

COMPLIANCE DASHBOARD SUMMARY

Resource	Type	2018	2019	2020	2021	2022	2023	2024	2025	2026	TOTAL	% Completed	
OVERALL FINDINGS	DHCS	Total State Audit Findings	38	28	7	33	15	24	20	0		165	
		Total Self-Identified Issues	12	0	0	2	0	2	6	3	2	27	
		Total Findings	50	28	7	35	15	26	26	3	2	192	
		Total In Progress	0	0	0	0	0	3	0	0	2	5	
		Total Completed	50	28	7	35	15	23	26	3		187	97%
		Total Findings	50	28	7	35	15	26	26	3	2	192	
	DMHC	Total State Audit Findings			5	6	8	3		16		38	
		Total Self-Identified Issues			3	0	0	0		6		9	
		Total Findings			8	6	8	3		22		47	
		Total In Progress			0	0	0	0		18		18	
		Total Completed			8	6	8	3		4		29	62%
	Total Findings	NA	NA	8	6	8	3	NA	22	NA	47		
	DMHC Financial Services	Total State Audit Findings		5			4			2		11	
		Total Self-Identified Issues		0			0			0		0	
		Total Findings		5			4			2		11	
Total In Progress			0			0			1		1		
Total Completed			5			4			1		10	91%	
Total Findings	NA	5	NA	NA	4	NA	NA	2	NA	11			
STATE AUDIT FINDINGS		In Progress	0	0	0	0	0	3	0	13		16	
		Completed	38	33	12	39	27	24	20	5		198	93%
		Total Findings	38	33	12	39	27	27	20	18		214	
SELF-IDENTIFIED FINDINGS		In Progress	0	0	0	0	0	0	6	2		8	
		Completed	12	0	3	2	0	2	6	3	0	28	78%
		Total Findings	12	0	3	2	0	2	6	9	2	36	
TOTAL OVERALL FINDINGS			50	33	15	41	27	29	26	27	2	250	90%

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OVERALL FINDINGS	Type	TOTAL	%
	Total State Audit Findings	214	86%
	Total Self-Identified Issues	36	14%
	Total Findings	250	
	Total In Progress	24	10%
	Total Completed	226	90%
	Total Findings	250	
STATE AUDIT FINDINGS	In Progress	16	7%
	Completed	198	93%
	Total Findings	214	
SELF-IDENTIFIED FINDINGS	In Progress	8	22%
	Completed	28	78%
	Total Findings	36	

2026 DHCS Audit Summary			
OVERALL FINDINGS	Type	TOTAL	%
	Total State Audit Findings	0	0%
	Total Self-Identified Issues	2	100%
	Total Findings	2	
	Total In Progress	0	0%
	Total Completed	0	0%
	Total Findings	2	

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2025 DMHC Fiscal Examination			
OVERALL FINDINGS	Type	TOTAL	%
	Total State Audit Findings	2	100%
	Total Self-Identified Issues	0	0%
	Total Findings	2	
	Total In Progress	1	50%
	Total Completed	1	50%
	Total Findings	2	

2025 DHCS Audit Summary			
OVERALL FINDINGS	Type	TOTAL	%
	Total State Audit Findings	0	0%
	Total Self-Identified Issues	3	100%
	Total Findings	3	
	Total In Progress	0	0%
	Total Completed	3	100%
	Total Findings	3	

2025 DMHC Audit Summary			
OVERALL FINDINGS	Type	TOTAL	%
	Total State Audit Findings	16	73%
	Total Self-Identified Issues	6	27%
	Total Findings	22	
	Total In Progress	18	82%
	Total Completed	4	18%
	Total Findings	22	

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2024 DHCS Audit Summary			
OVERALL FINDINGS	Type	TOTAL	%
	Total State Audit Findings	20	77%
	Total Self-Identified Issues	6	23%
	Total Findings	26	
	Total In Progress	0	0%
	Total Completed	26	100%
	Total Findings	26	

2023 DMHC Follow-Up Review			
OVERALL FINDINGS	Type	TOTAL	%
	Total State Audit Findings	3	100%
	Total Self-Identified Issues	0	0%
	Total Findings	3	
	Total In Progress	0	0%
	Total Completed	3	100%
	Total Findings	3	

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2023 DHCS Focused Audit Summary			
OVERALL FINDINGS	Type	TOTAL	%
	Total State Audit Findings	9	100%
	Total Self-Identified Issues	0	0%
	Total Findings	9	
	Total In Progress	3	33%
	Total Completed	6	67%
	Total Findings	9	

2023 DHCS Audit Summary			
OVERALL FINDINGS	Type	TOTAL	%
	Total State Audit Findings	15	88%
	Total Self-Identified Issues	2	12%
	Total Findings	17	
	Total In Progress	0	0%
	Total Completed	17	100%
	Total Findings	17	

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2022 DMHC BHI Audit Summary			
OVERALL FINDINGS	Type	TOTAL	%
	Total State Audit Findings	2	100%
	Total Self-Identified Issues	0	0%
	Total Findings	2	
	Total In Progress	0	0%
	Total Completed	2	100%
	Total Findings	2	

2022 DMHC RBO Audit: Delegate			
OVERALL FINDINGS	Type	TOTAL	%
	Total State Audit Findings	3	100%
	Total Self-Identified Issues	0	0%
	Total Findings	3	
	Total In Progress	0	0%
	Total Completed	3	100%
	Total Findings	3	

Compliance Dashboard Summary

2022 DMHC RBO Audit: Delegate			
OVERALL FINDINGS	Type	TOTAL	%
	Total State Audit Findings	3	100%
	Total Self-Identified Issues	0	0%
	Total Findings	3	
	Total In Progress	0	0%
	Total Completed	3	100%
	Total Findings	3	

2022 DMHC Financial Services Summary			
OVERALL FINDINGS	Type	TOTAL	%
	Total State Audit Findings	4	100%
	Total Self-Identified Issues	0	0%
	Total Findings	4	
	Total In Progress	0	0%
	Total Completed	4	100%
	Total Findings	4	

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2022 DHCS Audit Summary			
OVERALL FINDINGS	Type	TOTAL	%
	Total State Audit Findings	15	100%
	Total Self-Identified Issues	0	0%
	Total Findings	15	
	Total In Progress	0	0%
	Total Completed	15	100%
	Total Findings	15	

2021 DMHC Joint Audit Summary			
OVERALL FINDINGS	Type	TOTAL	%
	Total State Audit Findings	6	100%
	Total Self-Identified Issues	0	0%
	Total Findings	6	
	Total In Progress	0	0%
	Total Completed	6	100%
	Total Findings	6	

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2021 DHCS Joint Audit Summary			
OVERALL FINDINGS	Type	TOTAL	%
	Total State Audit Findings	33	94%
	Total Self-Identified Issues	2	6%
	Total Findings	35	
	Total In Progress	0	0%
	Total Completed	35	100%
	Total Findings	35	

2020 DHCS Focused Audit Summary			
OVERALL FINDINGS	Type	TOTAL	%
	Total State Audit Findings	7	100%
	Total Self-Identified Issues	0	0%
	Total Findings	7	
	Total In Progress	0	0%
	Total Completed	7	100%
	Total Findings	7	

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2020 DMHC Medical Services Audit Summary			
OVERALL FINDINGS	Type	TOTAL	%
	Total State Audit Findings	5	63%
	Total Self-Identified Issues	3	38%
	Total Findings	8	
	Total In Progress	0	0%
	Total Completed	8	100%
	Total Findings	8	

2019 DMHC Financial Services Audit Summary			
OVERALL FINDINGS	Type	TOTAL	%
	Total State Audit Findings	5	100%
	Total Self-Identified Issues	0	0%
	Total Findings	5	
	Total In Progress	0	0%
	Total Completed	5	100%
	Total Findings	5	

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2019 DHCS Medical Services Audit Summary			
OVERALL FINDINGS	Type	TOTAL	%
	Total State Audit Findings	28	100%
	Total Self-Identified Issues	0	0%
	Total Findings	28	
	Total In Progress	0	0%
	Total Completed	28	100%
	Total Findings	28	

