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

REPORT ON THE MEDICAL AUDIT OF

Alameda Alliance for Health

Contract Number: 04-35399

Audit Period: June 1, 2017
Through
May 31, 2018

Report Issued: December 21, 2018

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I. INTRODUCTION

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

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

As of April 5, 2018, the Plan had 264,637 members of which 258,833 (97.81%) were Medi-Cal members and 5,804 (2.19%) were commercial members (IHSS).

II. EXECUTIVE SUMMARY

This report presents the audit findings of the DHCS medical audit for the audit period of June 1, 2017 through May 31, 2018. The onsite review was conducted from June 11, 2018 through June 22, 2018. The audit consisted of document review, verification studies, and interviews with Plan representatives.

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, 2015 through May 31, 2017) was issued on January 23, 2018. The corrective action plan (CAP) closeout letter was sent to the Plan on May 22, 2018. This audit examined documentation for compliance and to determine to what extent the Plan has operationalized their CAP.

An Exit Conference was held on November 28, 2018 with the Plan. The Plan was allowed 15 calendar days from the date of the Exit Conference to provide supplemental information addressing the draft audit report findings. The Plan did not provide additional information to address the draft after the exit conference.

The summary of the findings by category follows:

Category 1 – Utilization Management

The audit revealed deficiencies in the Plan's Utilization Management (UM) program. The Plan is required to develop, implement and continuously update the UM program for covered services. The Plan did not continuously update and improve its UM program.

The Plan is required to have procedures for pre-authorization, concurrent review, and retrospective review; the Plan's processes did not meet utilization review requirements. The Plan did not ensure consistent application of UM criteria, used incorrect criteria to determine medical necessity and did not document consultation with medical director or requesting providers. In addition, the Plan did not communicate clear and concise reasons for denials, and reviewed retrospective service requests without documentation of a qualified health care professional's review for medical necessity.

The contract requires the Plan to have a referral tracking process as a part of monitoring for under- and over-utilization. The Plan did not have a policy or process for tracking open prior authorizations to completion.

The Plan did not ensure health care professionals with appropriate clinical expertise in treating member's conditions resolved pharmacy appeals. The Plan process allowed pharmacists to resolve appeals for medication requests instead of requiring a clinical professional with expertise in treating the member's condition.

The Plan is required to maintain a system to ensure accountability for delegated UM activities. The Plan did not review ownership and disclosure information, did not require corrective actions for deficiencies identified, and did not continuously monitor and evaluate the functions of its UM delegates.

Category 2 – Case Management and Coordination of Care

The Plan is required to cover and ensure the provision of an Initial Health Assessment (IHA) to each new member. The Plan did not ensure that new members receive an IHA within 120 days of enrollment.

The Plan is required to maintain procedures for monitoring coordination of members' care, including complex case management (CCM) activities. The review of the Plan's processes identified deficiencies in its provision of complex case management services; the Plan did not implement its monitoring of the CCM program to address member needs and did not ensure primary care provider participation in the provision of CCM.

Category 3 – Access and Availability of Care

Category 3 covers the adjudication of claims for emergency room services (ER) and family planning (FP) services. It also covers the Plan's process for ensuring members' access to providers and prescription drugs.

The Plan is required to ensure prior authorization requirements are not applied to ER and FP services. Members may access ER and FP services through any provider. The Plan improperly denied emergency room service and family planning claims containing procedures that require prior authorization outside of ER and FP settings. The Plan also improperly denied family planning claims from out-of-network, non-contracted providers. The Plan did not disclose the specific rationale used in determining why claims are rejected.

The Plan is required to monitor wait times for providers to answer and return telephone calls. The Plan did not initiate and implement steps to monitor wait times for providers to answer members' telephone calls.

The Plan did not ensure the provision of sufficient amounts of drugs prescribed in emergency situations.

Category 4 – Member's Rights

Category 4 covers the appropriate handling of grievances and protected health information (PHI).

The Plan did not document that a medical director reviewed quality of care grievances prior to sending resolution letters. The Plan's grievance system did not capture and process all complaints and expressions of dissatisfaction, and sent resolution letters without completely resolving all complaints.

The Plan is required to immediately notify DHCS Contracting Officer, Privacy Officer, and Information Security Officer upon discovery of any suspected security incident or unauthorized disclosure of PHI. The Plan did not report all suspected security incidents or unauthorized disclosures of PHI to the DHCS Information Security Officer.

Category 5 – Quality Management

The Plan is required to ensure all providers receive training regarding the Medi-Cal Managed Care program and operate in full compliance with the contract. The Plan did not ensure all newly contracted providers received provider training; did not delegate, in writing, its provider training responsibilities; and did not ensure its provider training materials included information on Plan policies, procedures, services, and member rights and responsibilities.

Category 6 – Administrative and Organizational Capacity

The Plan is required to establish administrative and management arrangements and procedures designed to guard against fraud and abuse. The contract requires the Plan to identify, investigate, and provide a prompt response against fraud and abuse; the results of any preliminary investigation shall be reported to DHCS within 10-working days. The Plan did not conduct and report preliminary investigations of suspected cases of fraud and abuse to DHCS within 10-working days, and did not consistently conduct prompt and complete investigations of suspected fraud and abuse incidents.

III. SCOPE/AUDIT PROCEDURES

SCOPE

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

PROCEDURE

The onsite review was conducted from June 11, 2018 through June 22, 2018. 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: 31 medical and 31 pharmacy prior authorization requests were reviewed for timeliness, consistent application of criteria, and appropriate review.

Appeal procedures: 29 prior authorization appeals were reviewed for appropriate and timely adjudication.

Category 2 – Case Management and Coordination of Care

Coordination of Care and Initial Health Assessment (IHA) requirements: 15 medical records were reviewed to confirm coordination of care and fulfillment of IHA requirements.

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

Continuity of Care (COC): 10 Plan COC files were reviewed to confirm the performance of services.

Behavioral Health Treatment (BHT): 15 Plan BHT records were reviewed to confirm the coordination of care.

Non-Emergency Medical Transportation: 16 claims were reviewed to confirm compliance with the Non-Emergency Medical Transportation requirements.

Non-Medical Transportation: 15 claims were reviewed to confirm compliance with the Non-Medical Transportation requirements.

Category 3 – Access and Availability of Care

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

Claims: 30 emergency services and 24 family planning claims were reviewed for appropriate and timely adjudication.

Category 4 – Member's Rights

Grievance procedures: 80 grievances were reviewed for timely resolution, response to complainant, and submission to the appropriate level for review.

Health Insurance Portability and Accountability Act (HIPAA): 13 HIPAA cases were reviewed for appropriate reporting and processing.

Category 5 – Quality Management

New provider training: 35 new provider training records were reviewed for timely Medi-Cal managed care program training.

Potential quality of care issues: Seven samples were reviewed for appropriate reporting and proper treatment.

Category 6 – Administrative and Organizational Capacity

Fraud and abuse: 16 fraud and abuse cases were reviewed for appropriate reporting and processing.

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

❖ COMPLIANCE AUDIT FINDINGS (CAF) ❖

PLAN: Alameda Alliance for Health

AUDIT PERIOD: June 1, 2017 through May 31, 2018
DATE OF AUDIT: June 11, 2018 through June 22, 2018

CATEGORY 1 - UTILIZATION MANAGEMENT

1.1	UTILIZATION MANAGEMENT PROGRAM

Utilization Management (UM) Program Requirements:
Contractor shall develop, implement, and continuously update and improve, a Utilization Management (UM) program that ensures appropriate processes are used to review and approve the provision of Medically Necessary Covered Services. …(as required by Contract)
2-Plan Contract A.5.1

There is a set of written criteria or guidelines for utilization review that is based on sound medical evidence, is consistently applied, regularly reviewed, and updated.
2-Plan Contract A.5.2.C

Review of Utilization Data:
Contractor shall include within the UM Program mechanisms to detect both under- and over-utilization of health care services. Contractor's internal reporting mechanisms used to detect Member Utilization Patterns shall be reported to DHCS upon request.
2-Plan Contract A.5.4

SUMMARY OF FINDING:

1.1.1 Utilization Management Program

The Plan shall develop, implement, and continuously update and improve, a Utilization Management (UM) program that ensures the Plan uses appropriate processes to review and approve the provision of medically necessary covered services. (*Contract, Amendment 11, Exhibit A, Attachment 5(1)*)

Plan policy *UM-001 Utilization Management* in effect as of October 2017 stated the Plan would review the UM Program at least annually. The Plan's chief medical officer (CMO) would develop and implement the UM Program Description (UMPD).

The Plan did not continuously update and improve its UM program during the audit period.

Prior to October 2017 Plan policy *UM-001* did not describe the development of a UMPD. Documentation showed the UM Committee (UMC) did not meet during the 2017 portion of the audit period. The Plan's 2017 UM Evaluation dated April 2018 cited the departure of key UM staff as the reason for limited UM activity during 2017, and stated the Health Care Quality Committee (HCQC) assumed UM oversight after the first quarter of 2017. An interim CMO presided over the HCQC during that time. The HCQC meeting minutes showed approval of the Plan's 2017 UMPD on January 4, 2018. The Utilization Management Committee (UMC) approved the Plan's 2018 UMPD on March 20, 2018. The Plan confirmed its 2017 UM leadership challenges and the above information in an interview.

Untimely rather than continuous and regular updating and improvement of the UM program could result in adverse member health outcomes.

RECOMMENDATION:

1.1.1 Develop and implement policy and processes to ensure the continuous updating and improvement, and timely approval of the UM Program.

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1.2	PRIOR AUTHORIZATION REVIEW REQUIREMENTS

Prior Authorization and Review Procedures:
Contractor shall ensure that its pre-authorization, concurrent review and retrospective review procedures meet the following minimum requirements…(as required by Contract)
2-Plan Contract A.5.2.A, B, D, F, H, and I.

Exceptions to Prior Authorization:
Prior Authorization requirements shall not be applied to emergency services, family planning services, preventive services, basic prenatal care, sexually transmitted disease services, and HIV testing.
2-Plan Contract A.5.2.G

Timeframes for Medical Authorization
Pharmaceuticals: 24 hours or one (1) business day on all drugs that require prior authorization in accordance with Welfare and Institutions Code, Section 14185 or any future amendments thereto.
2-Plan Contract A.5.3.F

Routine authorizations: Five (5) working days from receipt of the information reasonably necessary to render a decision (these are requests for specialty service, cost control purposes, out-of-network not otherwise exempt from prior authorization) in accordance with Health and Safety Code, Section 1367.01, or any future amendments thereto, but, no longer than 14 calendar days from the receipt of the request. The decision may be deferred and the time limit extended an additional 14 calendar days only where the Member or the Member's provider requests an extension, or the Contractor can provide justification upon request by the State for the need for additional information and how it is in the Member's interest. Any decision delayed beyond the time limits is considered a denial and must be immediately processed as such.
2-Plan Contract A.5.2.H

Denial, Deferral, or Modification of Prior Authorization Requests:
Contractor shall notify Members of a decision to deny, defer, or modify requests for prior authorization, in accordance with Title 22 CCR Sections 51014.1 and 53894 by providing written notification to Members and/or their authorized representative...This notification must be provided as specified in 22 CCR Sections 51014.1, 51014.2, and 53894, and Health and Safety Code Section 1367.01.
2-Plan Contract A.13.8.A

SUMMARY OF FINDINGS:

1.2.1 Consistent Application of UM Criteria

The Plan shall consistently apply, regularly review, and update its written criteria or guidelines for utilization review. (*Contract, Amendment 11, Exhibit A, Attachment 5(2)(C)*)

Plan policy *UM-006 Inter-rater Reliability (IRR) Testing for UM Decision Making* stated the Plan would conduct IRR testing with a standardized tool to monitor the consistency of clinical criteria application in UM decisions.

