CONTRACT AND ENROLLMENT REVIEW – SAN FRANCISCO
AUDITS AND INVESTIGATIONS
DEPARTMENT OF HEALTH CARE SERVICES

REPORT ON THE MEDICAL AUDIT OF

Alameda Alliance for Health

2023

Contract Number:	04-35399
Audit Period:	April 1, 2022 Through March 31,2023
Dates of Audit:	April 17, 2023 Through April 28, 2023
Report Issued:	October 20, 2023

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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, 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, 2023, the Plan had 355,716 members. There were 349,991 (98.39 percent) Medi-Cal members and 5,725 (1.61 percent) group care commercial members.

II. EXECUTIVE SUMMARY

This report presents the audit findings of the Department of Health Care Services (DHCS) medical audit for the audit period of April 1, 2022 through March 31, 2023. The audit was conducted from April 17, 2023 through April 28, 2023. The audit consisted of document review, verification studies, and interviews with Plan representatives.

An Exit Conference with the Plan was held on September 26, 2023. 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 April 1, 2021 through March 31, 2022) was issued on September 9, 2022. This audit examined documentation for Contract compliance and assessed implementation of the Plan's 2022 Corrective Action Plan (CAP).

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

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 prior authorization appeal process.

The Plan is required to provide members and providers with written notice of an adverse benefit determination using the appropriate DHCS-developed standardized Notice of Action (NOA) templates. The Plan did not ensure Community Health Center Network (CHCN), a delegate, sent NOA letters to providers and members.

Category 2 – Case Management and Coordination of Care

Category 2 includes requirements for Complex Case Management (CCM), Health Risk Assessments (HRA), Initial Health Assessments (IHA), Behavioral Health Treatment (BHT), and coordination of mental health services.

The Plan is required to cover and ensure the provision of an IHA, which consists of a comprehensive history and physical examination, and preventive services. The Plan did not ensure that a complete IHA was provided for new members.

The Plan is required to provide medically necessary BHT services as stated in a member's treatment plan. A Plan approved behavioral treatment plan is required to include but is not limited to the following criteria: the member's current level of need, date of introduction, estimated date of mastery, and crisis plan. The Plan did not ensure members' BHT treatment plans contained all the required elements.

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 services, and provisions for Non-Emergency Medical Transportation (NEMT) and Non-Medical Transportation (NMT).

The Plan's policies and procedures are required to ensure that a member's first prenatal visit be available within two weeks upon request. The Plan's policies and procedures did not ensure a first prenatal visit for a pregnant member was available within two weeks upon request.

The Plan is required to pay for emergency services at the lesser of usual charges to the public, maximum Medi-Cal fee-for-service rate or negotiated rate. The Plan did not pay non-contracted providers at the appropriate Medi-Cal fee-for-service rate.

The Plan is required to pay qualified family planning providers a fixed add-on amount for specified family planning services as required by All Plan Letter (APL) 22-011. The Plan did not distribute add-on payments for specified family planning services as required.

The Plan is required to use a DHCS approved Physician Certification Statement (PCS) form to determine the appropriate level of service for members needing NEMT services. The Plan did not ensure PCS forms were on file for members receiving NEMT services.

The Plan is required to comply with the enrollment requirements set forth in APL 19-004 or any superseding APL. The Plan may allow NEMT and NMT providers to participate in its network for up to 120 days. If the NEMT or NMT providers are unable to successfully enroll in Medi-Cal, the Plan cannot continue to contract with the providers during the period in which the provider resubmits its enrollment application. The Plan did not ensure all transportation providers were enrolled in the Medi-Cal program.

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.

The Plan is required to provide written acknowledgement to members within five calendar days and written notice of resolution within 30 calendar days of receipt of a grievance. The Plan did not send acknowledgement and resolution letters within the required timeframes.

The Plan is required to provide fully translated member information in identified threshold languages, including grievance letters, to members at no cost. The Plan did not send acknowledgement, resolution delay, and resolution letters in threshold languages.

The Plan is required to notify members in writing of the grievance status and the estimated date of resolution should the resolution not be reached within 30 calendar days. Plans are restricted from applying a federal 14 calendar day extension timeframe as a standard. The Plan did not send delay letters for grievances that were not resolved within 30 calendar days and did not resolve grievances by the estimated completion date specified in the delay letters sent. The Plan inappropriately utilized a 14-calendar day delay timeframe for grievance resolutions.

The Plan is required to resolve all exempt grievances by close of the next business day. The Plan did not resolve exempt grievances by close of the next business day.

The Plan is required to process all complaints as grievances. An inquiry is a request for information that does not include an expression of dissatisfaction. The Plan did not process and resolve all member expressions of dissatisfaction as grievances.

Category 5 – Quality Management

Category 5 includes procedures and requirements to monitor, evaluate, and take effective action to address any needed improvements in the quality of care delivered by providers.

There were no deficiencies identified in this category.

Category 6 – Administrative and Organizational Capacity

Category 6 includes a review of the Plan’s administrative and management arrangements or procedures, as well as a mandatory compliance plan, which are designed to guard against fraud and abuse.

There were no deficiencies identified in this category.

