DASHBOARD KEY

Internal CAP Status Performance Measures	
Indicator	**Criteria**
Green	CAP responses have been completed and fully address the findings

Notes
1) **Potential Self-Identified findings** are developed by the Alliance from regulatory agency feedback or self identification of a deficiency found. They are monitored internally by the Alliance.
2) **State Audit Findings** have been issued by the regulatory agencies in a audit report that requires a corrective action.
3) **Compliance Internal Audit** is conducted as the last step once the item has been fully resolved and all actions have been completed.

COMPLIANCE DASHBOARD SUMMARY										
	Resource	Type							TOTAL	% Completed
			2018	2019	2020	2021	2022	2023		
OVERALL FINDINGS	DHCS	Total State Audit Findings	38	28	7	33	15	15	136	
		Total Self-Identified Issues	12	0	0	2	0	2	16	
		Total Findings	**50**	**28**	**7**	**35**	**15**	**17**	**152**	
		Total In Progress	0	0	0	0	0	3	3	
		Total Completed	50	28	7	35	15	14	149	**98%**
		Total Findings	**50**	**28**	**7**	**35**	**15**	**17**	**152**	
	DMHC	Total State Audit Findings			5	6	8		19	
		Total Self-Identified Issues			3	0	0		3	
		Total Findings			**8**	**6**	**8**		**22**	
		Total In Progress			0	0	1		1	
		Total Completed			8	6	7		21	**95%**
		Total Findings	**NA**	**NA**	**8**	**6**	**8**	**NA**	**22**	
	DMHC Financial Services	Total State Audit Findings		5			4		9	
		Total Self-Identified Issues		0			0		0	
		Total Findings		**5**			**4**		**9**	
		Total In Progress		0			0		0	
		Total Completed		5			4		9	**100%**
		Total Findings	**NA**	**5**	**NA**	**NA**	**4**	**NA**	**9**	
STATE AUDIT FINDINGS		In Progress	0	0	0	0	1	3	4	
		Completed	38	33	12	39	26	12	160	**98%**
		Total Findings	**38**	**33**	**12**	**39**	**27**	**15**	**164**	
SELF-IDENTIFIED FINDINGS		In Progress	0	0	0	0	0	0	0	
		Completed	12	0	3	2	0	2	19	**100%**
		Total Findings	**12**	**0**	**3**	**2**	**0**	**2**	**19**	
TOTAL OVERALL FINDINGS			**50**	**33**	**15**	**41**	**27**	**17**	**183**	

COMPLIANCE DASHBOARD SUMMARY			
	Type	**TOTAL**	**%**
OVERALL FINDINGS	Total State Audit Findings	164	90%
	Total Self-Identified Issues	19	10%
	Total Findings	**183**	
	Total In Progress	4	2%
	Total Completed	179	98%
	Total Findings	**183**	
STATE AUDIT FINDINGS	In Progress	4	2%
	Completed	160	98%
	Total Findings	**164**	
SELF-IDENTIFIED FINDINGS	In Progress	0	0%
	Completed	19	100%
	Total Findings	**19**	

2023 DHCS Audit Summary			
	Type	**TOTAL**	**%**
OVERALL FINDINGS	Total State Audit Findings	15	88%
	Total Self-Identified Issues	2	12%
	Total Findings	**17**	
	Total In Progress	3	18%
	Total Completed	14	82%
	Total Findings	**17**	

2022 DMHC BHI Audit Summary			
	Type	**TOTAL**	**%**
OVERALL FINDINGS	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**	

2022 DMHC RBO Audit: Delegate			
	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**	

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

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

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

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

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

2020 DHCS Focused Audit Summary			
	Type	**TOTAL**	**%**
OVERALL FINDINGS	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**	

2020 DMHC Medical Services Audit Summary			
	Type	**TOTAL**	**%**
OVERALL FINDINGS	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			
	Type	**TOTAL**	**%**
OVERALL FINDINGS	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**	

2019 DHCS Medical Services Audit Summary			
	Type	**TOTAL**	**%**
OVERALL FINDINGS	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			
	Type	**TOTAL**	**%**
OVERALL FINDINGS	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**	

