DHCS AUDITS AND INVESTIGATIONS

CONTRACT AND ENROLLMENT REVIEW DIVISION

REPORT ON THE MEDICAL AUDIT OF ALAMEDA ALLIANCE FOR HEALTH FISCAL YEAR 2024-2025

Contract Numbers: 04-35399 and 23-30212

Audit Period: June 1, 2023 — May 31, 2024

Dates of Audit: June 17, 2024 — June 28, 2024

Report Issued: November 18, 2024

DHCS

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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 California Welfare and Institutions Code (W&I Code) section 14087.54. While it is a part of the county's health system, the Plan is an independent entity 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.

Effective January 1, 2024, Alameda County changed the Medi-Cal Managed Care model from a Two-Plan model to a Single-Plan model. Medi-Cal members in Alameda County who were not enrolled in the Plan prior to January 1, 2024, were transitioned to the Plan.

As of May 31, 2024, the Plan had a total of 405,174 members of which 399,531 (98.6 percent) were Medi-Cal and 5,643 (1.4 percent) were Group Care.

II. EXECUTIVE SUMMARY

This report presents the audit findings of the DHCS medical audit for the period of June 1, 2023, through May 31, 2024. The audit was conducted from June 17, 2024, through June 28, 2024. The audit consisted of documentation review, verification studies, and interviews with the Plan's representatives.

An Exit Conference with the Plan was held on October 16, 2024. The Plan was allowed 15 calendar days from the date of the Exit Conference to provide supplemental information addressing the draft audit findings. On October 31, 2024, the Plan submitted a response after the Exit Conference. The evaluation results 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 Management, and Administrative and Organizational Capacity.

The prior DHCS medical audit for the period of April 1, 2022, through March 31, 2023, March 31, 2023was issued on October 20, 2023. This audit examined the Plan's compliance with the DHCS Contract and assessed the implementation of the prior year's 2023 Corrective Action Plan (CAP).

The summary of the findings by category follows:

Category 1 – Utilization Management

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

The Plan is required to refer members identified as potential organ or bone marrow transplant candidates to a transplant program evaluation that meets criteria set forth by the DHCS within 72 hours of receiving the referral. Finding 1.2.1: The Plan did not directly refer an adult member to a transplant program for evaluation within 72 hours of the member's specialist identifying the member as a potential candidate for Major Organ Transplants (MOT).

The Plan must ensure all MOT procedures are performed in a Medi-Cal approved Centers of Excellence (COE) transplant program. Finding 1.2.2: The Plan did not ensure that all MOT procedures were performed in a Medi-Cal approved COE transplant program. The Plan did not confirm that COEs were unable to perform a MOT surgery before arranging the MOT at a transplant program that is not a Medi-Cal approved COE.

The Plan's appeal system must allow a provider or authorized representative, with the member's written consent, to request an appeal on behalf of a member and include in each member notification a Nondiscrimination Notice (NDN) and a Language Assistance Tagline (LAT) that meet the minimum requirements in All Plan Letter (APL) 21-004., Standards for Determining Threshold Languages, Nondiscrimination Requirements, and Language Assistance Services; Notice of Nondiscrimination Template and Taglines Template. Finding 1.3.1: The Plan did not obtain members' written consent when providers requested appeals on behalf of members. Finding 1.3.2: The Plan did not send NDN and LAT information that meet the minimum requirements in APL 21-004 with member notifications for appeals.

The Plan is required to maintain an adequate oversight procedure to ensure delegate compliance with all quality improvement delegated activities, including UM. The Plan is required to include within the UM program mechanisms to detect both under- and over-utilization of health care services. The Plan is required to provide all medically necessary Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) services and must ensure provision of coordination of care and appointment scheduling assistance. Finding 1.5.1: The Plan did not ensure that the delegate Community Health Center Network (CHCN) had mechanisms to detect overutilization of subacute level of facility care; the delegate inappropriately approved higher levels of subacute care for members who required lower levels of regular skilled nursing facility care. Finding 1.5.2: The Plan did not ensure that the delegate CHCN provided medically necessary EPSDT services, care coordination, and appointment scheduling assistance to members under the age of 21.

Category 2 – Case Management and Coordination of Care

Category 2 includes requirements for Initial Health Appointment (IHA), California Children Services (CCS), Complex Case Management (CCM), Behavioral Health Treatment (BHT), Continuity of Care (COC), and coordination of mental health services.

IHA is an assessment that must be completed within 120 days of Plan enrollment for new members and must include an identification of risks, an assessment of need for preventive screens or services, and a diagnosis and plan for treatment of any diseases. The Plan is required to cover and ensure the provision of blood lead screening tests to members under six years of age. Finding 2.1.1: The Plan did not ensure that blood lead screening tests were conducted for members up to six years of age.

For members under the age of 21, the Plan is required to provide and cover, or arrange as appropriate, all medically necessary EPSDT services, including BHT services, when

they are covered under Medicaid. Finding 2.3.1: The Plan did not ensure the provision of BHT services in accordance with approved BHT plans for members under the age of 21. Finding 2.3.2: The Plan did not arrange and coordinate BHT services for members under the age of 21 within a timely manner.

Members who need or are receiving services and/or programs from Out-of-Network (OON) providers, can request COC from the Plan. For COC requests that are denied, the Plan must include the following information in the notice: a statement of the Plan's decision, a clear and concise explanation of the reason for denial, and the member's right to file a grievance or appeal. Finding 2.4.1: The Plan did not ensure that Notice of Action (NOA) letters sent to members for COC requests contained a clear explanation of the denial decision.

Category 3 – Access and Availability of Care

Category 3 includes requirements regarding member access to care, 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 is required to have mechanisms to continuously monitor, review, evaluate, and improve access to and availability of, all covered services. The mechanisms are required to include oversight processes that ensure members can obtain medically necessary appointments within established standards for time or distance, timely access, and alternative access. Finding 3.1.1: The Plan did not ensure members are able to obtain medically necessary appointments within established timely access standards. One of the Plan's medical groups placed a large number of members on an appointment waitlist and had members waiting up to six months to make an appointment.

The Plan is required to monitor appointment waiting times in network providers' offices. The Plan is also required to ensure that telephone triage or screening services are provided in a timely manner appropriate for the member's condition, and the triage screening wait time does not exceed 30 minutes. Findings 3.1.2: The Plan did not monitor in-office wait times for specialists and behavioral health providers. Finding 3.1.3: The Plan did not monitor telephone calls for specialists and behavioral health providers.

Category 4 – Member's Rights

Category 4 includes requirements to establish and maintain a grievance system, the handling of Protected Health Information (PHI), and requirements for the Plan's Cultural and Linguistic Services Program.

The Plan is required to ensure that the person making the decision on the grievance has clinical expertise in treating a member's condition or disease when deciding any grievance involving clinical issues. Finding 4.1.1: The Plan did not ensure that a person with clinical expertise in treating a member's condition made the resolution decision for grievances involving clinical issues.

The Plan is required to provide a Notice of Resolution Letter to the member as quickly as the member's health condition requires, not to exceed 30 calendar days from the date the member makes a request to the Plan for a standard grievance. Resolved means that the grievance has reached a final conclusion with respect to the member's submitted grievance. The Plan's written resolution shall contain a clear and concise explanation of the Plan's decision. All member information notices including written notices to an individual such as grievance letters must include NDN and LAT notices that are compliant with requirements in APL 21-004. Finding 4.1.2: The Plan did not completely resolve the members' grievances. Finding 4.1.3: The Plan's written resolution did not contain a clear and concise explanation of the Plan's decision. Finding 4.1.4: The Plan did not include updated NDN and LAT information with grievance acknowledgement and resolution letters.

The Plan must develop and implement policies and procedures for assessing the performance of employees, contracted staff, and other individuals who provide linguistic services. Finding 4.2.1: The Plan did not assess the performance of vendors' staff that provided linguistic services such as interpreter services.

The Plan is required to notify the DHCS within 24 hours by email (or by telephone if unable to email the DHCS) of the discovery, including but not limited to, any suspected security incident which risks unauthorized access to PHI and/or other confidential information and any intrusion or unauthorized access, use or disclosure of PHI. Finding 4.3.1: The Plan did not notify the DHCS within 24 hours upon discovery of any suspected breach or security incident, unauthorized access, and use or disclosure of PHI or Personal Information (PI).

Category 5 – Quality Management

Category 5 covers requirements to maintain an effective Quality Improvement System (QIS), including provider qualification and delegation of quality improvement (such as credentialing).

The Plan is required to promptly notify the DHCS when the Plan receives information about a change in a network provider's, subcontractor's, or downstream subcontractor's

circumstances that may affect eligibility to participate in the Medi-Cal Managed Care program. This includes the termination of a network provider agreement, subcontractor agreement, or downstream subcontractor agreement with the Plan. The Plan is required to ensure members are notified in writing of any termination of a network provider, subcontractor, or downstream subcontractor. Finding 5.3.1: The Plan did not meet DHCS reporting and member notification requirements for provider terminations.

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 findings noted for this category during the audit period.

III. SCOPE/AUDIT PROCEDURES

SCOPE

The DHCS, Contract and Enrollment Review Division conducted the audit 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 DHCS conducted an audit of the Plan from June 17, 2024, through June 28, 2024, for the audit period of June 1, 2023, through May 31, 2024. The audit included a review of the Plan's Contract with the DHCS, policies and procedures for providing services, 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

Services Requests: 35 clinical service requests, including 11 for Seniors and Persons with Disabilities (SPD) members, were reviewed for timeliness, consistent application of criteria, and appropriate review.

Appeals Procedures: 20 prior authorization appeals, including nine for SPD members, were reviewed for appropriate and timely adjudication.

Delegated Authorization Requests: A total of 32 medical service requests from CHCN were reviewed for consistent application of criteria, and appropriate and timely adjudication.

Category 2 – Case Management and Coordination of Care

CCS: 20 cases were reviewed to confirm care coordination for members with CCS conditions and developmental disabilities.

IHA: 20 cases were reviewed to confirm the performance and completeness of assessment.

CCM: Ten cases were reviewed to confirm provision of CCM for eligible members.

BHT: 15 BHT case files, including cases for nine SPD members, were reviewed to confirm the performance of services and complete case file elements.

COC: 15 cases, including cases for two SPD members, were reviewed for timely processing of members' COC requests.

Category 3 – Access and Availability of Care

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

NEMT: 17 records were reviewed to verify compliance with the NEMT requirements.

NMT: 20 records were reviewed to verify compliance with NMT requirements.

Category 4 – Member's Rights

Grievances: 66 standard grievances, six expedited grievances, and ten exempt grievances were reviewed for timely resolution, response to complainant, and submission to the appropriate level for review. The 66 standard grievance cases included 41 Quality of Service (QOS) and 25 Quality of Care (QOC) grievances.

Confidentiality Rights: 17 Health Insurance Portability and Accountability Act (HIPAA)/ PHI breach and security incidents were reviewed for processing and timeliness requirements.

Category 5 – Quality Management

Potential Quality Issues (PQI): Eight PQI cases, including five for SPD members, were reviewed for appropriate evaluation and effective action taken to address needed improvements.