III. SCOPE/AUDIT PROCEDURES

SCOPE

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

PROCEDURE

The audit was conducted from April 17, 2023 through April 28, 2023. 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: 12 medical prior authorization requests were reviewed for timeliness, consistent application of criteria, and appropriate review.

Prior Authorization Appeal Procedures: 12 medical prior authorization appeals were reviewed for appropriate and timely adjudication.

Delegated Prior Authorization Requests: 28 medical prior authorization requests were reviewed for appropriate and timely adjudication.

Category 2 – Case Management and Coordination of Care

HRA: 15 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.

BHT: 15 Plan BHT files were reviewed to confirm the performance of services and complete case file elements.

IHA: 15 Plan member files were reviewed to confirm the performance of the assessment.

Category 3 – Access and Availability of Care

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

NMT: 30 claims were reviewed for timeliness and appropriate adjudication. Twenty-four contracted NMT providers were reviewed for Medi-Cal enrollment.

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

Category 4 – Member's Rights

Grievance Procedures: 53 standard grievances, three expedited grievances, ten exempt, and ten call inquiries were reviewed for timely resolution, response to complainant, and submission to the appropriate level for review. The 53 standard grievance cases included 40 quality of service and 13 quality of care grievances.

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

Category 5 – Quality Management

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

Provider Qualifications: 15 new provider training records were reviewed for the timeliness of Medi-Cal Managed Care program training.

Category 6 – Administrative and Organizational Capacity

Fraud and Abuse: Ten 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.

CATEGORY 1 - UTILIZATION MANAGEMENT

1.5	DELEGATION OF UTILIZATION MANAGEMENT

1.5.1 Notice of Action Letters

The Plan is accountable for all functions and responsibilities, including UM, that are delegated to subcontractors. The Plan is required to maintain a system to ensure accountability for delegated activities that at a minimum ensures a delegate meets standards set forth by the Plan and DHCS. *(Contract, Exhibit A, Attachment 4(6) (A and B))*

The Plan is required to provide members and providers with written notice of an adverse benefit determination using the appropriate DHCS-developed standardized NOA templates. *(APL 21-011 Grievance and appeal requirements, notice and "your rights" templates)*

Plan policy, *UM-054 Notice of Action (revised 2/21/2023),* stated the Plan provides members and providers with written notifications of UM decisions. These include NOA letters for denials, modifications, and deferrals/delays in easily understandable language to be able to understand the decision and decide whether to appeal the decision.

Plan policy, *UM-060 Delegation of Utilization Management (revised 2/21/2023),* stated that the Plan monitors delegated functions through routine reporting and annual audits, which include file reviews. It also stated that focused audits may occur between annual audits if the Plan determines the need to evaluate the delegate's performance in specific areas.

The Delegation Agreement between the Plan and Community Health Center Network (CHCN) *(signed 4/27/2018),* stated the NOA must be consistent with the Plan's policies and procedures, state regulations, and National Committee of Quality Assurance standards. It also stated that the Plan's oversight included an annual review of relevant UM policies and procedures as well as file review of randomly selected denial authorization files.

Finding: The Plan did not ensure CHCN sent NOA letters to providers and members.

A verification study showed that in 12 of 28 cases CHCN did not send NOA letters to members and providers.

In an interview, CHCN acknowledged it did not send NOA letters for 435 member service requests due to a computer system update which caused a gap in time for which NOA letters were not sent. As a result, some NOA letters processed after the update were not sent to the CHCN's vendor to be mailed.

In interviews and written statements, the Plan stated that during the DHCS audit preparation it discovered that NOA letters were missing in the files submitted by CHCN. The Plan confirmed the NOA letters were not sent due to a computer system update. The Plan acknowledged the systemic failure began occurring in October 2021.

The Plan conducted an annual delegation audit of CHCN that covered the period of July 1, 2021 through June 30, 2022. The Plan's audit was not effective in detecting the NOA letter deficiency.

If NOA letters are not sent to members and providers, they will not receive the necessary information to exercise their rights.

Recommendation: Implement policies and procedures to ensure that delegated entities send required NOA letters.

CATEGORY 2 – CASE MANAGEMENT AND COORDINATION OF CARE

2.1	INITIAL HEALTH ASSESSMENT

2.1.1 Provision of an Initial Health Assessment

The Plan is required to cover and ensure the provision of an IHA. An IHA consists of a history and physical examination and an Individual Health Education Behavioral Assessment that enables a provider of primary care services to comprehensively assess the member's current acute, chronic and preventive health needs and identify those members whose health needs require coordination with appropriate community resources and other agencies for services not covered under this Contract. *(Contract, Exhibit A, Attachment 10 (3))*

The Plan is required to follow the latest edition of the Guide to Clinical Preventive Services published by the United States Preventive Services Task Force (USPSTF) to provide preventive services to asymptomatic, healthy adult members. All preventive services identified as USPSTF "A" and "B" recommendations must be provided, and the status must be documented. *(Contract, Exhibit A, Attachment 10(6) (B) (1))*

Plan policy, *QI-124 Initial Health Appointment (IHA) (approved 3/21/2023),* stated that a primary care physician is required to perform an IHA with a member within 120 days of enrollment. The IHA will be comprised of comprehensive history and exam, preventive services, diagnosis, and plan of care. The Plan monitors IHA completion through routine Facility Site Reviews and at least annually review 30 member records to ensure all required components have been completed. Failure to meet all of the IHA requirements may result in the issuance of a CAP.

