated the Plan would make a reasonable effort to provide oral notice and a written statement on the disposition or pending status of the grievance provided to the member no later than 72 hours from receipt of the grievance.

Finding: The Plan did not send acknowledgement and resolution letters within the required timeframes. The Plan did not promptly notify the members that expedited grievances would not be resolved within the required timeframe.

A verification study of 49 standard and three expedited grievances found the following deficiencies:

- One standard grievance acknowledgement letter was not sent to member.
- Seven standard grievance acknowledgement letters were not sent within the required timeframe.
- Eight standard grievance resolution letters were not sent within the required timeframe.
- Four standard grievance resolution letters in threshold languages were not sent within the required timeframe
- In three expedited grievances, members were not notified promptly of the delay.

During interviews, the Plan stated that in August 2020 it transitioned its grievance system from one software system to another. This transition caused confusion among member services staff which led to late grievance processing of acknowledgment and resolution letters.

❖ COMPLIANCE AUDIT FINDINGS (CAF) ❖

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For the three expedited grievances, the Plan stated that complaints related to diabetic medicine were automatically categorized as expedited. However, due to vendor issues it was unable to resolve the grievances within the required timeframe. The Plan could not provide an explanation for the lack of prompt oral notice of the delay to the members.

When the Plan does not notify members of acknowledgement and resolution of grievances timely, members may not have all the information they need to make health care decisions.

Recommendation: Implement policies and procedures to ensure acknowledgement and resolution letters are sent within the required timeframes and prompt notification of members when there is delay in resolving expedited grievances.

4.1.4 Grievance Letters in Threshold Languages

The Plan shall comply with *42 CFR 438.10(d)(4)* and provide, at minimum, the linguistic services at no cost to Medi-Cal members such as fully translated member information including grievance and appeal acknowledgement and resolution letters. The Plan shall provide translated written informing materials to all monolingual or limited English proficiency (LEP) members that speak the identified threshold or concentration standard languages. (*Contract, Exhibit A, Attachment 9(B)(2)*)

The Plan is required to make its written materials that are critical to obtaining services, available in the prevalent non-English languages in its particular service area. The Plan must make interpretation services available and free of charge to members. This includes oral interpretation requirements that applies to all non-English languages, not just those that the state identifies as prevalent. (*42 CFR 438.10(d)(3)(4)*)

Plan policy *G&A-001 Grievance and Appeals System Description* (revised 1/21/20) stated the Plan addressed the linguistic and cultural needs of its members. All members with limited English proficiency could have access to and can fully participate in the grievance and appeals system through translations of grievance and appeals procedures, forms, and the Plan responses to grievance and appeals, as well as access to interpreters.

Plan policy *CLS-003 Language Assistance Services* (revised 1/21/20) stated the Plan provided members written informing materials in the Plan's threshold language based on the member's language of preference. Informing materials include, but are not limited to, form letters including NOA letters and grievance acknowledgement and resolution letters.

❖ COMPLIANCE AUDIT FINDINGS (CAF) ❖

PLAN: Alameda Alliance For Health

AUDIT PERIOD: June 1, 2019 through March 31, 2021

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Finding: The Plan did not send acknowledgement and resolution letters in threshold languages.

A verification study of 49 standard grievance found the following deficiencies:

- In two cases, acknowledgement letters were not sent in threshold languages.
- In four cases, resolution letters were not sent in threshold languages.

Review of the Plan's G&A quarterly internal audits also showed that standard and appeal resolution letters were not translated in member's threshold language. The Plan acknowledged that corrective action for its G&A internal audits are incomplete.

If the Plan does not send translated acknowledgment and resolution letters in threshold languages, members may not understand their rights which may lead to barriers to care.

Recommendation: Implement policies and procedures to ensure acknowledgement and resolution letters are translated into the threshold languages.

4.1.5 Grievance Resolution / Grievance Process

The Plan 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. (*Cal. Code Regs., Title 22, § 53858(a)*)

The Plan's grievance system shall provide for a prompt review of grievances by the management or supervisory staff responsible for the services or operations which are the subject of the grievance. Resolved means that the grievance has reached a final conclusion with respect to the enrollee's submitted grievance. (*Cal. Code Regs., Title 28, §1300.68(a)(4)(d)(2)*)

Plan policy *G&A-001 Grievance and Appeals System Description* (revised 1/21/20) stated the Plan would ensure 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 member's submitted grievance.