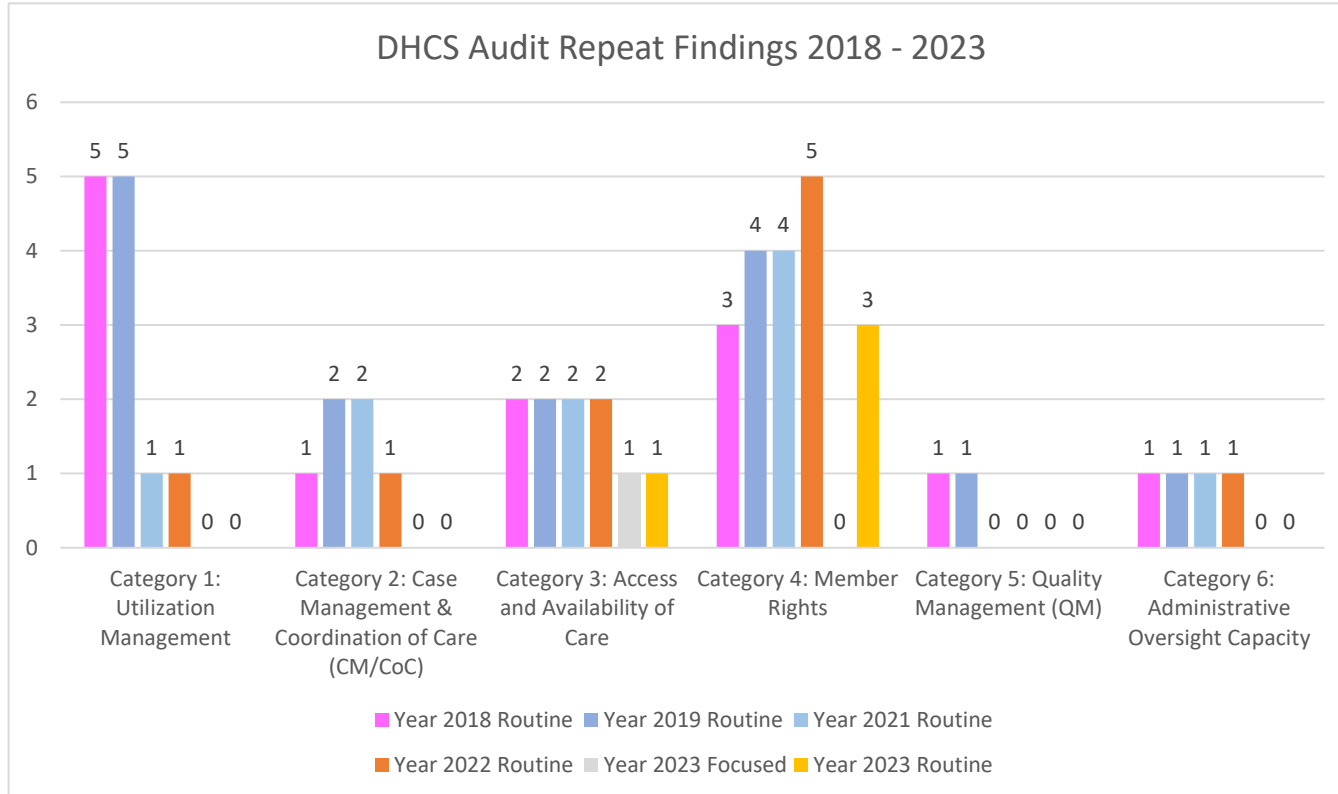
2018 DHCS Medical Services Audit Summary			
OVERALL FINDINGS	Type	TOTAL	%
	Total State Audit Findings	38	76%
	Total Self-Identified Issues	12	24%
	Total Findings	50	
	Total In Progress	0	0%
	Total Completed	50	100%
	Total Findings	50	

Compliance Dashboard Summary

DHCS Audit Repeat Findings 2018 - 2023

Category	Year						TOTAL
	2018 Routine	2019 Routine	2021 Routine	2022 Routine	2023 Focused	2023 Routine	
Category 1: Utilization Management	5	5	1	1	0	0	12
Category 2: Case Management & Coordination of Care (CM/CoC)	1	2	2	1	0	0	6
Category 3: Access and Availability of Care	2	2	2	2	1	1	10
Category 4: Member Rights	3	4	4	5	0	3	19
Category 5: Quality Management (QM)	1	1	0	0	0	0	2
Category 6: Administrative Oversight Capacity	1	1	1	1	0	0	4
TOTAL	13	15	10	10	1	4	53

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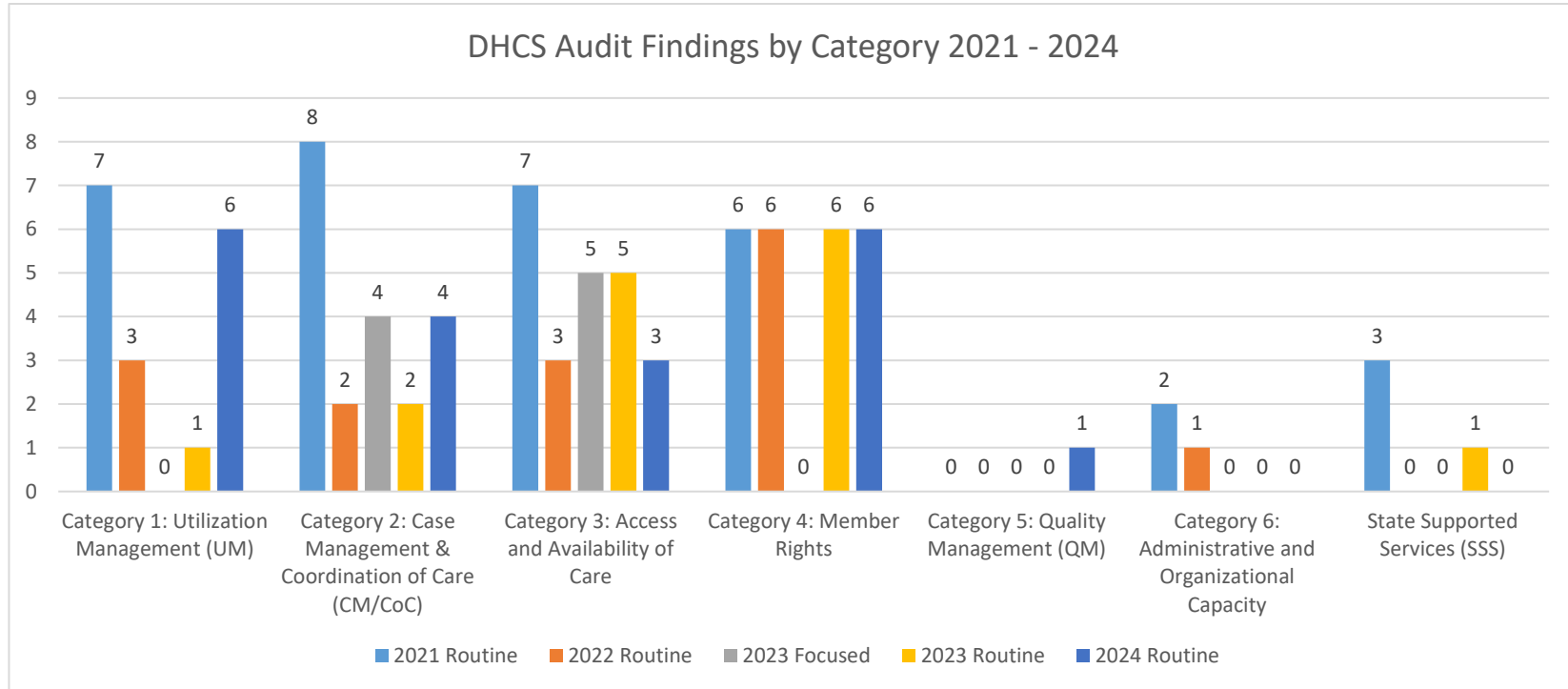


