COMPLIANCE DASHBOARD SUMMARY													
	Resource	Type										TOTAL	% Completed
			2018	2019	2020	2021	2022	2023	2024	2025	2026		
OVERALL FINDINGS	DHCS	Total State Audit Findings	38	28	7	33	15	24	20	0	10	175	
		Total Self-Identified Issues	12	0	0	2	0	2	6	3	5	30	
		Total Findings	**50**	**28**	**7**	**35**	**15**	**26**	**26**	**3**	**15**	**205**	
		Total In Progress	0	0	0	0	0	0	0	0	15	15	
		Total Completed	50	28	7	35	15	26	26	3	0	190	**93%**
		Total Findings	**50**	**28**	**7**	**35**	**15**	**26**	**26**	**3**	**15**	**205**	
	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		12		12	
		Total Completed			8	6	8	3		10		35	**74%**
		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			0		0	
		Total Completed		5			4			2		11	**100%**
		Total Findings	**NA**	**5**	**NA**	**NA**	**4**	**NA**	**NA**	**2**	**NA**	**11**	
STATE AUDIT FINDINGS		In Progress	0	0	0	0	0	0	0	12	10	22	
		Completed	38	33	12	39	27	27	20	6	0	202	**90%**
		Total Findings	**38**	**33**	**12**	**39**	**27**	**27**	**20**	**18**	**10**	**224**	
SELF-IDENTIFIED FINDINGS		In Progress	0	0	0	0	0	0	0	0	5	5	
		Completed	12	0	3	2	0	2	6	9	0	34	**87%**
		Total Findings	**12**	**0**	**3**	**2**	**0**	**2**	**6**	**9**	**5**	**39**	
TOTAL OVERALL FINDINGS			**50**	**33**	**15**	**41**	**27**	**29**	**26**	**27**	**15**	**263**	**90%**

Compliance Dashboard Summary

COMPLIANCE DASHBOARD SUMMARY			
	Type	**TOTAL**	**%**
OVERALL FINDINGS	Total State Audit Findings	224	85%
	Total Self-Identified Issues	39	15%
	Total Findings	**263**	
	Total In Progress	27	10%
	Total Completed	236	90%
	Total Findings	**263**	
STATE AUDIT FINDINGS	In Progress	22	10%
	Completed	202	90%
	Total Findings	**224**	
SELF-IDENTIFIED FINDINGS	In Progress	5	13%
	Completed	34	87%
	Total Findings	**39**	

2026 DHCS Audit Summary			
	Type	**TOTAL**	**%**
OVERALL FINDINGS	Total State Audit Findings	10	67%
	Total Self-Identified Issues	5	33%
	Total Findings	**15**	
	Total In Progress	15	100%
	Total Completed	0	0%
	Total Findings	**15**	

2025 DMHC Fiscal Examination			
	Type	**TOTAL**	**%**
OVERALL FINDINGS	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**	

Compliance Dashboard Summary

2025 DHCS Audit Summary			
	Type	**TOTAL**	**%**
OVERALL FINDINGS	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			
	Type	**TOTAL**	**%**
OVERALL FINDINGS	Total State Audit Findings	16	73%
	Total Self-Identified Issues	6	27%
	Total Findings	**22**	
	Total In Progress	12	55%
	Total Completed	10	45%
	Total Findings	**22**	

Compliance Dashboard Summary

2024 DHCS Audit Summary			
	Type	**TOTAL**	**%**
OVERALL FINDINGS	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			
	Type	**TOTAL**	**%**
OVERALL FINDINGS	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