ALAMEDA ALLIANCE FOR HEALTH
COMPLIANCE DASHBOARD

KEY
Yellow = Plan Observations (Included in the Preliminary Report)
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2023 DHCS Audit - *Audit Review Period* 4/1/2022 - 3/31/2023 *Audit Onsite Dates - April 17, 2023 - April 28, 2023*							INTERNAL AUDITS		
#	Category	Deficiency	Corrective Action Plan (CAP)	Completion Date	Internal CAP Status	Department Responsible	State/Self Identified	Agency	Year
1	UM	(1.5.1) Notice of Action (NOA) Letters The Plan did not ensure a delegate sent NOA letters to providers and members.	The Plan received the delegate's Root Cause Analysis (RCA) and CAP on 04/14/2023. After review and evaluation of the delegate's document the Plan issued a formal CAP on 05/31/2023 and received the delegate's CAP response on 06/27/2023. The initial corrective actions completed by the delegate includes updating their IT script and ensuring the identified missing NOA letters were sent out to the members and that outreach was completed to confirm that services approved or had denial modification authorizations were utilized by members. The delegate also developed workflows to detect and mitigate failures. The CAP includes the delegate's implementation of a remediation plan. The remediation plan includes updates in their workflow, training, and an internal monthly audit- with results submitted to The Alliance for review. The Plan reviewed and evaluated the delegate's CAP implementation and progress during the interim and provided guidance. The CAP was approved and closed on 09/25/2023. (Completed) The delegate is expected to continue its internal monthly audit for the NOA letters and fax confirmation. The Plan will continue to monitor the audit results for compliance. Please see document 1.5.1_AAH Response for full details. (On Track) Additionally, the Plan will review the UM delegates' P&P's to ensure that preventative, detective, and oversight measures are in place for internal NOA letter generation and fax confirmation and these will be evaluated annually at minimum. (On Track) 1a. Monitoring of the delegate's monthly internal audit is ongoing. (On Track) 2. Review the UM delegates' policies and procedures to ensure that preventative, detective, and oversight measures are in place for internal NOA letter generation and fax confirmation. (On Track) **Update 3/8/2024** P&P review complete and P&P deemed adequate. Review of the delegate's P&P regarding NOAs is ongoing and The Alliance will continue to meet with the delegate to have P&P appropriately updated	In Progress	Closed 9/25/2023 Closed 8/31/2023 3/31/2024	Compliance UM	State	DHCS	2023
2	QI	(2.1.1) Provision of an Initial Health Assessment (IHA) The Plan did not ensure the provision of a complete IHA for new members.	1. Update IHA policy 124 (On Track) 1a. Update IHA policy 124 to include requirement regarding outreach attempts (On Track) 2. Provider education and feedback through Joint Operational Meetings (On going) 2a. Deliver provider education webinars with information about IHA requirements (On Track) 2b. Develop a "Measure Highlights" tool for providers. This tool will encompass outreach requirements, IHA elements, USPSTF screenings, and claim codes used to account for IHA completion 3. Expand code set to include additional codes for capturing IHA-related activities (On Track) **Update 3/8/2024**: Codes updated and included in policy QI-124. 3a. Communicate and provide code sets to providers (On Track) 4. Monitor IHA rates (Ongoing) 5. Enhance the volume of medical records subjected to review for completeness, including review of USPSTF requirements. (On Track)	In Progress	3/30/2024 3/30/2024 3/30/2024 3/30/2024 Completed **Completed 2/28/2024** 3/30/2024 3/30/2024 Completed 12/31/2023	Quality	State	DHCS	2023