Compliance Dashboard Summary

DHCS Audit Findings by Category 2021 - 2024

	2021 Routine	2022 Routine	2023 Focused	2023 Routine	2024 Routine	TOTAL
Category 1: Utilization Management (UM)	7	3	0	1	6	17
Category 2: Case Management & Coordination of Care (CM/CoC)	8	2	4	2	4	20
Category 3: Access and Availability of Care	7	3	5	5	3	23
Category 4: Member Rights	6	6	0	6	6	24
Category 5: Quality Management (QM)	0	0	0	0	1	1
Category 6: Administrative and Organizational Capacity	2	1	0	0	0	3
State Supported Services (SSS)	3	0	0	1	0	4
TOTAL	33	15	9	15	20	92

Compliance Dashboard Summary



ALAMEDA ALLIANCE FOR HEALTH
COMPLIANCE DASHBOARD

KEY	
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2026 DHCS Audit - Audit Review Period March 1, 2025 to December 31, 2025 Virtual Audit Dates March 2, 2026 to March 13, 2026						
#	Category	Plan Observations - DHCS Preliminary Findings expected June 2026	Corrective Action Plan (CAP)	Completion Date	Internal CAP Status	Department Responsible
1	PHM & CoC (Enhanced Care Management)	The Plan's 2025 ECM Provider Directory did not show ECM providers for the months of January-February, and July - December.	<p>The Alliance experienced a glitch in the provider directory data extraction process that caused the ECM providers to be excluded from the extraction. The Alliance has corrected the data template to ensure that required data elements are included in the reporting template and include ECM providers. In addition, on March 11, 2026, we also confirmed requirements with our vendor, KP, who uses the data extraction reports to create a PDF version of the directory. The new data extraction template will also be used going forward for subsequent Provider Directories.</p> <p>Recommend PS to develop an oversight element that addressed whether the directories are reviewed for accuracy and at what cadence so that the Plan may identify and correct errors timely.</p> <p>5/5/2026 Update: IT and C&O includes Provider Services when sending the Provider Directory files for ongoing oversight.</p>	TBD	Pending	Provider Services
2	PHM & CoC (Pregnant & Postpartum Members)	Regarding CPSP reimbursement, the Plan does not have an oversight mechanism in place for CPSP providers.	<p>CPSP approval is administered by the California Department of Public Health (CDPH) and is not reflected within Medi-Cal enrollment systems or Plan credentialing data sources. The Plan confirmed that there is no CPSP indicator available within the Medi-Cal enrollment portal or other DHCS-managed systems to validate CDPH CPSP approval status.</p> <p>Recommend to develop an oversight mechanism for CPSP claims monitoring and verification for CPSP approved providers.</p>	TBD	Pending	Credentialing Provider Services Claims

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2025 DMHC Routine Fiscal Examination - Audit Review Period January 1, 2025 to March 31, 2025 Audit Date August 4, 2025						
#	Category	Deficiencies	Corrective Action Plan (CAP)	Completion Date	Internal CAP Status	Department Responsible
1	Finance	The Department's examination disclosed that the Plan failed to pay interest on late claim payments related to Targeted Provider Rate Increases (TRI) issued after December 31, 2024. On June 20, 2024, The California Department of Health Care Services (DHCS) issued an All-Plan Letter (APL) 24-007 instructing Medi-Cal managed care plans to "achieve full compliance with this APL by December 31, 2024," including retroactive payment adjustments. Claim payments issued by the Plan after December 31, 2024, related to the TRI did not include interest on the late payments.	On September 10, 2025, prior to issuance of the Preliminary Report, the Plan paid the interest and penalties due on late claim payments resulting in additional payments of interest of \$54,261 and penalties of \$66,120 on 6,612 claims.	9/10/2025	Complete	Claims
2	Finance	The Department's examination disclosed that the Plan failed to follow up with its capitated providers on two claims forwarded by the Plan to the capitated providers. The Plan did not check the status of the forwarded claims with the capitated providers, nor did it keep any records to indicate whether these forwarded claims were received and processed by the capitated providers. The Department's examination also indicated that the Plan does not have written policies and procedures to ensure that claims forwarded to the Plan's capitated providers are processed in compliance with the requirements of Sections 1371, 1371.35, and Rule 1300.71.	The Plan currently forwards claims identified as the responsibility of delegates/capitated providers within regulatory timeframes per Cal. Code Regs. Tit. 28, § 1300.71(b)(2). 3/2/26 Update: To strengthen our oversight of misdirected claims, the Plan reviewed and enhance existing policies and procedures, as applicable, to clearly define the steps to audit forwarded claims and ensure compliance with Sections 1371, 1371.35, and Rule 1300.71. - CLM-009 P&P and CMP-403 Approved at AOC on 2/18/26; P&Ps were submitted to DMHC on 3/2/26. 4/3/26 Update: Compliance implemented the forwarded claims validation process to ensure oversight and compliance. 4/20/26 Update: DMHC confirmed that the CAP is completed and closed. 5/1/26 Update: Monthly forwarded claims validation is ongoing.	Ongoing	In Progress	Compliance - DO Claims