New Provider Training: 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: 15 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

Category 1 – Utilization Management

1.2 Prior Authorization Review and Requirements

1.2.1 Referral to Transplant Program Within 72 Hours

The Plan is required to refer members identified as potential organ or bone marrow transplant candidates to a transplant program evaluation that meets criteria set forth by the DHCS within 72 hours of receiving the referral. (*2023 Contract A38, Exhibit A, Attachment 10 (8)(I)(2)*)

The Plan is required to refer members identified as potential organ or bone marrow transplant candidates to a transplant program evaluation that meets criteria set forth by the DHCS within 72 hours of receiving the referral. (*2024 Contract A01, Exhibit A, Attachment III, 5.3.7 (F)(3)*)

The Plan is required to directly refer adult members or authorize referrals to a transplant program that meets the DHCS criteria for an evaluation within 72 hours of a member's Primary Care Provider (PCP) or specialist identifying the member as a potential candidate for the MOT and receiving all the necessary information to make a referral or authorization. (*APL 21-015, Benefit Standardization and Mandatory Managed Care Enrollment Provisions of the California Advancing and Innovating Medi-Cal Initiative, Attachment 2, Major Organ Transplant Requirements*)

Plan policy, *UM-071 Major Organ and Bone Marrow Transplants* (approved 9/19/2023), stated the Plan will directly refer adult members or authorize referrals to a transplant program that meets regulatory criteria for an evaluation within 72 hours of a member's PCP or specialist identifying the member as a potential candidate for transplant.

Plan procedure, *Outpatient Utilization Management Major Organ Transplant Pre-Evaluation* (revised 5/20/2024), stated the Plan must authorize, refer, and coordinate the delivery of the MOT benefit and all medically necessary covered services associated with MOTs, including pre-transplantation assessments.

Finding: The Plan did not directly refer an adult member to a transplant program for evaluation within 72 hours of the member's specialist identifying the member as a potential candidate for MOT.

A verification study of 35 medical service requests demonstrated that in one of one MOT evaluation request, the Plan did not refer the adult member to the approved transplant program within 72 hours of the specialist's identification of potential transplant candidacy. In the deficient sample, a specialist submitted a routine service request for bone marrow transplant evaluation at an Out-of-Network (OON) transplant program along with medical records describing the clinical reasons why the member was a potential transplant candidate. For the authorization decision, the Plan denied the OON request and instead approved a transplant evaluation at an in-network Medi-Cal approved COE transplant program.

- The Plan processed the request as routine and made the authorization decision 101 hours after receipt of the request instead of within 72 hours.
- 120 hours after receipt of the request, the Plan faxed the denial notification letter to the requesting specialist and OON transplant program. However, the Plan did not inform the in-network COE transplant program of the authorized transplant evaluation and did not send a referral notice or authorization letter to the in-network COE.

During interviews, the Plan stated it determined the decision timeframe for processing requests based on the expedited or routine status selected by the provider on the service request form. The Plan acknowledged that it did not expedite all MOT evaluation requests with a 72-hour timeframe during the audit period.

The Plan's pre-evaluation procedure that was in effect during the audit period did not describe timeframe requirements for transplant evaluation requests. The Plan stated it faxed authorization letters to transplant programs if the requesting provider indicated the rendering transplant program information on the service request. However, the Plan did not maintain a process to ensure that referrals were sent directly to approved transplant programs within 72 hours of receipt of request, especially for requests that had been modified to approve a different transplant program. In addition, the Plan's UM Committee reviewed a specialty referral report, but the report did not track whether initial transplant evaluation referrals to transplant programs were completed within 72 hours.

When the Plan does not directly refer members to transplant programs within 72 hours of being identified as a potential candidate, members may experience delays in receiving evaluations at transplant programs, which can lead to adverse outcomes.

Recommendation: Revise and implement procedures to ensure that the Plan directly refers adult members to a transplant program for an evaluation within 72 hours of the member's specialist identifying the member as a potential candidate.

1.2.2 Centers of Excellence for Major Organ Transplants

The Plan is required to comply with all existing final APLs issued by the DHCS. (*2023 Contract A26, Exhibit E, Attachment 2 (1)(D))*

The Plan is required to comply with all DHCS guidance, including but not limited to, APLs, Policy Letters (PLs), the California Medicaid State Plan, and the Medi-Cal Provider Manual. (*2024 Contract A01, Exhibit E, 1.1.2*)

The Plan is required to ensure all MOT procedures are performed in a Medi-Cal approved COE transplant program. Under circumstances in which the transplant program cannot perform the MOT surgery and an organ is available, the Plan may arrange for the surgery to be performed at a different transplant program OON (not a COE) that meets the DHCS requirements based on the following criteria: Centers for Medicare and Medicaid Services (CMS) approval for the appropriate organ and either Organ Procurement and Transplantation Network (OPTN) membership for solid organ transplants or accreditation by the Foundation for the Accreditation of Cellular Therapy (FACT) for bone marrow transplants. (*APL 21-015, Benefit Standardization and Mandatory Managed Care Enrollment Provisions of the California Advancing and Innovating Medi-Cal Initiative, Attachment 2, Major Organ Transplant Requirements*)

Plan policy, *UM-071 Major Organ and Bone Marrow Transplants* (approved 9/19/2023), stated the Plan will ensure members receive covered MOT benefits at a facility designated as a Medi-Cal approved COE for the following MOT including, but not limited to, bone marrow, heart, kidney, liver, and lung. When the transplant program cannot perform the transplant surgery and an organ is available, the Plan may arrange for the surgery to be performed at a different transplant program OON that meets the following criteria: CMS approval for the appropriate organ and either OPTN member for solid organ transplants or accreditation by FACT for bone marrow transplants.

Plan procedure, *Outpatient Utilization Management Major Organ Physical Transplant* (revised 5/20/2024), stated that bone marrow transplants are not required to be done at a COE.

Finding: The Plan did not ensure that all MOT procedures were performed in a Medi-Cal approved COE transplant program. The Plan did not confirm that COEs were unable to perform a MOT surgery before arranging the MOT at a transplant program that is not a Medi-Cal approved COE.

A verification study of five MOT requests included three approvals for bone marrow transplant and two approvals for liver transplant. In one of three bone marrow transplant approvals, the Plan inappropriately approved for the adult bone marrow transplant procedure to be performed at an OON transplant program, which was not a Medi-Cal approved COE.

For the deficient sample, the Plan did not communicate with the two in-network COE transplant programs to confirm they could not perform the procedure and did not request additional information from the requesting provider on why the transplant could not be re-directed to a COE program. After the Plan verified that the requested transplant program was CMS approved and FACT accredited, the Plan approved the request to allow continuity of treatment with the same provider.

In written responses, the Plan stated that the procedure to allow bone marrow transplants to be performed at programs that are not COEs was incorrect. The Plan acknowledged that during the audit period it did not require confirmation that contracted COEs were unable to perform MOTs before the Plan approved transplants at programs that were not designated COEs.

When the Plan does not ensure that MOT procedures are performed in a Medi-Cal approved COE and does not follow MOT requirements in APL 21-015, members may receive substandard transplant care that does not meet the DHCS' expectations.

Recommendation: Revise and implement policies and procedures to ensure the Plan authorizes MOT surgeries at Medi-Cal approved COEs and follows requirements in APL 21-015 for circumstances in which the Plan may arrange a transplant at a treatment program that is not a Medi-Cal approved COE.

1.3 Prior Authorization Appeals Process

1.3.1 Written Member Consent

The Plan is required to ensure that the following requirement is met through the appeal system: member, provider, or authorized representative acting on behalf of a member,

and with the member's written consent, may request an appeal with the Plan either orally or in writing. (*2023 Contract A26, Exhibit A, Attachment 14 (1)(A)*)

The Plan is required to ensure that the appeal system allows the member, provider, or authorized representative, with the member's written consent, to request an appeal with the Plan either orally or in writing. (*2024 Contract A01, Exhibit A, Attachment III, 4.6.1 (A)*)

Appeals filed by the provider on behalf of the member require written consent from the member. The Plan must comply with this requirement in accordance with the DHCS Contract. (*APL 21-011, Grievance and Appeal Requirements, Notice and "Your Rights" Templates*")

Plan policy, *G&A-008 Adverse Benefit Determination Appeals Process* (approved 10/19/2023), stated the Plan will make a reasonable effort to acquire the written consent from the member when a provider files on behalf of the member. The Plan will not delay processing of the appeal if consent is not obtained.

Finding: The Plan did not obtain members' written consent when providers requested appeals on behalf of members.

A verification study of 20 member appeals demonstrated that in three of five standard appeals filed by providers, the Plan did not obtain written consent from the member prior to closing cases. The Plan notified the members that the provider filed the appeal and requested written consent through a mailed acknowledgement letter form, which instructed the members to sign and return the form to the Plan. In all three deficient samples, the Plan did not receive signed consent forms.

During interviews, the Plan explained that it sent acknowledgement letter forms to members and then processed and resolved appeals even if members did not return signed consent forms. The Plan confirmed it did not require staff to conduct phone outreach or reminder calls to the member to obtain the signed consent form.

When the Plan does not obtain written member consent prior to case closure when providers file standard appeals on behalf of members, the Plan is not allowing members to exercise their rights.

Recommendation: Revise and implement policies and develop procedures to ensure that the Plan obtains members' written consent when providers request standard appeals on behalf of members.

1.3.2 Appeals Letters: Nondiscrimination Notice and Language Assistance Taglines

The Plan is required to comply with all existing final APLs issued by the DHCS. (*2023 Contract A26, Exhibit E, Attachment 2 (1)(D)*)

The Plan is required in APL 21-004 to ensure that the appeal system includes NDN and LAT information with member notifications. (*2024 Contract A01, Exhibit A, Attachment III, 4.6.1 (G)*)

The NDN and LAT must be posted in all member informational notices, including written notices to an individual such as those pertaining to rights and benefits. The DHCS updated templates for NDN to include additional characteristics protected under state nondiscrimination laws as well as contact information for members to file a discrimination grievance directly with the DHCS' Office of Civil Rights (OCR). The DHCS also updated the LAT template to conform to federal law and to include additional top California languages (Mien and Ukrainian) with a subsequent addition of Simplified Chinese. Although the DHCS does not require Plans to use the DHCS-provided templates verbatim, notices must be compliant with requirements in APL 21-004 and with information in the DHCS-provided templates. (*APL 21-004, Standards for Determining Threshold Languages, Nondiscrimination Requirements, and Language Assistance Services; Notice of Nondiscrimination Template and Taglines Template*)

Plan policy, *G&A-008 Adverse Benefit Determination Appeals Process* (approved 10/19/2023), stated the Plan includes the LAT with all acknowledgement and resolution letters, and the LAT informs members of the availability of no-cost language assistance services, including assistance in non-English languages and the provision of free auxiliary aids and services.

Finding: The Plan did not send NDN and LAT information that met the minimum requirements in APL 21-004 with member notifications for appeals.

A verification study demonstrated that in 20 of 20 appeals samples, the Plan did not send current NDN and LAT information to members with appeals acknowledgement and resolution letters.

- In 20 of 20 samples, the Plan sent outdated NDN information to members. The NDNs did not contain all non-discrimination characteristics (such as medical condition, genetic information, gender identity, etc.) and did not provide information on how to file grievances with the DHCS' OCR. The deficient letters were sent in English, Spanish, Vietnamese, and Chinese languages.