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2023 DHCS Audit - *Audit Review Period* 4/1/2022 - 3/31/2023 *Audit Onsite Dates - April 17, 2023 - April 28, 2023*							INTERNAL AUDITS		
#	Category	Deficiency	Corrective Action Plan (CAP)	Completion Date	Internal CAP Status	Department Responsible	State/Self Identified	Agency	Year
3	BHT	(2.3.1) Behavioral Health Treatment (BHT) Plan Elements The Plan did not ensure members' BHT treatment plans contained all the required elements.	1. The Behavioral Heath team developed the attached Treatment Plan Guidelines for our ABA Providers (please see attachment). This document outlines the treatment plan elements that are listed in APL 23-010. All treatment plans and prior-authorization requests for ABA services are reviewed by Board Certified Behavior Analysts (BCBA).The guidelines were emailed to all providers and will also be available on-line for providers to access. In addition to the document, the ABA clinicians worked with the Provider communication team to send out updates/reminders to providers regarding the treatment plan guidelines. Our team is also available to meet with providers and educate them on how to apply the guidelines to their treatment plan templates. (Completed) 1a. Pending Project: We are currently developing an on-line treatment plan template/form that will be utilized by our ABA providers when completing the initial assessment and subsequent progress reports. This form includes the treatment plan elements required in APL 23-010 and providers will be required to complete this form when submitting the initial assessment/FBA and subsequent progress reports. This will ensure that all ABA providers use the same template and include the required elements in their reports/assessments. (On Track) In the interim while the project is pending, if information is missing from the Treatment Plan, the Plan will inform the provider and ask that they add the information and re-submit. 1b. The Plan intends to conduct audits on our Treatment Review documentation to ensure that all required elements are covered in the review process in compliance with the requirements in the APL. The expected implementation date of this audit is Q1 of 2024. (On Track) 1c. The Provider/PCP Manual is also pending updates that will include a FAQ for PCPs, provider education regarding the prior authorization process, and the referral process. This is currently under review-pending completion. (On Track)	In Progress	4/1/2023 Q1 2024 Audit Q1 2024 Q1 2024 Q1 2024	Behavioral Health	State	DHCS	2023
4	Access and Availability	(3.1.1) First Prenatal Visit The Plan's policies and procedures for a first prenatal visit for a pregnant member is not compliant with the standard of two weeks upon request.	The Plan has edited Timely Access Standard table, policy QI-107 and QI-114 to reflect the first prenatal visit standard within 2 weeks of the request. (Completed)	Q4 2023	Completed	Quality	State	DHCS	2023
5	Family Planning and State Supported Services	(3.6.1) Non-contracted Provider Payments The Plan did not pay non-contracted providers at the appropriate Medi-Cal fee-for-service rate.	A Change Request was entered to change non-contract mid-level providers reimbursements to 100% of the Medi-Cal rate moving forward. (Completed)	11/16/2023	Completed	Claims	State	DHCS	2023
6	Family Planning and State Supported Services	(3.6.2) Proposition 56 Family Planning Payments The Plan did not distribute add-on payments for institutional family planning service claims as required by APL 22-011.	1. P&P has been revised to ensure that Family Planning services paid on institutional claims are paid As part of Prop 56 payments. 1a. The Plan's Analytics Team is in the midst of preparing the payment details for the retro payment on the FP institutional data and looking to complete by 11/30/2023 timeline. (On Track) 2. The Analytics dept has calculated the retroactive payments due to facilities as a result of finding 3.6.2, APL 22-011 and APL 23-008. (On Track) 2a. Payments will be distributed to providers prior to or latest by Nov 30, 2023. (On Track) 2b. Facility providers with qualifying Family Planning services as per APL 23-008 will be included as part of our monthly Prop 56 payment processing going forward starting Dec 2023. (On Track)	**1/15/2024**	**Completed**	Claims	State	DHCS	2023

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2023 DHCS Audit - *Audit Review Period* 4/1/2022 - 3/31/2023 *Audit Onsite Dates - April 17, 2023 - April 28, 2023*							INTERNAL AUDITS		
#	Category	Deficiency	Corrective Action Plan (CAP)	Completion Date	Internal CAP Status	Department Responsible	State/Self Identified	Agency	Year
7	NMT & NEMT	(3.8.1) **R** Physician Certificate Statement (PCS) Forms The Plan did not ensure PCS forms were on file for members receiving NEMT services.	1.The Plan made the decision to no longer allow courtesy NEMT trips for members without a PCS form on file and the decision to insource PCS form acquisition to the Plan's Case Management Department beginning 3/1/23. Working alongside the Plan's transportation subcontractor, the Plan created new workflows to ensure the transportation subcontractor was not scheduling NEMT trips for members unless there was a confirmed valid PCS form on file, or the Plan provided a verbal authorization due to a trip being of an urgent nature. The Plan hired two transportation coordinators to focus on PCS acquisition leveraging the Plan's preexisting relationships with the provider network and access to EHR's. Through the end of 2022 and beginning of 2023, the Plan's transportation subcontractor trained its call center agents on the new workflow. On 2/14/23, the Plan trained its transportation coordinators on PCS acquisition. On 2/21/23, the Plan trained its entire case management team, that participates in phone shifts for the Plan's case management phone line, on the parameters for verbal authorizations for NEMT trips of an urgent nature. The Plan continues to report on the success of the new workflows at the Plan's UM Committee. (On Track) 1a.The Plan is working with its analytics team to create a report using PCS data elements to match up against subcontractor's report of all NEMT trips taken each month. This report will assist in finding any gaps in PCS compliance. The Plan estimates this report to go live 12/1/2023. (On Track)	**12/15/2023**	**Completed**	Case Management	State	DHCS	2023
8	NMT & NEMT	(3.8.2) Transportation Providers' Medi-Cal Enrollment Status The Plan did not ensure all transportation providers were enrolled in the Medi-Cal program.	The Plan has updated the P&P VMG-005 from reviewing the Transportation Providers (TP) on a quarterly review to a monthly review. Attached for reference is the updated P&P. The Plan began reviewing the TP monthly for the utilization from April 2023 to current. (Completed and Ongoing)	4/1/2023	Completed	Vendor Management	State	DHCS	2023
9	Member Rights	(4.1.1) **R** Grievance Acknowledgement and Resolution Letter Timeframes The Plan did not send acknowledgement and resolution letters within the required timeframes.	A grievance processing timeline was created to outline the grievance 30 calendar day process, day by day. The timeline outlines that by day 5, acknowledgement letters will be sent out. We will continue to monitor the daily aging report to ensure that acknowledgement letters are sent in a timely manner. The timeline also outlines that on Day 20, "If response is not received, after at least two follow-up attempts, task to a Medical Director in Quality Suite." Complying with this process will ensure that the Medical Director has sufficient time to reach out to the provider or facility to assist in obtaining a response. The Grievance and Appeals staff were trained on the new timeline on 8/1/2023, copies of the timeline were distributed to the department. (Completed and Ongoing)	8/1/2023	Completed	G&A	State	DHCS	2023