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2025 DMHC Audit - Audit Review Period 10/1/2022 - 9/30/2024 Audit Onsite Dates - March 5, 2025 to March 7, 2025					
#	Category	Deficiency	Corrective Action Plan (CAP)	Completion Date	Department Responsible
1	Quality Assurance	The Plan did not document that quality of care provided is reviewed, problems are identified, effective action is taken to improve care where deficiencies are identified, and follow-up is planned where indicated.	The PQI CAP workflow was modified (orange) to include the following: 1) QI RN case owner to review response to each CAP question and reviewed by the MD, 2) for non-compliant/responsive providers, added that if noted by the MD, the QI RN case owner will be referred to the Peer Review Committee and/or report the quality issue to the appropriate regulatory bodies, 3) the provider or facility will be tracked on the Escalation Log maintained by Compliance. In addition, the MD will use a templated final note: "Medical Director CAP Review and Attestation" to ensure all CAP issues are addressed and follow up is planned where indicated. The PQI CAP template was revised to include a table with lines to ensure that each deficiency (problem) and corrective action(s) are addressed. 5/2026 Update: Implementation is tied to the BOG meeting scheduled for 5/8/26 to allow formal inclusion in the CEO report and documentation in meeting minutes.	TBD	Quality Assurance
2	Grievance and Appeals	The Plan's governing body did not thoroughly document it periodically reviewed a written record of grievances.	The Plan revised its grievance governance reporting process to ensure that the written grievance report documentation the Board of Governors (BOG) periodically receives specifically includes aggregate grievance trends, categories, representative summaries, dispositions, and identification of systemic or recurring issues. The Plan implemented dedicating a duration of time for standardized grievance and appeals at BOG meetings and updated documentation requirements to ensure meeting minutes explicitly reflect the BOG's review of the written grievance record during each meeting, including reference to the report. 5/2026 Update: Implementation is tied to the BOG meeting scheduled for 5/8/26. 06/03/26 Update: Health Plan audit team is working with stakeholders to validate CAP implementation.	TBD	G&A
3	Grievance and Appeals	181. The Plan did not consistently provide immediate notification to complainants of their right to contact the Department regarding an expedited grievance. Section 1368.01(b); Rule 1300.68.01(a)(1).	Monthly internal audits are conducted for expedited grievances and appeals. 06/03/26 Update: Grievance resolution letter template coverage disputes updated. The Plan submitted its CAP and DMHC has reviewed, per DMHC final report, this deficiency has been corrected.	4/1/2026	G&A
4	Grievance and Appeals	The Plan's written response to expedited grievances involving a determination that the requested service was not a covered benefit did not include a notice that the enrollee should contact the Department if they believed a denial was based on lack of medical necessity. Rule 1300.68(d)(5).	5/19/2026 - Corrected per DMHC. The Plan will update its Grievance Resolution template letters to include language for when requested service are not a covered benefit, the enrollee should contact the Department if they believed the denial was based on lack of medical necessity. Once the templates are finalized, the Grievance and Appeals Department will provide training to staff of the new templates to utilize.	TBD	G&A
5	Access and Availability	The Plan did not monitor telephone triage service wait times to ensure the wait times did not exceed 30 minutes.	The Plan provided standard operating procedure file "CM_SOP_Nurse Line" detailing the monitoring workflow. Please also see included example file "Alameda Quarterly Telemetrics 2025_Q4" showing average wait times in seconds for all of 2025.	TBD	CM
6	Access and Availability	The Plan's notification to providers did not include the information required in Section 1367.27(i)(2)(A)-(C).	The Plan will update its Provider Demographic Form to include the information that providers may utilize the Plan's online interface through the Alliance Provider Portal to review the information in the directory (the Provider Demographic Attestation) and that failure to respond may result in a delay of payment or reimbursement of a claim pursuant to Section 1367.27 subdivision (p). In addition, the Plan will create a new provider notice that provides instructions on how providers can use the Alliance Provider Portal to review and attest to the Provider Directory information (the Provider Demographic Attestation) and work with our Provider Portal vendor to see if there are any available options to enhance the use of the Provider Demographic Attestation within the Alliance Provider Portal. 3/30/26 Update: The Plan updated its provider communication document, Provider Demographic Attestation Form.	TBD	Provider Services
7	Access and Availability	The Plan did not have a process to monitor whether its provider networks experienced a 10 percent change.	Plan has updated its policy, PRV-003 Provider Network Capacity Standards, to include a process to monitor whether the network has experienced a 10 percent change. The policy was presented and reviewed in its Administrative Oversight Committee (AOC) Meeting on 1/21/2026 and anticipates it to be approved in the subsequent AOC meeting on 2/18/2026. In addition, the Plan has created a workflow that outlines the steps that will be taken to monitor (see DMHC Significant Network Filing Workflow). 2/18/26 Update: PRV-003 P&P approved at AOC. 06/03/26 Update: Health Plan audit team is working with stakeholders to validate CAP implementation.	TBD	Provider Services
8	UM	The Plan did not consistently notify the requesting provider within 24 hours of a decision to modify or deny a request. Section 1367.01(h)(3).	The Plan has initiated corrective actions to ensure notification timeliness fully complies with DMHC regulatory requirements. Specifically, the Plan will conduct audits of the provider notification timeliness to address previously identified deficiencies. The Plan has updated policy UM-051 Timeliness of UM Decision Making and Notification to include the process for auditing the timeliness of member and provider notifications. The policy will be presented and reviewed at the next QIHEC meeting scheduled for 2/13/2026 and is anticipated to be presented for approval at the subsequent AOC meeting.	TBD	UM
9	UM	The Plan failed to demonstrate that in the case of concurrent review denials, care was not discontinued until the enrollee's treating provider was notified and agreed to an appropriate care plan. Section 1367.01(h)(3).	The Plan has updated its policy, UM 003 Concurrent Review, to clarify the steps for reaching an agreement with the Treating Provider. The Policy will be presented and reviewed at the next QIHEC meeting scheduled for 2/13/2026 and is anticipated to be presented for approval at the subsequent AOC meeting.	TBD	UM
10	UM	The Plan did not conduct adequate oversight of its delegates to ensure written communications to enrollees regarding decisions to deny or modify services were clear and concise. Section 1367.01(h)(4).	In regards to the Carelon/ Beacon findings, the plan has taken the proactive steps to de-delegate Carelon/ Beacon and bring the UM responsibilities for Behavioral and Mental Health in house with all functions performed by the Alliance effective April 2023. For the CFMG Delegate oversight, the plan has identified these same findings during the 2025 Annual Audit. The plan has a Corrective Action Plan (CAP) in place with CFMG that became effective on 11/14/2025. The CAP requires CFMG to provide evidence of efforts to monitor this requirement through internal audits. They must provide quarterly and annual internal audit results to the Alliance showing evidence of compliance/corrected deficiencies and submit documentation via the HICE reports for oversight and monitoring.	TBD	UM Compliance - DO

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2025 DMHC Audit - Audit Review Period 10/1/2022 - 9/30/2024 Audit Onsite Dates - March 5, 2025 to March 7, 2025					
#	Category	Deficiency	Corrective Action Plan (CAP)	Completion Date	Department Responsible
11	UM	The Plan did not conduct adequate oversight of its delegates to ensure delegates consistently provided the reviewer's required contact information. Section 1367.01(h)(4).	The Plan agrees with the findings. In regards to the Carelon/ Beacon findings, the Plan took proactive steps to de-delegate Carelon/ Beacon and transitioned all UM responsibilities for behavioral and mental health services in house, with all functions performed by the Alliance effective April 2023. With respect to CFMG Delegate oversight, the Plan identified the same findings during the 2025 Annual Audit and implemented a Corrective Action Plan (CAP) effective 11/14/2025. CFMG has corrected the deficiency to ensure that the peer-to-peer phone number listed on adverse decision letters connects directly to CFMG Medical Directors. CFMG completed re-recording of the peer-to-peer line with enhanced instructions in October 2025, and the updated number is now aligned with the adverse determination notices.	TBD	UM Compliance - DO
12	Pharmacy	The Plan did not consistently include a description of the criteria or guidelines used for the decision in formulary exception denial and modification letters. Section 1367.01(h)(4).	Contested: The Plan reviewed DMHC reports and confirmed their applicability to several identified criteria documents. The Plan prepared a narrative explaining how the Alliance develops clinical criteria and applies to them clearly, concisely, and on an individualized basis to member-specific circumstances.	TBD	Pharmacy
13	Pharmacy	(R) The Plan's published formulary did not meet regulatory requirements. Rule 1300.67.205(b), (c)(4)-(6), (d)(2), (4)-(7), (9)-(18).	The Plan has initiated corrective actions to ensure the online searchable formulary fully complies with DMHC regulatory requirements. Specifically, the Plan will update the formulary webpage to incorporate a direct link to the DMHC-approved Formulary Cover Page, thereby addressing previously identified deficiencies. This enhancement will ensure that members, providers, and regulators have immediate access to the approved formulary cover information, including all mandated disclosures.	TBD	Pharmacy
14	Behavioral Health	The Plan did not demonstrate that all staff who conducted utilization review of mental health and substance use disorder treatment services and benefits completed the formal education program for each nonprofit association criteria or guidelines utilized by the Plan. Section 1374.721(a), (b), and (e)(1)	Contested: The Plan documents in the Post-Audit file 145_NPA Guidelines Training that six (6) team members successfully completed training on ASAM, ECSII, LOCUS, and CALOCUS-CASII. Only Behavioral Health staff who have completed training on the Non-Profit Professional Association (NPA) guidelines are authorized to review Group Care mental health (MH) and substance use disorder (SUD) authorization requests (see documents 145_BH NPA Guidelines Training and 145_BH Training Certificates). The Plan further confirms that all utilization management (UM) staff who review transgender care authorizations have completed training on the World Professional Association for Transgender Health (WPATH) standards (see documents AAH WPATH Training Compliance Grid and WPATH Certificates of Completion). As documented in the APL 24-007 comment table (File Number: 20242576-7), the Plan does not conduct medical necessity reviews for applied behavior analysis (ABA) services for Group Care members and therefore does not utilize CASP guidelines. The comment table also documents the Plan's use of the American Psychiatric Association and American Psychological Association guidelines for the review of psychological testing, neuropsychological testing, transcranial magnetic stimulation (TMS), and electroconvulsive therapy (ECT) services.	TBD	Behavioral Health
15	Behavioral Health	The Plan did not conduct interrater reliability testing to ensure consistency in medical necessity decision making covering all aspects of mental health and substance use disorder utilization review. Section 1374.721(b), (e)(5) and (f)(3)(A).	5/19/2026 - Corrected per DMHC. Contested: The Plan develops Inter-Rater Reliability (IRR) testing to ensure consistency in authorization determinations and to confirm that appropriate clinical guidelines are applied throughout the review process. These IRRs are designed to validate that decision-making aligns with established standards for mental health and substance use disorder services. The urgency classification of an authorization request (routine, urgent, or retrospective) does not affect the application of medical necessity criteria; rather, it only determines the applicable turnaround timeframe for the authorization decision. The Plan believes that utilization management staff have been appropriately tested through IRR processes to ensure accurate and consistent application of medical necessity guidelines.	TBD	Behavioral Health
16	Behavioral Health	The Plan did not ensure its delegate used only those criteria from nonprofit associations listed in the All Plan Letter 21-002 Attachment A, and alternative criteria approved by the Department, when making medical necessity determinations for requested mental health and substance use disorder services. Section 1367.01(j); Section 1374.721(a), (b) and (h).	06/03/26 Update: Health Plan audit team is working with stakeholders to validate CAP implementation. 5/19/2026 - Corrected per DMHC. Contested: The Plan documented in its APL 22-002 comment table (File Number: 20211181) that it confirmed with its delegate the required utilization management Non-Profit Professional Association (NPA) guidelines would be used to determine medical necessity for Group Care/HSS members. At that time, the delegate submitted a written attestation and training logs as part of the DMHC comment table, which were accepted by the DMHC. The Plan also reviewed the delegate's policies requiring use of the applicable guidelines and completion of annual Inter-Rater Reliability (IRR) testing. In addition, the Plan audited a random sample of Notices of Action, which documented use of the appropriate guideline by service type and line of business. The Plan did not conduct a separate audit of this specific requirement because the delegate had provided written confirmation of compliance with SB 855, and this documentation was accepted by DMHC. The Plan subsequently insured all behavioral health utilization review activities in April 2023. In August 2025, DMHC accepted the Plan's comment table (File Number: 20242576-7) documenting implementation of SB 855 and compliance with APL 24-007. 06/03/26 Update: Health Plan audit team is working with stakeholders to validate CAP implementation.	TBD	Behavioral Health
A	Compliance	Corrective Action Plan (CAP) tracking, monitoring, and management.	The Plan's Compliance Team has enhanced its CAP form to facilitate a more efficient and streamlined review process. CAP items incorporated into meetings with delegates and subcontractors, ensuring thorough follow-up and reinforcing monitoring efforts. Additionally, the DO team oversees annual and ad hoc audit CAPs, reporting them to SDOC for review and closure, further strengthening compliance oversight. Finally, the DO team will conduct training for SMEs on CAP verification and monitoring, ensuring a timely and thorough review process. 06/03/26: Guidance provided at Internal kick-offs meeting and adhoc meetings.	Already in Place Already in Place Already in Place TBD	Compliance