- In four of 20 samples, the Plan sent outdated LAT information to members. The LAT notices did not include taglines in Mien, Ukrainian, and Simplified Chinese. The deficient letters were sent in non-English languages including Spanish, Vietnamese, and Chinese languages.

During interviews, the Plan could not explain why the appeal system sent outdated NDN and LAT notices. Although the Plan stated it updated all NDN and LAT attachments in the Plan's system in March 2024, the verification study did not confirm the update. Out of two appeals samples resolved after the Plan's appeal system update in April 2024, both samples' resolution letters contained outdated NDNs, and one sample showed outdated LAT.

In a written response, the Plan acknowledged it did not have a formal coordination process between the Compliance Department and Grievance and Appeal Department for updating DHCS-issued templates. In addition, the Plan's policies did not describe NDN requirements for appeals.

When the Plan does not follow member notice requirements set forth by the DHCS, members may not receive information necessary to understand appeal decisions and may not be able to exercise their rights.

Recommendation: Develop and implement policies and procedures to ensure that the Plan sends NDN and LAT information that meet the minimum requirements in APL 21-004 with member appeal notifications.

1.5 Delegation of Utilization Management

1.5.1 Overutilization of Subacute Level of Facility Care

The Plan is required to maintain a system to ensure accountability for delegated quality improvement activities, including UM. (*2023 Contract A26, Exhibit A, Attachment 4 (6)(B)*)

The Plan is required to include within the UM program mechanisms to detect both under- and over-utilization of health care services. (*2023 Contract A26, Exhibit A, Attachment 5 (4)*)

The Plan is required to maintain an adequate oversight procedure to ensure the delegate's compliance with all quality improvement or health equity delegated activities, including UM. (*2024 Contract A01, Exhibit A, Attachment III, 2.2.5 (B)*)

The Plan is required to include within the UM program mechanisms to detect both under- and over-utilization of health care services including behavioral health services. (*2024 Contract A01, Exhibit A, Attachment III, 2.3.3 (A))*

The Plan is required to comply with all DHCS guidance, including but not limited to, APLs, PLs, the California Medicaid State Plan, and the Medi-Cal Provider Manual. (*2024 Contract A01, Exhibit E, 1.1.2*)

Effective January 1, 2023, Plans in all counties are required to authorize and cover medically necessary skilled nursing facility services. All Plans are required to ensure that members in need of skilled nursing facility services are placed in a health care facility that provides the level of care most appropriate to the member's medical needs. (*APL 23-004, Skilled Nursing Facilities – Long Term Care Benefit Standardization and Transition of Members to Managed Care)*

Revenue codes describe the appropriate level of care, facility type, and facility payment that is medically necessary for a member's stay at a facility. Revenue code 0101 indicates regular services at a skilled nursing facility; the code is an all-inclusive rate that includes custodial (room and board with no skilled nursing) and skilled nursing levels of care. Revenue code 0190 indicates adult subacute level of facility care. Adult subacute care is defined as a level of care needed by a patient who does not require hospital acute care but requires intensive licensed skilled nursing care. Subacute care is clinically indicated for members requiring intensive treatments, such as breathing tube care, mechanical ventilation, intravenous or tube feeds, continuous intravenous medications, and specialized wound care. (*Medi-Cal Provider Manual, Long Term Care section, January 2024)*

The delegation agreement between Plan and delegate CHCN (signed 4/27/2018), stated that the delegate must comply with all applicable requirements, including DHCS APLs, federal and state regulations, Plan policies and procedures, and the Plan's UM program.

Plan policy, *UM-060 Delegation of Utilization Management* (approved 3/19/2024), stated the Plan conducts an annual delegation audit for UM, and delegates are required to report UM performance data to the Plan.

Delegate document, *2024 Utilization Management Program Description* (approved 3/28/24), stated that the delegate reviewed total skilled nursing facility days but did not describe monitoring of appropriate levels of care for skilled nursing facility requests.

Finding: The Plan did not ensure that the delegate CHCN had mechanisms to detect overutilization of subacute level of facility care; the delegate inappropriately approved

higher levels of subacute care for members who required lower levels of regular skilled nursing facility care.

A verification study of 32 medical service requests demonstrated that in one of one request for a skilled nursing facility stay, the delegate inappropriately approved 15 days of adult subacute level of care using revenue code 0190. Based on clinical records, the member did not have medical conditions that warranted specialized or intensive treatments, and the member qualified for the 0101 revenue code for regular skilled nursing facility level of care.

The Plan delegated UM for skilled nursing facility stays less than 60 days to the delegate. During interviews, the delegate acknowledged that the member in the deficient sample required the lower level of regular skilled nursing facility care, and subacute facility care was not medically necessary.

In written responses, the delegate confirmed that it approved all regular service requests at skilled nursing facilities with the subacute care revenue code 0190 even though subacute care was not medically necessary. During the audit period, the delegate inappropriately approved subacute level of care for 99 members.

The delegate's UM program did not have effective methods to detect concerning trends of overutilization of services. The delegate did not implement a monitoring process for skilled nursing facility services and associated levels of care. The delegate stated that if a skilled nursing facility case were to be included in the random sample for a monthly internal UM audit, the delegate would review the case. However, the delegate's reviewer did not comment on the clinical appropriateness of codes approved for five skilled nursing facility requests that were included in monthly audits. The delegate did not maintain UM policies describing requirements for mechanisms to detect under- and over- utilization of services.

The Plan did not ensure that the delegate's UM program monitored authorized skilled nursing facility cases for clinical appropriateness and potential overutilization. In addition, during the audit period, the Plan did not identify that the delegate was inappropriately approving a higher level of care for regular skilled nursing facility stays.

The Plan and delegate provided conflicting statements on the reason for the deficiency. The delegate claimed it used the 0190 code based on the Plan's guidance and stated that the Plan did not provide the updated list of revenue codes from the Medi-Cal Provider Manual. Based on the Plan's training materials that were provided to the delegate, the Plan did not train the delegate on new revenue codes for facility services.

Overall, the delegate's UM staff did not have adequate knowledge of the DHCS revenue codes as published in the Medi-Cal Provider Manual for each level of care once the long-term care benefit was carved into Plans.

When the delegate does not detect overutilization of subacute facility level services, the delegate and Plan may generate facility overpayments, waste, and unnecessary costs to the Medi-Cal program for rendered services that are not medically necessary.

Recommendation: Develop and implement Plan oversight processes to ensure that the delegate detects overutilization of services and approves appropriate levels of care for skilled nursing facility services.

1.5.2 Early and Periodic Screening, Diagnostic, and Treatment Services

The Plan is required to maintain a system to ensure accountability for delegated quality improvement activities, including UM. (*2023 Contract A26, Exhibit A, Attachment 4 (6)(B)*)

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. (*2023 Contract A26, Exhibit A, Attachment 10 (5)*)

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. (*2023 Contract A26, Exhibit A, Attachment 11 (1)*)

The Plan is required to maintain an adequate oversight procedure to ensure the delegate's compliance with all quality improvement or health equity delegated activities, including UM. (*2024 Contract A01, Exhibit A, Attachment III, 2.2.5 (B)*)

For members less than 21 years of age, the Plan must comply with all requirements identified in APL 23-005, Requirements for Coverage of Early and Periodic Screening, Diagnostic, and Treatment Services for Medi-Cal Members Under the Age of 21. (*2024 Contract A01, Exhibit A, Attachment III, 5.3.4 (E)(1)*)

Plans are required to provide and cover all medically necessary EPSDT services when the services are determined to be medically necessary to correct or ameliorate defects and physical and mental illnesses or conditions. Plans must ensure the provision of case management services, including coordination of care for all medically necessary EPSDT services delivered both within and outside the Plan's provider network. Plans are also required to provide appointment scheduling assistance and necessary transportation for

the medically necessary EPSDT services. (*APL 23-005, Requirements for Coverage of Early and Periodic Screening, Diagnostic, and Treatment Services for Medi-Cal Members Under the Age of 21*)

The delegation agreement between the Plan and delegate CHCN (signed 4/27/2018), stated that basic case management, UM, and EPSDT services are delegated to CHCN, and the delegate must comply with all applicable requirements including DHCS APLs and federal and state regulations. The delegate must meet both care coordination standards and state and federal regulations to assure availability and access to care, clinical services, specialty services, and care management services. The delegate must assist PCPs in the care coordination of members.

Plan policy, *UM-060 Delegation of Utilization Management* (approved 3/19/2024), stated the Plan conducts an annual delegation audit for UM, which includes review of policies and procedures for coordination of care.

Plan document, *2024 AAH Case Management Program Description* (approved 4/19/2024), stated the Plan provides oversight of delegated care coordination activities through an annual delegation audit of case management and review of delegates' reports.

Delegate document, *2024 CHCN Case Management Program Description* (approved 3/28/2024), stated the delegate's case management program provides care coordination and service coordination. The delegate accepts referrals for case management from UM staff and other sources.

Finding: The Plan did not ensure that the delegate, CHCN, provided medically necessary EPSDT services, care coordination, and appointment scheduling assistance to members under the age of 21.

A verification study of 32 medical service requests included eight requests for EPSDT services with OON providers for members under the age of 21. In all eight requests, the delegate found the services to be medically necessary but denied the requests because the pediatric members could receive the services with in-network providers. The following deficiencies were identified:

- In seven of eight OON EPSDT requests, the delegate did not provide care coordination or appointment scheduling assistance after the OON services were denied. The delegate did not coordinate with PCPs or assist members' families with scheduling appointments with in-network providers for the medically necessary services.

    - In six samples, the member was never referred to the delegate's case management program, which provides care coordination.
    - In one sample, the member was referred to case management, but the delegate did not assist in scheduling an in-network appointment.
- In four of eight OON EPSDT requests, the delegate did not ensure provision of medically necessary EPSDT services. Based on claims data, members never received the medically necessary EPSDT services, either in-network or OON, after the OON requests were denied. The delegate did not provide the following needed EPSDT services: genetic testing for cystic fibrosis (genetic disorder) in a 16-year-old member with intestinal symptoms and weight loss, physical therapy for a 6-year-old member with loose joints and frequent falls, physical therapy for a 19-year-old member with congenital hip condition and hip pain, and speech therapy for a 2-year-old member with autism and speech delay.

During interviews and in written responses, the delegate confirmed that it did not maintain policies for provision of medically necessary EPSDT services or care coordination for EPSDT services. The delegate stated that UM decision-makers sent referrals to case management on a case-by-case basis based on the complexity of the member's condition. The delegate did not have an established process to refer all denied OON EPSDT requests to case management. The delegate acknowledged staffing shortages in the case management program during the audit period that prevented the delegate from confirming timely access to in-network providers and assisting members with scheduling appointments.

During the 2023 delegation audit, the Plan did not review the delegate's EPSDT policies or specific samples of EPSDT service requests to ensure that the delegate met all medical necessity, provision, and care coordination requirements in APL 23-005.

When the delegate does not provide and coordinate care for EPSDT services for members under the age of 21, members are at risk of delayed or inadequate treatment and poor health outcomes.