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2023 DHCS Audit - *Audit Review Period* 4/1/2022 - 3/31/2023 *Audit Onsite Dates - April 17, 2023 - April 28, 2023*							INTERNAL AUDITS		
#	Category	Deficiency	Corrective Action Plan (CAP)	Completion Date	Internal CAP Status	Department Responsible	State/Self Identified	Agency	Year
10	Member Rights	(4.1.2) **R** Grievance Letters in Threshold Languages The Plan did not send acknowledgement, resolution delay, and resolution letters in threshold languages.	The Plan's Grievance and Appeals Department has created a reporting mechanism in our daily aging reports to monitor what cases are still pending translation and when was the request for translation sent out, this was implemented on 4/12/2023. We have then assigned one specific team member to be responsible for following up on translation letters to ensure that they are getting the attention that they need to be completed in a timely manner. The Grievance Processing Timeline will be updated to include when a request for translation needs to be sent out and the Grievance and Appeals staff will be provided with the updated timeline and a refresher training will be conducted on 10/10/2023. (Completed and ongoing)	10/10/2023	Completed	G&A	State	DHCS	2023
11	Member Rights	(4.1.3) **R** Written Notification of Grievance Resolution Delays The Plan did not notify members of resolution delays in writing for grievances not resolved within 30 calendar days and did not resolve grievances by the estimated resolution date in the delay letters.	The Plan's Grievance and Appeals Department will be updating our system, Quality Suite, to better capture data on if and/or when a delay letter is sent out. Once the system is updated, we will be able to create a reporting mechanism in our daily aging reports to monitor for when a case needs a delay letter and if the letter was sent out. The Grievance Processing Timeline will also be updated to include the process for sending out a delay letter and the Grievance and Appeals staff will be provided with the updated timeline and a refresher training will be conducted. (Completed and Ongoing)	12/1/2023	Completed	G&A	State	DHCS	2023
12	Member Rights	(4.1.4) Grievance Delay Timeframes The Plan inappropriately utilized a 14 calendar day delay timeframe for grievance resolutions.	In review of our current policy and procedures, and workflows; they were in line with the APL requirements. There was miscommunication in the staff training to use 14 calendar days instead of an estimated resolution date in the delay letters. There was a refresher training for the Grievance and Appeals staff held on 4/18/2023, the staff was provided the requirement and were reminded to provide an estimated resolution date in the delay letters if a resolution is not reached within 30 calendar days. (Completed)	4/18/2023	Completed	G&A	State	DHCS	2023
13	Member Rights	(4.1.5) Exempt Grievance Resolution The Plan did not resolve exempt grievances by close of the next business day.	In conjunction with the Grievance Department, the Member Services Grievance Guide was revised on 10/9/2023. (Completed) Training was provided to all Member Services staff on these revisions by 11/1/2023. (Completed)	11/1/2023	Completed	Member Services	State	DHCS	2023
14	Member Rights	(4.1.6) Grievance Identification The Plan did not process and resolve all member expressions of dissatisfaction as grievances.	Member Services has implemented a process to identify expressions of dissatisfaction that were not classified appropriately. (Completed) A Member Services Supervisor works with the agent to ensure the case is classified accurately and resolved in a timely manner. (Completed)	3/15/2023	Completed	Member Services	State	DHCS	2023
15	State Supported Services	(SSS.1) Minimum Proposition 56 Payments The Plan did not distribute minimum payments for a State Supported Services claim as described in APL 19-013.	The claims system configuration team has corrected the fee schedule for the provider and adjusted the impacted claims to pay the correct rate. (Completed)	4/26/2023	Completed	Claims	State	DHCS	2023
16	CM	(2.2) PCP and members are not consistently notified of Case Management case closures	Configuration made in TruCare to ensure consistent notification	4/26/2023	Completed	Case Management	Self	DHCS	2023
17	Fraud and Abuse	(6.2) The Plan did not report preliminary investigations of all suspected cases of fraud and abuse to DHCS within 10 working days of the Plan receiving notification of the incident.	The Plan has created an interdepartmental team working in collaboration to develop a reporting process for timely submissions of possible HIPAA and FWA incidents to Compliance. Six points of entry for possible incidents have been identified. The team is utilizing technological improvements as well as developing staff training to be able to identify a possible incident for immediate reporting to compliance. At the initiation of the Reporting Process Enhancement, the FWA Specialist will conduct training designed for each department identified as a point of entry. The FWA Specialist will be responsible to track and monitor all privacy related referrals to the compliance department for timeliness Training provided to staff and new tools being used consistently	4/26/2023	Completed	Compliance	Self	DHCS	2023