Pharmacy policy *RX-002 PA Review Process* stated the Plan would conduct IRR testing for health care professionals who applied medical necessity criteria.

The Plan did not conduct IRR testing to evaluate the consistency of UM criteria application during the audit period.

IRR testing is a standardized and objective method of assessing UM staff's consistency in deciding member service requests. The Plan's 2017 UM Program Evaluation described IRR testing as the process it used to evaluate this clinical decision-making process. However, the evaluation also stated that the Plan did not perform IRR testing for UM clinical or non-clinical staff in 2017.

In interviews, the Plan reported challenges in implementing UM processes during the audit period due to key staff vacancies. It stated it reviewed samples of both medical and pharmacy service requests for the appropriateness of UM determinations. However, it did not provide records of the testing or evaluate the consistency of case resolutions among decision makers with a standardized process.

IRR testing provides the Plan with a standardized and objective method of assessing whether UM staff apply medical necessity criteria consistently. Without this evaluation, the Plan will not have important information about the decision-making process, and inappropriate adverse benefit determinations may result.

1.2.2 Determining the Medical Necessity of PA Requests

The Plan shall provide or arrange for all medically necessary covered services for members. (*Contract, Amendment 11, Exhibit A, Attachment 10(1)(A)*)

The Plan shall ensure it uses appropriate processes and established criteria to review requests for medically necessary covered services. (*Contract, Amendment 11, Exhibit A, Attachment 5(1) and (1)(D)*)

Plan policy *UM-057 Authorization Request* stated the Plan required medical necessity PA reviews to approve certain services. Medical directors reviewed the requests using appropriate criteria and consulting the requesting provider as necessary. If there were no criteria, the medical director might consult with an expert physician and use their opinion to make a final decision.

Plan policy *RX-002 Prior Authorization Review Process* stated the Plan used evidence-based criteria reviewed yearly, updated as needed and approved by the Pharmacy Committee. The Plan might use the *RX-003 Exception Review Process* if criteria did not lead to a decision about a requested medication. The Plan might contact the requesting provider for additional information or refer complicated cases to a medical director for review and decision.

The Plan did not use appropriate processes to determine medical necessity for PA requests. The Plan's UM staff used outdated criteria and criteria that did not meet the case details.

A verification study revealed examples of deficient PA processing:

- In four pharmacy cases, the Plan used criteria that did not match the case details and outdated criteria to deny requests for skin, antibiotic and rheumatologic medications.
- In two pharmacy denials, the requested medications were for treating complicated lung conditions. One request met criteria; neither case included documentation of a discussion with a medical director or the requesting specialist though members were seriously ill.
- Three pharmacy requests for anti-inflammatory eye drops met criteria. The Plan denied two cases because claims data did not show that the member tried and failed (TF) preferred medicines, though the provider listed TF medications in the request. In the third case, claims data supported the prior use of TF medication, but the Plan denied the request.
- In one medical case, the member qualified for continued treatment of a multiple sclerosis-related condition with her out of network (OON) neurologist; however, the Plan denied the follow-up neurology visit and medication.
- In four medical cases, the Plan did not defer cases for more information, call the requesting provider, or ensure that an in-plan provider could care for the members before denying continued or new OON treatment requests.

In interviews, the Plan reported that the Chief Medical Officer now meets weekly with pharmacists to discuss their PA decisions after reviewing appeals. Pharmacy Department staff stated they now make three attempts to obtain more information from providers if needed.

The Plan described examples of peer-to-peer discussions between medical directors and requesting providers before denials. The Plan stated that its own medical directors decided the final outcome of cases reviewed by outside experts, but acknowledged the expert's potential influence on the decision.

Without consistently implementing appropriate processes for determining the medical necessity of requested services, the Plan may inadvertently affect member health outcomes in adverse ways.

1.2.3 Retrospective Reviews

The Plan shall ensure that its prior authorization, concurrent review, and retrospective review procedures meet the following minimum requirements: a qualified health care professional with appropriate clinical expertise in treating the condition and disease shall decide to deny or to authorize an amount, duration or scope that is less than requested. (*Contract, Amendment 11, Exhibit A, Attachment 5(2)(A)*)

Plan policy *UM-001 UM Authorization Process* stated qualified health care professionals with appropriate clinical expertise in treating the condition or disease would make decisions to deny or modify service requests. Prior to October 12, 2017, the policy did not address retrospective reviews. After October 12, 2017, policy *UM-001* stated the Plan had policies and processes for resolving retrospective reviews; however, the policy did not detail the process.

The Plan's *2018 UMPD* stated retrospective review is the process of reviewing a request for an already completed service that required PA. The Plan accepted retrospective requests when member coverage became active for the treatment date after that date, when the Plan could not confirm the member was covered during a hospitalization, and in urgent and emergent cases.

The Plan denied retrospective service requests for medical services without documentation of a qualified health care professional's review for medical necessity.

A verification study showed 4 of 31 medical cases were retrospective service requests for services. The Plan denied 4 of 4 retrospective requests without documentation of medical director review:

- A non-clinical coordinator documented the retrospective request and the administrative denial in all cases.
- A medical director signed the notice of action letter in all cases but did not document medical necessity reviews.

An undated provider online training presentation stated the Plan would no longer accept outpatient and facility retrospective reviews, which it would deny upon receipt. An online document *Summary of Key Information for Providers*, dated September 2015, stated the same. In contrast, the Provider's Utilization Management section of the Plan's website stated it granted retrospective reviews when member eligibility at the time of service was in question, or for emergently delivered services, and that it would perform case-by case considerations.

In interviews, the Plan stated that it processed retrospective requests as administrative denials without clinician review. It acknowledged some retrospective requests might meet medical necessity and that it was reconsidering its current processing of these cases.

Retrospective review policies and processes that are inconsistent and non-compliant with the contract may result in denial of payment for medically necessary services, and in negative effects on the provision of services to Plan members.

1.2.4 Pharmacy PA Timely Review

The Plan shall process all PA pharmaceutical requests within 24 hours in accordance with Welfare and Institutions Code (WIC), Section 14185. (*Contract, Amendment 11, Exhibit A, Attachment 5(3)(F)*)

The Plan shall respond to authorization requests for medications within 24 hours or one business day. (*WIC, Section 14185(a)(1)*)

Responses to requests for medications include approval, denial, or requests for more information. (Managed Care Quality and Monitoring Division (MCQMD) *Pharmaceutical PAs-Final*, official electronic communication, May 8, 2015)

Plan policy *RX-011 Decision and Notification Requirements* stated the Plan would deny, defer, approve or modify pharmaceutical PA requests within 24 hours of receiving the request.

Plan policy *RX-002 PA Review Process* stated the Pharmacy Director reviewed a monthly authorization report that provided data to ensure provider and member notification of pharmacy decisions within regulatory timeframes.

The Plan did not respond to pharmacy requests within 24 hours or one business day.

A verification study of 31 PA requests for pharmaceuticals revealed response times that did not meet requirements. Seven of 31 cases reviewed had late denial decisions without a prior response such as a deferral; neither requests for more information nor intervening holidays or weekends delayed the cases.

The 2018 UM Work Plan for Medi-Cal established a goal for timeliness of processed referrals, but did not include pharmacy PA timeframes. Plan internal audits did not include pharmacy turn-around-time (TAT) data. Internal Quality Improvement Committee meeting minutes from July 2017 noted that pharmacy prior authorization TAT changed from one working day to 24 hours, but did not contain other information about TATs for pharmacy requests. The Utilization Management Committee, Board of Governors and HCQC meeting minutes did not show review of pharmacy prior authorization TATs.

In an interview, the Plan reported it reviewed pharmacy approvals and denials for on-time decisions. The Plan reported recent challenges due to the departure of a key Pharmacy Department staff person.

Late pharmacy PA responses may result in adverse health effects for members.

1.2.5 Member Notice of Action (NOA) Letters

The Plan shall notify members of decisions to deny, modify or defer PA requests as specified in HSC Section 1367.01. (*Contract, Amendment 11, Exhibit A, Attachment 13(8)(A)*)

The notification shall clearly and concisely explain the reasons for the Plan's decision, and describe the criteria used. (*HSC 1367.01(h)(4)*)

The Plan shall ensure that all written Member information is at sixth grade reading level or at the level determined by the group needs assessment approved by DHCS. (*Contract, Amendment 11, Exhibit A, Attachment 13(4)(C)*)

Plan policy *UM-054 Notice of Action* stated NOA letters would include "a clear and concise explanation of the reasons for the PA decision. The specific reasons for the denial shall be in easily understandable language..." The Plan would monitor NOA letters for compliance monthly or bimonthly until they met requirements for three months, and then quarterly.

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

The Plan's NOA letters were not clear and concise, or at sixth grade reading level.

A verification study of 31 pharmacy cases and 31 medical cases revealed deficiencies in 25 pharmacy and 13 medical NOA letters:

- Unnecessary and disorganized content made letters confusing.
- Letters contained technical and high level words.
- Letters contained misstatements (i.e., content did not reflect actual reason for denial, did not match case details).
- In two cases, the Plan sent denial instead of modified decision letters.

The Plan reported the pharmacy benefits manager (PBM) wrote the pharmacy NOA letters, including the reason for the decision. The verification study confirmed the Plan's statement.

The Plan described the UM Department's medical NOA process: the reviewing medical director wrote the rationale for medical necessity decisions (file review confirmed this) and sent it to a UM coordinator, who inserted it into an appropriate letter template. Document review showed the Plan used DHCS templates.

The UM Department did not review NOA letters, though the Compliance Department conducted quarterly internal audits, reviewing letters for clear and concise explanations for PA decisions. The internal audit revealed deficiencies in the NOA letters and resulted in a corrective action to improve the letters.

Unclear and unconcise letters may not accurately convey the reasons for the Plan's decisions. Poorly informed members and providers may make decisions leading to adverse health outcomes.

1.2.6 Member Rights in Threshold Languages (Pharmacy NOA Letters)

The Plan shall follow Health and Safety Code (HSC) 1367.01 in notifying members of a decision to deny, defer or modify requests for PA. (*Contract, Amendment 11, Exhibit A, Attachment 13(8)(A)*)

The Plan shall provide information about how to file grievances and obtain a state fair hearing (SFH) in these member notices. (*HSC 1367.01(h)(4)*)

Members have 60 days to file an appeal after an adverse PA decision and 120 days to file an SFH after an appeal decision. Members can file a grievance at any time. Member rights NOA letter attachments shall follow the DHCS format. (*APL 17-006*)

Plan policy *RX-011 Decision and Notification Requirements* stated the Plan would notify members of their right to request a SFH in 90 days.