Finding: The Plan did not ensure the provision of a complete IHA for new members.

A verification study showed that four of 15 member records did not contain a complete IHA.

- One of four member records did not document a comprehensive history and physical examination.

- Two of four member records did not document depression and hepatitis C screenings were offered to the members or that the members had declined them. The USPSTF A and B recommendations include screening for depression in the general adult population and hepatitis C virus infection in adults aged 18 to 79 years.

- Two of four member records did not document that colorectal cancer and hepatitis C screenings were offered to the member or that the member had declined it. The USPSTF A and B recommendations include screening for colorectal cancer in all adults aged 50 to 75 years and hepatitis C virus infection in adults aged 18 to 79 years.

In a written response, the Plan cited ongoing challenges from the Covid-19 public health emergency, including staffing shortages and limited access to care, as barriers to IHA completion.

Subsequent to the Exit Conference, the Plan provided additional information regarding challenges with ensuring IHAs were completed. The Plan stated it did not adequately monitor provider completion of IHAs for new members. In addition, the Plan attributed the finding to providers' lack of knowledge of preventive screenings and member outreach requirements.

When the Plan does not ensure the provision of a complete IHA, members may not receive important screenings for mental, physical, psychological, and preventative health needs.

Recommendation: Implement policies and procedures to ensure the provision of a complete IHA to each new member.

2.3	BEHAVORIAL HEALTH TREATMENT

2.3.1 Behavioral Health Treatment Plan Elements

The Plan is required to provide medically necessary BHT services as stated in the member's treatment plan and/or continuation of BHT services under continuity of care with the member's BHT provider. *(Contract, Exhibit A, Attachment 10(5)(G))*

The Plan-approved behavioral treatment plan is required to include but is not limited to the following criteria: the member's current level of need (baseline, behavior parent/guardian is expected to demonstrate, including condition under which it must be demonstrated and mastery criteria), date of introduction, estimated date of mastery, and crisis plan. *(APL 19-014 Responsibilities for Behavioral Health Treatment Coverage for Members under the Age of 21)*

Plan policy, *UM-062 Behavioral Health Treatment (revised 6/28/22),* stated that BHT services must be provided, observed, and directed under the Plan's behavioral treatment plan. The approved BHT plan must include but is not limited to the following criteria: an estimated date of mastery and a crisis plan.

The Delegation Agreement between the Plan and Beacon Health Strategies LLC (signed 9/9/22), stated Behavioral Health Services shall further include BHT services as set forth in the DHCS Contract and DHCS APL 15-025 (Superseded by APL 19-014).

Finding: The Plan did not ensure members' BHT treatment plans contained all the required elements.

A verification study showed in five of 15 BHT treatment plans the following deficiencies:

- Three samples did not contain an estimated date of mastery for goals.
- Two samples did not contain a crisis plan.

In a written response, the Plan submitted a narrative from Beacon Health Strategies LLC that acknowledged some of the samples with missing estimated dates of mastery and a crisis plan from their BHT treatment plans. Beacon Health Strategies LLC stated for one sample that a behavioral intervention plan covered the requirement of a crisis plan. However, the behavioral intervention plan covers only ways to decrease challenging behaviors and does not address crisis interventions. The BHT record showed that a crisis plan was not created and would be created if warranted.

When the Plan does not ensure BHT treatment plans contain all the required elements, members may not receive individualized care to maintain or improve emotional, behavioral, and physical health needs.

Recommendation: Implement policies and procedures to ensure member's BHT treatment plans contain all the required elements.

CATEGORY 3 – ACCESS AND AVAILABILITY OF CARE

3.1	APPOINTMENT PROCEDURES AND MONITORING WAITING TIMES

3.1.1 First Prenatal Visit

The Plan is required to implement and maintain procedures for members to obtain appointments for prenatal care. The Plan is required to ensure the first prenatal visit for a pregnant member will be available within two weeks upon request. (*Contract, Exhibit A, Attachment 9 (3) (A and B))*

Plan policy, *QI-114 Monitoring of Access and Availability Standards (approved 3/21/2023),* stated the Plan annually conducts a survey to ensure its network providers are in compliance with the DHCS first prenatal visit standard within ten business days of request.

Finding: The Plan's policies and procedures for a first prenatal visit for a pregnant member is not compliant with the standard of two weeks upon request.

Review of the Plan's 2021 Timely Access Survey showed the Plan monitored the first prenatal visit using the contractually required two-week standard from a member's request. However, the Plan's policies used ten business days as a standard for a first prenatal visit.

In a written response, the Plan stated it followed a ten business day appointment availability standard in accordance with California Code of Regulations (CCR), Title 28, section 1300.67.2.2. However, the CCR regulation does not include a standard for prenatal visit appointment availability. In addition, ten business days is less strict than two weeks.