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2022 DMHC Behavioral Health Investigation - *Audit Review Period* 4/1/2020 - 4/30/2022 *Audit Onsite Dates - September 7, 2022 - September 8, 2022*							INTERNAL AUDITS	
#	**Category**	**Deficiency**	**Corrective Action Plan (CAP)**	**Completion Date**	**Internal CAP Status**	**Department Responsible**	**State/Self Identified**	**Agency**
1	UM	The Plan failed to timely implement the requirements of Sections 1374.72 and 1374.721 (SB 855)	The Alliance reviews and/or updates all policy and procedures at least annually, to ensure our policy and procedures content is reflective of current regulatory requirements. All UM policy and procedures including any updates and the UM Program Description, are reviewed in the Utilization Management Committee (UMC), subsequently reviewed, and approved at our Board Delegated Quality Improvement Health Equity Committee (QIHEC) which reports directly to the Alliance Board of Governors. In response and in compliance with SB 855, The Alliance has updated UM-063 - Gender Affirmation Surgery and Transgender Services and the Alliance UM Program Description. Both bodies of work are aligned with current WPATH Standards of Care. The Alliance is contracted with WPATH to provide training on WPATH Standards of Care - all UM decision makers (including RNs and physicians) are required to complete WPATH training to ensure the most current WPATH standards required by SB 855 are used for medical necessity decision-making. 100% of current UM reviewers will complete WPATH Training by Q2 2024 & 100% of newly hired UM reviewers will complete WPATH Training within 90-days of their start date The Alliance also conducts annual Inter-Rater Reliability Studies (IRR) with all UM decision makers to ensure that documented criteria is being applied consistently and accurately by decision makers. Additional training and testing is conducted when a passing score is not met. Annual IRR: 100% of UM reviewers will complete the Annual IRR Studies by Q3 2024	In Progress	Closed 9/27/2022 Q2 2024 Q3 2024	UM Behavioral Health	State	DMHC
2	Quality Assurance	The Plan does not ensure its delegate consistently documents quality of care provided is being reviewed, problems are being identified, effective action is taken to improve care where deficiencies are identified, and follow-up is planned where indicated.	As of 4/1/2023, The Alliance has terminated its contract with the delegate. Since termination, The Alliance has insourced all mental and behavioral health services and processes all quality of care issues identified. The Alliance follows its internal policy and procedures and workflows to ensure that all quality of care problems are identified, reviewed and further, that effective action is taken to improve care where deficiencies are identified, and that follow-up is planned where indicated.	4/1/2023	Completed	UM Quality Assurance Behavioral Health Compliance	State	DMHC
#	**Category**	**Barriers to Care**	**Plan Response**	**Completion Date**	**Internal CAP Status**	**Department Responsible**	**State/Self Identified**	**Agency**
1	Pharmacy Services	The Plan has limited ability to provide Office Based Opioid Treatment (OBOT) and Opioid Treatment Program (OTP) therapy and lacks policies and procedures for these treatments.	We will continue to take action to ensure that our members are not experiencing any barriers to behavioral health services.	TBD	TBD	UM Behavioral Health Pharmacy Provider Contracting	State	DMHC
2	Cultural Competency and Health Equity	Neither the Plan nor its delegate conduct assessments pertaining to cultural competency and health equity specific to the Plan's enrollee population.	We will continue to take action to ensure that our members are not experiencing any barriers to behavioral health services.	TBD	TBD	Quality Assurance Behavioral Health	State	DMHC
3	Enrollee Experience	Enrollees experience difficulties obtaining appointments.	We will continue to take action to ensure that our members are not experiencing any barriers to behavioral health services.	TBD	TBD	Quality Assurance Behavioral Health	State	DMHC