Recommendation: Develop and implement Plan oversight policies and procedures to ensure that the delegate provides medically necessary EPSDT services, care coordination, and appointment scheduling assistance to members under the age of 21. Ensure the delegate develops and implements EPSDT policies and procedures.

COMPLIANCE AUDIT FINDINGS

Category 2 – Case Management and Coordination of Care

2.1 California Children's Services, Initial Health Appointment

2.1.1 Provision of Blood Lead Screening

The Plan is required to cover and ensure the provision of a blood lead screening test to members at ages one and two in accordance with California Code of Regulations (CCR), Title 17, division 1, chapter 9, articles 1 and 2, commencing with section 37000. The Plan is required to document and appropriately follow up on blood lead screening test results. *(2023 Contract A26, Exhibit A, Attachment (5)(D))*

The Plan is required cover and ensure the provision of blood lead screening tests to members at the ages and intervals specified in CCR, Title 17, sections 37000 to 37100, and in accordance with APL 20-016. The Plan is required to ensure network providers follow the Childhood Lead Poisoning Prevention Branch (CLPPB) guidelines when interpreting blood lead levels and determining appropriate follow-up activities, including, without limitation, appropriate referrals to the local public health department. *(2024 Contract A01, Exhibit A, Attachment III, 5.3.4 (D))*

The Plan is required to ensure that a complete, legible medical record is maintained for each member in accordance with CCR, Title 22, section 53861, which reflects all aspects of patient care, including, but not limited to, documentation of blood lead screening, immunizations, and other preventive services. *(2024 Contract A01, Exhibit A, Attachment III (5.2.14) (G)(4)(k))*

The Plan is required to ensure network providers (physicians, nurse practitioners, and physician's assistants) who perform periodic health assessments on child members between the ages of six months to six years (72 months), comply with current federal and state laws and industry guidelines for health care providers issued by the CLPPB, including any future updates or amendments to these laws and guidelines. The Plan must ensure that the network provider documents the reason(s) for not performing the blood lead screening test in the child member's medical record. *(APL 20-016, Blood Lead Screening of Young Children).*

Plan policy, *QI-125 Blood Lead Screening for Children* (approved 3/19/2024), stated that the Plan will ensure contracted providers, including laboratories, performing blood lead analysis on blood specimens drawn in California, electronically report all results to CLPPB, along with specified patient demographic, ordering physician, and analysis data on each test performed. Since no level of lead in the body is known to be safe and clinical guidelines are subject to change, the Plan will ensure contracted providers follow the CLPPB guidelines when interpreting blood lead level and determining appropriate follow-up monitoring activities. The Plan will provide contracted providers education materials to ensure they are aware of the appropriate Common Procedure Terminology (CPT) coding for blood lead screenings. These CPT codes outlined by the Plan will be monitored to ensure providers are compliant in providing screening services and reporting the appropriate CPT codes to the Plan.

Finding: The Plan did not ensure that blood lead screening tests were conducted for members up to six years of age.

A verification study of 20 samples, which included four members under six years of age, revealed that four of four cases did not contain documentation of blood lead screening tests results or member refusal in the medical records.

Plan policy QI-125 did not specifically address monitoring the documentation of lead level results by providers for ordered blood lead tests and any necessary follow-up activities/services for members. As part of the Plan's Facility Site Review and Medical Record Review, the Plan used an IHA audit tool to determine providers' compliance with blood lead level screening requirements.

In an interview, the Plan stated that a barrier to blood lead level testing was due to some providers not having point-of-care testing at the offices which meant the member would have to go to the lab to complete the lead level test. The Plan further acknowledged that it had not met the minimum performance level for blood lead screening quality metrics during the audit period.

Subsequent to the Exit Conference, the Plan submitted documents showing efforts to improve blood lead screening rates such as provider education webinars and training.

When the Plan does not ensure that blood lead screening tests are completed and documented, elevated lead levels may remain untreated and pediatric members may not receive medically necessary interventions to prevent poor health outcomes.

Recommendation: Revise and implement policies and procedures to ensure that providers document blood lead test results in the medical record and provide follow-up care for all members under six years of age.

2.3 Behavioral Health Treatment

2.3.1 Provision of Behavioral Health Treatment Services

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 COC with the member's BHT provider. *(2023 Contract A26, Exhibit A, Attachment 10 (5)(G)(1))*

For members less than 21 years of age, the Plan must cover medically necessary BHT services regardless of diagnosis in compliance with APL 23-010. *(2024 Contract A01, Exhibit A, Attachment III, 5.3.4 (F))*

For members under the age of 21, Plans are required to provide and cover, or arrange as appropriate, all medically necessary EPSDT services, including BHT services when they are covered under Medicaid. BHT services must be provided, observed, and directed under a Plan approved behavioral treatment plan. Decreasing the amount and duration of services is prohibited if the therapies are medically necessary. Plans must not limit BHT services based on school attendance or other categorical exclusions. *(APL 23-010, Responsibilities for Behavioral Health Treatment Coverage for Members under the Age of 21)*

Plan policy, *BH-004 Behavioral Health Therapies: Applied Behavioral Analysis* (approved 4/10/2024), stated that for members under the age of 21, the Plan has primary responsibility for medically necessary BHT services provided across environments including community-based settings, on-site at schools, or during virtual school sessions in coordination with the local education agency. The Plan ensures that BHT services are provided and supervised in accordance with a Plan-approved behavioral treatment plan that is developed by a BHT service provider who meets the requirements in California's Medicaid State Plan. The Plan is required to ensure that treatment plans include a plan for the delivery of BHT services in a home or community-based setting, including clinics. BHT intervention services that are provided in schools, in the home, or other community settings, must be clinically indicated, medically necessary, and delivered in the most appropriate setting for the direct benefit of the member. BHT service hours delivered across the settings, including during school, must be proportionate to the member's medical need for BHT services in each setting.

Finding: The Plan did not ensure the provision of BHT services in accordance with approved BHT plans for members under the age of 21.

A verification study revealed that in five of 15 samples, the Plan did not provide all the BHT services according to the approved BHT plan. Examples of deficiencies included:

- In one sample, the BHT plan included 15 hours a week of one-to-one services directly provided to the individual member. The BHT provider was unable to provide these hours and only offered parent training. The member's services were put on hold because of BHT staffing shortages and the provider discharged the member. The member's parent called the Plan to request a new BHT provider; however, BHT services were not restarted until six months later.
- In another sample, the member was approved for eight hours a week of one-to-one services but only received one hour a week for part of the audit period. The BHT provider discharged the member since the provider was unable to offer in-person BHT services. Three months later, the Plan connected the member with another BHT provider.
- In another sample, the member was approved for four hours a week of one-to-one services and did not receive all hours during a portion of the audit period because services were temporarily suspended due to provider staff availability.
- In another sample, the member was approved for ten hours of one-to-one services per week. However, the BHT provider discharged the member due to staffing shortages and the member temporarily leaving the country. The Plan did not provide any evidence that the member was connected to another BHT provider.

During an interview, the Plan stated it tracked BHT hours on a macro level but was unable to provide specific details about the amount of received hours for the deficient samples. Additionally, the Plan was requested, but did not provide supplemental documentation showing how many hours the five sample members had received from BHT providers during the audit period.

In an interview, the Plan stated it had identified patterns of staffing shortages with BHT providers due to disruption of BHT staffing from the pandemic. The Plan described an unstable BHT provider workforce due to low wages, with high staff turnover for in-home BHT services. In a written response, the Plan claimed that clinical staff review for medical necessity when one-to-one services hours are no longer recommended by the BHT provider. However, a review of the samples indicated that the Plan did not review for

medically necessity when a BHT provider requested a reduction in hours or member discharge based in part or whole on BHT staffing shortages.

When the Plan does not ensure the provision of BHT services, pediatric members may not receive medically necessary care to maintain or improve behavioral health conditions.

Recommendation: Revise and implement policies and procedures to ensure members under the age of 21 receive BHT services in accordance with approved BHT plans.

2.3.2 Timely Access to Behavioral Health Treatment Services

For members under the age of 21, the Plan is required to provide, or arrange and pay for, EPSDT services unless otherwise excluded in this Contract. The Plan is required to also ensure that appropriate EPSDT services are initiated in a timely manner, as soon as possible but no later than 60 calendar days following either preventive screening or other visit that identifies a need for follow-up. *(2023 Contract Exhibit A, Attachment 10 (5)(F))*

The Plan is required to arrange for any medically necessary diagnostic and treatment services identified at a preventive screening or other visit indicating the need for diagnosis or treatment. The Plan is required to ensure that all medically necessary EPSDT services are provided in a timely manner, as soon as possible but no later than 60 calendar days following the preventive screening, or other visit identifying a need for diagnosis or treatment. Without limitation, the Plan is required to identify available providers, including, if necessary, OON providers, to ensure the timely provision of medically necessary EPSDT services. *(2024 Contract Exhibit A, Attachment 3, 5.3.4 (E)(2))*

Plans are responsible for ensuring members under the age of 21 have timely access to all medically necessary services and that appropriate diagnostic and treatment services are initiated as soon as possible, but no later than 60 calendar days following either a preventive screening or other visit that identifies a need for follow-up. The Plan is required to ensure the provision of comprehensive medical case management services, including coordination of care for all medically necessary EPSDT services delivered both within and outside the Plan's provider network. The Plan is also required to provide appointment scheduling assistance. *(APL 23-005, Requirements for Coverage of Early and Periodic Screening, Diagnostic, And Treatment Services for Medi-Cal Members Under the Age Of 21)*

The Plan is required to provide and cover, or arrange as appropriate, all medically necessary EPSDT services, including BHT services, when they are covered under Medicaid for members under the age of 21. Plans are required to provide case management and coordination of care to ensure that members can access medically necessary BHT services. For members under the age of 21, Plans must provide BHT services in accordance with timely access standards pursuant to W&I Code section 14197 and the Plan's Contracts. *(APL 23-010, Responsibilities for Behavioral Health Treatment Coverage for Members under the Age of 21)*

Plan policy, *BH-004 Behavioral Health Therapies: Applied Behavioral Analysis* (approved 4/10/24), stated that the Plan will ensure that all the member's medical needs for BHT services are being met in a timely manner, regardless of payer, and based on the individual needs of the member. The Plan is responsible for the management of BHT benefits for members according to the following procedures: if a diagnosis is complete or there is prior BHT history, the member is triaged by the Plan's clinical staff. The Plan's clinical staff reviews the provided information and refers the member to a BHT provider for a medically necessary Functional Behavioral Assessment (FBA) if a current FBA is not already completed.

Plan policy, *BH-005 Care Coordination – Behavioral Health* (approved 3/19/24), stated that the Plan is responsible to provide comprehensive medical case management services for members with non-specialty or specialty health mental service needs, including coordination of care to ensure the provision of all medically necessary services, whether those services are delivered in the Plan or OON.

Plan policy, *QI-135 EPSDT (Medi-Cal for Kids & Teens)* (approved 12/19/23), stated that the Plan will cover and ensure the provision by network providers of exams, screening, diagnostic testing, and treatment for preventative and all medically necessary services for members under the age of 21 in accordance with the EPSDT program benefit. The policy also stated that the services to be provided must meet the criteria of timely access to all medically necessary services and that appropriate diagnostic and treatment services are initiated as soon as possible, but no later than 60 calendar days following either a preventive screening or other visit that identifies a need for follow-up.