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2025 DMHC Audit - Audit Review Period 10/1/2022 - 9/30/2024 Audit Onsite Dates - March 5, 2025 to March 7, 2025					
#	Category	Deficiency	Corrective Action Plan (CAP)	Completion Date	Department Responsible
B	UM	Communication and notification process for decision letters, delay notices, and notification letters.	UM departments have P&Ps that detail our notification processes, including the required timeframes, content, and enclosures for all letters.	Already in Place	UM
C	UM	Utilization Management policy and procedures regarding 24 hour, seven day a week availability for urgent / emergent requests regarding members.	Currently, Plan contracted and non-contracted hospitals do have 24-hour access to the Alliance UM department to make authorization requests through on-call Plan RNs and MDs.	Already in Place	UM
D	Grievance and Appeals	Appeal process for terminally ill members	Grievance and Appeals has policy and procedure for accepting and resolving expedited appeals.	Already in Place	UM G&A
E	Access and Availability	Accuracy of provider network and directory information	Provider Services has in place a process to proactively outreach to providers to verify provider directory information as well as what steps to take when provider directory inaccuracies are reported.	Already in Place	Provider Services
F	Member Rights	Monitoring of calls and member services for expressions of dissatisfaction.	The Member Services Department has a process in place to monitor calls to ensure all expressions of dissatisfaction are appropriately identified.	Already in Place	Member Services G&A

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2024 DHCS Audit - Audit Review Period 6/1/2023 - 5/31/2024 Audit Onsite Dates - June 17, 2024 - June 28, 2024							INTERNAL AUDITS		
#	Category	Deficiency	Corrective Action Plan (CAP)	Completion Date	Internal CAP Status	Department Responsible	Validation Status	State/Self-Identified	Agency
1	UM	(1.2.1) Referral to Transplant Program Within 72 Hours The Plan did not directly refer an adult member to a transplant program for evaluation within 72 hours of the member's specialist identifying the member as a potential candidate for MOT.	1. The Plan's Standard Operating Procedures (SOP) were updated to reflect the 72 hours MOT TAT and all UM staff were re-trained on 6/20/2024. 2. The UM team instituted a formal internal review process to ensure all operating procedures align with Policy & Procedures. A Standard Operating Procedures (SOP) was developed and staff were trained on the internal review process. 3. Policy & Procedure Tracker developed to ensure at least annual and ad-hoc updates to P&Ps are monitored and aligned with regulatory guidance. The Plan monitors MOT turnaround times via daily operational reports.	1/15/2025	Completed	UM		State	DHCS
2	UM	(1.2.2) Centers of Excellence (COE) for Major Organ Transplants The Plan did not ensure that all MOT procedures were performed in a Medi-Cal approved COE transplant program. The Plan did not confirm that its COEs were unable to perform a MOT surgery before arranging the MOT at a transplant program that is not a Medi-Cal approved COE.	1. On 6/27/2024 The Plans Medical Directors were notified that Bone Marrow Transplant (BMT) and other regulatory Major Organ Transplants (MOT) are only managed in-network unless Continuity Of Care (COC) or related to urgent/emergent hospitalization. In addition, The Plan took the following actions: On 6/27/2024 the MOT workflows were updated to include Chief Medical Officer (CMO) Denial oversight. On 8/14/2024 The Plan conducted Delegate training for the new CHCN Medical Director and CHCN Utilization Management Director. On 8/1/2024 a copy of the current DHCS Centers Of Excellence list was distributed to staff. The Plan updated policy UM-071 and submitted to Utilization Management Committee on 8/30/2024. 2. The Plan updated Standard Operating Procedures to include DHCS Center Of Excellence requirements. 3. The UM team instituted a formal internal review process to ensure all operating procedures align with Policy & Procedures. A Standard Operating Procedures was developed, and staff were trained on the internal review process. <u>Update 2/15/2025</u> ; Operation Major Organ Transplant reported created and being used to monitor the appropriate use of Medi-Cal COEs.	4/15/2025	Completed	UM		State	DHCS
3	UM	(1.3.1) Written Member Consent The Plan did not obtain members' written consent when providers requested appeals on behalf of members.	1. The Plan updated G&A-008 Adverse Benefit Determination Appeal Process to meet the requirements of Member Written Consent in accordance with The Plan's DHCS contract. The workflow was updated and staff training completed on 11/6/2024 2. Internal audits for requirement of written member consent started in January 2024 and will continue.	4/15/2025	Completed	G&A		State	DHCS
4	UM	(1.3.2) Appeals Letters: Nondiscrimination Notice (NDN) and Language Assistance Taglines (LAT) The Plan did not send NDN and LAT information that met the minimum requirements in APL 21-004 with member notifications for appeals.	1. CLS-003 Non-discrimination Language Assistance Services and Effective Communication for Individuals with Disabilities has been submitted and accepted by the MCOD. 2. The Your Rights Package was updated with the current Non-Discrimination Notice (NDN) and Language Assistance Tagline (LAT). The NDN and LAT were added to the Member Rights package and updated in the G&A system. 3. The G&A Department in conjunction with the Compliance Department will review all enclosures on an annual basis to ensure compliance. G&A is completing an Internal Audit SOP that outlines the self-monitoring / internal audit process. 5/9/2025: G&A completed an internal audit Standard Operating Procedure (SOP) the outlines the self-monitoring / internal audit process. In addition, a focused audit tool that identifies NDN and LAT information has been implemented for internal monitoring to ensure that the NDN and LAT information is correct.	4/15/2025	Completed	G&A	✓	State	DHCS