The Plan provided incorrect appeal, grievance, and state fair hearing information in translated pharmacy member notifications. The translated "Your Rights" attachments did not follow the required format.

A verification study showed the Plan translated 7 of 31 pharmacy NOA letters into member threshold languages of Spanish, Vietnamese, and Chinese as required. Seven of the 7 cases contained outdated appeal, grievance, and State Fair Hearing information:

- All seven letters informed members of a 90-day instead of a 60-day filing timeframe for appeals, a 90-day instead of 120-day filing timeframe for SFH, and 180 days for grievance filing instead of an unlimited filing timeframe.
- The format of the letters' "Your Rights Under Medi-Cal Managed Care" attachment did not meet regulatory requirements.
- All seven cases contained English language NOA letters and attachments with compliant appeal, grievance, and SFH filing timeframes and format.

The Plan reported the PBM wrote the pharmacy NOA letters, including the reason for the decision. The verification study confirmed the Plan's statement.

Member NOA letters with incorrect information may result in untimely filed appeals, grievances and SFH requests, with subsequent adverse effects for members.

1.2.7 Provider Notification of PA Processes

The Plan shall communicate to health care practitioners the procedures and services that require PA and ensure that all contracting health care practitioners are aware of the procedures and timeframes necessary to obtain prior authorization for these services. (*Contract, Amendment 11, Exhibit A, Attachment 5(1)(E)*)

Plan policy *UM-057 Authorization Service Request* stated, "The Alliance shall communicate to all contracted health care practitioners the procedures, treatments, and services that require authorization and the procedures and timeframes necessary to obtain such authorizations."

The Plan provided conflicting information to providers about podiatry benefits, which required PA; it therefore did not clearly communicate to providers the services that required PA.

The Plan's website contained a list of services requiring PA; the list stated the Plan only covered podiatry services for certain conditions for members 21 and over. An undated online provider training presentation stated the Plan would consider podiatry services only for members 21 and older who were diabetic. The online document *Summary of Key Information for Providers*, dated September 2015, stated the Plan provided podiatric services for members 21 and over even though Medi-Cal did not. Members had to demonstrate disorders secondary to or complicated by chronic disease, or disorders that significantly impaired the ability to walk. The Plan's 2018 Provider Manual did not address the podiatry benefit.

Conflicting and outdated information about services requiring PA may result in missed opportunities to provide members with needed services and subsequent adverse health outcomes.

RECOMMENDATIONS:

1.2.1 Implement policies and procedures for regular and standardized testing of UM decision makers.

1.2.2 Revise and implement appropriate procedures to ensure consistency of medical necessity reviews.

1.2.3 Develop and implement policies and procedures for retrospective review; include medical director review of denied retrospective cases. Ensure consistent provider information about retrospective reviews.

1.2.4 Develop and implement procedures to ensure timely pharmacy PA response.

1.2.5 Revise and implement policies and procedures to ensure pharmacy and medical service NOAs communicate the Plan's PA decisions in clear and concise language and at an appropriate reading level.

1.2.6 Revise Plan policies to reflect correct appeal, grievance, and SFH timeframes for pharmacy PA decisions. Implement procedures to ensure the Plan sends threshold language letters with compliant appeal, grievance, and SFH information in the required format.

1.2.7 Develop and implement procedures to communicate consistent and current information to providers about PA procedures and services.

❖ COMPLIANCE AUDIT FINDINGS (CAF) ❖
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AUDIT PERIOD: June 1, 2017 through May 31, 2018 **DATE OF AUDIT:** June 11, 2018 through June 22, 2018

1.3	REFERRAL TRACKING SYSTEM
Referral Tracking System: Contractor is responsible to ensure that the UM program includes: … An established specialty referral system to track and monitor referrals requiring prior authorization through the Contractor. The system shall include authorized, denied, deferred, or modified referrals, and the timeliness of the referrals. 2-Plan Contract A.5.1.F	

SUMMARY OF FINDING:

1.3.1 Prior Authorization Referral Tracking

The Plan shall ensure that the UM program includes an established specialty referral system to track and monitor referrals requiring PA. The system shall include authorized, denied, deferred, or modified referrals, and the timeliness of the referrals. This specialty referral system should include non-contracting providers. The Plan shall inform all contracting health care practitioners of the referral processes and tracking procedures. (*Contract, Amendment 11, Exhibit A, Attachment 5(1)(F)*)

Plan policy *MED-UM-0050 Tracking and Monitoring of Services Prior Authorized*, last revised December 15, 2016, stated the Plan had an established tracking system for PAs. The Plan would track open approved authorizations by monitoring for receipt of a claim showing the delivery of the service.

Plan policy *UM-057 Authorization Service Request* stated that the Plan entered PA requests into its clinical information system. The policy stated reports would track authorization requests by type, determination and timeliness.

The Plan did not track authorized PAs to completion and inform providers of the referral tracking process.

Plan document review revealed multiple PA reports including timeliness of authorization (daily aging report), monthly and quarterly turn-around-time summary reports, turn-around-time by staff, and inpatient and outpatient authorizations with request date and referring and rendering providers. The reports did not track completion of approved services. The 2018 Alliance Provider Manual and provider online resources did not discuss PA referral tracking.

In an interview, the Plan reported it did not have a policy or process for tracking open prior authorizations. A referral tracking process outlined in an outdated policy was not operational; the Plan did not produce a tracking report for open prior authorizations during the audit period. The Plan reported that it did not notify providers of referral tracking. Documentation review confirmed the Plan's statement.

By tracking approved authorizations to their completion, the Plan obtains information about service utilization that helps with planning for improved service delivery.

RECOMMENDATION:

1.3.1 Revise and implement policies and processes for tracking approved prior authorizations to their completion. Inform providers about the referral tracking process.

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1.4	PRIOR AUTHORIZATION APPEAL PROCESS
Appeal Procedures: There shall be a well-publicized appeals procedure for both providers and patients. 2-Plan Contract A.5.2.E	

SUMMARY OF FINDINGS:

1.4.1 Pharmacy Appeals

The Plan shall ensure that any grievance involving the appeal of a denial based on lack of Medical Necessity, appeal of a denial of a request for expedited resolution of a grievance, or an appeal that involves clinical issues shall be resolved by a health care professional with appropriate clinical expertise in treating the Member's condition or disease. (*Contract, Amendment 11, Exhibit A, Attachment 14(2)(D)*)

Plan policy *G&A-008 Adverse Benefit Determination Appeals Process* stated, "AAH [Alameda Alliance for Health] ensures that the reviewer of the appeal involving clinical issues has appropriate training and experience in the field of medicine involved in the case must review the appeal."

The Plan did not ensure health care professionals with appropriate clinical expertise in treating the member's condition resolved pharmacy appeals. The Plan allowed the Pharmacy Director to resolve appeals for medication requests instead of requiring a clinical professional with expertise in treating the member's condition.

The verification study showed that the Pharmacy Director reviewed 3 of 8 sampled pharmacy appeals:

- One case was a request for Entresto, a medication used for congestive heart failure (CHF), for a patient with CHF class 3 who had tried valsartan and amlodipine without success.
- Another case was a request for Veltassa, a medication used for the treatment of hyperkalemia (elevated potassium levels in the blood), for a patient with hypertension (high blood pressure); the member was unable to take the alternative recommended by the Plan as it could increase sodium levels and blood pressure.
- A third case was a request for Entocort EC, a medication used for the treatment of Crohn's disease and ulcerative colitis, for a patient with Crohn's disease who had tried 5ASA and mesalamine without success. The provider included a letter explaining why the Plan's choice of treatment was not an appropriate next treatment option.

In an interview, the Plan's CMO agreed that a peer-to peer discussion of these cases would have been appropriate.

During interviews, Plan staff confirmed that their previous Pharmacy Director, who was on paid administrative leave as of April 2018, was the Plan official resolving pharmacy appeals. After his departure, medical directors reviewed pharmacy appeals, which was confirmed in the verification study.

Appeals center on complex medical questions requiring evaluation and resolution by a health care professional with appropriate clinical expertise in treating the member's condition. If an individual without the required expertise makes a decision on an appeal, there is risk of not providing necessary treatments to prevent adverse health outcomes.

1.4.2 Threshold Languages

Written Member-informing materials shall be translated into the identified threshold and concentration languages. (*Contract, Amendment 11, Exhibit A, Attachment 13(4)(C)(1)*)

The Plan shall provide, at minimum, the following linguistic services; fully translated written informing materials, including, form letters including notice of actions letters, grievance acknowledgement letters, and resolution letters. (*Contract, Amendment 11, Exhibit A, Attachment 9(14)(B)(2)*)

All Plan Letter (APL) 17-006, *Grievance and Appeal (G&A) Requirements and Revised Notice Templates and "Your Rights" Attachments* stated, "The DHCS Contract additionally requires MCPs to fully translate beneficiary-informing materials into the required threshold languages."

Plan policy *G&A-008 Adverse Benefit Determination Appeals Process* did not address sending letters in members' threshold language. Plan policy *G&A-001 Grievance and Appeals System Description* contained a check list that included sending acknowledgment and resolution letters in the member's preferred language.

The Plan did not translate acknowledgement and resolution appeal letters into the required threshold languages.

The verification study showed that 3 of 5 cases with threshold languages included letters that were not translated. In one case, the acknowledgement letter was not translated; and in the other two cases the resolution letters were not translated. The languages were Spanish and Chinese. The Plan confirmed the letters were not translated in the members' language.

If member informing materials are not translated when indicated, this could lead to miscommunication and impose barriers to effective and equitable healthcare.

1.4.3 Provider Manual

The Plan shall issue a provider manual and updates to the providers of Medi-Cal services. The manual and updates shall serve as a source of information to contracting and subcontracting health care providers regarding Medi-Cal services including the State Fair Hearing process. (*Contract, Amendment 11, Exhibit A, Attachment 7(4)*)

All Plan Letter 17-006 Grievance and Appeal Requirements and Revised Notice Templates and "Your Rights" Attachments stated, "New federal regulations require beneficiaries to request a State Hearing within 120 calendar days from the date of the Notice of Appeal Resolution (NAR)."

Plan policy *G&A-007 State Fair Hearings* stated, "A member must request a State Fair Hearing within one-hundred twenty (120) calendar days from the date of the NAR."

The Plan did not update its provider manual to include the new timeframes for filing a state fair hearing that became effective July 1, 2017.

In an interview, the Plan stated it was unaware the 2018 provider manual did not include the current State Fair Hearing information. Document review showed updated appeal filing information.

If the provider manual is not updated with current information, such as new timeframes on when to file a state hearing, members may be prevented from exercising their right to file a state hearing in a timely manner.

RECOMMENDATIONS:

1.4.1 Revise and implement policies and procedures to ensure that pharmacy appeals are resolved by a health care professional with appropriate clinical expertise in treating the member's condition or disease.

1.4.2 Revise and implement policies and procedures to ensure that written member-informing materials are translated into threshold and concentration languages.

1.4.3 Develop and implement procedures to ensure consistent updating of the provider manual including correct timeframes for filing a State Fair Hearing.