Finding: The Plan did not arrange and coordinate BHT services for members under the age of 21 within 60 calendar days.

A verification study demonstrated that in three of 15 BHT samples, the Plan did not arrange BHT appointments within 60 business days when members requested new

appointments with a different BHT provider. In all three samples, the members' parents requested a new BHT provider, which required a new FBA appointment to re-assess the members' needs.

- In one sample, the member's parent called the Plan to request assistance with restarting BHT services. The Plan did not contact the parent to follow up on obtaining services for two months. In a written response, the Plan stated there was no documented care coordination during this time period. The member was connected with BHT services three months after the initial request to restart BHT services.
- In a second sample, the member's parent called to discuss appointment availability with the Plan, and the Plan emailed BHT network providers the same day. However, there was no further documentation indicating the Plan had followed up with providers or parents. The member was connected with BHT services three months after the initial request.
- In a third sample, the member's parent called the Plan to request assistance with changing BHT providers due to wanting clinic-based services. The parent called two months later with the same request. In a written response, the Plan stated that the member had been referred to network providers a month after the second phone call but was not accepted for BHT services until four months after the initial request.
- Two of these samples had filed grievances regarding a lack of access to BHT services which the Plan acknowledged and resolved in favor of the member.
- In all deficient samples, there is no evidence the Plan attempted to arrange BHT services with OON providers when it was not able to provide the services in-network.

During the audit period, the Plan had identified patterns of staffing shortages with BHT providers. In an interview, the Plan described that barriers to care coordination existed because of member, parent, and provider scheduling conflicts. Due to the pandemic, there was a two-year disruption to staffing levels for BHT providers. Another barrier occurred from a backlog of members waiting to receive needed BHT services who were transferred from the previous BHT delegate to the Plan shortly before the audit period started.

Plan policy BH-004 did not contain details on monitoring and oversight mechanisms to ensure that members requiring BHT services are receiving care coordination and that BHT provider staffing shortages or network capacity are being monitored to ensure timely access.

When the Plan does not arrange and coordinate BHT services, members may experience delays in receiving medically necessary services to improve or maintain behavioral health conditions.

Recommendation: Revise and implement policies and procedures to ensure that the Plan arranges, coordinates, and provides BHT services for members under the age of 21 within 60 calendar days.

2.4 Continuity of Care

2.4.1 Notice of Action Letters for Continuity of Care Requests

The Plan is required to implement and maintain a written description of the QIS that shall include the description of the activities designed to assure the provision of case management, coordination, and COC services. *(2023 Contract 04-35399, Exhibit A, Attachment 4 (7)(I))*

The Plan is required to ensure quality care in each of the following areas: COC and care coordination across settings and at all levels of care. This includes transitions in care, with the goal of establishing consistent provider-patient relationships, and member experience with respect to COC and care coordination. *(2024 Contract A01, Exhibit A, Attachment III, 2.2 (A)(5) and (6))*

The Plan must send an NOA letter with each authorization decision, detailing information that impacts a member's access to covered services. The Plan's NOA letter informing the member of an Adverse Benefit Determination (ABD) must include, but not limited to, the following: a clear and concise explanation of the action that the Plan has taken or intends to take, including a fully translated clinical rationale for the Plan's decision at the point of each determination. *(2024 Contract A01, Exhibit A, Attachment III, 4.6.4 (E)(1))*

For COC requests that are denied, the Plan must include the following information in the notice: a statement of the Plan's decision, a clear and concise explanation of the reason for denial, and the member's right to file a grievance or appeal. If the Plan and the OON provider cannot reach an agreement on the rate, the Plan must offer the member an

alternative network provider. *(APL 23-022, Continuity Of Care For Medi-Cal Beneficiaries Who Newly Enroll In Medi-Cal Managed Care From Medi-Cal Fee-For-Service, On Or After January 1, 2023)*

For all other ABDs that are not based on medical necessity (e.g., denials based on a lack of information, or benefit denials, etc.), Plans are required to still ensure that the NOA letter provides a clear and concise explanation of the reasons for the decision. *(APL 21-011, Grievance And Appeal Requirements, Notice And "Your Rights" Templates)*

Plan policy, *UM-036 Continuity of Care for Terminated and Non-Participating Providers* (approved 12/19/23), stated that if the non-participating provider does not agree to the rates, terms and conditions, or fails to respond to the Plan within 30 calendar days of the request for COC, the following will occur: Contract Management will notify Plan Medical Services (UM team) to reverse the authorization, and the Plan's UM team will send the member and the provider a notice that COC services have been denied because the Plan and the noncontracted provider were unable to reach an agreement.

Plan policy, *UM-054 Notice of Action* (approved 6/20/23), stated that members and requesting providers are provided with written notifications of UM decisions. These include NOA letters for denials, modifications, and deferrals/delays which clearly and concisely document and communicate the reasons for the decision so that members and providers receive sufficient information in easily understandable language to be able to understand the decision and decide whether to appeal the decision.

Finding: The Plan did not ensure that NOA letters for COC requests that were sent to members contained a clear explanation of the reason for the denial decision.

A verification study of 15 members with COC requests included four samples that were denied. In three of four samples, the Plan did not send the member a NOA letter with a clear explanation for the denial of the COC request.

- In one sample, the member's COC request was denied due to a lack of an existing relationship with the OON provider. The Plan sent the member a NOA letter that referenced APL 22-022 incorrectly as the COC APL. However, this APL discusses abortion services and not COC. The correct APL reference should have been APL 23-022, which discusses COC requirements.
- In a second sample, the member's COC request was denied due to the provider not accepting the Plan's payment rate. However, the NOA letter incorrectly stated that the request was denied because the provider asked the Plan to approve an office visit with a PCP.

- In a third sample, the member's COC request was also denied due to the provider not accepting the Plan's payment rate. However, the NOA letter incorrectly stated the denial reason was because the provider had requested office visits with a specialist. In a written response, the Plan acknowledged that the NOA letter did not state the reason for denial, leaving the member unaware.

In an interview, the Plan explained that templated NOA letters are used for denials. In a written response, the Plan stated that the standard COC denial process is to generate two letters. One letter is a COC denial letter with specific COC language, along with a separate NOA letter related to the treatment/service being requested. The Plan's process of sending two letters resulted in one of the samples not receiving a COC denial letter.

The Plan stated that each NOA letter is reviewed individually, however it did not have a process which ensures that the NOA letters for COC denials include the actual denial reason and complete information used to make the decision.

When the Plan does not ensure NOA letters sent to members contain clear information about the denial, members may not have accurate information to make informed decisions about their healthcare including filing grievances and appeals.

Recommendation: Revise and implement policies and procedures to ensure NOA letters for COC denials contain clear explanations of the reason for the denial decision.

COMPLIANCE AUDIT FINDINGS

Category 3 – Access and Availability of Care

3.1 Appointment Procedures and Monitoring Waiting Times

3.1.1 Appointment Waitlist Timeliness

The Plan is required to establish acceptable accessibility requirements in accordance with CCR, Title 28, section 1300.67.2.1 for geographic accessibility standards. The Plan is required to communicate, enforce, and monitor network providers' compliance with these requirements. The Plan is required to implement and maintain procedures for members to obtain appointments for routine care, urgent care, routine specialty referral appointments, prenatal care, children's preventive periodic health assessments, and adult IHA. *(2023 Contract A26, Exhibit A, Attachment 9 (3)(A))*

The Plan is required to have mechanisms to continuously monitor, review, evaluate, and improve access to and availability of all covered services. The mechanisms are required to include oversight processes that ensure members can obtain medically necessary appointments within established standards for time or distance, timely access, and alternative access in accordance with APL 23-001, and W&I Code sections 14197 and 14197.04. *(2024 Contract A01, Exhibit A, Attachment III, 2.2.6 (N))*

The Plan is required to develop, implement, and maintain procedures to monitor and ensure that the Plan, network providers, subcontractors, and downstream subcontractors comply with requirements for members to obtain appointments for routine care, urgent care, routine specialty referral appointments, prenatal care, children's preventive periodic health assessments, and adult IHAs in accordance with W&I Code section 14197 and CCR, Title 28, section 1300.67.2.2. *(2024 Contract A01, Exhibit A, Attachment III, 5.2.5)*

The Plan is required to provide or arrange for the provision of covered health care services in a timely manner appropriate for the nature of the member's condition consistent with good professional practice. The Plan shall establish and maintain networks, policies, procedures, and quality assurance systems sufficient to ensure compliance with this clinical appropriateness standard. *(CCR, Title 28, section 1300.67.2.2 (C)(1), Timely Access to Non-Emergency Health Care Services and Annual Timely Access and Network Reporting Requirements)*

Plan policy, *QI-107 Access and Availability Standards* (approved 9/19/2023), stated that non-urgent primary care appointments are required within ten business days of the request and call return time is one business day. The Plan's Access and Availability (A&A) Committee monitors access to, and availability within, the Plan's network.

Plan policy, *QI-115 Access and Availability Committee* (approved 3/21/2023), stated that the A&A Committee reviews the Plan's A&A information, data, and reports on an ongoing basis to identify network adequacy and address any areas of non-compliance or deficiency related to member access to care and provider availability. If non-compliance or deficiencies are identified through the monitoring process, prompt investigation and corrective action is implemented to rectify identified deficiencies.

Finding: The Plan did not ensure members were able to obtain medically necessary appointments within established timely access standards. One of the Plan's medical groups placed members on an appointment waitlist and had members waiting up to six months to make an appointment.

In a Joint Operation Meeting (JOM) with the Plan, Alameda Health System (AHS) stated that it had a waitlist with 2,000 members waiting for primary care appointments at the Highland location. The Highland location is at maximum capacity and the added providers are not able to absorb the demands of the waitlist. In another JOM with CHCN, which has a contractual relationship with AHS, the Plan stated that due to access to care complaints from members, the Plan has identified a waitlist that has members waiting three to six months for a call back to make an appointment.

The Plan conducted monthly timely access surveys of AHS throughout the audit period. According to the Plan's CAP tracker, 45 CAPs have been issued to AHS throughout the audit period. The CAPs issued included, but not limited to, non-compliance with non-urgent and urgent PCP appointment availability, non-urgent specialist appointment availability, and the first prenatal appointment. All 45 CAPs issued by the Plan to AHS were closed, however, the CAPs are ineffective in correcting the access deficiencies since appointment availability is still a recurring issue for AHS.

In a written response, the Plan stated that it has been holding ongoing JOMs with AHS and holding internal meetings with the A&A Committee to address the waitlist at AHS. AHS also informed the Plan that it has been redirecting members to other locations with available appointments. However, the Plan stated that as of June 2024, AHS continues to have members on a waitlist for the Highland location, and the estimated wait time to schedule an appointment remains three to six months.

When the Plan does not schedule appointments for members in a timely manner, members may not receive medically necessary care.

Recommendation: Implement policies and procedures for members to obtain medically necessary appointments within established timely access standards.