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#	Category	Deficiency	Corrective Action Plan (CAP)	Completion Date	Internal CAP Status	Department Responsible	Validation Status	State/Self-Identified	Agency
5	UM	(1.5.1) Overutilization of Subacute Level of Facility Care The Plan did not ensure that its delegate had mechanisms to detect overutilization of subacute level of facility care; the delegate inappropriately approved higher levels of subacute care for members who required lower levels of regular skilled nursing facility care.	<ol style="list-style-type: none"> The delegate reports over/under-utilization measures in their quarterly HICE report. The Plan has instituted a Standardized Operating Procedure that delineates roles and responsibilities for reviewing delegate reports, including a formal sign-off process, to be used in conjunction with P&P UM-060 Delegation Management and Oversight. The Plan will request the delegate include post-acute cases in their annual UM audit universe and monthly internal UM audit reports. <u>Update 1/15/2025</u>: The Plan received the delegate's internal UM audit report submission on 12/27/2024 and completed a review of the delegate's audit results on 12/31/2024, and noted adequate strategies to address findings. The Plan has requested the delegate include nursing facility utilization as part of their over/under utilization measures, reported in the Quarterly HICE report (auth volume by facility levels of care). The Q4 2024 HICE report is pending. <u>Update 5/9/2025</u>: The Q4 2024 HICE report has been submitted to the Plan for review that overutilization is being monitored. The Plan shares all newly issued DHCS APLs and guidance, including billing instructions related to revenue codes, and collects attestations from delegates <u>Update 7/11/2025</u>: The Plan confirmed attestations for APLS 24-009 and 24 010 were received from the delegate and all revenue codes have been implemented 	7/11/2025	Completed	UM		State	DHCS
6	UM	(1.5.2) Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) Services The Plan did not ensure that its delegate provided medically necessary EPSDT services, care coordination, and appointment scheduling assistance to members under the age of 21.	<ol style="list-style-type: none"> The delegate created a new policy and procedure specific to EPSDT care coordination. This policy will be reviewed by the delegate's internal committee on 1/22/2025 and then the policy will be submitted to the Plan for review. <u>5/9/2025</u>: The Policy for EPSDT Services has been finalized. The Plan requested the delegate identify EPSDT cases in their monthly internal Case Management audit reports, as well as identifying EPSDT cases in their annual UM audit universe and monthly internal UM audit reports. The Plan will audit EPSDT cases to evaluate whether members are receiving appropriate EPSDT services, care coordination, and appointment scheduling as needed. <u>Updated 1/15/2025</u>: The Plan received confirmation that the delegate updated their internal audit tool to include the appropriate EPSDT elements. The Plan will review the delegate's next internal audit to verify use of the revised audit tool. <u>Update 2/15/2025</u>: The Plan received the delegate's internal audit tool and has confirmed it reflects the EPSDT elements were added appropriately. The Plan will report the delegate's CM and UM audit outcomes at the UM Committee, upon receipt of reports. <u>Update 7/11/2025</u>: The delegate's audit tool was revised for EPSDT elements and an audit was completed by the delegate and reviewed by the Plan for March. The Plan will continue to monitor new EPSDT audit elements. 	7/11/2025	Completed	UM		State	DHCS
7	CM and CoC	(2.1.1) Provision of Blood Lead Screening The Plan did not ensure that blood lead screening tests were conducted for members up to six years of age.	<ol style="list-style-type: none"> The Plan updated Policy QI-125 to include a requirement for providers to follow up on lab orders. Policy QI-125 will be approved in Quality Committee by 2/30/2025 and the Administrative Oversight Committee by 4/16/2025. Funding for point-of-care testing units was provided in January 2024 to the delegate. These units aim to eliminate the need for members to make an additional visit to the lab. The Plan conducted member outreach and member incentives; members were offered a gift card to complete their services at the lab. The Plan continues to monitor the HEDIS lead screening rates. Monitoring includes tracking of the documentation of lead level results by providers for ordered blood lead tests and any necessary follow-up activities and services for members, which is done through IHA audits and facility site reviews. The Plan has conducted provider education through webinars, 1:1 meetings, CLPP training 1) Healthcare Services All-Staff meeting, 2) Provider webinar (live) and video (posted on Alliance website) and Measure Highlight tools. The Plan previously conducted annual IHA audits to review provider charts for completion of preventive screenings. The frequency of these audits has now increased to twice a year. Additionally, during Facility Site Reviews (FSRs), charts are monitored for lead screening compliance. An audit is conducted for Blood Lead Screening, and charts are reviewed for evidence of discussion, orders/refusal and results. When evidence of lead screening is not found, the Plan sends education letters to providers indicating the discrepancy. <u>Update 2/15/2025</u>: The Plan conducted an IHA audit Q3 2024 for IHA period 10/1/2023-05/31/2024. Lead screening rates and IHA results are reviewed at the Quality Improvement Health Equity Committee meetings. <u>Update 5/9/2025</u>: The IHA audit was completed for Q3 2025. 	In Progress	Completed	QI		State	DHCS

