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

REPORT ON THE MEDICAL AUDIT OF

ALAMEDA ALLIANCE FOR HEALTH

2022

Contract Number:	04-35399
Audit Period:	April 1, 2021 Through March 31, 2022
Dates of Audit:	April 4, 2022 Through April 13, 2022
Report Issued:	September 9, 2022

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I. INTRODUCTION

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

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

As of March 31, 2022, the Plan had 306,787 members. There were 300,937 (98.1 percent) Medi-Cal members of which 24,737 were Seniors and Persons with Disabilities (SPD) members, and 5,850 (1.9 percent) were commercial members under the In-Home Supportive Services Program.

II. EXECUTIVE SUMMARY

This report presents the audit findings of the DHCS medical audit for the audit period of April 1, 2021 through March 31, 2022. The audit was conducted from April 4, 2022 through April 13 2022. The audit consisted of document review, verification studies, and interviews with Plan representatives.

An Exit Conference with the Plan was held on August 11, 2022. The Plan was allowed 15 calendar days from the date of the Exit Conference to provide supplemental information addressing the draft audit report findings. The Plan submitted a response after the Exit Conference. The results of DHCS' evaluation of the Plan's response are reflected in this report.

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

The prior DHCS medical audit (for the period of June 1, 2019 through March 31, 2021) was issued on August 17, 2021. This audit examined documentation for Contract compliance and assessed implementation of the Plan's 2021 Corrective Action Plan (CAP).

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

The summary of findings by category follows:

Category 1 – Utilization Management

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

The Plan is required to provide the member with written acknowledgment of a standard appeal within five calendar days of receipt of the appeal. The Plan did not send acknowledgement letters for standard appeals within the required timeframe of five calendar days.

The Plan is required to notify members receiving a Notice of Appeal Resolution (NAR) that they have an additional 120 days over and above the initial 120 days allowed to request a State Fair Hearing (SFH) during the COVID-19 Public Health Emergency (PHE). The Plan did not comply with existing All Plan Letters (APL) to notify members receiving a NAR that they have an additional 120 days allowed to request a SFH.

Subcontractors are required to provide written disclosure of information on subcontractors' ownership and control. The Plan is required to collect and review this information. The Plan did not ensure that its subcontractors submitted complete ownership and control disclosure information.

Category 2 – Case Management and Coordination of Care

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

The Plan is required to ensure that new members receive an IHA and make reasonable attempts to contact members and schedule the IHA. The Plan did not make reasonable attempts to contact members and schedule the IHA.

The Plan is required to execute a Memorandum of Understanding (MOU) with the county Mental Health Plan (MHP). The Plan is responsible for updating, amending, or replacing existing MOUs with MHPs to delineate Plan and MHPs responsibilities when covering mental health services. The Plan's MOU with the county MHP did not include the responsibilities for the review of disputes between the Plan and the MHP.

Category 3 – Access and Availability of Care

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

The Plan is required to communicate, enforce, and monitor providers' compliance with accessibility and availability standards. The Plan is required to ensure that when timeframes for appointments are extended, a qualified health care professional determines and documents that it is clinically appropriate. The Plan did not monitor providers' compliance with requirements for when appointments were extended.

The Plan is required to pay for emergency services received by members from non-contracting providers. The Plan improperly denied emergency services claims from non-contracting providers.

The Plan and its transportation brokers are required to use a DHCS approved Physician Certification Statement (PCS) form to determine the appropriate level of service for members needing NEMT services. The Plan did not use PCS forms for NEMT services.

Category 4 – Member's Rights

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

The Plan is required to have a grievance and appeals system in place that provides written acknowledgement to members within five calendar days of receipt of a grievance, grievance resolution within 30 calendar days, and fully translated grievance and appeals acknowledgement and resolution letters to members that speak threshold languages. In addition, the Plan is required to resolve the grievance by reaching a final conclusion and notify members in writing of the grievance status and the estimated date of resolution should the resolution not be reached within 30 calendar days.

The Plan did not send acknowledgement and resolution letters within the required timeframes or in members' threshold languages. In addition, the Plan did not send extension letters for grievances that were not resolved within 30 calendar days and did not resolve grievances by the estimated completion date specified in the extension letter. Lastly, the Plan did not thoroughly investigate and resolve grievances prior to sending resolution letters.

The Plan is required to notify the DHCS Program Contract Manager, the DHCS Privacy Officer and the DHCS Information Security Officer (ISO) within 24 hours of the discovery of any suspected security incident, send an updated Privacy Incident Report (PIR) within 72 hours of discovery, and send a complete report of the investigation within ten working days of discovery. The Plan did not report suspected security incidents or unauthorized disclosures of PHI to DHCS within the required timeframes and did not notify the DHCS Program Contract Manager and DHCS ISO of suspected security incidents or unauthorized disclosures of PHI or Personal Information (PI).

Category 5 – Quality Management

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

There were no deficiencies identified in this category.