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2022 DMHC RBO Audit: Delegate - *Audit Review Period* 1/1/2022 - 3/31/2022							INTERNAL AUDITS			
#	Category	Deficiency	Corrective Action Plan (CAP)	Completion Date	Internal CAP Status	Department Responsible	Validation Status	State/Self Identified	Agency	Year
1	Claims Payment Accuracy	The Department's examination disclosed that the RBO failed to reimburse one paid claim correctly due to a systematic error. The claims system failed to classify the provider as a contracted provider. The claim was paid incorrectly at the non-contracted rate, which was less than the contracted rate. The RBO represented to the Department that this deficiency was due to a contract amendment, effective February 1, 2021, that was not updated in their claims system. This deficiency was noted in paid claims sample number P-18.	Delegate updated claims system to accurately reflect all providers listed on the provider roster as contracted with the effective date of 2/1/2021 to align with the contract amendment. A claims sweep was completed with a lookback to 2/1/2021. All claims previously paid noncontracted were reprocessed as contract and have been paid with any accrued interest and/or penalties associate with each claim reprocessed on 10/12/2022. Evidence of the complete claims audit sweep associated with members was sent to The Alliance on 1/19/2023 via secure email. Draft policy was created to ensure provider contracts and rosters are appropriately loaded within delegate's claims system. Draft policy will be presented to the delegate's Compliance Committee on 3/29/2023 for review and approval. Update 4/14/2023: The delegate's Compliance Committee rescheduled to 4/26/2023. The updated policy will be approved at that time. Update 5/12/2023: The delegate approved the policy at their Compliance Committee	5/12/2023	**Completed**	Claims Compliance		State	DMHC	2022
2	Claims Payment Accuracy	The Department's examination disclosed that the RBO failed to reimburse two high dollar claims correctly due to a systematic error. The contracted provider was not paid per contract for laboratory procedures. The RBO stated the laboratory procedures were based on an old boiler plate and should not have been included in the contract. The contract was amended on 9/1/2022. This deficiency was noted in high dollar claims sample numbers HD-18 and HD-24	There were no Alliance members impacted by this deficiency. Effective 10/12/2022 all claims were reprocessed and paid.	10/12/2022	Completed	Claims Compliance		State	DMHC	2022
3	Incorrect Claim Denials	The Department's examination disclosed that the RBO failed to reimburse one denied claim correctly due to a systematic error. The RBO incorrectly denied claims for podiatric and chiropractic services at federally qualified health centers and rural health clinics. The denial reason instructed the provider to bill "Medi-Cal EDS" when it should have been paid. This deficiency was noted in denied claims sample number D-29.	There were no Alliance members impacted by this deficiency. Effective 10/12/2022 all claims were reprocessed and paid.	10/12/2022	Completed	Claims Compliance		State	DMHC	2022

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2022 DMHC RBO Audit: Delegate - *Audit Review Period* 1/1/2022 - 3/31/2022							INTERNAL AUDITS			
#	Category	Deficiency	Corrective Action Plan (CAP)	Completion Date	Internal CAP Status	Department Responsible	Validation Status	State/Self Identified	Agency	Year
1	Claims Payment Accuracy	The Department's examination disclosed that one of 30 high dollar claims were not reimbursed correctly. The claims billed with Current Procedural Terminology (CPT) codes 93005 were underpaid. This deficiency was noted in high dollar claim sample number 28.	The RBO is reprocessing all claims with code 93005 underpaid from January 2021 to present and will upload corrected explanations of benefits upon completion. Corrected explanations of benefits showing additional payment (plus interest and penalty where applicable) as well as the requested report and policies will be submitted to DMHC on or before 1/30/2023.	1/30/2023	Completed	Claims Compliance		State	DMHC	2022
2	Misdirected Claims	The Department's examination disclosed that five out of 40 denied claims were not forwarded. This deficiency was noted in the following denied claims sample numbers: 3, 6, 20, 34, and 37. This deficiency was also noted in the high dollar claim sample numbers: 3, 5, 9, 10, and 25.	There is a system limitation (i.e. mapping issue) where some of the claims (837I encounters) are not being forwarded through our claims processing system. Because of this issue, 837I claims are not being forwarded to health plans. 837I misdirected claims are denied as health plan responsibility and providers are notified via weekly explanations of benefits. The mapping issue was discovered Q1 2022 and tests began at that time with health plans and clearinghouses. 837P files continue to be submitted successfully. The delegate is working with IT to upgrade the server so that updates provided by our software vendors can be implemented for the mapping issue to be resolved. The expected compliance date will be on or before 2/28/2023. 1/26/2023: server updates completed, system updates happening this week. 1/27/2023: system consultant met with the software vendor and their development team to identify and resolve issues so that system updates can happen successfully. 1/30/2023: all system updates completed successfully on test environment	1/30/2023	Completed	Claims Compliance		State	DMHC	2022
3	Reimbursement of Claims Overpayments	The Department's examination disclosed that the RBO failed to send a written request for overpayment reimbursement to the provider. This deficiency was noted in the following late claim sample numbers: 16, 32, and 35.	Examiner error. When the claims examiner reprocessed these claims, the overpayment was reversed instead of a refund request letter being sent to the provider. Compliance met September 27, 2022 when the claims examiner was reminded in a verbal meeting of the above rule as well as the Delegate's internal policy on overpayments. Also, there is a report run prior to the weekly check run to ensure compliance. Because the overpayment was reversed in the adjusted claims, a refund request was not sent for the original claims.	1/30/2023	Completed	Claims Compliance		State	DMHC	2022