Finding: The Plan did not consistently resolve grievances prior to sending resolution letters.

❖ COMPLIANCE AUDIT FINDINGS (CAF) ❖

PLAN: Alameda Alliance For Health

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A verification study found ten of 49 standard grievances were not completely resolved. Examples included:

- In one case, the member complained the transportation did not arrive to pick up the member at scheduled appointment. The transportation provider reported to the Plan that the member did not show up at the scheduled appointment. The Plan closed the case without doing further investigation to verify the information.
- In another case, the member complained about not being able to schedule an appointment with a specialist and not receiving a call back. The Plan's resolution letter stated, it reached out to the provider and confirmed the member spoke with the specialist and was able to get an appointment. However, the Plan did not confirm with the member if the statement from the provider was accurate.
- In another case, the member's parent complained their physician was not providing prior authorization for their child's medication. The Plan's resolution letter stated it reached out to the pharmacy to confirm the member obtained the medication. However, the Plan did not investigate why the physician did not submit the prior authorization and did not verify with the member that the medication was received.
- In another case, the member's parent complained about the delegate not being able to schedule telehealth sessions for speech therapy due to the delegate's lack of telehealth capabilities. The Plan's resolution letter stated the member had been assigned to a new medical group and a new prior authorization request was submitted. The Plan closed the grievance prior to resolving the member's complaint.

During interviews, the Plan stated that its grievance process was to submit requests for provider responses, however, the Plan did not validate documentation to confirm the accuracy of providers' responses.

As a corrective action to the 2019 audit finding, 4.1.4 Grievance Resolution/Grievance Process, the Plan updated the standard grievance checklist, including draft resolution letter instructions. The instructions were to record all the grievances and resolve each complaint. The Plan also developed G&A internal audit tools to ensure all grievances were captured and resolved. The Plan's quarterly G&A internal audit showed that resolution letters were not addressing all grievances. In a written response, the Plan acknowledged that the CAP for internal audits of G&A was incomplete.

This is a repeat finding.

❖ COMPLIANCE AUDIT FINDINGS (CAF) ❖

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When the Plan does not completely resolve grievances, this may result in missed opportunities for improved health care delivery and poor health outcomes for members.

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

❖ COMPLIANCE AUDIT FINDINGS (CAF) ❖

PLAN: Alameda Alliance For Health

AUDIT PERIOD: June 1, 2019 through March 31, 2021

DATE OF AUDIT: April 13, 2021 through April 23, 2021

4.3

CONFIDENTIALITY RIGHTS

4.3.1 Reporting of Health Insurance Portability and Accountability Act (HIPAA) Incidents and Disclosures

The Plan is required to notify DHCS within 24 hours by email or fax of the discovery of any suspected security incident, intrusion, or unauthorized access, use, or disclosure of PHI or personal information in violation of this agreement and this addendum, or potential loss of confidential data affecting this agreement. A breach shall be treated as discovered by the Plan as of the first day on which the breach is known, or by exercising reasonable diligence would have been known, to any person (other than the person committing the breach) who is an employee, officer, or other agent of the Plan. The Plan is required to immediately investigate such security incidents, breach, or unauthorized access, use or disclosure of PHI or PI. Within 72 hours of discovery, the Plan shall submit an updated “DHCS Privacy Incident Report” containing the information marked with an asterisk and all other applicable information listed on the form, to the extent known at that time. The Plan is required to provide a complete report of the investigation to the DHCS Program Contract Manager, the DHCS Privacy Officer, and the DHCS Information Security Officer within ten working days of the discovery of the breach or unauthorized use or disclosure. (*Contract, Exhibit G, Attachment 3 (J)*)

Plan policy *CMP-013 HIPAA Privacy Reporting* (revised 11/11/19) stated that the Compliance Department shall report, within 24 hours, of any potential loss of confidential data concerning the DHCS contract, or any suspected security incident, intrusion or unauthorized use or disclosure of PHI, to the DHCS Contract Officer/manager, DHCS Privacy Officer and DHCS Information Security Officer regarding privacy breach for Medi-Cal members. The investigation report will be provided to DHCS within 72 hours of discovery. The policy did not address the requirements to submit a complete report of the investigation within ten working days of discovery.