Category 6 – Administrative and Organizational Capacity

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

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

III. SCOPE/AUDIT PROCEDURES

SCOPE

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

PROCEDURE

The audit was conducted from April 4, 2022 through April 13, 2022. The audit included a review of the Plan's policies for providing services, the procedures used to implement the policies, and verification studies of the implementation and effectiveness of the policies. Documents were reviewed and interviews were conducted with Plan administrators and staff.

The following verification studies were conducted:

Category 1 – Utilization Management

Prior authorization requests: 20 medical prior authorization requests (six approvals and 14 denials) including seven SPD cases, were reviewed for timeliness, consistent application of criteria, and appropriate review.

Appeal procedures: 15 prior authorization appeals (four pharmacy appeals and 11 medical appeals) including five SPD cases were reviewed for appropriate and timely adjudication.

Category 2 – Case Management and Coordination of Care

HRA: Ten files were reviewed to confirm coordination of care and fulfillment of HRA requirements.

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

IHA: 20 Plan members were reviewed to confirm the performance of the assessment.

Category 3 – Access and Availability of Care

Claims: 19 emergency services and 20 family planning claims were reviewed for appropriate and timely adjudication.

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

NEMT: 42 claims were reviewed for timeliness and appropriate adjudication. Nine contracted NEMT providers were reviewed for Medi-Cal enrollment.

Category 4 – Member's Rights

Grievance Procedures: 76 grievances, including 47 standard quality of service, 16 quality of care, ten exempt, and three expedited were reviewed for timely resolution, response to complainant, and submission to the appropriate level for review. 22 grievances were for SPD members.

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

Category 5 – Quality Management

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

Category 6 – Administrative and Organizational Capacity

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

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

CATEGORY 1 - UTILIZATION MANAGEMENT

1.3	PRIOR AUTHORIZATION APPEAL PROCESS

1.3.1 Acknowledgement Letters for Appeals

The Plan must ensure timely acknowledgement of a member's request for an appeal in a written format. *(Contract, Exhibit A, Attachment 14(1)(B))*

The Plan must provide the member with written acknowledgment of a standard appeal within five calendar days of receipt of the appeal. (*APL 21-011, Grievance and Appeal Requirements, dated 8/31/21*)

Plan Policy *G&A-008 Adverse Benefit Determination Appeals Process* (revised 11/18/21) stated, "Acknowledgement letters will be dated and postmarked within five calendar days of receipt for standard review. The written appeal acknowledgement will advise the member that the appeal has been received, the date of receipt, and provide the name, telephone number, and address of the representative who may be contacted about the appeal."

Finding: The Plan did not send acknowledgement letters for standard appeals within the required timeframe of five calendar days.

A verification study showed that in four of 15 cases it took the Plan more than five calendar days to send acknowledgement letters to members. The number of days ranged from six to 30.

During the interview, the Plan stated that due to a high case load and being understaffed, they had a difficult time sending timely acknowledgement letters during the audit period. During the audit period, the Plan's Compliance Department performed an internal audit of their grievance and appeals unit. The audit showed that in 17 of 60 cases reviewed, acknowledgement letters were sent beyond the required five calendar days. The number of days ranged from six to 140.

The Plan's delayed acknowledgement of a member's request for an appeal may lead to delays in decision making and appropriate medical care for members.

Recommendation: Implement policies and procedures to ensure that acknowledgement letters for standard appeals are sent within the required timeframe of five calendar days.

1.3.2 State Fair Hearing Request

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

Supplement to APL 17-006: Emergency State Fair Hearing Timeframe Changes (from 03/20), stated that during the COVID-19 PHE period, the Plan is required to notify members receiving a NAR that upholds an adverse benefit determination that they have an additional 120 days over and above the initial 120 days allowed to request a SFH (i.e. initial 120 day timeframe plus an additional 120 days, for a total of 240 days). If the Plan is unable to include this temporary SFH rights information with the NAR at the time of the mailing, it must call the member at the time the NAR is being mailed to notify the member of the right to request a SFH within 240 days from the date of the NAR. As the PHE was extended, the timeframe to file a SFH continued to be 240 days according to APL 20-004 *Emergency Guidance for Medi-Cal Managed Care Health Plan in Response to COVID-19* dated 9/9/21.

Finding: The Plan did not comply with existing APLs to notify members receiving a NAR that upholds an adverse benefit determination that they have an additional 120 days in addition to the initial 120 days allowed to request a SFH.

A verification study showed that in eight of eight cases that were upheld by the Plan, the NARs stated that the member had 120 days to request an SFH. There was no mention of the additional 120 days that the member was allowed during the PHE. Additionally, there was no evidence that the Plan notified members via other methods such as a call.

In a written response, the Plan acknowledged that it had not notified its members of the extended timeframe to file a SFH.

The Plan’s failure to notify members of the extended timeframe information could negatively impact the appropriate care, service, and rights of members.

Recommendation: Develop and implement policy and procedures to ensure members receive timely and accurate information about their rights.