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1.5	DELEGATION OF UTILIZATION MANAGEMENT
Delegated Utilization Management (UM) Activities: Contractor may delegate UM activities. If Contractor delegates these activities, Contractor shall comply with Exhibit A, Attachment 4, Provision 6. Delegation of Quality Improvement Activities. 2-Plan Contract A.5.5	

SUMMARY OF FINDINGS:

1.5.1 Ownership and Control Disclosure Reviews

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

The Plan must require each disclosing entity to disclose the information: (1) the name and address of each person with an ownership or control interest in the disclosing entity or in any subcontractor in which the disclosing entity has direct or indirect ownership of 5 percent or more; (2) whether any of the persons named is related to another as spouse, parent, child, or sibling; (3) The name of any other disclosing entity in which a person with an ownership or control interest in the disclosing entity also has an ownership or control interest. The Plan shall not approve a provider agreement or a contract with a fiscal agent, and must terminate an existing agreement or contract, if the provider or fiscal agent fails to disclose ownership or control information. (*Title 42, CFR, Section 455.104*)

Plan policy *CMP-019 Delegation Oversight* stated the Compliance Department will review the delegate's policies, procedures and all required submissions pre-delegation.

Plan policy *QM-111 Delegation of Management and Oversight* stated the Plan audits each delegate prior to contracting to evaluate the delegate capacity meets DHCS, Department of Managed Health Care (DMHC), and Plan requirements. The Plan reviews the delegates written policies and procedures, program descriptions, and activities under consideration.

The Plan did not collect and review ownership and control disclosure information for their UM delegates.

The Plan has policies and procedures in place to address general functions of the pre-delegation and annual delegation audits; however, these policies and procedures do not specifically address a process to collect and review the delegates' ownership and control disclosure information.

If the Plan does not collect and review ownership and control disclosure information of their UM delegates, they cannot ensure that the delegate has the capacity to provide services required by the Plan and DHCS.

1.5.2 Corrective Action Plans for Identified Deficiencies

The Plan is accountable for all quality improvement functions and responsibilities (e.g. Utilization Management) that are delegated to subcontractors. (*Contract, Amendment 11, Exhibit A, Attachment 4(6)(A)*)

The Plan shall maintain a system to ensure accountability for delegated quality improvement activities, that at a minimum, ensures subcontractor meets standards set forth by the Plan and DHCS. (*Contract, Amendment 11, Exhibit A, Attachment 4(6)(B)*)

Plan policy *CMP-019 Delegation Oversight* stated on an annual basis the Compliance Department will conduct an on-site audit to assess compliance with the Plan's criteria as well as all applicable state and federal regulations. The delegate will be provided with the results of the audit and a corrective action plan. The contracted delegate is required to respond to areas of deficiency within 30 days of when the audit corrective action plan is issued by the Plan to the delegate.

The Plan did not require corrective action for all identified deficiencies as a part of their annual oversight audits.

The Plan conducts an onsite audit of each delegate on an annual basis. These audits consisted of a verification study of prior authorizations and a policy and procedure review. During the 2017 annual delegation audits, the Plan identified multiple deficiencies during the review of three UM delegates' policies and procedures. The Plan only required corrective action plans for deficiencies cited during the prior authorization case/sample review, not the policy and procedure review.

The Plan cannot ensure that the subcontractors meet the standards set forth by the Plan and DHCS if they do not implement effective corrective action to remedy the identified deficiencies.

1.5.3 Monitoring and Oversight of UM Delegates

The Plan is accountable for all quality improvement functions and responsibilities (e.g. Utilization Management) that are delegated to subcontractors. (*Contract, Amendment 11, Exhibit A, Attachment 4(6)(A)*)

The Plan shall maintain a system to ensure accountability for delegated quality improvement activities that at a minimum, includes the continuous monitoring, evaluation and approval of the delegated functions. (*Contract, Amendment 11, Exhibit A, Attachment 4(6)(B)*)

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

The Plan did not continuously monitor and evaluate the functions of its UM delegates. The Plan did not ensure receipt of all contractual and regulatory reports during the audit period.

The Plan did not require 3 of 7 UM delegates to send any contractual and regulatory reports during the audit period. In the interview, the Plan stated it identified this as an opportunity for improvement and began working on consistently receiving reports from all delegates.

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

RECOMMENDATIONS:

1.5.1 Revise and implement policies and procedures to collect and review delegates' ownership and control disclosure information.

1.5.2 Implement policies and procedures to ensure subcontractor meets the standards set forth by the Plan and DHCS.

1.5.3 Implement policies and procedures to continuously monitor and evaluate the UM delegated functions.

CATEGORY 2 – CASE MANAGEMENT AND COORDINATION OF CARE

2.4	INITIAL HEALTH ASSESSMENT

Provision of Initial Health Assessment:
Contractor shall cover and ensure the provision of an IHA (complete history and physical examination) in conformance with Title 22, CCR, Sections 53851(b)(1) to each new Member within timelines stipulated in Provision 5 and Provision 6 below.
2-Plan Contract A.10.3.A

Provision of IHA for Members under Age 21
For Members under the age of 18 months, Contractor is responsible to cover and ensure the provision of an IHA within 120 calendar days following the date of enrollment or within periodicity timelines established by the American Academy of Pediatrics (AAP) for ages two and younger whichever is less.

For Members 18 months of age and older upon enrollment, Contractor is responsible to ensure an IHA is performed within 120 calendar days of enrollment.
2-Plan Contract A.10.5

IHAs for Adults, Age 21 and older

1) Contractor shall cover and ensure that an IHA for adult Members is performed within 120 calendar days of enrollment.
2) Contractor shall ensure that the performance of the initial complete history and physical exam for adults includes, but is not limited to:
   a) blood pressure,
   b) height and weight,
   c) total serum cholesterol measurement for men ages 35 and over and women ages 45 and over,
   d) clinical breast examination for women over 40,
   e) mammogram for women age 50 and over,
   f) Pap smear (or arrangements made for performance) on all women determined to be sexually active,
   g) chlamydia screen for all sexually active females aged 21 and older who are determined to be at high-risk for chlamydia infection using the most current CDC guidelines. These guidelines include the screening of all sexually active females aged 21 through 25 years of age,
   h) screening for TB risk factors including a Mantoux skin test on all persons determined to be at high risk, and
   i) health education behavioral risk assessment.

2-Plan Contract A.10.6

2.4	INITIAL HEALTH ASSESSMENT

Contractor shall make reasonable attempts to contact a Member and schedule an IHA. All attempts shall be documented. Documented attempts that demonstrate Contractor's unsuccessful efforts to contact a Member and schedule an IHA shall be considered evidence in meeting this requirement.
2-Plan Contract A.10.3.D

SUMMARY OF FINDING:

2.4.1 Provision of Initial Health Assessment (IHA)

The Plan is required to ensure the provision of an IHA (comprehensive history and physical examination) to each new member within 120 calendar days of enrollment. (*Contract, Amendment 11, Exhibit A, Attachment 10(3)(A)*) and to have procedures for monitoring IHA completion (*MMCD Policy Letter 08-003, Initial Comprehensive Health Assessment*).

Plan policy *QM-124 Initial Health Assessment/Health Information Form/Member Evaluation Tool* stated the Plan ensures that new members receive an Initial Health Assessment within 120 days of becoming a Plan member.

The Plan did not ensure that new members receive an IHA within 120 days from enrollment. The Plan's IHA completion records were inaccurate.

Medical records of fifteen adult members, which the Plan identified as having received IHAs, were reviewed. Seven of 15 had no record of the visit and/or member was never seen at the clinic.

In an interview, the Plan reported it did not conduct validity testing to ensure that the visit codes selected to determine the Plan's IHA completion rate indeed represented a complete IHA.

Without the provision of an IHA, providers will not be able to comprehensively assess and manage the healthcare needs of the member.

RECOMMENDATION:

2.4.1 Revise and implement procedures for the provision of IHA and monitoring of IHA completion.

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2.5	COMPLEX CASE MANAGEMENT

Case Management and Coordination of Services:
Contractor shall ensure the provision of Comprehensive Medical Case Management to each Member.

Contractor shall 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 Contractor's provider network. These services are provided through either basic or complex case management activities based on the medical needs of the member.

Complex Case Management Services are provided by the primary care provider, in collaboration with the Contractor, and shall include, at a minimum:

1) Basic Case Management Services
2) Management of acute or chronic illness, including emotional and social support issues by a multidisciplinary case management team
3) Intense coordination of resources to ensure member regains optimal health or improved functionality
4) With Member and PCP input, development of care plans specific to individual needs, and updating of these plans at least annually

Contractor shall develop methods to identify Members who may benefit from complex case management services, using utilization data, the Health Information Form (HIF)/Member Evaluation Tool (MET), clinical data, and any other available data, as well as self and physician referrals.
2-Plan Contract A.11.1

SUMMARY OF FINDINGS:

2.5.1 Monitoring of Complex Case Management Program (CCM)

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

Plan policy *CM-003 Complex Case Management Plan Evaluation and Closure* stated cases that fail to close within 90 days will be reviewed at case rounds. Case rounds are done twice a month with medical director, director of case management, behavioral health clinicians, health coaches and others.

The Plan did not implement its policy and did not consistently monitor its CCM program.

Verification study of 10 member's case notes showed that three cases were open for more than 90 days. The Plan confirmed that 1 of the 3 cases was reviewed during case rounds and the other two were not.

This is a finding from the Plan's 2016 Medi-Cal audit. As a part of its CAP, the Plan created the CCM Aging Report to track the number of days a case has been open. According to the Plan, it implemented the CCM Aging Report at the end of March 2018.

The lack of monitoring may prevent the Plan from determining the need for further action and possible improvements in the provision of complex case management to its members.

This is a repeat finding.

2.5.2 Primary Care Provider Participation

The Plan shall ensure the provision of comprehensive medical case management to each member through either basic or complex case management activities based on the medical needs of the member. Complex case management services are to be provided by the Plan, in collaboration with the primary care provider (PCP), and shall include, at a minimum, development of care plans specific to individual needs with member and PCP input. (*Contract, Amendment 11, Exhibit A, Attachment 11(1) and Amendment 14, (V)(B)*)

Plan policy *CM-002 Complex Case Management Plan Development and Management* stated the case manager collaborates with the member and/or caregiver and care providers to establish a care plan. After the care plan is developed, with the member's permission, the primary care provider is notified that the member is receiving care management services. The policy did not indicate the role of the PCP in the development of member's care plan.

The Plan did not ensure PCP participation in the provision of CCM services to each eligible member.

A verification study of members' case notes showed 10 out of 10 had no evidence of PCP participation in the development of members' care plans.

Providers interviewed during site visits were aware of the CCM services offered by the Plan, but did not remember having been contacted for the development of members' care plans.

This is a finding from the Plan's 2016 Medi-Cal audit. The Plan updated policy *CM-002*; however, the revised policy does not include PCP participation in the development of a member's care plan. The Plan's corrective action did not address the prior year finding.

A care plan individualized to the member's needs forms the foundation for care coordination. The primary care provider's participation in the care planning process is an important element in the care of members with complex needs.

This is a repeat finding.

RECOMMENDATIONS:

2.5.1 Implement procedures to monitor the provision of CCM services to eligible members.

2.5.2 Revise and implement policies and procedures to ensure PCP participation in the provision of CCM services to eligible members.