Finding: The Plan did not report suspected security incidents or unauthorized disclosures of PHI to DHCS within 24 hours of discovery, did not provide an updated investigation report within 72 hours, and did not submit a complete report of the investigation within ten working days.

❖ COMPLIANCE AUDIT FINDINGS (CAF) ❖

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The verification study revealed that the following:

- Six of 20 samples were not initially reported within 24 hours of the discovery of the breach or security incident.
 - Samples were reported late to the Compliance Department from other departments within the Plan (Grievances Department, Members Services, etc.), and therefore reported to DHCS late.
 - Samples were reported to DHCS three to four weeks after the Plan had discovered them.
- 11 of 20 samples did not have an updated DHCS Privacy Incident Report submitted with 72 hours of discovery of the breach or security incident.
- 11 of 20 samples did not have a complete report of the investigation submitted within ten working days of discovery of the breach or security incident

In the interviews and written responses, the Plan acknowledged that these cases were not reported in a timely manner. The Plan had inadequate staffing during the audit period. Staff were performing multiple tasks, and were not focused on specific tasks.

Untimely reporting of cases of HIPAA incidents may expose Medi-Cal members to potential intrusion of privacy and unauthorized disclosure of PHI.

Recommendation: Revise and implement policies and procedures to ensure that all suspected security incidents or unauthorized disclosures of PHI are monitored and reported timely.

❖ COMPLIANCE AUDIT FINDINGS (CAF) ❖

PLAN: Alameda Alliance For Health

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CATEGORY 6 – ADMINISTRATIVE AND ORGANIZATIONAL CAPACITY

6.2 FRAUD AND ABUSE

6.2.1 Fraud and Abuse Reporting

The Plan shall conduct, complete, and report to DHCS, the results of a preliminary investigation of suspected fraud and/or abuse within ten working days of the date the Plan first becomes aware of, or is on notice of, such activities. (*Contract, Exhibit E, Attachment 2 (26)(B)(7)*).

The Plan's policy *CMP-002 Fraud, Waste, and Abuse* (revised 11/11/19) stated that Plan would report all suspected Fraud, Waste, and Abuse (FWA) incidents to DHCS within ten working days of the date the Plan becomes first aware or notified of the suspected activity. This includes all incidents reported to the Compliance Department internally and externally through the various reporting methods and all FWA incidents reported by subcontractors, members, providers, or employees. The Compliance Department would submit the confidential DHCS Complaint Form (MC609) to DHCS Program Integrity Unit 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 ten working days.

A review of the FWA incidents revealed:

- Four of the 11 incidents were not reported to DHCS within ten business days of becoming aware of the incident. These four incidents exceeded the reporting timeframe by 1 to 23 days.

During the interview, the Plan stated that prior to the new Compliance Department leadership, the previous Compliance Department leadership did not clearly define the roles and responsibilities to staff.

This was a finding in 2017 (Finding 6.3.1), in 2018 (6.3.1) and in 2019 (6.2.1), Fraud and Abuse Reporting. The 2019 CAP included updates to the Plan's procedures to include preliminary investigation documents within ten working days reporting timeframe. Staff training of the updated procedure was conducted on 12/11/19.

This is a repeat finding from 2017-2019.

❖ COMPLIANCE AUDIT FINDINGS (CAF) ❖

PLAN: Alameda Alliance For Health

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If the Plan does not conduct preliminary investigation and reporting of suspected fraud and abuse incidents timely, it could delay detection and prevention of incidents of FWA.

Recommendation: Implement policies and procedures to ensure reporting of preliminary investigations of all suspected cases of fraud and abuse are reported within the required timeframe.