1.5 DELEGATION OF UTILIZATION MANAGEMENT

1.5.1 Ownership and Control Disclosure Review for Utilization Management (UM) Subcontractors

The Plan is required to comply with *Code of Federal Regulations (CFR), Title 42, section 455.104* by requiring each disclosing entity to disclose certain information, including the name, address, date of birth, and social security number of each person or other tax identification number of each corporation with an ownership or control interest in the disclosing entity. The disclosing entity must also include the name, address, date of birth, and Social Security Number of any managing employee. *(Contract, Exhibit A, Attachment 1(2)(B), 42 C.F.R., § 455.104)*

Subcontractors are required to provide written disclosure of information on subcontractors' ownership and control. The review of ownership and control disclosures applies to subcontractors contracting with a Plan. The Plan shall collect and review their subcontractors' ownership and control disclosure information as set forth in *42 CFR § 455.104*. The Plan must make the subcontractors' ownership and control disclosure information available, and upon request, this information is subject to audit by DHCS. *(APL 17-004, Subcontractual Relationships and Delegation, dated 4/18/17)*

Finding: The Plan did not ensure that its subcontractors submitted complete ownership and control disclosure information.

Review of four subcontractors' disclosure forms revealed the following deficiencies:

- One disclosure form did not contain the social security numbers and date of birth of all individuals with leadership positions.

- One disclosure form did not contain the name of individuals with controlling interest such as directors and managing employees

In the CAP for the 2021 audit finding, 1.5.3 Ownership and Control Disclosure Reviews, the Plan updated its Provider Services Standard Operating Procedure (SOP) to include collecting required disclosures from the managing employees, board of directors, and senior management team in cases where the entity is a non-profit with no majority ownership and/or owned by physician shareholders. The SOP update also included two levels of review. The Provider Services Department provides the first level review and submits to the Compliance Department for a second level review; however, in practice, the second level of review differed from the SOP. Review of the Ownership Disclosure

Form Tracking Log revealed that the second level review is conducted by Provider Services and not by Compliance Department as described in the SOP. Although the Plan has addressed prior findings in their CAP by modifying its procedures, it has not resolved the deficiency.

This is a Repeat Finding from prior years 2019 1.1.3 Ownership and Control Disclosures and 2021 1.5.3 Ownership and Control Disclosure Reviews. Although the Plan has made improvements in collecting ownership and control disclosures forms from its subcontractors, it is still not fully compliant with all the required elements for individual disclosures.

Subsequent to the Exit Conference, the Plan stated that one of its subcontractors is not owned by individuals so therefore only the name, address, and tax ID number of the entity were included in the ownership and disclosure form. Although the delegated entity does not have individuals with ownership in the entity, it has individuals with controlling interest and hold leadership positions such as on the board of directors and executives whose name, address, DOB, and SSN are required to be disclosed in accordance to *CFR, Title 42, section 455.104*. In addition, the Plan stated its other subcontractor sent the ownership and disclosure documents directly to the department. The documents sent were submitted by the subcontractor as a directly contracted Medi-Cal health plan and not as the Plan's delegated entity.

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

Recommendation: Revise and implement policies and procedures to ensure completion of all subcontractor's ownership and control disclosure information.

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CATEGORY 2 – CASE MANAGEMENT AND COORDINATION OF CARE

2.1	INITIAL HEALTH ASSESSMENT

2.1.1 Initial Health Assessment (IHA)

The Plan is required to ensure that each new member receives an IHA, including a complete history and physical examination, as required by *California Code of Regulations (CCR), Title 22, section 53851(b)(1)* within 120 days of enrollment. *(Contract, Amendment 26, Exhibit A, Attachment 10, 3A)*

The Plan is required to make reasonable attempts to contact a member and schedule an IHA. All attempts are required to be documented. Documented attempts that demonstrate the Plan's unsuccessful efforts to contact a member and schedule an IHA will be considered evidence in meeting this requirement. *(Contract, Amendment 26, Exhibit A, Attachment 10, 3D)*

Due to the COVID-19 PHE, DHCS temporarily suspended requirements for Plans to complete the IHA within the required timeframes outlined in the Contract (120 days for most members) and allowed Plans to defer completion of these IHAs until further notice. Starting October 1, 2021, Plans must begin resumption of IHA activities that they temporarily suspended during the period of December 1, 2019 through September 30, 2021. Plans should utilize available data sources to identify all members who were: newly enrolled since December 1, 2019; have not received an IHA and do not meet exclusion criteria as detailed in Contract and Policy Letter 08-003; have not engaged in primary care or perinatal services since enrollment; and, for whom an IHA or portions of an IHA are currently appropriate. Plans should outreach to members identified and coordinate access to providers as needed to facilitate primary care or perinatal care engagement. For all members who are newly enrolled as of October 1, 2021, Plans are required to complete this process and coordinate care engagement within the required contractual timeframes. *(APL 20-004)*

Plan policy *QI-124 IHA* (revised 11/18/21) stated the Plan informs members about the IHA through member handbook; welcome letters and videos on the website. This policy stated providers are trained for the documentation of the IHA.

Finding: The Plan did not document attempts to contact members and schedule the IHA.

In a verification study of 20 sampled newly enrolled members, 17 samples did not have records of the Plan's attempt to contact members and schedule the IHA.