If Plan policies and procedures are not in compliance with the appointment availability standard for the first prenatal visit, members may not receive timely care.

Recommendation: Revise and implement policies and procedures to ensure members receive timely access to first prenatal visits.

3.6	EMERGENCY SERVICES AND FAMILY PLANNING CLAIMS

3.6.1 Non-Contracted Provider Payments

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 is required to cover and pay for emergency services as described in CCR, Title 22, section 53855. *(Contract Exhibit A, Attachment 10(8)(E)(2)(a))*

The Plan is required to pay for emergency services at the lesser of usual charges to the general public, maximum Medi-Cal fee-for-service rate or negotiated rate. *(CCR, Title 22, section 53855)*

Plan policy, *CLM-003 Emergency Services Claims Processing (revised 9/27/22),* stated the Plan will reimburse out-of-plan providers at the Medi-Cal rate based on the service provided.

Finding: The Plan did not pay non-contracted providers at the appropriate Medi-Cal fee-for-service rate.

A verification study found one of 20 emergency services claims was not paid appropriately. The Plan did not pay a non-contracted emergency service claim, procedure code 99285, at the required Medi-Cal fee-for-service rate. The claim was paid at 85 percent the Medi-Cal fee-for-service rate.

During the interview, the Plan stated the claim was not paid at the required Medi-Cal fee-for-service rate as the provider was a mid-level practitioner. In a written statement, the Plan stated all non-contracted and contracted mid-level providers are paid at 85 percent of the Medi-Cal fee-for-service rate. However, Medi-Cal does not pay reduced fee-for-service rates for mid-level practitioners.

If the Plan does not appropriately pay emergency services claims, then providers may be discouraged from participating in the Medi-Cal program and members may not receive needed services.

Recommendation: Implement policies and revise procedures to ensure emergency services claims are paid at the appropriate rate.

3.6.2 Proposition 56 Family Planning Payments

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

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

The Plan is required to directly, or through their delegated entities, pay qualified family planning providers a fixed add-on amount for specified family planning services listed in APL 22-011, using Proposition 56 appropriated funds. This payment obligation applies to contracted and non-contracted providers. The uniform dollar add-on amounts for the services listed are in addition to whatever other payments eligible providers would normally receive from the Plan. Federally Qualified Health Centers, Rural Health Clinics, American Indian Health Service Programs, and Cost-Based Reimbursement Clinics are not eligible to receive this add-on payment. *(APL 22-011 Proposition 56 Directed Payments for Family Planning Services)*

Plan policy, *CLM-001 Claims Processing (revised 11/23/21),* 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 add-on payments for institutional family planning service claims as required by APL 22-011.

A verification study found in one of seven family planning claims the Plan did not distribute an add-on payment to an eligible provider according to APL 22-011.

In written statements, the Plan stated it does not distribute add-on payments for institutional provider claims, such as hospitals. However, APL 22-011 does not place limits on family planning add-on payments for institutional claims or any other type of claim.

When the Plan does not distribute applicable payments, providers may be discouraged from participating with the Plan, which may limit members' access to care.

Recommendation: Implement policies and revise procedures to distribute family planning service add-on payments according to APL 22-011.

3.8	NON-EMERGENCY MEDICAL TRANSPORTATION (NEMT) NON-MEDICAL TRANSPORTATION (NMT)

3.8.1 Physician Certification Statement (PCS) Forms

The Plan is required to cover transportation services as required in this Contract and directed in APL 17-010 (superseded by APL 22-008) to ensure members have access to all medically necessary services. The Plan is required to cover NEMT services required by members to access Medi-Cal services, as provided for in CCR, Title 22, section 51323, subject to Plan's PCS form being completed by the member's provider. *(Contract, Amendment 27, Exhibit A, Attachment 10, 8H(2))*

The Plan is required to ensure that a copy of the PCS form is on file for all members receiving NEMT services and that all fields are filled out by the provider. The PCS form is used to determine the appropriate level of service for members. In addition, each Managed Care Plan must have a mechanism to capture and submit data from the PCS form to DHCS. *(APL 22-008 Non-Emergency Medical and Non-Medical Transportation Services and Related Travel Expense)*

Plan policy, *UM-016 Transportation Guideline (revised 2/21/2023),* stated the Plan ensures that a copy of the PCS form is on file for all members receiving NEMT services and that all fields are filled out by the provider. The Plan has a mechanism to capture and submit data from the PCS form to DHCS.

Finding: The Plan did not ensure PCS forms were on file for members receiving NEMT services.

A verification study found the following deficiencies in 14 of 30 NEMT samples:

- Seven of 14 samples showed the Plan made attempts to obtain the PCS forms but was unsuccessful.

- In the remaining seven of 14 samples, PCS forms were not received for the transportation dates of service. The Plan submitted PCS forms covering transportation trips after the date of service.

As a corrective action to the prior year finding, the Plan educated providers on the PCS requirements, trained Plan and transportation vendor staff, and conducted a quarterly review of its vendor to ensure PCS forms were obtained. However, the Plan's corrective action did not address the prior year finding. In an interview, the Plan stated as of March 20, 2023 the PCS form acquisition was no longer the responsibility of its vendor. The Plan is now responsible for all PCS form acquisition.