6.2.2 Annual Overpayment Reporting

The Plan is required to annually report to DHCS recoveries of overpayments in accordance with 42 CFR 438.608(d)(3). (*Contract, Exhibit E, Attachment 2 (34)(C)*)

The Plan is required to report annually to DHCS on their recoveries of overpayments, including those made to a network provider that was otherwise excluded from participation in the Medicaid program and those made to a network provider due to fraud, waste, or abuse. These reports shall be submitted through the existing rate setting process in a manner specified by DHCS. (*APL 17-003 Treatment of Recoveries made by the Managed Care Health Plan of Overpayments to Providers.*)

The Plan policy *CLM-008 Overpayment Recovery* (revised 4/18/19) stated that the Plan would report annually to DHCS on their recoveries of overpayments. This included recoveries of overpayments made to a network provider that otherwise was excluded from participation in the Medicaid program and those made to a network provider due to fraud, waste, or abuse.

Finding: The Plan did not report recoveries of overpayments to DHCS annually.

Based on the Plan's Annual Report of Overpayment Recoveries, the Plan identified an overpayment sum of \$1,933,451 from 1,612 providers during the audit period. However, the Plan did not submit evidence of annual reporting of overpayment recoveries to DHCS.

If the Plan does not annually report overpayment recoveries, overpayments may not be monitored and the data may not be analyzed to help identify possible trends or issues.

Recommendation: Implement policies and procedures to ensure the annual reporting of overpayment recoveries to DHCS.

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

REPORT ON THE MEDICAL AUDIT OF

Alameda Alliance For Health

2021

Contract Number: 03-75793
State Supported Services

Audit Period: June 1, 2019
Through
March 31, 2021

Report Issued: August 17, 2021

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I. INTRODUCTION

This report presents the audit findings of the Alameda Alliance for Health (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 April 13, 2021 through April 23, 2021. The audit period is June 1, 2019 through March 31, 2021 and consisted of document review, verification study, and interviews with the Plan.

An Exit Conference with the Plan was held on July 20, 2021. 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 the Department of Health Care Services' (DHCS) evaluation of the Plan's response are reflected in this report.

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

❖ COMPLIANCE AUDIT FINDINGS (CAF) ❖

PLAN: Alameda Alliance for Health

AUDIT PERIOD: June 1, 2019 through March 31, 2021

DATE OF AUDIT: April 13, 2021 through April 23, 2021

STATE SUPPORTED SERVICES

SSS.1 Payment Distribution Timeframe

The Plan is bound by all applicable terms and conditions of the primary Contract as of the effective date of the State Supported Service Contract. (*Hyde Contract, Exhibit E(1)*)

The Plan shall comply with all existing final policy letters and All Plan Letters (APL) issued by DHCS. (*Contract, Exhibit E, Attachment 2 (D)*)

The Plan is required to pay the individual rendering providers that are qualified to provide and bill for medical pregnancy termination services with dates of service on or after July 1, 2017, using Proposition 56 appropriated funds. The Plan must distribute the payments required by *APL 019-013 Proposition 56 Hyde Reimbursement Requirements for Specified Services* to the rendering providers within 90 calendar days of receiving a clean claim or from the date the Plan began receiving capitation payments from DHCS accounting for the projected value of the reimbursement obligations. (*APL 19-013*)

Plan policy *CLM-001 Claims Processing* (revised 6/30/2020) stated all claims must be processed in accordance with federal and state laws and regulations governing the Plan's programs, plus all other applicable laws, regulations, and contractual stipulations pertaining to the Plan's standards.

Finding: The Plan did not distribute payments for State Supported Services claims within 90 calendar days as described in APL 19-013.

A verification study of 30 claims found payments were not distributed to six providers within 90 calendar days of claim receipt or from the date the Plan received the capitation payment increase from DHCS. In a written response, the Plan stated it started receiving capitation payment for reimbursement obligations on 4/15/20 but the increase in rate was not deployed in its claim system until 6/18/20. The Plan did not provide an explanation for the delay of implementation on their system.

When the Plan does not distribute payments within the required timeframe, this may discourage providers from participating with the Plan and limit members' access to care.

Recommendation: Implement policies and procedures to distribute State Supported Services payments in compliance with state regulation.