The Plan tracked new members and noted their IHA completion status, however, the Plan did not provide evidence that it conducted outreach efforts to contact members and schedule for an IHA.

In a written statement, the Plan acknowledged that there was no initial outreach to the members in the verification study due to a lack of coordinated oversight. The Plan did not have staff who was responsible for IHA coordination and oversight during the audit period.

A review of Plan policy *QI-124* found it included information about how the Plan informs members about the IHA but did not have information on how the Plan is to conduct and document member outreach attempts to schedule the IHA and who is responsible for coordination and oversight of the IHA.

Subsequent to the Exit Conference, the Plan explained they have multiple programs and educational materials that demonstrate their effort in contacting members to schedule an IHA. Programs and educational material include the member handbook, member orientation, member incentive program, and videos on the Plan website. The programs and educational materials are sent to all members and do not demonstrate the Plan's efforts in contacting specific members to schedule an IHA.

If the Plan does not make reasonable attempts to contact members and schedule an IHA then members may experience inadequate preventative health care services.

Recommendation: Revise and implement policies to include procedures for conducting and documenting reasonable attempts to schedule an IHA.

2.5 MENTAL HEALTH AND SUBSTANCE ABUSE

2.5.1 Memorandum of Understanding (MOU) with the County Mental Health Plan (MHP)

The Plan is required to execute a MOU with the county MHP as stipulated in the Contract. The MOU must specify the respective responsibilities of the Plan and the MHP in delivering medically necessary covered services and specialty mental health services to members. *(Contract, Attachment 12,(3)(A))*

The Plan is responsible for updating, amending, or replacing existing MOUs with MHPs to delineate Plan and MHPs responsibilities when covering mental health services. *(APL 18-015 Memorandum of Understanding Requirements for Med-Cal Managed Care Plans (dated 9/19/18)*

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

Section 1850.515, Departments' Responsibility for Review of Disputes: The Plan and the county MHP process for dispute resolution while maintaining member coverage of services

(a) The two departments shall each designate at least one and no more than two individuals to review the dispute and make a joint recommendation to directors of the departments or their designees.

(b) The recommendation shall be based on a review of the submitted documentation in relation to the statutory, regulatory and contractual obligations of the MHP and the Plan.

(c) The individuals reviewing the dispute may, at their discretion, allow representatives of both the MHP and the Plan an opportunity to present oral argument.

Finding: The Plan's MOU with the county MHP did not include the responsibility for the review of disputes between the Plan and the MHP.

In an interview, the Plan explained that the MOU with the County MHP was updated to include elements required in *APL 18-015* in regards to the responsibility for review of disputes.

The Plan did not complete the corrective action of updating its MOU with the county MHP in response to the 2021 audit finding. The updated MOU remained in draft form and was not signed nor did it take effect during the audit period.

This is a Repeat Finding from 2020 and 2021 audit finding 2.5.1 Memorandum of Understanding with the county MHP.

If the Plan does not include all required information in the MOU with the county MHP, both parties may not be aware of their roles and responsibilities during a dispute with each other.

Recommendation: Revise and implement the MOU to ensure compliance with all applicable requirements and responsibilities.

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CATEGORY 3 – ACCESS AND AVAILABILITY OF CARE

3.1	APPOINTMENT PROCEDURES AND MONITORING WAITING TIMES

3.1.1 Extending Timeframes for Obtaining Appointments

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

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

Plan policy *QI-107 Appointment Access and Availability Standards (revised 11/18/21)* stated the applicable waiting time to obtain a particular appointment may be extended if the referring or treating licensed health care practitioner, or the health professional providing triage or screening services, as applicable, acting within the scope of his or her practice and consistent with professionally recognized standards of practice, has determined and noted in the member's medical record that a longer waiting time will not have a detrimental impact on the health of the member.

Finding: The Plan did not monitor the network providers' compliance with requirements for when appointments were extended.

As a corrective action to the 2021 audit finding, 3.1.1 Extending Timeframes for Obtaining Appointments, the Plan stated it will include shortening or extending appointment timeframes in policy *QI-107*, its provider manual for January 2022, and quarterly provider communication sheet. However, review of provider manual showed that it did not contain information about shortening or extending appointment timeframes information until April 2022. Furthermore, the 1st quarter of 2022 provider communication sheet did not have the information. A review of Plan policy *QI-107* showed that it did not address how the Plan will monitor providers' compliance.

This is a Repeat Finding from 2021 3.1.1 Extending Timeframes for Obtaining Appointments.

Subsequent to the Exit Conference, the Plan explained they monitor extended appointments through member grievances and PQI. According to the Plan, the grievances are reviewed by a nurse for clinical and access issues. If it is triaged that appointment extensions resulted in poor care/outcome, it is referred to the QI Department for clinical investigation and follow up actions. The Plan also stated it conducts Facility Site Reviews (FSR) to monitor provider offices to ensure compliance with handling missed appointments. Neither the Plan's grievance, PQI, nor FSR processes addressed monitoring of providers' compliance with documentation that extending appointments will not have a detrimental impact on the member's health.