3.1.2 Monitoring In-Office Wait Times for Specialty and Behavioral Health Services

The Plan is required to develop, implement, and maintain a procedure to monitor waiting times in the network providers' offices, telephone calls (to answer and return), and time to obtain various types of appointments. *(2023 Contract A26, Exhibit A, Attachment 9 (3)(C))*

The Plan is required to ensure that members have access to specialists for medically necessary covered services in accordance with W&I Code section 14197, CCR, Title 22, section 53853, and CCR, Title 28, section 1300.67.2.2. The Plan is required to maintain an adequate network that includes adult and pediatric specialists, and at a minimum, the core specialists required in W&I Code section 14197(h)(2) within the network to ensure medically necessary specialty care is available in accordance with CCR, Title 22, section 53853(a), and W&I Code sections 14182(c)(2) and 14197. *(2024 Contract A01, Exhibit A, Attachment III, 5.2.1)*

The Plan is required to provide the appointment time standards to network providers, subcontractors, and downstream subcontractors, and monitor appointment waiting times in network providers' offices pursuant to Code of Federal Regulations (CFR), Title 42, section 438.206, W&I Code section 14197, and CCR, Title 28, section 1300.67.2.2 (*2024 Contract A01, Exhibit A, Attachment III, 5.2.5 (c))*

The Plan must maintain and monitor an appropriate network that includes, but not limited to, the following network provider types to ensure the Plan's network has the capacity to provide all medically necessary services: adult and pediatric core specialists, and adult and pediatric mental health outpatient providers. *(APL 20-003, Network Certification Requirements)*

Plan policy, *QI-114 Monitoring of Access and Availability Standards* (approved 3/21/2023), stated that the Plan will perform ongoing monitoring of the direct and delegated provider network including PCPs, behavioral health providers, and specialists. The Plan as often as quarterly conducts PCP post-visit surveys. The Plan measures member experience with health care providers and staff, as well as with in-office wait

time through the Clinical and Group Consumer Assessment of Healthcare Providers and Systems (CG-CAHPS).

Finding: The Plan did not monitor in-office wait time for specialists and behavioral health providers.

The Plan submitted the 2023 Provider Appointment Availability Survey (PAAS) for review, which is the Plan's annual survey that assesses the appointment availability wait times for providers. While the PAAS measured the appointment availability wait times for specialty and behavioral health providers, the survey did not assess the in-office wait times for specialty and behavioral health providers.

The Plan also submitted the annual Consumer Assessment of Healthcare Providers and Systems (CAHPS), which is the annual provider and member satisfaction survey. The survey measured members' experiences and satisfaction with the Plan's care, including, but not limited to, ratings of the health plan, health care, getting needed care, getting care quickly, coordination of care, and ratings of personal doctors and specialists. The survey did not measure timely access requirements.

During the audit period, the Plan conducted the quarterly CG-CAHPS survey, which included surveys for in-office wait time. The surveys asked members if wait times in the waiting room and exam room of their PCP lasted more or less than 60 minutes until the member was seen by the provider. The quarterly surveys did not include members' experience with specialists and behavioral health providers.

In a written response, the Plan stated that in-office wait time for behavioral health and mental health providers were not monitored in the quarterly CG-CAHPS survey during the audit period.

Subsequent to the Exit Conference, the Plan provided a written statement that they initiated surveys to monitor in-office wait times for behavioral health providers, however, the survey occurred outside of the audit period and the Plan did not provide any evidence in support of the written statement.

If the Plan does not monitor in-office wait times for specialist and behavioral health providers, members may experience barriers to receiving medically necessary care timely.

Recommendation: Revise and implement policy and procedures to monitor in-office wait times for specialist and behavioral health providers.

3.1.3 Monitoring Telephone Calls for Specialty and Behavioral Health Services

The Plan is required to develop, implement, and maintain a procedure to monitor waiting times in the network providers' offices, telephone calls (to answer and return), and time to obtain various types of appointments. *(2023 Contract A26, Exhibit A, Attachment 9 (3)(C))*

The Plan must require network providers to maintain a procedure for triaging members' telephone calls, providing telephone medical advice (if made available) and accessing telephone interpreters. *(2023 Contract A26, Exhibit A, Attachment 9 (3)(D))*

The Plan is required to monitor and enforce network providers', subcontractors', and downstream subcontractors' compliance with the requirements in W&I Code section 14197 (d)(1)(A), CCR, Title 28, section 1300.67.2.2, and the requirements in the Contract. *(2024 Contract A01, Exhibit A, Attachment III, 5.2.5)*

The Plan is required to provide or arrange for the provision, 24 hours per day, seven days per week, of triage or screening services by telephone. The Plan is required to ensure that telephone triage or screening services are provided in a timely manner appropriate for the member's condition, and the triage screening wait time does not exceed 30 minutes. *(CCR, Title 28, section 1300.67.2.2)*

Plan policy, *QI-107 Access and Availability Standards* (approved 9/19/2023), stated that during normal business hours, the wait time for members to speak by telephone with a provider staff member knowledgeable and competent in addressing members' questions and concerns shall not exceed ten minutes.

Plan policy, *QI-114 Monitoring of Access and Availability Standards* (approved 3/21/2023), stated that the Plan will perform ongoing monitoring of the direct and delegated provider network including PCPs, behavioral health providers, and specialists. The Plan conducts PCP post-visit surveys quarterly. The Plan measures member experience with health care providers and staff, as well as with provider time to answer calls during business hours and provider call return time during business hours through CG-CAHPS.

Finding: The Plan did not monitor wait times for specialty and behavioral health providers to answer and return telephone calls.

A review of the Plan's 2023 Provider Access After-Hours survey showed that the Plan did monitor after-hours telephone calls for specialist and behavioral health providers.

However, the Plan did not have a report to monitor telephone calls for specialty and behavioral health providers during business hours.

The Plan submitted the 2023 PAAS which is the Plan's annual survey that assesses the appointment availability wait times for providers. While the PAAS does measure the appointment availability wait times for specialty and behavioral health providers, the survey does not assess telephone calls during normal business hours for specialty and behavioral health providers.

The Plan also submitted the annual CAHPS which is the annual provider and member satisfaction survey. The survey measured members' experiences and satisfaction with the Plan's care, including, but not limited to, ratings of the health plan, health care, getting needed care, getting care quickly, coordination of care, and ratings of personal doctors and specialists. The survey did not measure wait times to answer and return telephone calls.

During the audit period, the Plan conducted the quarterly CG-CAHPS surveys, which included surveying PCPs for call return time and time to answer calls. The surveys asked members if members received a call back from their PCP office within one business day during business hours, and if members who reported their calls answered by their PCP office was within ten minutes during business hours. While the CG-CAHPS monitors PCPs for time to answer calls and call return time during business hours, it did not monitor behavioral health or specialist providers for these telephone requirements.

In a written response, the Plan stated that call return time and wait time to answer and return calls for behavioral health and mental health providers were not monitored in the CG-CAHPS survey during the audit period.

Subsequent to the Exit Conference, the Plan provided a written statement that they initiated surveys to monitor telephone call wait times for behavioral health providers. However, this occurred outside of the audit period and the Plan did not provide any evidence in support of this statement.

If the Plan does not monitor telephone call wait times for specialty and behavioral health, members may experience difficulties communicating and scheduling medically necessary services.

Recommendation: Revise and implement policy and procedures to monitor telephone wait times for specialty and behavioral health providers.

COMPLIANCE AUDIT FINDINGS

Category 4 – Member's Rights

4.1 Grievance System

4.1.1 Grievances Involving Clinical Issues

The Plan is required to ensure that the person making the final decision for the proposed resolution has clinical expertise in treating a member's condition or disease if deciding on any grievance involving clinical issues. (*2023 Contract A26, Exhibit A, Attachment 14 (1) (D)*)

The Plan is required to ensure that the person making the decision on the grievance has clinical expertise in treating a member's condition or disease when deciding any grievance involving clinical issues. (*2024 Contract A01, 4.6.1 (D)*)

Plan policy, *G&A-003 Grievance and Appeals Receipt, Review and Resolution* (approved 10/19/2023), stated the Medical Director is required to resolve grievances related to medical QOC. The decision-maker for any grievance involving clinical issues is a health care professional with clinical expertise in treating a member's condition or disease.

Plan procedure, *Review of Quality of Care Grievances – MD Review Workflow* (revised 12/30/2021), stated the Medical Director is required to review and resolve all levels of QOC grievances prior to sending a resolution letter to the member.

Finding: The Plan did not ensure that a person with clinical expertise in treating a member's condition made the resolution decision for grievances involving clinical issues.

A verification study demonstrated that in four of 27 grievances involving clinical issues, a reviewer with clinical expertise in treating a member's condition did not make the final resolution decision. In all four deficient samples, a non-clinical grievance staff member reviewed and resolved the clinical complaints.

- In one expedited sample, a member with diabetes had run out of insulin and other medications for a week and could not obtain a refill despite multiple attempts. The Plan categorized the complaint as an access grievance and did not send the grievance to a Medical Director for resolution.
- In three standard grievance samples, the Plan did not obtain provider responses or medical records for the grievance investigation and did not send the

grievances to the Medical Director for resolution. The clinical complaints included alleged professional misconduct by a provider, medical QOC concern for an emergency medicine provider, and inadequate medical care for a pregnant member giving birth.

During interviews, the Plan acknowledged that staff did not follow the procedure to send QOC grievances to the Medical Director for resolution, especially for cases in which the Plan had not obtained medical records or a provider response. In addition, the Plan's procedure did not require grievances with clinical issues, such as access or QOS grievances with clinical issues, to be resolved by the Medical Director.

When the Plan does not ensure that a person with clinical expertise in treating a member's condition makes the final decision for grievances with clinical issues, the resolution may not be clinically appropriate and may adversely impact a member's health.

Recommendation: Develop and implement policies and procedures to ensure that a person with clinical expertise in treating a member's condition makes the resolution decision for grievances involving clinical issues.

4.1.2 Resolution of Grievances

The Plan is required to provide a Notice of Resolution Letter to the member as quickly as the member's health condition requires, within 30 calendar days from the date the Plan receives the grievance. *(2023 Contract A26, Exhibit A, Attachment 14)*

The Plan is required to provide the Notice of Resolution Letter to the member as quickly as the member's health condition requires, not to exceed 30 calendar days from the date the member makes an oral or written request to the Plan for a standard grievance. *(2024 Contract 01, Exhibit A, Attachment III, 4.6.1 (B))*

Resolved means that the grievance has reached a final conclusion with respect to the member's submitted grievance as delineated in state regulations. *(APL 21-011, Grievance and Appeal Requirements, Notice And "Your Rights" Templates)*

Plan policy, *G&A-001 Grievance and Appeals System Description* (approved 10/19/2023), stated the Plan ensures that each issue is addressed and resolved when a complainant presents with multiple issues. This policy defines resolved as the grievance has reached a final conclusion with respect to the member's submitted grievance, and there are no pending member appeals within the Plan's grievance system, including entities with delegated authority.

Plan procedure, *Grievance Timeline* (revised 10/05/2023), stated that if a provider response is not received, Plan staff will make at least two follow-up outreach attempts to the provider (at least one by phone call). If no response is received, Plan staff will forward the case to the Medical Director for escalation and outreach.

Finding: The Plan did not completely resolve the members' grievances.