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2022 DMHC FINANCIAL SERVICES : *Audit Review Period 1/1/2022 - 3/31/2022*							INTERNAL AUDITS			
#	Category	Deficiency	Corrective Action Plan (CAP)	Completion Date	Internal CAP Status	Department Responsible	Validation Status	State/Self Identified	Agency	Year
1	Provider Dispute Resolutions	The Department's examination disclosed that the Plan failed to timely acknowledge receipt of 12 out of 71 provider disputes reviewed.	1. Policies and procedures, including internal claims audit procedures, implemented to ensure provider disputes are acknowledged timely. Update 2/13/2023: Policy updated and will be approved at Committee 3/25/2023 2. Staff training completed January 2023 and created a audit workflow effective 01/01/2023. 3. Claims Operations Support Manager and PDR Supervisor. PDR Supervisor will monitor all incoming PDR mail. A daily audit will be conducted before the 15th due date to assure all cases are acknowledged timely.	2/24/2023	Completed	Claims		State	DMHC	2022
2	Claims	The Department's examination disclosed that, due to systemic issues, claims were not reimbursed accurately, including interest and penalties.	CORRECTIVE ACTION TAKEN DURING EXAMINATION The Plan submitted evidence on October 28, 2022, that the Plan reprocessed and paid claims previously paid incorrectly. This correction and remediation resulted in the additional payment of $5,742.29, plus interest of $7,675.43, on 742 claims. In addition, the Plan submitted evidence on October 28, 2022, that the Plan reprocessed and paid claims previously denied incorrectly. This correction and remediation resulted in the additional payment of $64,718.77, plus interest of $6,002.98, on 750 claims. The Plan corrected the deficiencies noted above and completed the required remediation during the course of the examination; therefore, no additional response is required.	10/28/2022	Completed	Claims		State	DMHC	2022
3	Changes in Plan Personnel	**R** The Department's examination disclosed that the Plan did not timely file changes in plan personnel.	1. The Plan revised its Desktop Procedure to define the Key Personnel as "Persons holding official positions that are responsible for the conduct of the Plan including but not limited to all Senior Leadership, all members of the BOG and other principal officers." The Desktop Procedure further clarifies the activities that will constitute an official personnel change event for Senior Leadership versus Board of Governors members. Finally, the Desktop Procedure was revised reflect that Key Personnel Change filings must be submitted within five (5) calendar days. 2. We have taken steps to improve the communication with the internal stakeholders to ensure personnel change events are routed to the Regulatory Affairs and Compliance team in a timely manner. The Board Clerk is responsible to immediately notify the Compliance Department of any Board Member changes. To ensure no updates are missed, each month the Compliance Specialist will email the Board Clerk and the Human Resources Department to confirm whether the BOG or SLT has experienced any personnel changes. The Compliance Specialist also maintains a log of Key Personnel Changes. Furthermore, once a personnel change event is anticipated, the Compliance Specialist immediately begins an electronic file and begins preparation of the necessary documents for submission.	1/13/2023	Completed	Compliance		State	DMHC	2022
4	Fidelity Bond	The Department's examination disclosed that the Plan's fidelity bond did not have a provision for 30 days' notice to the Department prior to cancellation.	Immediately after receiving the DMHC's audit request, The Alliance finance staff requested its insurance broker to work with the insurer in adding the requested provision. Before the DMHC's audit exit conference, such requested provision was provided to the DMHC auditor, and the auditor expressed that the supplied document was satisfactory. The Alliance has also created a new Policy & Procedure effective 1/11/2023.	1/11/2023	Completed	Finance		State	DMHC	2022