This is a Repeat Finding of 2021 and 2022 finding 3.8.1 PCS Forms.

Without PCS forms, members may be subjected to an inappropriate mode of transportation that may result in unsafe conditions.

Recommendation: Implement policies and procedures to ensure the PCS forms are used to determine the appropriate level of services and maintained on file.

3.8.2 Transportation Providers' Medi-Cal Enrollment Status

The Plan is required to cover transportation services as required in this Contract and directed in APL 17-010 (superseded by APL 22-008) to ensure members have access to all medically necessary services. *(Contract, Amendment 27, Exhibit A, Attachment 10, 8H(2))*

All NEMT and NMT providers must comply with the enrollment requirements set forth in APL 19-004 or any superseding APL. The Plan may allow NEMT and NMT providers to participate in its network for up to 120 days, pending the outcome of the enrollment process. However, the Plan must terminate its contract with a NEMT or NMT provider upon notification from DHCS that the provider has been denied enrollment in the Medi-Cal program, or upon expiration of the one 120-day period. If the NEMT or NMT providers are unable to successfully enroll in Medi-Cal, the Plan cannot continue to contract with the providers during the period in which the provider resubmits its enrollment application to DHCS or with the Plan. The Plan can only re-initiate a contract upon the provider's successful enrollment as a Medi-Cal provider. *(APL 22-008 Non-Emergency Medical and Non-Medical Transportation Services and Related Travel Expense)*

Plan policy, *VMG-005 Transportation Providers Registration with Department of Health Care Services (revised 9/27/2022),* stated if transportation providers are not enrolled with PAVE (Medi-Cal's Provider Application and Validation), they cannot provide transportation to Plan members. If the transportation provider is not enrolled with PAVE and currently has an application in process, the Plan and the transportation vendor will monitor the transportation provider to ensure the application is approved. Transportation providers with applications in process can provide transportation to Plan members for 120 days, or until the application has been finalized with DHCS. If their application is denied by DHCS, or if 120 days have passed, the transportation vendor will notify the Plan and cease providing transportation to Plan members. Quarterly the Plan will request from the transportation vendor a listing of providers and verify enrollment in the Medi-Cal program. The Plan will notify the vendor of any providers who should not be transporting Plan members.

Finding: The Plan did not ensure all transportation providers were enrolled in the Medi-Cal program.

A verification study found one of 16 NEMT providers and eight of 24 NMT providers were not enrolled in the Medi-Cal program but remained in the Plan's network.

- One of 16 NEMT providers' Medi-Cal applications was denied, but continued transporting members while a second application was in process. The Plan sent a letter to its transportation vendor to terminate this provider as they are not to transport members due to the application status. The letter was sent 335 days after the first application was denied.

- Six of 24 NMT providers' Medi-Cal applications were denied, but continued transporting members while subsequent applications were in process. The Plan sent letters to its transportation vendor to terminate the providers as they are not to transport members due to the application status. The letters were not sent until between 121 days and 473 days after the first application were denied.

- One of 24 NMT providers' Medi-Cal applications was denied, but continued transporting members while subsequent applications were in process. The Plan was notified by its vendor that the provider closed their business and terminated the provider's contract; however, the provider remained contracted with the Plan for 1,176 days after the first application was denied.

- One of 24 NMT providers with a Medi-Cal application in-progress over 120 days continued transporting members. The Plan sent a letter to its transportation vendor to terminate this provider as they are not to transport members due to the application status. The letter was sent 118 days after the 120-day temporary enrollment period had expired.

In an interview, the Plan could not explain why it did not disenroll providers after denial of a DHCS application or after the 120-day temporary enrollment period elapsed.

When the Plan does not ensure transportation providers are enrolled in the Medi-Cal program, members may not receive services from qualified providers in accordance with state regulations.

Recommendation: Implement policies and procedures to ensure that transportation providers are enrolled in the Medi-Cal program.

❖ COMPLIANCE AUDIT FINDINGS (CAF) ❖
PLAN: Alameda Alliance for Health
AUDIT PERIOD: April 1, 2022 through March 31, 2023 **DATES OF AUDIT: April 17, 2023 through April 28, 2023**

CATEGORY 4 – MEMBER'S RIGHTS

4.1	GRIEVANCE SYSTEM

4.1.1 Grievance Acknowledgement and Resolution Letter Timeframes

The Plan is required to have a system in place in accordance with Code of Federal Regulations (CFR), Title 42, section 438.402-424 which refers to grievance and appeals requirements. *(Contract, Exhibit A, Attachment 14(1)(2))*

The Plan is required to provide written acknowledgement to the member that is dated and postmarked within five calendar days of receipt of the grievance. The Plan must comply with the state's established timeframe of 30 calendar days for grievance resolution. *(APL 21-011 Grievance and Appeals Requirements, revised 8/31/22)*

Plan policy, *G&A-003 Grievance and Appeals Receipt, Review and Resolution (revised 11/18/22),* stated the Plan provides a written acknowledgement that is dated and postmarked within five calendar days of receipt. The Plan provides a written resolution within 30 calendar days of receipt.