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

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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 August 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.	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. 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. **5/5/2026 Update:** IT and C&O includes Provider Services when sending the Provider Directory files for ongoing oversight.	Already In Place	Pending	Provider Services
2	PHM & CoC (Enhanced Care Management)	2.1 - Care Management Plan Clinical Oversight: The Plan did not ensure clinical oversight of the care management plan. 2.25.2: The Plan did not ensure that comprehensive assessments and CMPs are completed, clinically reviewed, and properly documented.	Current monitoring occurs during IDT Rounds meetings to detect whether clinical oversight is occurring. The Plan's ECM RNs can confirm participants during the meeting (including clinicians internal to the ECM provider). The Plan's ECM RNs' participation at the IDT rounds was intended to meet the clinical oversight explained in the Plan's P&P. The Plan's current bi-annual audit tool documents evidence of multidisciplinary care team involvement, but not 'signing off' of the care management plan. The Plan intended for our involvement in the multidisciplinary care team rounds to constitute ensuring clinical oversight of the care management plan. The audit tool is reviewed bi-annually (prior to each audit) by the clinician ECM team (including leadership) to assess for any changes with existing policies or state requirements. **08/14/2026 Update:** The Plan will be further refining the bi-annual audit tool to request evidence of 'sign-off' of the care management plan by a clinician with the ECM provider's organization. The Plan has updated the bi-annual audit tool to request for evidence of 'sign-off' of the care management plan by a clinical with each ECM provider. This was incorporated in time for the ECM Provider Spring Audit 2026 and	Ongoing	Pending	Case Management
3	PHM & CoC (Enhanced Care Management)	2.2 - ECM Written Materials: The Plan did not provide member facing ECM written material that included all of the minimum required elements.	While the Plan didn't have member-facing written materials that explained ECM is voluntary, may be discontinued at any time, and explaining the process by which a member may change their LCM at any time, these processes still applied to the ECM providers and the community. The Plan conducts at least annual reviews of ECM policies and procedures (more often, as needed) to align with current DHCS guidance. Not having the required content in the member-facing written materials was an oversight. **08/14/2026 Update:** C&O Request has been submitted to update AAH member (public) facing website - Alliance Website (https://alamedaalliance.org/members/medi-cal/cmdm/) has been updated to include: ECM is voluntary, may be discontinued at any time, and explaining the process by which a member may change their LCM at any time as well as requested edits to EOC to include updated appropriate language. **09/01/26- Update:** The Plan is reviewing to contest or agree with the finding.	Already In Place	Pending	Case Management

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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 August 2026	Corrective Action Plan (CAP)	Completion Date	Internal CAP Status	Department Responsible
4	PHM & CoC (Pregnant & Postpartum Members)	2.31 Pregnant and Postpartum Members CPSP Reimbursement: The Plan does not have an oversight mechanism in place for CPSP providers	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. Recommend to develop an oversight mechanism for CPSP claims monitoring and verification for CPSP approved providers. **06/03/26 Update:** The Plan is still researching the oversight mechanism for CPSP claims monitoring and verification for CPSP approved providers. **08/14/2026 Update:** Next steps is to determine method of oversight, as CDPH website has an enrollment process for CPSP, but team is researching provider list.	TBD	Pending	Credentialing Provider Services Claims
5	Utilization Management (PA)	1.1 - PA of preventive services: The Plan applied PA requirements to preventive services.	**08/14/2026 Update:** Preventative Screenings only require a PA when performed at a TQ center, so they can be re-directed to an in-network community-based facility. The Alliance's UM 068- Tertiary and Quaternary Review Process Policy (AOC Day 12/17/2025) does not specifically call out preventative services as requiring a prior authorization, but does state in Section D "The Alliance considers the following requests to tertiary or quaternary centers as appropriate for potential redirection to an in-network community-based specialists provided redirection does not compromise care:" Bullet 3 states "requests for ancillary services (e.g., radiology or laboratory testing) that will not result in a delay of treatment or coordination of care. The Alliance therefore reviews Radiology and Laboratory requests using the prior authorization process to determine whether they could appropriately, and without delays in care be completed by a community-based in-network provider.	TBD	Pending	Utilization Management (PA)
6	Utilization Management (PA)	1.2.1 - Medical Necessity Determinations: The Plan did not ensure that prior authorization (PA) decisions were based on medical necessity consistent with criteria or guidelines used.	**08/14/2026 Update:** In general, the Alliance's process is that the UM Coordinators are always the first person to view the cases. They are looking for basic eligibility and other information and then would forward to the UM clinical reviewer (Nurse) when appropriate. If the Clinical reviewer determines the authorization does not meet medical necessity criteria, then it is forwarded to a Medical Director for review and determination. **09/01/26 Update** The Plan is reviewing to contest or agree with the finding.	TBD	Pending	Utilization Management (PA)
7	Utilization Management (PA)	1.2.2 Processing of Expedited Authorization Requests Within 72 Hours	**08/14/2026 Update:** The Plan experienced an increase in volume in October and December 2025 as compared to 2024, however overall, the Inpatient and Outpatient volumes from 2024 to 2025 remained fairly consistent. The Plan experienced some staffing shortages during the audit period. There were 2 MD positions vacated in early 2025 that were filled by Dr. Parag Sharma and Dr. Maninder Khalsa temporarily before Dr. Sharma transitioned into the permanent UM Medical Director position. The Inpatient Team had 1 open RN Onsite position during the audit timeframe that was officially filled in August 2025. And a coordinator position open from May through August. The Outpatient Team had an open Coordinator position that was filled June through December with a temporary employee. Oversight of timeliness compliance is measured and shared in monthly meetings.	Already In Place	Pending	Utilization Management (PA)