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CATEGORY 3 – ACCESS AND AVAILABILITY OF CARE

3.1	APPOINTMENT PROCEDURES AND MONITORING WAITING TIMES

Appointment Procedures:
Contractor shall 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 initial health assessments. Contractor shall also include procedures for follow-up on missed appointments.
2-Plan Contract A.9.3.A

Members must be offered appointments within the following timeframes:
3) Non-urgent primary care appointments – within ten (10) business days of request;
4) Appointment with a specialist – within 15 business days of request;

2-Plan Contract A.9.4.B

Prenatal Care:
Contractor shall ensure that the first prenatal visit for a pregnant Member will be available within two (2) weeks upon request.
2-Plan Contract A.9.3.B

Monitoring of Waiting Times:
Contractor shall develop, implement, and maintain a procedure to monitor waiting times in the providers' offices, telephone calls (to answer and return), and time to obtain various types of appointments…
2-Plan Contract A.9.3.C

SUMMARY OF FINDINGS:

3.1.1 Monitoring of Telephone Calls

The Plan is required to develop, implement, and maintain a procedure to monitor telephone calls (to answer and return). (*Contract, Amendment 11, Exhibit A, Attachment 9(3)(C)*)

Plan policy *QM-107 Appointment Access & Availability Standards* stated the Plan has established a mechanism for ongoing monitoring to ensure health care services are reasonable and accessible to all members as described in policy *CMP-0024 Monitoring of Access & Availability Standards*. The Alliance monitors and evaluates access, availability, and continuity of care for its member through the Access and Availability sub-committee.

The Plan did not initiate and implement steps to monitor wait times for providers to answer members' telephone calls.

In the prior audit, the Plan did not monitor provider office wait times and telephone wait times (to answer and return calls). As a corrective action to the prior audit finding, the Plan conducted member surveys that measured office wait times and times for a provider to return a telephone call; however, the surveys did not measure how long it took for a provider to answer a telephone call during business hours. The Plan's policies did not specify a timeframe for providers to answer and return telephone calls.

The Plan's lack of monitoring of providers' answering of member calls may lead to missed opportunities for improvement in members' access to care.

3.1.2 Provider Directory Accuracy

The Plan is required to distribute a provider directory that includes the following information: name, provider number, and telephone number of each Service Location. In the case of a medical group/foundation or independent practice association, the medical group name, provider number, address and telephone number shall appear for each physician provider. *(Contract, Amendment 11, Exhibit A, Attachment 13(4)(D)(4)*)

The Plan is required to provide, upon request, a list of contracting providers and update this information at least quarterly. The Plan is required to ensure the accuracy of the provider directory information by updating the online directory at least weekly or more frequently and when informed of and upon confirmation by the Plan of any information that affects the content or accuracy of the provider directory. Health Plans shall take appropriate steps to ensure the accuracy of the information concerning each provider listed in the Plan's provider directory in accordance with this section, and shall, at least annually, review and update the entire provider directory for each product offered. (*H&S Code Section 1367.27*)

The Plan did not maintain an accurate provider directory.

DHCS conducted an appointment availability verification study that included 28 providers. This study measured the Plan's average member wait times to obtain an appointment and verified the accuracy of the Plan's provider directory information. The following deficiencies related to the Plan's printed and online provider directory information were identified:

- 6 of 28 providers were not practicing physicians or were no longer practicing at the location identified on the provider directory.
- 6 of 28 providers had incorrect hours and/or business days listed on the provider directory.
- 6 of 28 providers had incorrect phone numbers listed on the provider directory.
- 4 of 28 providers listed on the provider directory were unreachable.
- 1 of 28 provider had an incorrect address listed on the provider directory.
- 1 of 28 providers had incorrect information about accepting new patients on the provider directory.

Our review also identified incorrect phone numbers of all the pharmacies located at one of the cities in the Plan's network. The phone numbers listed were for pharmacy administrative offices. The Plan's 2017 pharmacy benefits manager (PBM) audit report showed that the PBM does not have a process to ensure accurate information in the provider directory.

In an interview, the Plan stated it reaches out to providers annually and to delegates semi-annually to confirm the accuracy of the providers' information. There has been a push to move the providers to the online portal to establish annual attestations of provider contact information; however, this process has not been as successful as the Plan envisioned due to low response rates.

Inaccurate information on the provider directory may lead to barriers for members' access to care.

RECOMMENDATIONS:

3.1.1 Revise and implement policies and procedures to monitor wait times for providers to answer members' telephone calls.

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

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3.5	EMERGENCY SERVICES AND FAMILY PLANNING CLAIMS

Emergency Service Providers (Claims):
Contractor is responsible for coverage and payment of Emergency Services and post stabilization care services and must cover and pay for Emergency Services regardless of whether the provider that furnishes the services has a contract with the plan.
2-Plan Contract A.8.13.A

Contractor shall pay for emergency services received by a Member from non-contracting providers. Payments to non-contracting providers shall be for the treatment of the emergency medical condition including Medically
Necessary inpatient services rendered to a Member until the Member's condition has stabilized sufficiently to permit referral and transfer in accordance with instructions from Contractor or the Member is stabilized
sufficiently to permit discharge….
2-Plan Contract A.8.13.C

At a minimum, Contractor must reimburse the non-contracting emergency department and, if applicable, its affiliated providers for Physician services at the lowest level of emergency department evaluation and management Physician's Current Procedural Terminology (CPT) codes, unless a higher level is clearly supported by documentation, and for the facility fee and diagnostic services such as laboratory and radiology.
2-Plan Contract A.8.13.D

For all other non-contracting providers, reimbursement by Contractor, or by a subcontractor who is at risk for out-of-plan emergency services, for properly documented claims for services rendered on or after January 1, 2007 by a non-contracting provider pursuant to this provision shall be made in accordance with Provision 5, Claims Processing, and 42 USC Section 1396u-2(b)(2)(D). 3
2-Plan Contract A.8.13.E

Contractor shall cover emergency medical services without prior authorization pursuant to Title 28 CCR, Section 1300.67(g) and Title 22 CCR Section 53216.
2-Plan Contract A.9.7.A

Family Planning (Claims):
Contractor shall reimburse non-contracting family planning providers at no less than the appropriate Medi-Cal FFS rate….(as required by Contract)
2-Plan Contract A.8.9

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Claims Processing—Contractor shall pay all claims submitted by contracting providers in accordance with this section…Contractor shall comply with Section 1932(f), Title XIX, Social Security Act (42 U.S.C. Section 1396u-2(f), and Health and Safety Code Sections 1371 through 1371.36.
2-Plan Contract A.8.5

Time for Reimbursement. A plan and a plan's capitated provider shall reimburse each complete claim, or portion thereof, whether in state or out of state, as soon as practical, but no later than thirty (30) working days after the date of receipt of the complete claim by the plan or the plan's capitated provider, or if the plan is a health maintenance organization, 45 working days after the date of receipt of the complete claim by the plan or the plan's capitated provider, unless the complete claim or portion thereof is contested or denied, as provided in subdivision (h).
CCR, Title 28, Section 1300.71(g)

SUMMARY OF FINDINGS:

3.5.1 Emergency Room and Family Planning Claims

Prior authorization requirements shall not be applied to emergency services, family planning services, preventive services, basic prenatal care, sexually transmitted disease services, and HIV testing. (*Contract, Amendment 11, Exhibit A, Attachment 5(2)(G)*)

Plan policy *CLM-003 Emergency Services Claims Processing* stated emergency services claims do not require Prior Authorization or clinical review by the Alliance staff.

Plan policy *CLM-010 Family Planning and Sensitive Services Claims Processing* stated family planning and sensitive services claims do not require Prior Authorization or clinical review by the Alliance staff.

The Plan denied emergency room (ER) service and family planning (FP) claims containing procedures that normally require prior authorization outside of an ER or FP setting.

A verification study of 30 ER claims and 24 FP claims found three ER claims and 10 FP claims were improperly denied for the services not being authorized. The Plan did not consistently implement its policies and procedures of not requiring prior authorization for the reimbursement of ER and FP claims. These claims were denied based on edits in the Plan's claims system and review by claims analysts; the Plan's process did not include exceptions for FP or ER services.

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

3.5.2 Interest Payments for Late ER Claims

Late payment on a complete claim for emergency services and care, which is neither contested nor denied, shall automatically include the greater of $15 for each 12-month period or portion thereof on a non-prorated basis, or interest at the rate of 15 percent per annum for the period of time that the payment is late. (*CCR, Title 28, Section 1300.71(i)*)

The Plan is required to automatically include in its payment of the claim all interest that has accrued if a complete claim is not reimbursed within 45 working days of receipt. (*H&S Code Section 1371*)

Plan policy *CLM-003 Emergency Services Claims Processing* stated the Plan will pay the greater of $15 per annum or interest payment at a rate of 15 percent per annum if an uncontested emergency services claim is not reimbursed within forty-five working days after receipt.

The Plan did not pay the greater of $15 or 15 percent interest annually for emergency service claims not reimbursed within 45 working days of receipt.

A verification study for late ER claims found four ER claims were paid at 15 percent interest instead of $15 even though $15 is the greater of the two payments. The Plan's claims system automatically calculated a percentage interest payment based on the delay and type of claim. The Plan's claims system was not configured to pay the greater of $15 or 15 percent interest annually for emergency service claims not reimbursed within 45 working days after receipt.

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

3.5.3 Out of Network Family Planning Claims

The Plan shall reimburse non-contracting family planning providers at no less than the appropriate Medi-Cal fee for service rate. (*Contract, Amendment 11, Exhibit A, Attachment 8(9)*)

Plan policy *CLM-010 Family Planning and Sensitive Services Claims Processing* stated the Plan will process claims or any portion of a claim for family planning, whether in-plan or out-of-plan, as soon as practical but no later than forty-five working days after receipt of the claim. The Plan will reimburse in-plan providers based on their contract and out-of-plan providers at the prevailing Medi-Cal rate based on the service provided.

The Plan improperly denied family planning claims for out of network, non-contracted providers. These claims were denied based on edits in the Plan's claims system and subsequent review by claims analysts.

A verification study found 4 of 24 FP claims were flagged by the Plan's claims processing system as out-of-network, non-contracted providers and denied. The Plan did not consistently implement its policies and procedures to process family planning claims, whether in-plan or out-of-plan.

Improper denials of out-of-network family planning claims may cause these providers to be reluctant to treat Plan members in the future.

3.5.4 Remittance Advice Denial Reasons

The Plan is required to reimburse each complete claim, or portion thereof, whether in state or out of state as practical, but no later than 45 working days after the date of receipt of the complete claim. (*CCR, Title 28, Section 1300.71(g)*)

The Plan is required to disclose the specific rationale used in determining why the claim was rejected. (*H&S Code Section 1399.55*)

The notice that a claim is being contested shall identify the portion of the claim that is contested and the specific reasons for contesting the claim. (*H&S Code Section 1371*)

Plan policies *CLM-003 Emergency Services Claims Processing* and *CLM-010 Family Planning and Sensitive Services Claims Processing* stated the Plan will notify the provider in writing the portion of the claim that is being contested or denied with the specific reason(s) for contesting or denying the claim.

The Plan did not disclose the specific rationale used in determining why claims are rejected.