❖ COMPLIANCE AUDIT FINDINGS (CAF) ❖

PLAN: Alameda Alliance for Health

AUDIT PERIOD: June 1, 2019 through March 31, 2021

DATE OF AUDIT: April 13, 2021 through April 23, 2021

SSS.2 Interest Payment

The Plan is bound by all applicable terms and conditions of the primary Contract as of the effective date of the State Supported Services Contract. (*Hyde Contract, Exhibit E(1)*)

The Plan shall comply with all existing final policy letters and APL issued by DHCS. (*Contract, Exhibit E, Attachment 2 (D)*)

The Plan is required to pay the individual rendering providers that are qualified to provide and bill for medical pregnancy termination services with dates of service on or after July 1, 2017, using Proposition 56 appropriated funds. The Plan must distribute the payments required by *APL 19-013 Proposition 56 Hyde Reimbursement Requirements for Specified Services* to the rendering providers within 90 calendar days of receiving a complete claim or from the date the Plan began receiving capitation payments from DHCS accounting for the projected value of the reimbursement obligations. (*APL 19-013*)

Plan policy *CLM-001 Claims Processing* (revised 6/30/2020) stated that for claims not paid within the required timeframe, or that are identified as underpaid, interest must be paid for the period of the time that the payment is late or portion underpaid, 15 percent annually, per claim.

Finding: The Plan did not pay interest for State Supported Services claims processed beyond the 90 calendar day timeframe specified in *APL 19-013*.

A verification study of 30 claims found two samples processed late were not paid interest. The *APL 19-013* had been published and/or the Plan began receiving capitation payments from DHCS with Prop 56 increase accounted for by the time these claims were submitted. Although the Plan had been informed of its responsibility to pay the claims within the 90 calendar day requirement, and it had a policy in place to include interest when claims were paid late, several claims processed late were still not paid interest.

Insufficient interest payments on claims may cause financial harm to a provider's practice and limit members' access to care.

Recommendation: Implement policies and procedures to pay interest for State Supported Services claims reimbursed over 90 calendar days from receipt.

❖ COMPLIANCE AUDIT FINDINGS (CAF) ❖

PLAN: Alameda Alliance for Health

AUDIT PERIOD: June 1, 2019 through March 31, 2021

DATE OF AUDIT: April 13, 2021 through April 23, 2021

SSS.3 Denial of Claims

The Plan is bound by all applicable terms and conditions of the primary Contract as of the effective date of this State Supported Service Contract. (*Hyde Contract, Exhibit E(1)*)

The Plan is required to make payments in compliance with the contractual claims requirements and timeframes for abortion services regardless of network affiliation. If a member chooses an out-of-network provider for abortion services, the reimbursement rate must not be lower, and is not required to be higher, than the Medi-Cal fee-for-service rate unless the out-of-network provider and the Plan mutually agree to a different reimbursement rate. (*APL 15-020 Abortion Services*)

The Plan shall not improperly deny or contest a claim or portion thereof. For each claim that is denied or contested, the Plan shall provide an accurate and clear written explanation of the specific reasons. (*Cal Code Regs., tit. 28, section 1300.71 (d) (1) and (h)*)

Plan policy *CLM-010 Family Planning and Sensitive Services Claims Processing* (revised 6/30/20) stated the Plan would process claims or any portion of a claim for family planning and sensitive services, whether in-network or out-of-network, as soon as practical, but no later than 45 working days after receipt. The Plan would reimburse in-network providers based on their Contract, and out-of-network providers at the prevailing Medi-Cal rate based on the service provided.

Finding: The Plan improperly denied State Supported Services claims.

A verification study of 30 claims found the following deficiencies:

- Five claims were denied as misdirected claims and were automatically forwarded to a delegated provider. Although the members were assigned to the delegated entity, State Supported Services provided out-of-network were the Plan's responsibility.
- One claim was denied because it was paid in the original claim. However, the original claim showed the amount paid was less than the Medi-Cal rate.
- One claim was denied because the drug code was invalid. When the Plan reviewed the provider resolution dispute, it determined that the drug code was valid.

❖ COMPLIANCE AUDIT FINDINGS (CAF) ❖

PLAN: Alameda Alliance for Health

AUDIT PERIOD: June 1, 2019 through March 31, 2021

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During the interview, the Plan stated it conducted an internal audit every week to ensure claims were not improperly denied. The Plan also stated it updated its claim system annually for enhancement and corrections. However, those described procedures did not prevent claims from being improperly denied by the Plan.

When the Plan denies payment for covered services, providers may be discouraged from treating members and members' access to care may be limited.

Recommendation: Implement policies and procedures to ensure claims are appropriately processed.