If the Plan does not monitor providers' compliance for extending appointment timeframes, it may lead to a delay in care which may result in a detrimental impact on the member's health.

Recommendation: Revise and implement policy and procedures to ensure providers' compliance in extending timeframes for obtaining appointments.

3.6	EMERGENCY SERVICES AND FAMILY PLANNING CLAIMS

3.6.1 Denial of Emergency Services Claims

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

The Plan is required to provide an accurate and clear written explanation for each claim that is denied or contested. *(CCR, Title 28, section 1300.71 (d) (1) and (h))*

Finding: The Plan improperly denied emergency services claims.

A verification study found three of 20 Emergency Response (ER) claims were improperly denied as follows:

- Two ER claims were denied because the Plan's vendor for converting paper claims into electronic version processed the claim information incorrectly. This vendor processed about 13% of the Plan's claim volume. In a written response, the Plan stated that IT monitored the claims to ensure there is not formatting issues. The Plan acknowledged these two errors were discovered as part of the DHCS audit and only communicated with the vendor about these specific errors after this discovery

- One ER claim was denied in error because Plan staff thought an additional procedure code was required for procedure code 99285. The Plan confirmed this should not have been denied.

If the Plan does not properly process ER service claims, then providers may be discouraged from participating in the Medi-Cal program and members may suffer as a consequence.

Recommendation: Revise and implement policy and procedure to ensure emergency services claims are properly adjudicated.

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

3.8.1 Physician Certification Statement (PCS) Forms

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

The Plan and transportation brokers are required to use a DHCS approved PCS form to determine the appropriate level of service for members. Once the member's treating physician prescribes the form of transportation, the Plan cannot modify the authorization. NEMT PCS forms must include, at a minimum, the following: function limitations justification, dates of service needed, modes of transportation needed, and certification statement. The Plan must have a mechanism to capture and submit data from the PCS form to DHCS. *(APL 17-010 Non-Emergency Medical and Non-Medical Transportation Services, dated 7/17/17)*

Plan policy *UM-016: Transportation Guidelines* (revised 5/20/21) stated the Plan must use the DHCS approved PCS form with requests for transportation services. The PCS form collected data regarding the member's functional limitations, prescribed dates of service, and prescribed mode of transportation. The completed PCS form must be submitted to the Plan's transportation broker for coordination of services. The PCS form must be completed before NEMT services can be prescribed and provided to the member.

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

A verification study found that in 17 of 30 samples, there were no completed PCS forms at the time of the trip and on file with the transportation vendor. The following were found:

- 11 of 17 samples did not have a PCS form on file for the member and no attempts to obtain the PCS form were noted by the vendor

- Six of 17 samples did not have PCS form on file for the member but attempts to obtain were noted on the vendor's reservation documents

During the interview, the Plan stated a new process to monitor outstanding PCS forms was initiated in late December 2021 as a result of the prior year audit finding. The Plan's PCS Workflow stated that the transportation vendor will make three attempts to obtain the PCS form; the vendor will send a monthly report to the Plan's case management department for members that they were not able to obtain a PCS form; and the case management will conduct outreach to member's provider.

An additional 12 samples with dates of service after December 2021 were selected to review the implementation of the new process. The following were found:

- In ten of 12 samples, the vendor did not have PCS forms on file for members who received NEMT services and no attempts were made or noted by the transportation vendor.

As a corrective action to the 2021 audit finding, 3.8.2 – PCS Form the Plan proposed to implement the following actions:

1. Require transportation vendor to provide ongoing reports on rates of obtaining PCS forms from providers.

2. The Plan will analyze trends in provider practices on a quarterly basis.

3. The Plan will educate providers on PCS requirements and provide data on their performance via a newsletter and individual contacts.

4. The Plan will finalize process workflow to obtain missing PCS forms.

5. The Plan will conduct staff trainings on process workflow.

6. The Plan will provide a quarterly report to UM Committee.

During the audit period, the Plan continued to have outstanding PCS forms for members' NEMT services. The CAP stated the Plan will complete the actions by the end of the first quarter in 2022, however corrective actions two, three and six remain in progress during the audit period.

During the interview, the Plan confirmed they allowed their transportation vendor to provide NEMT services before PCS forms were collected which was not in compliance with their UM policy. The Plan stated that its transportation vendor arranged and provided NEMT services even though PCS forms were not available. The Plan initiated a monthly review of missing PCS forms but forms continued to remain outstanding.

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This is a Repeat Finding of 2021 finding 3.8.2 Physician Certification Statement Form Requirement.

Without the PCS forms, members may be subject to inappropriate modes of transportation that may result in unsafe transportation conditions.

Recommendation: Revise and implement policy and procedure to ensure that the members' treating physician prescribes the form of transportation on the PCS forms.

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CATEGORY 4 – MEMBER'S RIGHTS

4.1	GRIEVANCE SYSTEM

4.1.1 Grievance Acknowledgement and Resolution Letter Timeframes

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

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

Plan policy *G&A-003 Grievance and Appeals Receipts, Review, and Resolution* (revised 11/21/20) stated that the Plan will provide a written acknowledgement that is dated and postmarked within five calendar days of receipt. The Plan will provide a written resolution within 30 calendar days of receipt. The resolution will contain a clear and concise explanation of the Plan's decision.