A review of emergency service and family planning claims showed the following deficiencies with the Plan's reason codes:

- One emergency service claim was denied by the Plan as being a non-covered benefit. The provider resubmitted the claim by adding a modifier which was approved for payment. The original claim incorrectly disclosed the denial reason as a non-covered benefit instead of requiring a modifier.
- Four family planning claims were not properly identified as duplicate claims. These samples showed that the Plan would either pay the claim at $0 or deny the claim citing the original denial reasons.
- One family planning claim was identified as having both a paid and denial reason code for the same claim line.

The Plan did not consistently implement its policies and procedures to disclose the specific rationale used in determining why the claim was rejected. The reason codes within the Plan's claims system were not properly configured to disclose the specific rationale for the denial.

Disclosing incorrect information on the remittance advice can be misleading and may prevent a provider from resubmitting a claim correctly.

RECOMMENDATIONS:

3.5.1 Develop and implement procedures to adjudicate emergency services and family planning claims without a prior authorization.

3.5.2 Implement policies and procedures to pay the greater of $15 or 15 percent interest for emergency service claims not adjudicated within 45 working days of receipt.

3.5.3 Develop and implement policies and procedures to pay for out-of-network family planning claims.

3.5.4 Implement policies and procedures and configure claims system to disclose the specific rationale used in determining why the claim was rejected.

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3.6	ACCESS TO PHARMACEUTICAL SERVICES

Pharmaceutical Services and Prescribed Drugs:
Contractor shall cover and ensure the provision of all prescribed drugs and Medically Necessary pharmaceutical services. Contractor shall provide pharmaceutical services and prescription drugs in accordance with all Federal and State laws and regulations...

At a minimum, Contractor shall arrange for pharmaceutical services to be available during regular business hours, and shall ensure the provision of drugs prescribed in emergency circumstances in amounts sufficient to last until the Member can reasonably be expected to have the prescription filled.
2-Plan Contract A.10.8.G.1

SUMMARY OF FINDING:

3.6.1 Emergency Provision of Drugs

The Plan is required to at a minimum, arrange for pharmaceutical services to be available during regular business hours, and is required to ensure the provision of drugs prescribed in emergency circumstances in amounts sufficient to last until the Member can reasonably be expected to have the prescription filled (*Contract A11, Exhibit A, Attachment 10(G)(1)* and *CCR, Title 22, Section 53854(1), (2) & (3)*).

Plan policy *RX-009 Emergency Supply Provision* stated the Plan allows for payment of the 3-day supply of the drugs even in the event that the prior authorization or exceptions request is subsequently denied. The Plan will monitor the utilization of the 3-day override process to minimize the potential abuse of misuse of such provision. The findings of such monitoring will be reported to the Pharmacy Sub-committee.

The Plan did not ensure the provision of sufficient amounts of drugs prescribed in emergency situations.

Until April 2018, the Plan did not have a process in place to monitor the provision of drugs prescribed in emergency situations. As of April 2018, the Plan began utilizing a monthly Emergency Supply Report. The Plan reviewed the report by looking at total prescription counts, types of drugs, number of high-value non-formulary and controlled substances, and pharmacy location. The report included only paid or overridden claims.

The Plan did not review denied emergency supply claims to ensure members had access to a sufficient amount of drugs prescribed until the member could reasonably be expected to have a prescription filled. Due to the departure of a key Pharmacy Department staff, the Plan paused monitoring the provision of drugs in an emergency situations until April 2018 and the Pharmacy Sub-committee did not hold any meetings.

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

RECOMMENDATION:

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

❖ COMPLIANCE AUDIT FINDINGS (CAF) ❖

PLAN: Alameda Alliance for Health

AUDIT PERIOD: June 1, 2017 through May 31, 2018
DATE OF AUDIT: June 11, 2018 through June 22, 2018

CATEGORY 4 – MEMBER'S RIGHTS

4.1	GRIEVANCE SYSTEM

Member Grievance System and Oversight:
Contractor shall implement and maintain a Member Grievance System in accordance with Title 28, CCR, Section 1300.68 and 1300.68.01, Title 22 CCR Section 53858, Exhibit A, Attachment 13, Provision 4, Paragraph D.13), and 42 CFR 438.420(a)-(c).
2-Plan Contract A.14.1

Contractor shall implement and maintain procedures…to monitor the Member's grievance system and the expedited review of grievances required under Title 28, CCR, Sections 1300.68 and 1300.68.01 and Title 22 CCR Section 53858….(as required by Contract)
2-Plan Contract A.14.2

Contractor shall maintain, and have available for DHCS review, grievance logs, including copies of grievance logs of any subcontracting entity delegated the responsibility to maintain and resolve grievances. Grievance logs shall include all the required information set forth in Title 22 CCR Section 53858(e).
2-Plan Contract A.14.3.A

SUMMARY OF FINDINGS:

4.1.1 Review of Quality of Care (QOC) Grievances

The Plan's medical director is required to resolve grievances related to medical quality of care. Resolved means that the grievance has reached a final conclusion with respect to the enrollee's submitted grievance, and there are no pending enrollee appeals within the Plan's grievance system, including entities with delegated authority. If the Plan has multiple internal levels of grievance resolution or appeal, all levels must be completed within 30 calendar days of the Plan's receipt of the grievance. (*Contract, Amendment 11, Exhibit A, Attachment 1(6)(E)* and *CCR, Title 28, Section 1300.68(a)(4)(A)*)

Plan policy *G&A-003 Grievance Receipt, Review and Resolution* stated, "All grievances related to medical quality of care issues are immediately submitted to the medical director for action."

The Plan's process omitted medical director review of QOC grievances prior to sending resolution letters.

The verification study showed that 9 of 10 sampled quality of care grievances were not reviewed by a medical director prior to sending the resolution letters:

- Seven were reviewed by a medical director months after a resolution letter was sent.
- One case review was still pending medical director review at the time of the audit although a resolution letter had been sent.
- One case was never reviewed by a medical director as it was determined by the quality nurse that there was no potential quality incident.

The Plan confirmed its grievance review process:

- The grievance and appeals (G&A) nurse conducted an initial clinical review.
- The Plan sent a resolution letter stating "Your concerns were sent to the Alliance Quality doctors and nurses for further investigation and careful review."
- The G&A nurse forwarded the clinical review to the Quality Department for a quality nurse and medical director review.

There was no evidence that the medical director reviewed the quality of care grievances prior to sending a resolution letter. When asked why the Plan decided to follow this procedure they stated that they have always done it this way mainly due to staffing issues. At one point, they had only one medical director. As of January 2018, the Plan had four medical directors; however, the Plan did not have a process to ensure all quality of care grievances were reviewed prior to sending a resolution letter.

If quality of care grievances are not evaluated by a medical director in a timely manner, the Plan risks delaying a potential quality of care issue which could be detrimental to the members' health and well-being.

4.1.2 Grievance Resolutions/Grievance Process

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

Contractor shall implement and maintain a Member Grievance System in accordance with Title 22 CCR Section 53858. (*Contract, Amendment 11, Attachment 14(1)*)

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

Plan policy *G&A-001 Grievance and Appeals System Description* stated the Plan ensures that each issue is addressed and resolved when a complainant presents with multiple issues. A member does not need to use the term 'Grievance' for a complaint to be captured as an expression of dissatisfaction and, therefore, a Grievance. Resolved means that the grievance has reached a final conclusion with respect to the enrollee's submitted grievance, and there are no pending enrollee appeals within the Plan's grievance system, including entities with delegated authority.

Plan policy *G&A-003 Grievance Receipt, Review and Resolutions* stated the Plan will provide a written resolution within 30 calendar days of receipt of the grievance. In the event a resolution is not reached within 30 calendar days, the Alliance will notify the complainant in writing of the status of the grievance and provide an estimated completion date of resolution.

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

The verification study found the following deficiencies:

- Seven of 40 standard grievance resolutions did not address all complaints. Three standard grievances did not investigate why voice messages left with the provider were not returned. One standard grievance did not address the member's complaint about long wait times and the rude demeanor of a clinic pharmacist. The resolution letter stated the member had not been seen at the clinic in years and that the member was no longer assigned to the Plan; however, the Plan did not resolve the member's grievance even though the member was enrolled at the time the grievance was submitted.
- Four of 10 expedited grievance resolutions did not address all complaints. In one expedited grievance, a member requested catheter supplies from the Plan's medical supplies vendor. The resolution letter recommended the member reach out to their primary insurance carrier and primary care provider; the Plan did not address the primary complaint of needing urgent medical supplies.

Plan policy *G&A-001* included a checklist to be used by member service representatives and grievance coordinators to ensure each complaint was identified and resolved; however, the grievance files did not include the checklist.

The prior audit identified that the Plan sent resolution letters without resolving the grievance. The CAP included staff training, a policy revision, and implementation of quarterly monitoring to ensure resolution of grievances within 30 days. The Plan did not consistently implement their revised policies and procedures to resolve all grievances.

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

This is a repeat finding.

4.1.3 Grievance Timeframes

There shall be a well-publicized appeals procedure for both providers and members. The Plan is required to issue a provider manual and updates to the providers of Medi-Cal services. The provider manual shall include the member's right to file grievances and appeals and their requirements and timeframes for filing. The Plan is required to provide all new members with written member information including the requirements and timeframes to filing a grievance or appeal. (*Contract, Amendment 11, Exhibit A, Attachment 7(4)*)

All Plan Letter 17-006 Grievance and Appeal Requirements and Revised Notice Templates and "Your Rights" Attachments stated, "While existing state regulations establish a timeframe of at least 180 calendar days from the date of the incident subject to the beneficiary's dissatisfaction, new federal regulations allow grievances to be filed at any time."

Plan policy *G&A-003 Grievance Receipt, Review and Resolution* stated, "The Alliance will allow the complainant any time to file a grievance about an incident or action that is subject of the member's dissatisfaction for our Medi-Cal members."

The Plan did not update its provider manual to include the new timeframes for filing grievances that became effective July 1, 2017.

The Plan's provider manual incorrectly stated members have 180 days within the incident to file a grievance. In an interview, the Plan stated it was unaware the 2018 provider manual did not include the current grievance submission timeframe.

When the Plan does not update provider resources, members may receive incorrect information about their rights to file a complaint.

4.1.4 Capturing All Grievances

The Plan shall implement and maintain a Member Grievance System in accordance with Title 22 CCR Section 53858. (*Contract A11, Attachment 14(1)*)

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

The Plan's grievance system did not capture and process all complaints and expressions of dissatisfaction.

During the onsite visits conducted, 2 of 2 providers from delegated entities stated that grievances were processed internally and not forwarded to the Plan.

Document review showed that a Plan's delegation agreement with one entity stated that all member grievances received must be forwarded to the Plan. However, review of the delegated entity's newly contracted provider training materials found it did not include training on the grievance process.

The provider manual stated when a provider has become aware that a member is dissatisfied with the delivery of care a member can call the Plan Member Services Department to file a grievance and grievance forms and assistance should be readily available. The provider manual did not clearly communicate that the Plan is responsible for processing and resolving grievances. The provider manual did not instruct providers to forward all grievances to the Plan.

In the November 2017 Access & Availability Subcommittee meeting the Plan discussed issues related to two providers who were handling their own grievances. The Plan became aware of the issue after members contacted the Plan after filing the grievance directly with the provider and no response was received.