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9	CM and CoC	(2.3.1) Provision of Behavioral Health Therapy (BHT) Services The Plan did not ensure the provision of BHT services in accordance with approved BHT treatment plans for members under the age of 21.	<p>1. The Plan's existing policies support BHT services in accordance with BHT plans for members under the age of 21. The Plan insured BHT services on 4/1/23 with the goal of increasing member access to care. The Plan has a dedicated team of care coordinators and BCBA's to support access to care. The Plan continues to explore opportunities to improve access to BHT care. This includes interventions to enhance the network and incentivize agencies to prioritize AAH members for services. The Plan continues to authorize out-of-network services whenever possible.</p> <p>2. The Plan authorizes care within the required timeframes as requests are received. To monitor this issue, The Plan has established a metric to track the number of authorized hours to bill services. This functions as an indicator of the need for additional provider resources. This is a continuous process that started 5/10/2024. The Plan has ongoing efforts to onboard and contract additional BHT/ABA providers as additional resources are necessary. A monitoring and reporting process has been put in place to show the monthly authorized services for each member receiving BHT/ABA Treatment and for each QASP. The plan compares the # of authorized hours of BHT/ABA to the # of hours delivered based on claims data to monitor, track and report the % of authorized hours that are delivered. The plan reports these findings to the UM committee and identifies the QASPs with the lowest delivered services for outreach and intervention. <u>Update 5/9/2025</u>; Member utilization reports are being reviewed to measure utilization rates. The Plan works with providers who have low utilization to identify gaps or barriers preventing the fulfillment of authorized hours. <u>Update 7/11/2025</u>; Training for updated BHT-ABA Forms was completed on 4/30/2025 and BHT Utilization is being reported out at UM Committee. <u>Update 10/16/2025</u>; IA conducted an audit for this area beginning 08/26/25; the audit was closed on 10/16/25 with no CAPs.</p> <p>3. The Plan has drafted parent advisement that is scripted and provided to each parent/guardian when BHT/ABA services are authorized that asks for parents/guardians to call the Alliance BHT/ABA case management team if they experience disruption or barriers in receiving the BHT/ABA services that have been authorized for their child.</p>	7/11/2025	Completed	Behavioral Health	<input checked="" type="checkbox"/>	State	DHCS
8	CM and CoC	(2.3.2) Timely Access to Behavioral Health Therapy (BHT) Services The Plan did not arrange and coordinate BHT services for members under the age of 21 within 60 calendar days.	<p>1. The Plan established an EPSDT Policy & Procedure QI-135. The Plan established care coordination guidelines for staff providing care coordination with expectations. The Plan has a dedicated team of care coordinators and BCBA's to support access to care. The Plan has increased staffing to better support member' access to care.</p> <p>2. BH Navigators are required to conduct monthly follow-up with parents or guardians to inform them of the status of Mental Health (MH), Behavioral Health Treatment (BHT), or Comprehensive Diagnostic Evaluation (CDE) referrals. This process ensures timely communication and continuity of care for families.</p> <p>3. Mandatory training was provided to the BH Navigators with written standard work.</p> <p>4. The Plan is developing a report that will be utilized in an ongoing manner to monitor compliance with current case management protocols and DHCS requirements. The implementation is scheduled for the end of the first quarter of 2025. <u>Update 2/15/2025</u>; Fields are undergoing validation to ensure accuracy with a goal to have a functional report ready by March 31, 2025 for monitoring and oversight. <u>Update 5/9/2025</u>; Draft Caregiver Update Report created that outlines criteria and dashboard. <u>Update 7/11/2025</u>; SOP created for monitoring and auditing process for timely caregiver updates. <u>Update 10/16/2025</u>; IA conducted an audit for this area beginning 08/26/25; the audit was closed on 10/16/25 with no CAPs.</p> <p>5. BH will conduct biweekly reviews to confirm that follow-ups are performed consistently and on-schedule. Feedback loops will be established to address any barriers encountered during follow-ups and adjust the protocol accordingly. BH Navigators will undergo mandatory training to reinforce the importance of consistent monthly follow-ups, effective communication with parents, and accurate documentation. <u>Update 5/9/2025</u>; The standard operating procedure for the monitoring and auditing process for timely caregiver updates has been created. <u>Update 7/11/2025</u>; The monitoring and auditing report has been successfully deployed and is now utilized for monitoring and oversight. <u>Update 10/16/2025</u>; IA conducted an audit for this area beginning 08/26/25; the audit was closed on 10/16/25 with no CAPs.</p>	7/11/2025	Completed	Behavioral Health	<input checked="" type="checkbox"/>	State	DHCS
10	CM and CoC	(2.4.1) Notice of Action (NOA) Letters for Continuity of Care (COC) Requests The Plan did not ensure that NOAs for COC requests that were sent to members contained a clear explanation of the reason for the denial decision.	<p>1. Policy UM-054 Notice of Action supports the process to ensure NOAs contain clear explanations of denial reasons. SOPs were updated to reflect utilization of new CoC NOA in a single letter, Medical Directors were trained, and all impacted staff were notified on 8/14/2024.</p> <p>2. The Plan will include CoC denial notices in the monthly operational NOA audits, reported quarterly at UMC. <u>Update 5/9/2025</u>; Two CoC audit tools have been created to monitor appropriate processing of the CoC requests, which includes a review of NOAs, and a more specific audit tool to look at each element of the NOA. <u>Update 7/11/2025</u>; Policies have been updated to correspond with the monthly audits, and regular monitoring and oversight are now in process.</p>	7/11/2025	Completed	UM		State	DHCS

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11	Access and Availability	(3.1.1) Appointment Waitlist Timeliness The Plan did not ensure members were able to obtain medically necessary appointments within established timely access standards. One of the Plan's medical groups placed members on an appointment waitlist and had members waiting up to six months to make an appointment.	1. The Plan worked with the provider to close their panel in September, preventing additional wait listed members. (9/1/2024). The Plan met with the provider related to access in an On-going manner during Joint Operating Meetings (JOM) and Plan/provider Access Meetings. The provider actively outreached to members on the wait list. Progress reports were reviewed at Plan/provider Access meetings. In September 2024 the provider brought in two new providers to support with provider wait list. In review of grievances data, the number of grievances declined for timely access at this provider's location. The Plan has implemented QI initiatives to improve access to care, including pay for performance (P4P), extended office hours incentives and provider recruitment/retention incentives (AAH provider grant live as of 6/1/2024). 2. Provider access data shows outreach efforts have been effective in getting new members schedule for appointments and off the waitlist. The Plan is working on outreach reports from the provider to show continues self-monitoring as well as written procedures to support. <u>Update 5/9/2025</u> ; Outreach reports have been obtained from the provider, and an analysis of grievance data for this provider show that timely access related grievances have declined.	4/15/2025	Completed	QI		State	DHCS
12	Access and Availability	(3.1.2) Monitoring In-Office Wait Times for Specialty and Behavioral Health Services The Plan did not monitor in-office wait time for specialists and behavioral health providers.	1. The Plan added in-office wait times measure to CG-CAHPS survey for BH providers on 5/6/2024. The finalized report was presented at the Access & Availability Committee in September. Specialist providers will be added to the CG-CAHPS survey starting on 1/21/2025. The final report is expected to be completed by Q2, 6/30/2025 QI-114 Monitoring of Access and Availability Standards was revised to include monitoring of in-office wait times for specialist and behavioral health providers.	4/15/2025	Completed	Behavioral Health		State	DHCS
13	Access and Availability	(3.1.3) Monitoring Telephone Calls for Specialty and Behavioral Health Services The Plan did not monitor wait times for specialty and behavioral health providers to answer and return telephone calls.	1. The Plan added telephone wait times measure to CG-CAHPS survey for BH providers. The finalized report was presented at the Access & Availability Committee in September. Specialist providers will be added to the CG-CAHPS survey starting on 1/21/2025. The final report is expected to be completed by Q2, 6/30/2025. QI-114 Monitoring of Access and Availability Standards was revised to include monitoring of telephone wait times for specialist and behavioral health providers	4/15/2025	Completed	Behavioral Health		State	DHCS
14	Member Rights	(4.1.1) Grievances Involving Clinical Issues The Plan did not ensure that a person with clinical expertise in treating a member's condition made the resolution decision for grievances involving clinical issues.	1. Policy G&A-003 Grievance and Appeals Receipt, Review, and Resolution was updated to require grievances with clinical issues, such as access or QOS grievances with clinical issues, to be resolved by the Medical Director. 2. The G&A Department will provide additional training to ensure that a person with clinical expertise in treating a member's condition made the resolution decision for grievances involving clinical issues. The Timeline will also need to be updated to include the contractual language. <u>Update 5/9/2025</u> ; Training was completed in February 2025. 3. The G&A Department will begin to conduct monthly internal audits in January 2025 to ensure that the requirement for grievances involving clinical issues is being met. <u>Update 5/9/2025</u> ; Internal audits were started in February 2025. <u>Update 7/11/2025</u> ; Internal audits are now in progress and findings are shared with the G&A supervisor for retraining and coaching 4. The G&A Department will provide an Internal Audit Standard Operating Procedure that outlines our self-monitoring/internal auditing processes. <u>Update 5/9/2025</u> ; The SOP for the self-monitoring process was completed.	7/11/2025	Completed	G&A		State	DHCS
15	Member Rights	(4.1.2) Resolution of Grievances The Plan did not completely resolve the members' grievances.	1. The QA Grievance Audit Tool was reviewed to outline the future monitoring process to ensure that all grievances are resolved prior to being closed. 2. The G&A Department will begin to conduct monthly internal audits in January 2025 to ensure that the requirement for resolution of grievances is being met. <u>Update 5/9/2025</u> ; Internal audits started in February 2025 <u>Update 7/11/2025</u> ; Audits are continuing monthly and findings are shared with the G&A supervisor for retraining and coaching if needed. <u>Update 12/17/2025</u> ; Audit reports were presented during AOC meeting. <u>Update 10/21/2025</u> ; IA conducted an audit of this area starting 04/04/2025; the audit was closed 07/09/2025. The CAPs were closed on 10/21/2025.	12/17/2025	Completed	G&A		State	DHCS
16	Member Rights	(4.1.3) Clear and Concise Resolution Letters The Plan's written resolution did not contain a clear and concise explanation of the Plan's decision.	1. The QA Grievance Audit Tool was reviewed to outline the future monitoring process to ensure that all grievances have clear and concise resolution letters prior to being closed. The G&A Department will provide additional training to ensure that the Plan's written resolution contains a clear and concise explanation. <u>Update 5/9/2025</u> ; Internal audit tools and SOP governing the internal review were created. 2. The G&A Department will begin to conduct monthly internal audits in January 2025 to ensure that the requirement for Clear and Concise Resolution Letters is being met <u>Update 5/9/2025</u> ; Internal audits started in February 2025. <u>Update 7/11/2025</u> ; Audits are continuing monthly and findings are shared with the G&A supervisor for retraining and coaching if needed. <u>Update 12/17/2025</u> ; Audit reports were presented during AOC meeting. <u>Update 10/21/2025</u> ; IA conducted an audit of this area starting 04/04/2025; the audit was closed 07/09/2025. The CAPs were closed on 10/21/2025.	12/17/2025	Completed	G&A	<input checked="" type="checkbox"/>	State	DHCS