Plan policy, *Grievance & Appeal Intake Guide (revised 2/17/23),* stated if no provider response is received after three attempts by Plan staff, the grievance is escalated to the Medical Director by day 23.

Finding: The Plan did not send acknowledgement and resolution letters within the required timeframes.

A verification study revealed in 33 of 53 standard grievances the following deficiencies:

- Three quality of care and two quality of service standard grievances did not have acknowledgement letters sent within five calendar days. The acknowledgement letters were sent between seven and 62 days after receipt.

- Eight quality of care and 24 quality of service standard grievances did not have resolution letters sent with 30 calendar days. The resolution letters were sent between 36 and 240 days after receipt.

In a written statement, the Plan stated staff errors caused the acknowledgement letters to be sent late. In addition, the Plan stated staffing shortages and a lack of case follow-up for resolutions beyond the 30 calendar days caused the delay.

As a corrective action to the prior year finding the Plan provided training to the Grievance & Appeals staff to review the regulatory requirements for mailing of acknowledgement and resolution letters. Additionally, the Plan reviewed daily reports of grievances for timely acknowledgment and resolution letters, and conducted monthly audits to ensure grievance coordinators sent timely letters. However, the Plan's corrective actions did not resolve the prior year audit finding.

This is a Repeat Finding of the 2018 audit finding 4.1.2 Grievance Resolution/Grievance Process, the 2019 audit finding 4.1.4 Grievance Resolution/ Grievance Process, the 2021 audit finding 4.1.3 Grievance Notification and Letter Timeframes, and the 2022 audit finding, 4.1.1 Grievance Acknowledgement and Resolution Letter Timeframes.

When the Plan does not notify members in a timely manner of the status of their grievance, members may be deprived of information that could affect their health care decisions.

Recommendation: Revise and implement procedures to ensure that acknowledgement and resolution letters are sent to members within the required timeframes.

4.1.2 Grievance Letters in Threshold Languages

The Plan is required to comply with *CFR, Title 42, section 438.10(d)(4)* Information Requirements for language and format, and provide fully translated member information including grievance acknowledgement and resolution letters at no cost. The Plan is required to provide translated written information to all monolingual or limited English proficient members that speak the identified threshold languages or concentration standard languages. *(Contract, Exhibit A, Attachment 9 (14)(B)(2))*

The Plan is required to comply with all existing final Policy Letters (PLs) and APLs issued by DHCS. *(Contract, Exhibit E, Attachment 2(1)(D))*

If a resolution of a standard grievance is not reached within 30 calendar days as required, the Plan is required to notify the member in writing of the status of the grievance and the estimated date of resolution. *(APL 21-011 Grievance and Appeals Requirements, revised 8/31/22)*

Plan policy, *CLS-003 Language Assistance Services (approved 3/21/23),* stated the Plan provides members written informing materials in the Plan's threshold languages based on the member's language of preference. Informing materials include all notices related to grievances including grievance acknowledgement and resolution letters.

The Plan's, *Grievance and Appeal Intake Guide (revised 2/17/23),* stated that standard grievance acknowledgement letters and resolution letters are to be sent in threshold languages. Resolution letters are sent to the Plan's vendor for translation prior to sending to members.

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

A verification study revealed in seven of ten standard grievances requiring translation into a threshold language the following deficiencies:

- Four grievances did not have a translated delay letter or resolution letter sent in the member's threshold language.
- One grievance did not have a translated acknowledgement letter or resolution letter sent in the member's threshold language.
- One grievance did not have a translated resolution letter sent in the member's threshold language.
- One grievance did not have a translated delay letter sent in the member's threshold language.

In a written statement, the Plan acknowledged grievance staff did not follow Plan processes to have acknowledgement, resolution delay, and resolution letters translated due to an increase in grievance numbers. The backlog of cases led to decreased oversight in grievance processing.

As a corrective action to the prior year finding the Plan updated its system to capture the dates the resolution letter was submitted for translation and the date it was mailed to the member. The Plan provided training to the Grievance & Appeals staff on the updates made to the system. The Plan conducted monthly audits to ensure grievance coordinators sent translated letters. However, the Plan's corrective actions did not resolve the prior year audit finding.

This is a Repeat Finding of the 2021 audit finding 4.1.4 Grievance Letters in Threshold Languages and 2022 audit finding, 4.1.2 Grievance Letters in Threshold Languages.

If the Plan does not send translated grievance letters in the members' threshold languages, members may not understand all information needed to make informed health care decisions.

Recommendation: Revise and implement procedures to ensure acknowledgement, resolution delay, and resolution letters are translated in the members' threshold language.