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

RECOMMENDATIONS:

4.1.1 Revise and implement policy and procedures to ensure that all levels of a grievance are resolved prior to sending a resolution letter to members.

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

4.1.3 Develop and implement procedures to ensure consistent updating of the provider manual including correct timeframes for filing grievances.

4.1.4 Develop and implement grievance process training to new and existing providers of delegated entities to ensure all complaints and expressions of dissatisfaction are captured and processed.

4.3	CONFIDENTIALITY RIGHTS

Members' Right to Confidentiality
Contractor shall implement and maintain policies and procedures to ensure the Members' right to confidentiality of medical information.

1) Contractor shall ensure that Facilities implement and maintain procedures that guard against disclosure of confidential information to unauthorized persons inside and outside the network.
2) Contractor shall counsel Members on their right to confidentiality and Contractor shall obtain Member's consent prior to release of confidential information, unless such consent is not required pursuant to Title 22 CCR Section 51009.

2-Plan Contract A.13.1.B

Health Insurance Portability and Accountability Act (HIPAA) Responsibilities:
Business Associate agrees:

Safeguards. To implement administrative, physical, and technical safeguards that reasonably and appropriately protect the confidentiality, integrity, and availability of the PHI, including electronic PHI, that it creates, receives, maintains, uses or transmits on behalf of DHCS, in compliance with 45 CFR sections 164.308, 164.310 and 164.312, and to prevent use or disclosure of PHI other than as provided for by this Agreement. Business Associate shall implement reasonable and appropriate policies and procedures to comply with the standards, implementation specifications and other requirements of 45 CFR section 164, subpart C, in compliance with 45 CFR section 164.316. Business Associate shall develop and maintain a written information privacy and security program that includes administrative, technical and physical safeguards appropriate to the size and complexity of the Business Associate's operations and the nature and scope of its activities, and which incorporates the requirements of section 3, Security, below. Business Associate will provide DHCS with its current and updated policies.

2-Plan Contract G.III.C.2.

Breaches and Security Incidents. During the term of this Agreement, Business Associate agrees to implement reasonable systems for the discovery and prompt reporting of any breach or security incident, and to take the following steps:

1. **Notice to DHCS**. (1) To notify DHCS **immediately by telephone call plus email or fax** upon the discovery of a breach of unsecured PHI or PI in electronic media or in any other media if the PHI or PI was, or is reasonably believed to have been, accessed or acquired by an unauthorized person, or upon the discovery of a suspected security incident that involves data provided

4.3	CONFIDENTIALITY RIGHTS

to DHCS by the Social Security Administration. (2) 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. 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.

2. **Investigation and Investigation Report**. To immediately investigate such security incident, breach, or unauthorized access, use or disclosure of PHI or PI. Within 72 hours of the discovery, Business Associate shall submit an updated "DHCS Privacy Incident Report" containing the information marked with an asterisk and all other applicable information listed on the form, to the extent known at that time, to the DHCS Program Contract Manager, the DHCS Privacy Officer, and the DHCS Information Security Officer:
3. **Complete Report**. To provide a complete report of the investigation to the DHCS Program Contract Manager, the DHCS Privacy Officer, and the DHCS Information Security Officer within ten (10) working days of the discovery of the breach or unauthorized use or disclosure.

2-Plan Contract G.III.J

SUMMARY OF FINDINGS:

4.3.1 Breach Notification Procedures

Upon discovery of a breach, the Plan shall notify the DHCS Medi-Cal Managed Care Division (MMCD) Contracting Officer, the DHCS Privacy Officer and the DHCS Information Security Officer. (*Contract, Amendment 11, Exhibit G 3(H)(1)*)

Plan policy *CMP-013 HIPAA Privacy Reporting* stated the Compliance Department shall send notice to the DHCS contract officer/manager, DHCS Privacy Officer and DHCS Information Security Officer regarding privacy breach for Medi-Cal members.

The Plan did not report the discovery of PHI breaches to the DHCS Information Security Officer.

The verification study revealed that in 12 of 13 cases reviewed, the Plan did not send the notification to the DHCS Information Security Officer. The Plan did not implement its policy to report discovery of breaches to all required officers. In an interview, the Plan acknowledged awareness of this requirement and stated this occurred due to the lack of supervision for a new compliance employee.

When the Plan does not send notice to all required DHCS officers, the Plan risks not mitigating the potential harm of unauthorized use of PHI from all angles.

4.3.2 Notification of Suspected Security Incidents

The Plan is required to notify DHCS immediately, or within 24 hours by e-mail or fax of any suspected security incident, intrusion or unauthorized use or disclosure of PHI. (*Contract, Amendment 11, Exhibit G 3(H)(1)*)

Plan policy *CMP-013 HIPAA Privacy Reporting* stated the Compliance Department shall report, within 24 hours, of any potential loss of confidential data concerning the DHCS contract, or any suspected security incident, intrusion or unauthorized use or disclosure of PHI, send notice to the DHCS contract officer/manager, DHCS Privacy Officer and DHCS Information Security Officer regarding privacy breach for Medi-Cal members.

The Plan did not report all suspected security incidents or unauthorized disclosures of PHI to DHCS within 24 hours of discovery.

The verification study revealed that in 2 of 13 incidents reviewed, DHCS was not notified within 24 hours by e-mail or fax. These were reported to DHCS two and three days after it was discovered by the Plan. The Plan did not implement its privacy reporting policy to report the discovery of breach of PHI to DHCS.

By ensuring that the Plan consistently reports all suspected security incidents within the required timeframes, the Plan will meet its contractual and regulatory requirements in safeguarding the privacy of members' protected health information.

RECOMMENDATIONS:

4.3.1 Implement policies and procedures to ensure the Information Systems Officer is included in notification to DHCS.

4.3.2 Implement policies and procedures to ensure privacy breaches and security incidents are reported to DHCS within 24 hours.

❖ COMPLIANCE AUDIT FINDINGS (CAF) ❖

PLAN: Alameda Alliance for Health

AUDIT PERIOD: June 1, 2017 through May 31, 2018
DATE OF AUDIT: June 11, 2018 through June 22, 2018

CATEGORY 5 – QUALITY MANAGEMENT

5.2	PROVIDER QUALIFICATIONS

Credentialing and Re-credentialing:
Contractor shall develop and maintain written policies and procedures that include initial credentialing, recredentialing, recertification, and reappointment of Physicians including Primary Care Physicians and specialists in accordance with the MMCD Policy Letter 02-03, Credentialing and Re-credentialing.
Contractor shall ensure those policies and procedures are reviewed and approved by the governing body, or designee. Contractor shall ensure that the responsibility for recommendations regarding credentialing decisions will rest with a credentialing committee or other peer review body.
2-Plan Contract A.4.12

Standards:
All providers of Covered Services must be qualified in accordance with current applicable legal, professional, and technical standards and appropriately licensed, certified or registered….Providers that have been terminated from either Medicare or Medicaid/Medi-Cal cannot participate in Contractor's provider network.
2-Plan Contract A.4.12.A

Medi-Cal Managed Care Provider Training:
Contractor shall ensure that all providers receive training regarding the Medi-Cal Managed Care program in order to operate in full compliance with the Contract and all applicable Federal and State statutes and regulations. Contractor shall ensure that provider training relates to Medi- Cal Managed Care services, policies, procedures and any modifications to existing services, policies or procedures. Training shall include methods for sharing information between Contractor, provider, Member and/or other healthcare professionals. Contractor shall conduct training for all providers within ten (10) working days after the Contractor places a newly contracted provider on active status….
2-Plan Contract A.7.*5*

Delegated Credentialing:
Contractor may delegate credentialing and recredentialing activities. If Contractor delegates these activities, Contractor shall comply with Provision 6, Delegation of Quality Improvement Activities…
2-Plan Contract A.4.12.B

❖ COMPLIANCE AUDIT FINDINGS (CAF) ❖
PLAN: Alameda Alliance for Health
AUDIT PERIOD: June 1, 2017 through May 31, 2018 **DATE OF AUDIT:** June 11, 2018 through June 22, 2018

5.2	PROVIDER QUALIFICATIONS
Disciplinary Actions: Contractor shall implement and maintain a system for the reporting of serious quality deficiencies that result in suspension or termination of a practitioner to the appropriate authorities. Contractor shall implement and maintain policies and procedures for disciplinary actions including reducing, suspending, or terminating a practitioner's privileges. Contractor shall implement and maintain a provider appeal process. 2-Plan Contract A.4.12.D	

SUMMARY OF FINDINGS:

5.2.1 Completion of Provider Training

The Plan is required to ensure that all providers receive training regarding the Medi-Cal managed care services, policies, procedures, and any modifications to existing services, policies or procedures. The Plan is required to conduct training for all providers within ten (10) working days after the Plan places a newly contracted provider on active status. (*Contract, Amendment 11, Exhibit A, Attachment 7(5)(A)*)

Contracting providers means a physician, nurse, technician, teacher, researcher, hospital, home health agency, nursing home, or any other individual or institution that contracts with the Plan to provide medical services. (*Contract, Amendment 11, Exhibit E, Attachment 1(21)*)

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

The Plan did not ensure provider training was conducted within 10 working days. The verification study found the following deficiencies:

- Five providers received training after the 10 working day requirement.

- One provider received training within six days of being placed on active status; however, the Plan did not have a signed attestation form from the provider as required by the Plan's policy as acknowledgement of provider training completion.
- One provider did not receive any provider training.

Additional review of the tracking log found 13 providers identified as having not received training; six providers on the log were listed as having been trained, but the Plan did not provide a signed attestation.

Comparison of the Plan's tracking log and newly contracted provider list found several new providers were not included on the tracking log. In a written response, the Plan confirmed 74 additional new providers did not receive training.

The Plan also stated provider training was not conducted for four occupational therapists (OT) and two physical therapists (PT) as it was not required. The contract requires all newly contracted providers receive training within 10 working days of being placed on active status. The Plan was unaware OTs and PTs were required to receive provider training.

The prior DHCS audit found the Plan did not conduct provider training within 10 working days. As part of the CAP, the Plan updated its policy, *PRV-001*, to ensure provider training completion through comparison of a list of newly contracted providers and a provider orientation log. The Plan did not implement its revised monitoring policy to ensure newly contracted providers received provider training.

When new provider training is not conducted, the Plan cannot ensure providers have the necessary information to provide services to members as required by the Contract.

This is a repeat finding.

5.2.2 Delegation of Provider Training

The Plan may enter into Subcontracts with other entities in order to fulfill the obligations of the Contract. All subcontracts shall be in writing and in accordance with the requirements of the 42 CFR 438.230(b)(2). All contracts or written arrangements must specify the delegated activities or obligations, and related reporting responsibilities. (*Contract, Amendment 11, Exhibit A, Attachment 6(14)(A)*)

Plan policy *CMP-024 Subcontracting Relationships and Delegation* stated the Plan will establish a written contractual agreement for any activity or obligation delegated. The written agreements will include the following terms:

- Specification of all delegated activities, obligations, and related reporting responsibilities.
- Delegate's agreement to perform delegated activities and related reporting requirements.

The Plan did not specify in its written agreement provider training responsibilities for two delegated entities.