Plan policy *G&A-005 Expedited Review of Urgent Grievances* (revised 3/18/21) stated that the Plan will ensure that grievance and appeals for cases involving an imminent and serious threat to the health of the patient, including, but not limited to, severe pain, potential loss of limb, or major bodily function are reviewed expeditiously and resolved within 72 hours or sooner if the medical condition requires.

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

A verification study of 63 standard grievances and three expedited grievances found the following deficiencies:

- Nine of 63 standard grievances did not have acknowledgement letters sent within five calendar days
- 43 of 63 standard grievances did not have resolution letters sent within 30 calendar days

- Two of three expedited grievances did not have resolution letters sent within 72 hours

In an interview and written statement, the Plan stated there was high inventory of grievances due to membership increases, staffing shortages, and changes in management which caused the resolution letters to be sent late. The Plan did not address the acknowledgement letter delay. The high inventory started in August 2020 and lasted until January 2022. Additionally, the Plan staff did not log grievances received via mail in a timely manner. The Plan also discussed in their committee meeting minutes that changes in handling coverage disputes as exempt resulted in an increase in grievances.

As a corrective action to the 2021 audit finding, 4.1.3 Grievance Notification and Letter Timelines, the Plan provided training to the grievance and appeals staff to review policies *G&A-003 Grievance and Appeals Receipt, Review and Resolution* and *G&A-005 Expedited Review of Urgent Grievances*. The staff attested that they understood the requirements and would send acknowledgement and resolution letters are sent within the required timeframes, however the Plan remained noncompliant during the audit period.

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

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

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

4.1.2 Grievance Letters in Threshold Languages

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

Plan policy *G&A-001 Grievance and Appeals Receipt, Review, and Resolution* (revised 1/21/21) stated that the Plan addresses the linguistic and cultural needs of its members as well as the needs of members with disabilities.

Plan policy *CLS-003 Language Assistance Services* (revised 3/22/22) stated that the Plan provides members written informing materials in the Plan's threshold languages based on the member's language of preference. Informing materials include grievance acknowledgement and resolution letters. The Plan has a grievance process in place with the capacity to capture grievances in the language spoken by the member. Additionally, the Plan ensures all members can participate in its grievance system by providing assistance to members with limited English proficiency.

The Plan's *Grievance and Appeal Intake Guide (*revised 4/9/19) for Plan staff stated that standard grievance acknowledgement letters and resolution letters are to be sent in threshold languages. Expedited grievance resolution letters are to be translated into threshold languages.

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

A verification study identified 11 of 63 standard grievances were from members who required translation into a threshold language.

- Three standard grievances did not have the acknowledgement letter sent in the member's threshold language

- Eight standard grievances did not have the resolution letter sent in the member's threshold language

In an interview, the Plan acknowledged that the translated letters were not sent as the documented process indicated. The Plan stated that the written process was not being followed and retraining for coordinators has occurred on an as needed basis.

As a CAP to the 2021 audit finding, 4.1.4 Grievance Letters in Threshold Languages, the Plan provided training to the grievance and appeals staff to review policies *G&A-001 Grievance and Appeals System Description* and *CLS-003 Language Assistance Services*. The staff attested that they understood the requirements and will ensure that acknowledgement and resolution letters are sent to members in their threshold languages, however, the Plan remained noncompliant during the audit period.

This is a Repeat Finding of 2021 audit finding 4.1.4 Grievance Letters in Threshold Languages.

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

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

4.1.3 Grievance Extension Letter Timeframes

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

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

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

Plan policy *G&A-003 Grievance and Appeals Receipt, Review, and Resolution* (revised 11/18/21) stated that in the event a resolution is not reached within 30-calendar days, the Plan will notify the complainant in writing that the complaint was received, investigated, and of the status of the grievance and provide an estimated completion date of resolution.

Finding: The Plan was not compliant with grievance extension letter timeframes; in some cases, it did not send extension letters for grievances that were not resolved within 30 calendar days and in other cases it did not resolve grievances by the estimated completion date specified in the extension letter.

A verification study of 20 standard grievances that required extension showed the following:

- In five cases that were not resolved within 30 calendar days, an extension letter was not sent to the member

- In 15 cases an extension letter was sent but the Plan failed to resolve the case by the estimated date of resolution in the extension letter

Plan policy *G&A-003* indicated that it did not address tracking or monitoring of extended grievances.

In an interview, the Plan stated that the documented processes for sending resolution letters by the date stated in the extension letter was not followed. The reason for this was a high inventory of grievances in 2021 due to large caseloads for coordinators.

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

Recommendation: Revise and implement policies and procedures to ensure the Plan sends extension letters for grievances not resolved within 30 calendar days and resolves extended grievances by the date stated in the extension letter.