A verification study revealed that in five of 27 QOC grievances, the Plan did not completely resolve the members grievances.

- In three QOC samples, the Plan did not obtain provider responses or medical records for the grievance investigations and did not resolve any of the members' QOC complaints prior to grievance resolution. In all three samples, the Plan did not escalate the missing records to the Medical Director. During interviews and in written responses, the Plan acknowledged that staff did not follow the Grievance Timeline procedure and did not escalate missing responses/records to the Medical Director to reach out to the involved entity.
    - In one sample, a pregnant member complained of waiting at the hospital for six hours while experiencing pregnancy-related bleeding and severe pelvic pain. The member stated they left the hospital without receiving medical care. Plan staff did not request medical records and a hospital response until 28 days after receipt of the complaint. Although Plan staff conducted outreach to the hospital three times, the Plan did not escalate the missing records to the Medical Director.
- In two QOC samples, the Plan did not resolve all the member's clinical complaints prior to the grievance resolution.
    - In one sample, the guardian of a pediatric member with autism requested the Plan to change the member's BHT provider nine months prior to the grievance and had not heard back from the Plan. The member needed BHT services, but their last appointment was more than six months prior to the grievance. The Plan did not expedite a BHT provider change. At the time of the grievance resolution, the Plan had not scheduled a BHT appointment with a new provider. In addition, the Plan's staff did not investigate why the Plan's Behavioral Health Department did not follow up with the member for nine months.

A verification study of 41 standard QOS grievances revealed that in 12 QOS samples, the Plan did not completely resolve the members' grievances. The following examples were not completely resolved.

- In one sample, the member complained about the earliest available appointment being a month out for a general physical. The Plan did not schedule an earlier appointment for the member within the timely access standard of ten business days for routine appointments. During the interview, the Plan confirmed this grievance was not resolved.
- In another sample, the member raised numerous complaints and the Plan did not resolve any of them. Complaints involved telephone access and language services of a mental health provider and the hospital's Mental Health Department. During the interview, the Plan admitted it did not address all complaints in the resolution letter.
- In another sample, the member complained about the small number of urologists in the network and experienced barriers (geographic distance and language preference) to receiving care from the existing urologists. During the interview, the Plan confirmed this grievance was not resolved as a urologist was not provided to the member.

In a written statement, the Plan stated the Grievance and Appeals Department has three quality assurance specialists that are responsible for the quality assurance checks of resolution letters to confirm complaints are fully resolved. However, the quality assurance checks did not confirm all complaints were resolved.

If the Plan does not completely resolve the members' grievances, the members may experience barriers to care and may not receive quality health care services to which they are entitled.

Recommendation: Implement policies and procedures to ensure the Plan has reached a final conclusion with respect to the member's submitted grievance before sending the resolution letter.

4.1.3 Clear and Concise Resolution Letters

The Plan is required to have in place a grievance system in accordance with CCR, Title 28, section 1300.68. *(2023 Contract A26, Exhibit A, Attachment 14 (1))*

The Plan is required to have in place a member grievance and appeal system that complies with CCR, Title 28, section 1300.68. *(2024 Contract A01, Exhibit A, Attachment III)*

The Plan's written resolution shall contain a clear and concise explanation of the Plan's decision. *(CCR, Title 28, section 1300.68 (d)(3))*

The Plan's written resolution must contain a clear and concise explanation of the Plan's decision. *(APL 21-011, Grievance and Appeal Requirements, Notice And "Your Rights" Templates)*.

Plan policy, *G&A-003 Grievance and Appeals Receipt, Review and Resolution* (approved 10/19/2023), stated the resolution contains a clear and concise explanation of the Plan's decision.

Finding: The Plan's written resolution did not contain a clear and concise explanation of the Plan's decision.

A verification study of 25 standard QOC grievances revealed that in three QOC samples, the Plan did not provide a clear explanation in the resolution letter. The Plan did not provide relevant information from investigation results that addressed the members' QOC complaints.

- In one sample, a member raised multiple complaints about a provider including delay in obtaining imaging, focus on the member's mental health condition rather than the member's liver lesion, and not receiving appropriate care for symptoms of black stools and rapid heart rate. The resolution letter stated, "you were provided with the best assessment and treatment." The Plan did not explain the relevant information from the medical records and provider response that addressed each of the member's complaints, such as the provider's assessment, outreach attempts to offer appointments to the member, and the status of the imaging referral.

During the interview and in written statements, the Plan confirmed that pertinent information from the provider response and medical records were not included in the resolution letter for all deficient QOC samples.

A verification study of 41 standard QOS grievances revealed two QOS samples in which the resolution letters had irrelevant information that was not clear and not concise.

- In one sample, the member was unable to make an appointment and had been waiting five months for a mental health appointment, but the clinic never

answered the phone. The Plan's written resolution letter was three pages long and contained reference to previous and future appointments that were not related to the mental health appointment, such as women's health, anemia follow-up, and dental appointments.

In a written statement, the Plan stated the Grievance and Appeals Department has three quality assurance specialists that are responsible for the quality assurance checks of resolution letters to confirm that the explanations are clear and concise. The Plan's quality assurance checks did not detect issues with clarity or conciseness.

If the Plan's written resolutions do not include clear and concise explanations for member grievances, then members may not understand important information about their health care.

Recommendation: Revise and implement policies and procedures to ensure the Plan's written resolutions contain clear and concise explanations of the Plan's decision.

4.1.4 Grievance Letters: Non-Discrimination Notice and Language Assistance Tagline

The Plan is required to comply with all existing final APLs issued by the DHCS. (*2023 Contract A26, Exhibit E, Attachment 2 (1)(D))*

The Plan is required to comply with all DHCS guidance, including, but not limited to, APLs, PLs, the California Medicaid State Plan, and the Medi-Cal Provider Manual. *(2024 Contract A01, Exhibit E, 1.1.2)*

The Plan is required to comply with the NDN and LAT requirements as outlined in APL 21-004, including any subsequent updates or revisions to this APL when sending the required grievance and appeals notifications to members. *(APL 21-011, Grievance and Appeal Requirements, Notice And "Your Rights" Templates)*

The NDN and LAT must be posted in all member informational notices, including written notices to an individual such as those pertaining to rights and benefits. The DHCS updated templates for NDN to include additional characteristics protected under state nondiscrimination laws as well as contact information for members to file a discrimination grievance directly with the DHCS' OCR. The DHCS also updated the LAT template to conform to federal law and to include additional top California languages (Mien and Ukrainian) with a subsequent addition of Simplified Chinese. Although the DHCS does not require Plans to use the DHCS-provided templates verbatim, notices

must be compliant with requirements in this APL and with information in the DHCS-provided templates. (*APL 21-004, Standards for Determining Threshold Languages, Nondiscrimination Requirements, and Language Assistance Services notice of Nondiscrimination and Taglines Templates)*

Plan policy, *CLS-003 Nondiscrimination, Language Assistance Services, and Effective Communication for Individuals with Disabilities* (approved 3/19/2024), stated NDN is included in notices that pertain to the members rights and benefits and LAT are posted in all member information and other information notices. The policy also states NDN includes all legally required elements, as well as information on how to file discrimination grievances with the DHCS' OCR and with the Plan, as described in the DHCS NDN template.

The Plan's 2023 and 2024 Cultural and Linguistic Program description stated the Communications and Outreach Department assists all departments in sending the appropriate NDN and LAT notices to members.

Finding: The Plan did not include updated NDN and LAT information with grievance acknowledgement and resolution letters.

In a verification study of 25 standard QOC grievance samples, 41 standard QOS grievance samples and six expedited grievance samples, the following deficiencies were identified:

- In 66 of 66 standard grievances, the Plan sent outdated NDN information to members in acknowledgement and resolution letters. The deficient letters were sent in English, Spanish, Chinese, and Vietnamese languages.
- In 28 of 66 standard grievances, the Plan sent outdated LAT information to members in acknowledgement and resolution letters. The deficient letters were sent in Spanish, Chinese, and Vietnamese languages.
- In six of six expedited grievances, the Plan sent outdated NDN information to members in the resolution letters. The deficient letters were sent in English and Chinese.
- In three of six expedited grievances, the Plan sent outdated LAT information to members in the resolution letters. The deficient letters were sent in Chinese and English languages.

The outdated NDNs did not contain all non-discrimination characteristics (medical condition, genetic information, gender identity, etc.) and did not provide information on

how to file grievances with the DHCS' OCR. The outdated LAT notices did not include taglines in Mien, Ukrainian, and Simplified Chinese.

During interviews, the Plan did not explain why the appeal system sent outdated NDN and LAT notices. In a written response, the Plan acknowledged it did not have a formal coordination process between the Compliance Department and Grievance and Appeal Department for updating DHCS-issued templates.

If the Plan does not include the current LAT and NDN information, then members may miss opportunities for filing discrimination grievances and obtaining needed language assistance services.

Recommendation: Develop and implement policies and procedures to ensure current LAT and NDN information is included in grievance acknowledgement and resolution letters.

4.2 Cultural and Linguistic Services

4.2.1 Monitoring of Linguistic Performance

The Plan is required to assess and track the linguistic capability of interpreters and contracted staff. The Plan is required to develop and implement policies and procedures for assessing the performance of individuals who provide linguistic services. (*2023 Contract A26, Exhibit A, Attachment 9 (B)(F))*

The Plan is required to develop and implement policies and procedures for assessing the performance of contracted staff who provide linguistic services. (*2024 Contract A01, Exhibit A, Attachment III, 5.2.11 (A)(1))*

Plan policy, *CLS-011 Compliance Monitoring of Cultural and Linguistic Services Program* (approved 3/19/2024), stated that the Quality Improvement (QI) Department monitors the Contract with the language service vendors and requests documentation on capacity and assessment of interpreter staff. A log of all requested interpretation services is kept demonstrating the availability of interpretation services to all members including the interpretative language being requested, date of service, and who provided the interpretation services. The QI Department requests and reviews a yearly update of the certifications of interpreters used through the interpreter service vendors.

Finding: The Plan did not assess the performance of the vendors' staff that provided linguistic services such as interpreter services.

Plan policy CLS-011, indicated that the Plan would request documentation on capacity and assessment of the vendor's staff, however it did not include procedures for assessing the performance of the vendor staff who provide linguistic services.

In a written response, the Plan stated it monitors the performance of the interpreter vendors through the business intelligence dashboard, which monitors utilization, language, status, language trends, and eligibility trends for all interpreter services. According to the Plan, other ways of monitoring linguistic performance are through quarterly PQI reports at JOMs, provider satisfaction surveys, and a member experience survey. However, these methods did not demonstrate the assessment of linguistic performance delivered by the vendor's employees.

Contracts with the vendors included language about availability of monthly and annual reviews of interpreters based on interpreter evaluation reports. However, there was no evidence that the Plan requested and reviewed these reports to ensure monitoring of the linguistic performance of individuals who provide linguistic services. The interpreter evaluation reports from three vendors were not requested by the Plan from the vendors until the DHCS audit team requested documentation. One of the vendor's reports did not indicate the date of review, the language provided, or the accuracy and proficiency of each interpreter.

Without monitoring the evaluation of linguistic services, the Plan cannot ensure that the interpreter services provided are accurate and effective.