4.1.3 Written Notification of Grievance Resolution Delays

The Plan is required to have a system in place in accordance with CFR, Title 42, section 438.402-424, which refers to grievance and appeals requirements. *(Contract, Exhibit A, Attachment 14(1)(2))*

The Plan is required to comply with all existing final PLs and APLs issued by DHCS. *(Contract, Exhibit E, Attachment 2(1)(D))*

CFR, Title 42, section 438.408(c) Extension of Timeframes allows for a 14-calendar day extension for standard and expedited appeals; however, this allowance does not apply to grievances. If a resolution of a standard grievance is not reached within 30 calendar days as required, the Plan must notify the member in writing of the status of the grievance and the estimated date of resolution. *(APL 21-011 Grievance and Appeals Requirements, revised 8/31/22)*

Plan policy, *G&A-003 Grievance and Appeals Receipt, Review and Resolution (revised 11/18/22),* stated that in the event a resolution is not reached within 30-calendar days, the Plan will notify the complainant in writing that the complaint was received, investigated, provide the status of the grievance, and provide an estimated completion date of resolution.

Finding: The Plan did not notify members of resolution delays in writing for grievances not resolved within 30 calendar days and did not resolve grievances by the estimated resolution date in the delay letters.

A verification study revealed in 21 of 24 standard quality of service grievances and in six of eight quality of care samples, which required delay letters, the following:

- Eight grievances were not resolved within 30 calendar days, delay letters were not sent to members.

- In 19 grievances delay letters were sent; however, the Plan failed to resolve the cases by the estimated date of resolution in the delay letters. Grievances were resolved between six and 150 days after the estimated resolution date.

In a written statement, the Plan acknowledged grievance staff did not follow Plan processes to send delay letters due to an increase in grievance numbers. The backlog of cases led to decreased oversight in grievance processing.

As a corrective action to the prior year finding the Plan updated its policy and provided training to the Grievance & Appeals staff regarding the new resolution deadline from the delay letter. The Plan conducted monthly audits of grievance processes. However, the Plan's corrective actions did not resolve the prior year audit finding.

This is a Repeat Finding of 2022 4.1.3 Grievance Extension Letter Timeframes.

If the Plan does not comply with the timeframes for extended grievance resolution this may lead to delays in care for members.

Recommendation: Implement policies and procedures to ensure the Plan sends delay letters for grievances not resolved within 30 calendar days and resolves grievances by the estimated date of resolution in the delay letter.

4.1.4 Grievance Delay Timeframes

The Plan is required to have a system in place in accordance with CFR, Title 42, section 438.402-424, which refers to grievance and appeals requirements. *(Contract, Exhibit A, Attachment 14(1)(2))*

The Plan is required to comply with all existing final PLs and APLs issued by DHCS. *(Contract, Exhibit E, Attachment 2(1)(D))*

CFR, Title 42, section 438.408(c) allows for a 14-calendar day extension for standard and expedited appeals; however, this allowance does not apply to grievances. If a resolution of a standard grievance is not reached within 30 calendar days as required, the Plan must notify the member in writing of the status of the grievance and the estimated date of resolution. *(APL 21-011 Grievance and Appeals Requirements, revised 8/31/22)*

Plan policy, *G&A-003 Grievance and Appeals Receipt, Review and Resolution (revised 11/18/22),* stated that in the event a resolution is not reached within 30-calendar days, the Plan will notify the member in writing that the complaint was received, investigated, provide the status of the grievance, and provide an estimated completion date of resolution.

Finding: The Plan inappropriately utilized a 14-calendar day delay timeframe for grievance resolutions.

A verification study revealed that 11 of 24 standard quality of service grievances and three of eight quality of care grievances, which required resolution delay letters, contained a 14-calendar day estimated date of resolution.

The Board of Governors Meeting Minutes (dated 11/11/22) showed the Plan discussing grievance delay letters within the context of a 14-calendar day standard. The Plan also conducted monthly audits to ensure grievance coordinators sent resolution letters within 14 days of the delay letter rather than the estimated date of resolution. The Contract

prohibits the use of a 14-calendar day extension and requires Plans to provide an estimated day of resolution based on the member's grievance.

In a written statement, the Plan acknowledged it had misinterpreted APL 21-011. The Plan allowed a 14-calendar day extension as the Plan's estimated date of grievance completion if the grievance was not resolved within 30 calendar days.

If the Plan does not comply with the timeframes for extended grievance resolution this may lead to delays in care for members.

Recommendation: Revise policies and procedures to ensure the Plan utilizes an appropriate grievance resolution timeframe.

4.1.5 Exempt Grievance Resolution

The Plan is required to have a system in place in accordance with CFR, Title 42, section 438.402-424 which refers to grievance and appeals requirements. *(Contract, Exhibit A, Attachment 14(1)(2))*

The Plan is required to comply with all existing final PLs and APLs issued by DHCS. *(Contract, Exhibit E, Attachment 2(1)(D))*

The Plan is required to comply with all state laws pertaining to exempt grievance handling. Grievances received over the telephone that are not coverage disputes or 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. *(APL 21-011 Grievance and Appeals Requirements, revised 8/31/22)*

Plan policy, *MBR-024 Exempt Grievances* (r*evised 1/11/23),* stated Member Services staff will review the complaint and provide a resolution to the member or authorized representative within the close of the next business day. If the complaint cannot be resolved within the close of the next business day, the complaint will be forwarded to the Grievance and Appeals Unit to process as a standard grievance.