4.1.4 Grievance Investigation and Resolution

The Plan is required to have a system in place in accordance with *CCR, Title 28 sections 1300.68 and 1300.68.01, and CCR, Title 22, section 53858. (Contract, Exhibit A, Attachment 14(1))*

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

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

Plan policy *G&A-001 Grievance and Appeals System Description* (revised 1/21/21) stated the Plan ensures that each issue is addressed and resolved when a complainant presents with multiple issues. Resolved means that the grievance has reached a final conclusion with respect to the enrollee's submitted grievance.

Finding: The Plan did not thoroughly investigate and resolve grievances prior to sending resolution letters.

A verification study identified 19 of 63 standard grievances with the following deficiencies:

- In seven transportation related grievances, the only supporting documentation was the vendor's complaint investigation summary. There were no additional supporting documentation indicating that the Plan reviewed other information such as transportation logs or trip reports

- In two durable medical equipment related grievances, the resolution letters did not contain information on whether or not the wheelchair was approved and scheduled for delivery

- In two standard quality of service grievances, the Plan did not obtain and review provider responses

- In seven quality of care grievances, the Plan did not obtain and review provider responses and medical records

- In one standard grievance, the resolution letter stated the member spoke with the clinic manager and the grievance was forwarded to the clinic compliance department; however, the Plan did not verify if the clinic was able to resolve the issue

In an interview, the Plan acknowledged the deficiencies identified above. The Plan stated that it relied on the information compiled in the transportation vendor's Complaint Report for the investigation, and does not review the actual transportation log. The Plan also stated resolution letters did not include information verifying whether the issues in the grievances were resolved. The Plan identified these as opportunities for improvement.

As a corrective action to the 2021 audit finding, 4.1.5 Grievance Resolution/Grievance Process, the Plan provided training to the grievance and appeals staff to review *G&A-001 Grievance and Appeals System Description*. The staff attested that they understood the requirements and would ensure that grievances were fully resolved prior to sending resolution letters, however the Plan remained noncompliant during the audit period.

This is a Repeat Finding of 2021 audit finding 4.1.5 Grievance Resolution / Grievance Process.

If the Plan does not thoroughly investigate and resolve grievances, members may receive poor health care services.

Recommendation: Develop and implement procedures to ensure all grievances are thoroughly investigated and appropriately resolved prior to sending a resolution letter to members.

4.3	CONFIDENTIALITY RIGHTS

4.3.1 Reporting of HIPAA Incidents and Disclosures

The Plan is required to notify DHCS within 24 hours by email or fax of the discovery of any suspected security incident, intrusion or unauthorized access, use or disclosure of PHI or PI in violation of this Agreement and this Addendum, or potential loss of confidential data affecting this Agreement. The Plan is required to submit a DHCS PIR within 72 hours of discovery. The Plan is required to provide a complete report of the investigation to the DHCS Program Contract Manager, the DHCS Privacy Officer, and the DHCS ISO within ten working days of the discovery of the breach or unauthorized use or disclosure. *(Contract, Exhibit G, Attachment 3 (J))*

Plan policy *CMP-013 HIPAA Privacy Reporting* (revised 11/23/21) stated that the Plan will investigate the incident and submit an initial PIR to DHCS within 24 hours of discovery of a breach, suspected breach or security incident. The Plan will submit a complete final PIR to DHCS within ten working days of discovery of a breach or security incident. All Plan employees, or persons or organizations that function as a business associate to the Plan that comes in contact with PHI in any form (written, electronic, oral) has the primary responsibility to report any unauthorized or impermissible disclosures of PHI to their manager, the Compliance Department, or the Chief Privacy Officer.

Plan policy *CMP-018 Employee Sanctions Policy* (revised 11/23/21) stated every employee who observes, becomes aware of, or suspects a wrongful use or disclosure of PHI or violations of the Plan's Code of Conduct is required to promptly (within no more than 24 hours) report the suspicion or breach to their manager or to the Compliance Department.

Finding: The Plan did not report suspected security incidents or unauthorized disclosures of PHI to DHCS within the required timeframes.

A verification study of ten HIPAA incidents found the following:

- Seven of ten cases were not reported within 24 hours of discovery
- One of ten cases did not have the final report sent within ten days of discovery

In an interview, the Plan stated that other internal departments failed to notify the Compliance Department within a timely manner of the discovery leading to a further delay in reporting to DHCS. The Plan conducted HIPAA training for all staff but did not include instructions to notify the Compliance Department of the incident within 24 hours. The Plan stated that the case that took more than ten days to send the final report was due to a delay in obtaining a provider response before the case could be closed.

As a corrective action to the 2021 audit finding, 4.3.1 Reporting of HIPAA Incidents and Disclosures, the Plan addressed staffing needs and streamlined its Compliance Department. The Plan had a dedicated staff member who focused on privacy. The Plan reviewed and updated *CMP-013 HIPAA Privacy and Reporting* to reflect the 24 hours, 72 hours, and 10 day reporting requirements, however the Plan remained noncompliant during the audit period.

This is a Repeat Finding of 2021 audit finding 4.3.1 Reporting of HIPAA Incidents and Disclosures.

Untimely reporting of HIPAA incidents may lead to patient harm from unauthorized disclosure of PHI.