Recommendation: Revise and implement policy and procedures for assessing the performance of contracted staff who provide linguistic services including interpreter service vendors.

4.3 Confidentiality Rights

4.3.1 Notification to DHCS

The Plan is required to notify the DHCS within 24 hours by email or fax of the discovery of any suspected security incident, intrusion, or unauthorized access, and use or disclosure of PHI or PI. A breach shall be treated as discovered by business associate 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 business associate. *(2023 Contract A26, Exhibit G, Attachment III (J)(1))*

The Plan is required to notify the DHCS within 24 hours by email (or by telephone if unable to email the DHCS) of the discovery, including but not limited to, any suspected security incident which risks unauthorized access to PHI and/or other confidential information, and any intrusion or unauthorized access, use or disclosure of PHI violation. *(2024 Contract A01, Exhibit G, 18.1.2)*

Breach means the acquisition, access, use, or disclosure of PHI in a manner not permitted which compromises the security or privacy of the PHI. *(CFR, Title 45, section 164.402*)

Plan policy, *CMP-013 HIPAA Privacy Reporting* (approved 6/20/2023), stated that the Plan will investigate an incident and submit an initial privacy incident report to the DHCS within 24 hours of discovery of a breach, suspected breach, or security incident.

Plan procedure, *Privacy Reporting Investigation & Reporting Desktop Procedure* (revised 7/28/2023), stated that all Plan employees are required to report suspected HIPAA privacy incidents to the Privacy Office. Suspected or identified incidents must be reported immediately.

Finding: The Plan did not notify the DHCS within 24 hours upon discovery of any suspected security incident, unauthorized access, use or disclosure of PHI or PI.

A review of 17 suspected breach incidents revealed that six were not reported to the DHCS within 24 hours. These suspected breach incidents exceeded the reporting timeframe by two to 23 working days. The following were examples of incidents not reported timely:

- In one sample, a Plan staff accessed a member's PHI record without consent and outside of the job responsibility. Information was shared with other Plan staff through email. The Plan did not immediately acknowledge that it was a HIPAA privacy breach and after seven working days, identified and notified the DHCS. During an interview, the Plan explained the nature of the information was unclear to the Privacy Officer. However, a review of the email found that it clearly indicated that the Plan staff has a personal relationship with the member and accessed the member's PHI outside of the job responsibility as compliance staff and sent it to the Privacy Officer and other Plan staff to obtain assistance regarding the member's difficulties with transportation.
- In the next sample, a member informed the Plan's Grievance and Appeal Coordinator that they received another member's ID card and membership packet. The Grievance and Appeal Coordinator emailed the incident to the Compliance Department twice on the same day it was discovered. The Plan did not notify the DHCS after four working days. During an interview, the Plan

explained that the email was sent to the general compliance inbox instead of the privacy compliance inbox.

- In another sample, a member emailed the Plan stating they received a grievance resolution letter that belonged to another member through the mail. The Grievance and Appeals Department took 23 working days to inform the Compliance Department of the incident.
- In another sample, a vendor emailed the Plan about a network interruption related to a cybersecurity incident. After two hours, the Plan's IT staff reported to the Plan's Privacy Officer and Privacy Manager. However, the Plan did not notify the DHCS until two working days after the discovery. During an interview, the Plan explained the necessity to wait to confirm the cybersecurity incident before determining it was a suspected security incident.

During the interview, the Plan explained that human error caused the delay in notifying the DHCS within 24 hours. The Plan's, annual HIPAA memorandum and *Privacy Incident Investigation and Reporting Desktop Procedure,* stated that staff must report actual or suspected HIPAA incidents immediately to the privacy office and the department management. The Plan's staff can report confirmed or suspected HIPAA privacy incidents by emailing the privacy compliance inbox or compliance inbox, calling the compliance hotline, contacting the department leadership, reaching out to the compliance/privacy staff, and making referrals through the Plan's system. However, the Plan did not ensure that staff promptly reported suspected security incidents.

When the Plan does not notify the DHCS within 24 hours upon discovering any suspected security incidents, the Plan increases the risk of data exposure of members' PHI.

Recommendation: Revise and implement policies and procedures to ensure suspected security incidents are reported within the required 24-hour timeframe.

COMPLIANCE AUDIT FINDINGS

Category 5 – Quality Management

5.3 Provider Qualifications

5.3.1 Notification of Provider Terminations

The Plan is required to make a good faith effort to give written notice of termination of a contracted provider within 15 calendar days after receipt or issuance of the termination notice to each member who received his or her primary care from, or was seen on a regular basis by, the terminated provider pursuant to CFR, Title 42, section 438.10 for information requirements. This notification must also be presented to, and approved in writing, by the DHCS prior to release. *(2023 Contract A26, Exhibit A, Attachment 13)*

The Plan is required to promptly notify the DHCS when the Plan receives information about a change in a network provider's, subcontractor's, or downstream subcontractor's circumstances that may affect the network provider's, subcontractor's, or downstream subcontractor's eligibility to participate in the Medi-Cal Managed Care program, including the termination of the network provider agreement, subcontractor agreement, or downstream subcontractor agreement with Plan in accordance with the Contract, state and federal law, including CFR, Title 42, section 438.608(a)(4) for program integrity requirements, and APL 21-003. *(2024 Contract A01, Exhibit A, Attachment III, 1.3.4)*

The Plan is required to ensure members are notified in writing of any changes in the availability or location of covered services, of any termination of a network provider, subcontractor, or downstream subcontractor either 30 calendar days prior to the effective date of the contract termination or at least 15 calendar days after receipt of issuance of the termination notice, whichever is longer, unless directed by the DHCS. The notification must be provided to each member who received primary care from, or was seen on a regular basis by, the terminated provider. This notification must also be submitted to the DHCS in writing for approval before release. *(2024 Contract A01, Exhibit A, Attachment III, 5.2.9)*

Terminations can be initiated by a Plan, network provider, subcontractor, or other contracted entities as necessary. The Plan is required to submit a written notice of the termination to the DHCS by emailing the Managed Care Operations Division Contract

Manager. The written notice must be accompanied by all required documentation within the timeframes outlined in the APL.

The Plan is required to meet the notification and reporting requirements by determining the overall member impact due to the termination. For all terminations, the Plan must mail appropriate member notifications and remain accountable for all functions and responsibilities of the terminated network provider/subcontractor to ensure that impacted members do not experience disruption in access to care. *(APL 21-003, Medi-Cal Network Provider and Subcontractor Terminations, Medi-Cal Network Provider and Subcontractor Terminations Frequently Asked Questions (FAQs))*

Plan policy, *PRV-005 Provider Terminations* (approved 9/19/2023), stated providers and delegates are required to notify the Plan at least 60-days prior to the effective date of the termination as outlined in the provider's contract. The Plan's Provider Services Department works collaboratively with various Plan departments to send member notices. For PCPs, all assigned members will be notified of the termination; for specialists who do not have assigned members, the Plan will work with the terminating provider to identify members who have upcoming scheduled appointments for notification. The Provider Services Department reports the information to the Compliance Department for notification to the DHCS. The Plan will follow all protocols for notification to the DHCS when a termination is determined to be significant. The Plan will notify the DHCS at least 60-days prior to the effective date of the contract termination, or immediately upon learning and obtaining details of the termination. The Plan will report all contract terminations to the DHCS in the Quarterly Provider Network Report as set forth in the Plan's Contract with the DHCS.

Finding: The Plan did not meet the DHCS reporting and member notification requirements for provider terminations.

During the interview, the Plan stated there was one provider termination and the DHCS was notified. Subsequently, the Plan submitted additional documentation. Based on the Plan's responses in written statements and additional documentation provided, there were a total of 38 provider terminations involving two credentialing delegates. The Plan did not determine the impact to members who received services from these providers and did not send members notification. The Plan also did not report the terminations to the DHCS as required by APL 21-003.

- 29 Children's First Medical Group terminations: After the interview, in a written statement, the Plan stated no members were impacted and the DHCS was not

notified because the resignations were not terminations for QOC.

- Nine Teladoc terminations: After the interview, the Plan confirmed the Teladoc terminations and stated that Teladoc does not share specific termination information due to peer review protection. In a written statement, the Plan stated it did not believe the Teladoc terminations would be reportable as the Plan is not directly contracted with the providers and has no way of determining if they are treating the Plan's members.

If the Plan does not notify members and report provider terminations to the DHCS, then members may not be able to schedule needed appointments for services and the DHCS may not be aware of network capacity changes.

Recommendation: Revise and implement policies and procedures to ensure the Plan notifies members of provider terminations and reports provider terminations to the DHCS.

DHCS AUDITS AND INVESTIGATIONS

CONTRACT AND ENROLLMENT REVIEW DIVISION

REPORT ON THE MEDICAL AUDIT OF ALAMEDA ALLIANCE FOR HEALTH FISCAL YEAR 2024-2025

Contract Numbers: 03-75793 and 23-30244

Contract Type: State Supported Services

Audit Period: June 1, 2023 — May 31, 2024

Dates of Audit: June 17, 2024 — June 28, 2024

Report Issued: November 18, 2024

DHCS

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I. INTRODUCTION

This report presents the results of the audit of Alameda Alliance for Health's (Plan) compliance and implementation of the State Supported Services contract numbers 03-75793 and 23-30244 with the California Department of Health Care Services. The State Supported Services Contracts cover abortion services with the Plan.

The audit covered the period of June 1, 2023, through May 31, 2024. The audit was conducted from June 17, 2024, through June 28, 2024, which consisted of a document review and verification study with the Plan administration and staff.

An Exit Conference with the Plan was held on October 16, 2024. No deficiencies were noted during the review of the State Supported Services Contracts.

COMPLIANCE AUDIT FINDINGS

State Supported Services

The Contract requires the Plan to provide eligible members the following State Supported Services: Current Procedural Terminology (CPT) codes 59840 through 59857 and the Centers for Medicare and Medicaid Services Common Procedure Coding System Codes X1516, X1518, X7724, X7726, and Z0336. These codes are subject to change upon the Department of Health Care Services implementation of Health Insurance Portability and Accountability Act of 1996 electronic transaction and code set provisions. *(2023 State Supported Services Contract, Exhibit A (1))*

The Contract requires the Plan to provide, or arrange to provide, to eligible members enrolled under either the Hyde Contract or the Primary Contract to provide the following private services: Current Procedural Terminology codes 59840 through 59857 and the Centers for Medicare and Medicaid Services Common Procedure Coding System Codes X1516, X1518, X7724, X7726, and Z0336. These codes are subject to change upon the Department of Health Care Services implementation of Health Insurance Portability and Accountability Act of 1996 electronic transaction and code sets provisions. *(2024 State Supported Services Contract A01, Exhibit A (1.2.1))*

The Plan is required to cover abortion services, as well as the medical services and supplies incidental or preliminary to an abortion consistent with the requirements in the Medi-Cal Provider Manual. The Plan, network providers, and subcontractors are prohibited from requiring medical justification, or imposing any utilization management or utilization review requirements, including prior authorization and on the coverage of outpatient abortion services. *(All Plan Letter 24-003, Abortion Services)*

Finding: No deficiencies were identified in this audit.

Recommendation: None.