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17	Member Rights	(4.1.4) Grievance Letters: Non-Discrimination Notice (NDN) and Language Assistance Tagline (LAT) The Plan did not include updated NDN and LAT information with grievance acknowledgement and resolution letters.	1. Current LAT and NDN were added to the Member's Rights package and updated in the G&A system. 2. The G&A Department in conjunction with the Compliance Department will review all enclosures on an annual basis to ensure compliance. <u>Update 5/9/2025</u> ; Internal audits started in February 2025. <u>Update 7/11/2025</u> ; Audits are continuing monthly and findings are shared with the G&A supervisor for retraining and coaching if needed	8/1/2025	Completed	G&A	✓	State	DHCS
18	Member Rights	(4.2.1) Monitoring of Linguistic Performance The Plan did not assess the performance of its vendors' staff that provided linguistic services such as interpreter services.	1. The Plan has completed updates of Policy and Procedure (P&P) CLS-011-CLS Program Monitoring to include additional language on monitoring information collected and reporting. The Plan anticipates approval date of the updated draft by Alliance Administrative Oversight Committee (AOC) for 4/16/2025. <u>Update 5/9/2025</u> ; The updated policy CLS-011 was approved by AOC on 4/16/2025. 2. The Plan anticipates that updates to vendor contracts to include reporting requirements for vendor interpreter qualifications and cadence will be implemented by 3/31/2025. <u>Update 5/9/2025</u> ; Reporting amendments for the contracts were submitted for the vendors 3. The Plan anticipates the implementation of monthly vendor interpreter qualifications reporting by 1/31/2025. The Plan anticipates implementation of a monthly attestation of monthly vendor interpreter qualifications review by 1/31/2025. The Plan will review and address concerns with vendor interpreter qualifications at Quarterly Vendor Joint Operations Meeting (JOM) by 3/31/2025. The Plan will report and address concerns with vendor interpreter qualifications at Quarterly Cultural and Linguistic Services Subcommittee (CLSS) meeting by 4/30/2025. <u>Update 5/9/2025</u> ; The monthly reporting and attestation process has been implemented, and discussions began at JOMs in April.	7/11/2025	Completed	Cultural and Linguistic Services		State	DHCS
19	Member Rights	(4.3.1) Notification to DHCS The Plan did not notify DHCS within 24 hours upon discovery of any suspected breach or security incident, unauthorized access, use or disclosure of PHI or PI.	1. The Plan updated CMP-013 "HIPAA Privacy Reporting" in September 2024 to include verbiage addressing the gap that contributed to the audit finding: "Referrals must be made immediately upon discovery, and no later than 24 hours after." Additional updates included a Corrective Action section to address late referrals: "Corrective actions will be taken for delayed referrals, including but not limited to education, training, and / or Corrective Action Plans (CAP)." CMP-013 also states, "The Alliance will investigate the incident and submit an Initial Privacy Incident Report (PIR) to DHCS within 24 hours of discovery of a breach, suspected breach or security incident." Verbiage of Privacy Incident Investigation and Reporting Procedure updated to formalize education and corrective action for late referrals. 2. Implement new monitoring process to address the gap in referrals from G&A and internally within Compliance that contributed to the audit finding: "The Privacy Office will monitor the Compliance inbox, Compliance hotline, Privacy Compliance Inbox, and HealthSuite system for referral of any HIPAA Privacy reporting incidents. Each will be checked daily at minimum." 3. The Privacy Office is conducting weekly audits of HealthSuite referrals to ensure privacy concerns reported by members are appropriately categorized by the Member Services Department. Appropriate categorization will enable timely reporting of privacy incidents. <u>Update 7/11/2025</u> : Annual Plan wide training was completed, and ad hoc training and escalation is done in the case of late reporting. <u>Update 8/15/2025</u> : IA conducted an audit of this area beginning 5/7/25; the final report was issued on 8/1/25. This audit was closed on 8/15/25. 4. The Plan will include review of the Internal Audit results at the Compliance Committee meetings.	7/11/2025	Completed	Compliance		State	DHCS
			1. The Plan will review and update the following impacted P&Ps as needed: PRV-005 & CRE-002. 3/14/2025: PRV-005 was reviewed and confirmed the information was present in the policy and no additional updates were identified. 2. The Plan will provide an advisory to delegates and/or providers that delegated for credentialing functions about timely reporting requirements. 3/14/2025: The Plan notified providers delegated for Credentialing functions about timely adverse termination reporting requirements by email and provided a PowerPoint Reminder Notice and a Adverse Reporting Template. In addition, the information was also shared with Teladoc during the Q1 2025 Joint Operations Meeting (JOM) on 02/04/2025. 3. The Plan conducts monthly review of the exclusion and suspension lists and this is an ongoing process that will support ongoing monitoring and the identification and reporting of adverse provider termination. This is ongoing. There are no changes to the Plan's provider notice templates and member notice templates. 4. The Plan's provider manual will be updated in Q1 2025. <u>Update 5/9/2025</u> : The provider manual was updated 5. The Plan will develop a log that will track Provider terminations, provider notification, and member notification including date of reports received and submitted to DHCS and date members were notified <u>Update 5/9/2025</u> : The		1. Completed 4/15/2025 2. Completed 4/15/2025 3. Completed 4/15/2025 4. Completed 4/15/2025				

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2024 DHCS Audit - Audit Review Period 6/1/2023 - 5/31/2024 Audit Onsite Dates - June 17, 2024 - June 28, 2024							INTERNAL AUDITS		
#	Category	Deficiency	Corrective Action Plan (CAP)	Completion Date	Internal CAP Status	Department Responsible	Validation Status	State/Self-Identified	Agency
20	Quality Management	(5.3.1) Notification of Provider Terminations The Plan did not meet DHCS reporting and member notification requirements for provider terminations.	log was completed. Update 7/11/2025: The Plan is now leveraging Potential Provider Terminations log and Adverse Event Report for tracking provider terminations 6. The Plan will develop a reporting template/instruction for Providers/Delegate/Subcontractor for reporting adverse terminations to the Plan. 2/15/2025: The Plan has developed a reporting template that includes instructions on how to complete for providers/delegates to use when reporting adverse terminations. The information was shared with providers delegated for Credentialing functions on 02/07/2025. 7. The Plan will review the quarterly HICE Credentialing report and confirm against the adverse termination log to determine if provider suspended/termed for quality of care has been reported during the month of termination. During this review, if providers are identified as having been suspended or terminated due to quality of care, the Plan will confirm submission of the 805 report to DHCS. Update 06/03/26 ; The Plan continues to monitor the quarterly credentialing report to ensure identified suspended or terminated providers due to QOC are appropriately reported to DHCS. 8. The Plan will include review of the reports/logs during Subcontractor Delegation Oversight Committee meetings. 9. The Plan will include review of the Internal Audit results at the Compliance Committee meetings. Update 2/27/2026: IA conducted an audit for this area beginning 6/20/25; the audit was closed on 2/27/26. CAPs are ongoing. The results for this audit will be presented to the AOC. Update 06/03/26 ; The CAP was closed on 05/29/26, and it will be reported at AOC this month.	In Progress	5. Completed 4/15/2025 6. Completed 4/15/2025 7. Completed 8. Completed 9. Completed	Operations		State	DHCS