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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 August 2026	Corrective Action Plan (CAP)	Completion Date	Internal CAP Status	Department Responsible
8	Network & Access to Care (Emergency Services)	3.1 Emergency Services: The Plan did not obtain supporting documentation when paying higher level codes.	**08/14/2026 Update:** Claims does not have a policy or process to review ER claims for the level of care billed for the ER professional visit. Since ER services do not have an authorization requirement, most of these claims auto adjudicate. The Plan utilizes an FWA vendor that reviews all of our claims for anomalies, including ER claims, and we can make ad-hoc requests to them to specifically review ER claims for any anomalies. We do not and are not able to specifically review against medical records unless billing abnormalities arose that would trigger us to then look at medical records.	Ongoing	Pending	
9	Grievances & Appeals and Member's Rights	4.1.1 Written Consent for Grievances Filed on a Member's Behalf	**08/14/2026 Update:** The Alliance will process a grievance by an authorized representative when an AOR form is on file or when we receive verbal consent from the member that an representative can talk on their behalf. The G&A Department follows the lead from Member Services. When the Member Services Department obtains verbal authorization, the grievance is logged and is processed accordingly. **09/01/26: Update:** The Plan is reviewing to contest or agree with the finding.	Ongoing	Pending	A&G
10	Grievances & Appeals and Member's Rights	4.1.2 Resolution of Expedited Grievances Within 72 Hours	**08/14/2026 Update:** The coordinator was not able to resolve the grievance within 72 hours with the information they had. The coordinator continued to work the case until it was resolved, outside of the 72 hours. The G&A Department has experienced a staffing shortage within the audit period leading to a large case load for the G&A coordinators, which is being addressed by the additional hiring of staff. Grievance timeliness are tracked and the compliance percentage for timely resolution is reported at monthly oversight meetings. **09/01/26 Update:** The Plan is reviewing to contest or agree with the finding.	Ongoing	Pending	A&G
11	Grievances & Appeals and Member's Rights	4.1.3 Resolution of Standard Grievances Within 30 Days	**08/14/2026 Update:** The G&A Department has experienced a staffing shortage within the audit period leading to a large case load for the G&A coordinators, creating the delay in sending the request for responses to providers late. The G&A department has since hired additional staff to address this, and currently track the resolution timeliness and report the monthly percentage of timely resolution at monthly oversight meetings. **09/01/26 Update:** The Plan is reviewing to contest or agree with the finding	Ongoing	Pending	A&G

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#	Category	Plan Observations - DHCS Preliminary Findings expected August 2026	Corrective Action Plan (CAP)	Completion Date	Internal CAP Status	Department Responsible
12	Grievances & Appeals and Member's Rights	4.13.1: The Plan did not ensure that members received all grievance and appeal information in the threshold language of their choice.	**08/14/2026 Update:** The Alliance identified that not all written notifications were sent in members threshold language. The Alliance identified that the notice of non-discrimination was erroneously sent in English. Additional steps of oversight are being developed. **09/01/26 Update:** The Plan is reviewing to contest or agree with the finding	TBD	Pending	A&G
13	Grievances & Appeals and Member's Rights	4.5.1 Written Consent for Appeals Filed on a Member's Behalf **(R)** (*Repeat Finding UM 1.3.1 2024 Audit)	**08/14/2026 Update:** Additional staff training has been conducted, and a SOP was put in place to outline the process for obtaining member written consent. **09/01/26 Update:** The Plan is reviewing to contest or agree with the finding	Already In Place	Pending	A&G
14	Grievances & Appeals and Member's Rights	4.5.2 Resolution of Expedited Appeals Within 72 Hours	**08/14/2026 Update:** The G&A Department has experienced a staffing shortage within the audit period leading to a large case load for the G&A coordinators, creating the delay resolutions. The G&A department has since hired additional staff to address this, and currently track the resolution timeliness and report the monthly compliance percentage at monthly oversight meetings. **09/01/26 Update:** The Plan is reviewing to contest or agree with the finding	Ongoing	Pending	A&G
15	5.1 Quality Oversight of Subcontractor	The Plan did not perform QA oversight of CHCN's ECM program. The Plan does not audit CHCN's ECM program as part of CHCN's annual delegation oversight audit. Instead, as a contracted ECM provider, CHCN's ECM program is audited two times per year, in the same manner as all other contracted ECM providers. During the audit period, the Plan presented ECM data in the UM Committees in June, September, and December of 2025. As CHCN is an ECM provider, the data presented, included CHCN. The data reported in committee does not specify trends by each ECM provider; however, that detail is available at each ECM provider level within the dashboard.	**08/14/2026 Update:** During the audit period, the Plan did not discuss the ECM dashboard reports with ECM providers; however, this changed post audit period. During the audit period, all ECM providers were audited (including CHCN) by the ECM team. The ECM team also meets with all ECM providers in a monthly meeting, with the ECM dashboard as a standing agenda item, with meeting minutes available.	Already In Place	Pending	Quality Management