Recommendation: Implement procedures to ensure that all suspected security incidents or unauthorized disclosures of PHI are reported within the required timeframes.

4.3.2 Notification of Privacy Incident Reports (PIR)

The Plan is required to notify the DHCS Program Contract Manager, the DHCS Privacy Officer and the DHCS ISO for the following: within 24 hours of the discovery of any suspected security incident, intrusion or unauthorized access, use or disclosure of PHI or PI, an updated PIR within 72 hours of discovery, and a complete report of the investigation within ten working days of discovery. *(Contract, Exhibit G, Attachment 3 (J))*

Plan policy *CMP-013 HIPAA Privacy Reporting* (revised 11/23/21) stated that the Plan will notify the following DHCS staff of HIPAA incidents: DHCS Program Contract Manager, DHCS Privacy Office, and DHCS ISO.

Finding: The Plan did not notify the DHCS Program Contract Manager and DHCS ISO of suspected security incidents or unauthorized disclosure of PHI or PI.

A verification study of 10 HIPAA incidents found the following:

- Two of ten cases did not include the ISO in the 72 hour updated PIR
- Three of ten did not include the ISO in the closing PIR
- Three of ten cases did not include the Contract Manager in the 24 hour initial PIR, 72 hour updated PIR, and closing PIR

In an interview, the Plan stated that emails for these cases were returned as undeliverable. The Plan only submitted documentation of undeliverable email to the Privacy Officer. The Plan did not submit documentation of undeliverable emails to the Contracting Manager or ISO when requested.

Failure to send PIRs to all required officers may result in delayed DHCS response to the HIPAA incidents.

Recommendation: Revise and implement procedures to ensure that PIRs are sent to the appropriate DHCS staff.

❖ COMPLIANCE AUDIT FINDINGS (CAF) ❖
PLAN: Alameda Alliance for Health
AUDIT PERIOD: April 1, 2021 through March 31, 2022 **DATES OF AUDIT: April 4, 2022 through April 13, 2022**

CATEGORY 6 – ADMINISTRATIVE AND ORGANIZATIONAL CAPACITY

6.2	FRAUD AND ABUSE

6.2.1 Fraud and Abuse Reporting

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

Plan policy *CMP-002 Fraud, Waste, and Abuse* (FWA) (revised 11/23/21) stated the Plan's Compliance Department will report all suspected FWA incidents to DHCS within ten working days of the date the Plan becomes first aware or notified of the suspected activity. This includes all incidents reported to the Compliance Department internally and externally through the various reporting methods. This includes all FWA incidents experienced by subcontractors, members, providers, or employees will be reported to DHCS.

Finding: The Plan did not report preliminary investigations of all suspected cases of fraud and abuse to DHCS within ten working days of the Plan receiving notification of the incident.

A verification study found four of ten fraud and abuse cases were not reported to DHCS within ten working days of the Plan receiving report of the incident.

In an interview, the Plan stated that the delay for the initial reporting within ten working days was due to other internal departments not forwarding the incident to the Compliance Department in a timely manner.

As a corrective action to the 2021 audit finding, 6.2.1 Fraud and Abuse Reporting, the Plan had a dedicated staff member in the Special Investigations Unit focused on FWA cases. The Plan updated policy *CMP-002 FWA* to reflect reporting requirements, however the Plan remained noncompliant during the audit period.

This is a Repeat Finding of the 2017 audit finding 6.3.1 Fraud and Abuse Case Reporting, the 2018 audit finding 6.3.1 Fraud and Abuse Reports, the 2019 audit finding 6.2.1 Fraud and Abuse Reporting, and the 2021 audit finding 6.2.1 Fraud and Abuse Reporting.

Failure to report preliminary investigations of all suspected incidents of fraud and abuse may result in delayed DHCS response to the fraud and abuse cases.

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

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

REPORT ON THE MEDICAL AUDIT OF

Alameda Alliance for Health

2022

Contract Number:	03-75793 State Supported Services
Audit Period:	April 1, 2021 Through March 31,2022
Dates of Audit:	April 4, 2022 Through April 13, 2022
Report Issued:	September 9, 2022

TABLE OF CONTENTS

I. INTRODUCTION

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

The audit was conducted from April 4, 2022 through April 13, 2021. The audit period is April 1, 2021 through March 31, 2022 and consisted of document review, verification study, and interviews with the Plan.

An Exit Conference with the Plan was held on August 11, 2022. The Plan was allowed 15 calendar days from the date of the Exit Conference to provide supplemental information addressing the draft audit report findings. The Plan submitted a response after the Exit Conference. The results of the Department of Health Care Services' evaluation of the Plan's response are reflected in this report.

20 State Supported Services claims were reviewed for appropriate and timely adjudication

❖ COMPLIANCE AUDIT FINDINGS (CAF) ❖

PLAN: Alameda Alliance for Health

AUDIT PERIOD: April 1, 2021 through March 31, 2022
DATES OF AUDIT: April 4, 2022 through April 13, 2022

STATE SUPPORTED SERVICES

SUMMARY OF FINDING(S):

No deficiencies were identified in this audit.

RECOMMENDATION(S):

N/A