Plan policy, *Member Services Exempt Grievances guide rev. (12/28/22),* listed timely access and provider/staff attitude grievances as exempt grievances that should be referred for PQIs.

Finding: The Plan did not resolve exempt grievances by close of the next business day.

A verification study revealed in three of ten exempt grievances the following deficiencies:

- In one grievance, the member complained the clinic rescheduled the member's appointment without the member's consent and that the doctor and staff were rude. The Plan's resolution was to change the member's primary care provider.

- In a second grievance, the member complained they could not schedule a timely appointment with the provider. The Plan's resolution involved providing other primary care provider information within the member's area.

- In a third grievance, the member complained they could not reach staff at the provider's office during office hours. The member did not receive a call back from the provider after leaving voice messages. The Plan staff attempted to contact the primary care provider's office but was unable to reach the provider's office and did not follow up. The member declined the Plan's offer for reassignment to a new primary care provider.

In a written statement, The Plan stated the grievances were categorized and closed according to the Member Service Exempt Grievance Guide. However, the Plan did not provide an explanation as to why the grievances were closed without resolution and the guide did not address resolution of grievances.

Incomplete resolution of member grievances may result in missed opportunities for improved health care delivery and poor health outcomes for members.

Recommendation: Revise and implement procedures to ensure all grievances are appropriately resolved.

4.1.6 Grievance Identification

The Plan is required to have a system in place in accordance with CFR, Title 42, section 438.402-424 which refers to grievance and appeals requirements. *(Contract, Exhibit A, Attachment 14(1)(2))*

The Plan is required to comply with all existing final PLs and APLs issued by DHCS. *(Contract, Exhibit E, Attachment 2(1)(D))*

A complaint is the same as a grievance. If the Plan is unable to distinguish between a grievance and an inquiry, it must be considered a grievance. An inquiry is a request for information that does not include an expression of dissatisfaction. Inquiries may include, but are not limited to, questions pertaining to eligibility, benefits, or other Plan processes. *(APL 21-011 Grievance and Appeals Requirements, revised 8/31/22)*

Plan policy, *G&A-001 Grievance and Appeals System Description (revised 11/23/21),* stated an "inquiry" is a request for information that does not include an expression of

dissatisfaction. Inquiries may include, but are not limited to, questions pertaining to eligibility, benefits, or other Plan processes. Where the Plan is unable to distinguish between a grievance and an inquiry, it shall be considered a grievance.

Finding: The Plan did not process and resolve all member expressions of dissatisfaction as grievances.

A verification study revealed the following deficiencies in four of ten call inquires:

- In one call, the member expressed dissatisfaction with the Plan's transportation provider.

- In the remaining three calls, the members expressed dissatisfaction with timely access to appointments and not being notified of a prior authorization denial.

In a written statement, the Plan acknowledged grievance staff did not follow Plan policies and procedures.

When member expressions of dissatisfactions are not processed as grievances, members will not receive notice of members' rights and their complaints may not be fully resolved.

Recommendation: Implement procedures to ensure all member expressions of dissatisfaction are appropriately processed and resolved.

CONTRACT AND ENROLLMENT REVIEW – SAN FRANCISCO
AUDITS AND INVESTIGATIONS
DEPARTMENT OF HEALTH CARE SERVICES

REPORT ON THE MEDICAL AUDIT OF

Alameda Alliance for Health

2023

Contract Number:	03-75793 State Supported Services
Audit Period:	April 1, 2022 Through March 31,2023
Dates of Audit:	April 17, 2023 Through April 28, 2023
Report Issued:	October 20, 2023

TABLE OF CONTENTS

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 audit was conducted from April 17, 2023 through April 28, 2023. The audit period is April 1, 2022 through March 31, 2023 and consisted of document review, verification study, and interviews with the Plan.

An Exit Conference with the Plan was held on September 26, 2023. 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.

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

❖ COMPLIANCE AUDIT FINDINGS (CAF) ❖

PLAN: Alameda Alliance for Health

AUDIT PERIOD: April 1, 2022 through March 31, 2023
DATES OF AUDIT: April 17, 2023 through April 28, 2023

STATE SUPPORTED SERVICES

SSS.1 Minimum Proposition 56 Payments

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

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 pay at least the rate for Current Procedural Terminology (CPT) – 4th Edition (CPT-4) code 59840 in the amount of $400. This payment obligation applies to contracted and non-contracted providers. *(APL 19-013 Proposition 56 Hyde Reimbursement Requirements for Specified Services)*

Plan policy, *CLM-001 Claims Processing (revised 11/23/21),* 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 minimum payments for a State Supported Services claim as described in APL 19-013.

A verification study of 20 claims revealed one sample where the Plan did not make the minimum payment for a contracted provider. The Plan paid procedure code 59840 at a rate of $179.

During the interview, the Plan stated the minimum APL 19-013 payments are set within the Plan's claim system and paid as part of its normal process. The Plan stated the fee schedule used for the sample was for contracted clinics. The Plan acknowledged that the rate for procedure code 59840 was inaccurate and not at the required amount of $400 per APL 19-013.

When the Plan does not distribute applicable payments, 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.