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2025 DMHC Audit - *Audit Review Period* 10/1/2022 - 9/30/2024
Audit Onsite Dates - March 3, 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 r	7/16/2026	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 repor	Ongoing	G&A
3	Grievance and Appeals	**(R)** 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).	The Plan's Member Services Department conducted training on 12/19/2024 to reinforce the requirem	Ongoing	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 in	4/1/2026	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. **06/03/26 Update:** The Health Plan audit team is working with stakeholders to validate CAP implementation. **8/14/2026 Update:** Nurse Line monitoring SOP implemented and monitoring reports submitted. Team is working with vendor to enhance reporting capabilities and obtain call-level data needed to demonstrate compliance with the 30-minute wait time requirement.	Ongoing	CM

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2025 DMHC Audit - *Audit Review Period* 10/1/2022 - 9/30/2024
Audit Onsite Dates - March 3, 2025 to March 7, 2025

#	Category	Deficiency	Corrective Action Plan (CAP)	Completion Date	Department Responsible
6	Access and Availability	The Plan's notification to providers did not include the information required in Section 1367.27(l)(2)(A)-(C).	The Plan will update its Provider Demographic Form to include the information that providers may uti	Ongoing	Provider Services
7	Access and Availability	The Plan did not have a process to monitor whether its provider networks experienced a 10 percent change.	**5/19/2026 - Corrected per DMHC.** 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:** The Health Plan audit team is working with stakeholders to validate CAP	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. **06/03/26 Update:** The Health Plan audit team is working with stakeholders to validate CAP implementation. **8/14/26 Update:** UM-051 and UM-003 revisions implemented and staff training completed. Internal monitoring is underway to demonstrate provider notifications are consistently issued within required timeframes.	Ongoing	UM

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Audit Onsite Dates - March 3, 2025 to March 7, 2025

#	Category	Deficiency	Corrective Action Plan (CAP)	Completion Date	Department Responsible
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 agreem	Ongoing	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 oversite, 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 provider 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 oversite and monitoring. **06/03/26 Update:** The Health Plan Audits team confirmed that, for the impacted delegate (CFMG), this element was reviewed during the 2025 annual audit. The delegate met the 95% compliance threshold based on case file review. In addition, the delegate conducts quarterly internal audits as part of its oversight activities. The Plan maintains ongoing oversight through the annual audit and by reviewing the delegate's quarterly audit results. **8/14/26 Update:** Alliance met with CFMG regarding denial letter deficiencies. CFMG is expected to	Ongoing	UM Compliance - DO
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 s	Ongoing	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. **06/03/26 Update:** The Health Plan audit team is working with stakeholders to validate CAP implementation. **8/14/26 Update:** Pharmacy leadership and Compliance met to discuss corrective action options regarding acceptable criteria language for formulary exception denial letters.	7/13/2026	Pharmacy

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Audit Onsite Dates - March 3, 2025 to March 7, 2025

#	Category	Deficiency	Corrective Action Plan (CAP)	Completion Date	Department Responsible
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. **06/03/26 Update:** The Health Plan audit team is working with stakeholders to validate the formulary and ensure the updates have been made to correct the deficiencies. **8/14/26 Update:** Formulary updates following DMHC discussion on 7/8/26 for Pharmacy to update online formulary content and address outstanding regulatory requirements.	7/13/2026	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. **06/03/26 Update:** The Health Plan audit team is working with stakeholders to validate CAP	Ongoing	Behavioral Health

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COMPLIANCE DASHBOARD

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Yellow = Plan Observations
Orange = Plan Observations (Not Included in the Preliminary Report)
White = State Finding in the final report that was not a Plan Observation
R = Repeat Findings

2025 DMHC Audit - *Audit Review Period* 10/1/2022 - 9/30/2024
Audit Onsite Dates - March 3, 2025 to March 7, 2025

#	Category	Deficiency	Corrective Action Plan (CAP)	Completion Date	Department Responsible
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. **06/03/26 Update:** The Plan develops IRR testing to ensure consistency in determinations and to confirm that appropriate clinical guidelines are applied during the review process (Implementation date 2022-2023).	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).	**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/IHSS 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 insourced 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.	TBD	Behavioral Health

ALAMEDA ALLIANCE FOR HEALTH
COMPLIANCE DASHBOARD

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#	Category	Deficiency	Corrective Action Plan (CAP)	Completion Date	Department Responsible
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.	Already in Place Already in Place Already in Place Already in Place	Compliance
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	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