In an interview, the Plan reported it informally delegated provider training to two delegated entities. The written delegation agreement for one delegated entity did not include provider training as a responsibility. The written delegation agreement for the second delegated entity containing provider training responsibilities was not effective until the end of the audit period.

Without identifying specific responsibilities in a written agreement, the Plan cannot ensure its delegate will fulfill delegated obligations as contractually required.

5.2.3 Provider Training Materials

The Plan is required to ensure that all providers receive training regarding the Medi-Cal managed care services, policies, procedures, and any modifications to existing services, policies or procedures. The Plan shall ensure that provider training includes information on all Member rights including the right to full disclosure of health care information and the right to actively participate in health decisions. (*Contract, Amendment 11, Exhibit A, Attachment 7(5)(A)*)

Plan policy *PRV-001 New Provider Orientation* stated provider training included information on: member rights, interpreter services, access standards, and policies and procedures related to each provider's specialty.

The Plan did not ensure training materials provided by two delegated entities included information on Plan policies, procedures, services, and member rights and responsibilities.

Training provided to one delegated entity did not relate to newly contracted providers, was optional, and did not cover all Plan services, policies, and procedures.

In an interview, the Plan stated a second delegate's provider training program was tailored specifically to the delegate's business and agreed to by the Plan. The training provided did not include information on member rights and responsibilities, grievance and appeals process, prior authorization and referral process, and Plan services.

When provider training materials do not include information on all Plan policies, procedures, services, and member rights and responsibilities, the Plan cannot ensure its subcontractors meet the standards set forth by the Plan and DHCS.

RECOMMENDATIONS:

5.2.1 Implement policies and procedures to ensure training for all providers is conducted within 10 working days.

5.2.2 Implement policies and procedures to ensure all delegated contractually required functions, responsibilities, and reporting activities (including the provision of provider training to newly contracted providers) are in writing.

5.2.3 Revise and implement policies and procedures to ensure delegated provider training for all newly contracted providers includes information on Plan policies, procedures, services, and member rights and responsibilities.

❖ COMPLIANCE AUDIT FINDINGS (CAF) ❖

PLAN: Alameda Alliance for Health

AUDIT PERIOD: June 1, 2017 through May 31, 2018
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CATEGORY 6 – ADMINISTRATIVE AND ORGANIZATIONAL CAPACITY

6.3	FRAUD AND ABUSE

Fraud and Abuse Reporting
Contractor shall meet the requirements set forth in 42 CFR 438.608 by establishing administrative and management arrangements or procedures, as well as a mandatory compliance plan, which are designed to guard against fraud and abuse

1) Contractor shall establish an Anti-Fraud and Abuse Program in which there will be a compliance officer and a compliance committee for all fraud and/or abuse issues, and who shall be accountable to senior management. This program will establish policies and procedures for identifying, investigating and providing a prompt response against fraud and/or abuse in the provision of health care services under the Medi-Cal Program, and provide for the development of corrective action initiatives relating to the contract.
2) Contractor shall provide effective training and education for the compliance officer and all employees.
3) Contractor shall make provision for internal monitoring and auditing including establishing effective lines of communication between the compliance officer and employees and enforcement of standards through well-publicized disciplinary guidelines.
4) Fraud and Abuse Reporting—Contractor shall report to DHCS all cases of suspected fraud and/or abuse where there is reason to believe that an incident of fraud and/or abuse has occurred by subcontractors, members, providers, or employees. Contractor shall conduct, complete, and report to DHCS, the results of a preliminary investigation of the suspected fraud and/or abuse within 10 working days of the date Contractor first becomes aware of, or is on notice of, such activity….
5) Tracking Suspended Providers—Contractor shall comply with 42 CFR 438.610. Additionally, Contractor is prohibited from employing, contracting or maintaining a contract with physicians or other health care providers that are excluded, suspended or terminated from participation in the Medicare or Medi-Cal/Medicaid programs….

2-Plan Contract E.2.26.B

SUMMARY OF FINDINGS:

6.3.1 Fraud and Abuse Reporting

The Plan shall report to DHCS all cases of suspected fraud or abuse where there is reason to believe that an incident of fraud and/or abuse has occurred by subcontractors, members, providers, or employees. The Plan shall conduct, complete, and report the results of a preliminary investigation of the suspected fraud or abuse to DHCS within 10-working days of the date the Plan first becomes aware of, or is on notice of, such activity. (*Contract Amendment 11, Exhibit E, Attachment 2(26)(B)(4)*)

Plan policy *CMP-002 Fraud, Waste, and Abuse* stated, "The Compliance Department will report all suspected FWA incident to the DHCS within 10 working days of the date the Alliance becomes first aware or notified of the suspected activity. All employees are required to report promptly all known or potentially suspected fraudulent, waste or abuse occurrences to their department supervisor/manager or directly to the Compliance Department. Supervisors and managers are responsible for ensuring that violations of which they are aware are immediately reported to the Compliance Department."

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

- In 12 of 16 cases reviewed, the Plan did not conduct a preliminary investigation.
- In 3 of the 12 above cases, the Plan reported the incidents between 16 and 52 working days after receipt by the Compliance Department.

The prior DHCS audit found the Plan did not report suspected cases of fraud and abuse within 10-working days. As part of the corrective action, the Plan updated policies *CMP-002 Fraud, Waste, and Abuse* and *CMP-003 False Claims Act* to state all suspected FWA incidents must be reported to DHCS within 10 working days of being aware of the incident. The corrective action also included compliance staff training on updated Plan policies and procedures regarding fraud and abuse reporting requirements.

Although the Plan updated its policies and provided training to staff, the Plan did not consistently implement its policies and procedures to ensure fraud and abuse cases were reported timely to DHCS. The Plan did not provide an explanation as to why preliminary investigations were not conducted and reported to DHCS.

If the Plan does not report suspected fraud and abuse cases to DHCS within the required timeframe, the Plan increases its exposure to fraud and abuse that could have been detected, investigated, and prevented.

This is a repeat finding.

6.3.2 Fraud and Abuse Investigation

The Plan shall meet the requirements set forth in 42 CFR 438.608 by establishing administrative and management arrangements or procedures, as well as a mandatory compliance plan, which are designed to guard against fraud and abuse. This program will establish policies and procedures for identifying, investigating and providing a prompt response against fraud and abuse in the provision of health care services under the Medi-Cal Program, and provide for the development of corrective action initiatives relating to the contract. (*Contract, Amendment 11, Exhibit E, Attachment 2(26)(B)(1)*)

The Plan policy *CMP-002 Fraud, Waste, and Abuse* stated, "This policy and procedures identifies the mechanisms of how the Alliance identifies, investigates, and provides a prompt response against fraud and/or or abuse."

The Plan's *Fraud, Waste, and Abuse (FWA) Investigations Desktop* procedure states, "The Compliance Manager or Auditor will immediately investigate the FWA incident and gather all pertinent information from the reporting department or person."

The Plan did not conduct prompt and complete investigations of all suspected fraud and abuse incidents.

- In 14 of 16 cases, the Plan did not begin investigations until one to eight months after the cases were submitted to DHCS.
- In 6 of 16 cases reviewed, the Plan did not conduct a complete investigation. The Plan's investigation did not address the cause of the suspected fraud incident, determine the extent of the incident, nor provide a response to prevent further incidents from occurring.

In one case, a staff member of a skilled nursing facility impersonated a member to get the member disenrolled in a call to the Plan's Member Service center. During the call, the member services representative overheard the staff member telling another coworker "she was pretending to sound ill to sound like the member." The Plan's investigation included acquiring audio of the call. However, documentation did not show that the Plan reviewed the call or reached out to the skilled nursing facility to conduct an investigation.

If the Plan does not promptly and adequately investigate suspected fraud and abuse cases, the Plan cannot guard against fraud and abuse and may potentially allow further incidents to occur.

RECOMMENDATIONS:

6.3.1 Implement policies and procedures to conduct and report preliminary investigations of all suspected cases of fraud and abuse to DHCS within 10-working days.

6.3.2 Implement policies and procedures to promptly and completely investigate all fraud and abuse incidents.

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

REPORT ON THE MEDICAL AUDIT OF

Alameda Alliance for Health

Contract Number:	03-75793 State Supported Services
Audit Period:	June 1, 2017 Through May 31, 2018
Report Issued:	December 21, 2018

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I. INTRODUCTION

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

The on-site review was conducted from June 11, 2018 through June 22, 2018. The audit period is June 1, 2017 through May 31, 2018 and consisted of document review, verification study, and interviews with Plan personnel.

❖ COMPLIANCE AUDIT FINDINGS (CAF) ❖

PLAN: Alameda Alliance for Health

AUDIT PERIOD: June 1, 2017 through May 31, 2018
DATE OF AUDIT: June 11, 2018 through June 22, 2018

STATE SUPPORTED SERVICES CONTRACT REQUIREMENTS

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

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

SUMMARY OF FINDINGS:

SSS.1 Prior Authorizations for State Supported Service Claims

Managed Care Plans must not require medical justification and/or prior authorization for outpatient abortion services. (*APL 15-020*)

Plan policy *CLM-011 Abortion Services Claims Processing*, stated abortion services claims for Medi-Cal members do not require prior authorization or clinical review by the Alliance staff when performed on an outpatient basis.

Plan policy *UM-029 Sensitive Services* stated Medi-Cal members have the ability to self-refer, without prior authorization, to a qualified practitioner within the Alliance Network, or self-refer to qualified out of network practitioners, also without prior authorization as described in the member's Explanation of Coverage handbook.

The Plan denied state supported services (SSS) claims containing procedures that normally require prior authorization outside of a SSS setting. These claims were denied based on edits in the Plan's claims system and review by claims analysts; the Plan's process did not include exceptions for state supported services.

A verification study of 23 SSS claims found four claims were improperly denied for the service not being authorized. The Plan did not consistently implement its policies and procedures of not requiring prior authorization for the reimbursement of SSS claims.

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

SSS.2 Remittance Advice Denial Reasons

The Plan is required to reimburse each complete claim, or portion thereof, whether in state or out of state as practical, but no later than 45 working days after the date of receipt of the complete claim. (*CCR, Title 28, Section 1300.71(g)*)

The Plan is required to disclose the specific rationale used in determining why the claim was rejected. (*H&S Code Section 1399.55*) The notice that a claim is being contested shall identify the portion of the claim that is contested and the specific reasons for contesting the claim. (*H&S Code Section 1371*)

Plan policy *CLM-010 Family Planning and Sensitive Services Claims Processing*, stated the Plan will notify the provider in writing the portion of the claim that is being contested or denied with the specific reason(s) for contesting or denying the claim.

The Plan did not disclose the specific rationale used in determining why claims are rejected.

A review showed that 3 of 23 SSS claims were denied using the wrong denial reason code. In all three cases, the Plan could not find the beneficiary in their system or eligibility list. The Plan denied these claims under the reason code "Procedure is not valid for patient age." These claims should have been denied; however, the Plan inaccurately disclosed the specific rationale used in determining why the claims were rejected.

Disclosing incorrect information on the remittance advice can be misleading and may prevent a provider from resubmitting a claim correctly.

RECOMMENDATIONS:

SSS.1 Develop and implement procedures to adjudicate SSS claims without a prior authorization.

SSS.2 Develop and implement procedures to disclose the specific rationale used in determining why the claim was rejected.