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2022 DHCS AUDIT FINDINGS: *Audit Review Period 1/1/2021 - 3/31/2022*							INTERNAL AUDITS			
#	**Category**	**Deficiency**	**Corrective Action Plan (CAP)**	**Completion Date**	**Internal CAP Status**	**Department Responsible**	**Validation Status**	**State/Self Identified**	**Agency**	**Year**
1	G&A	(1.3.1) The Plan did not send acknowledgement letters for standard appeals within the required timeframe of five calendar days.	1. The Daily Clerk Report is received daily by Grievance & Appeals Clerks and Leadership. The report will be reviewed by the Grievance & Appeals Leadership team to ensure acknowledgment letters are mailed timely. 2. The Plan provided training to the Grievance & Appeals staff to review the regulatory requirements for mailing of acknowledgement letters.	10/1/2022	Completed	G&A		State	DHCS	2022
2	G&A	(1.3.2) The Plan did not comply with existing APLs to notify members receiving a NAR that upholds an adverse benefit determination that they have an additional 120 days in addition to the initial 120 days allowed to request a SFH.	1. Your Rights enclosure was updated to reflect enrollees have 240 days to request a State Fair Hearing 2. Policy & Procedure G&A-007 State Hearings has been updated to reflect the member has 240 calendar days to request a State Hearing. The policy will go to committee for review and approval in December. Update 03/10/2022: Plan submitted draft policy G&A-007 State Fair Hearings that reflects current timeframe to request a SFH (240 calendar days) per the PHE. Policy pending internal committee approval. Plan will need to monitor end of PHE in order to revise policy to reflect normal regulatory requirement of 120 calendar days. PHE was extended through 1/11/23. Update 4/14/2023: The updated policy was approved at Compliance Committee on 3/21/2023	3/21/2023	Completed	G&A		State	DHCS	2022
3	Provider Relations	**R** (1.5.1) The Plan did not ensure that its subcontractors submitted complete ownership and control disclosure information.	1. The Alliance has made updates to its Provider Services Standard Operating Procedure (SOP) – Ownership and Control Disclosure Reviews for Delegates. This includes an additional layer of review from the Alliance Compliance Department when ownership and control forms are received from delegates. The SOP and tracking sheet has been updated. 2. The findings specifically mentioned two (2) forms: • The delegate who provided the Alliance with the email confirming that the form they submitted to the Alliance is the same form that it files with DHCS. According to the delegate, DHCS confirmed acknowledgement of the form with no additional feedback. • Another delegate who does not have a sole owner and provided a list of their leadership team with the FEIN for each of the clinics. The Alliance will notify the impacted delegates of the findings to receive forms that meet requirements by DHCS. 3. The Alliance will collect the new forms starting Q1 2023 Update 03/10/2023: Delegate has submitted an updated form and delegate is currently working toward completion of the form for submission to the Plan. Provider Services and Compliance will review to validate all fields are complete once all forms are received. Update 4/15/2023: The other delegate's form received on 3/2/2023, and two levels of review completed 3/10/2023.	3/10/2023	Completed	Provider Relations		State	DHCS	2022
4	QI	(2.1.1) The Plan did not document attempts to contact members and schedule the IHA.	1. The plan will continue to inform members of the IHA through the EOC, welcome letters to all new members, and videos. - In addition, all members are eligible for a new member orientation (including a financial incentive). - Information regarding the IHA will be included in the member newsletter. The Alliance will initiate a new phone campaign where all new members will receive a phone call encouraging the member to receive an IHA. This phone log will be appropriately documented. The Alliance will create a call script for new member phone calls. 2. The plan will create a report to identify new plan members. Update 5/12/2023: Fulfillment Report created to track mailing of member Orientation reports that contain reminder to schedule IHA to new members. Member Orientation Service Request tracking report tracks outreach attempts to members to complete new member orientation, which includes communication about scheduling IHAs 3. The plan will create workflows for informing members of the IHA. Update 5/12/2023: Clinical QI Program Coordinator will review IVR reports to determine all new members have received an outreach call.	9/8/2023	Completed	QI		State	DHCS	2022

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2022 DHCS AUDIT FINDINGS: *Audit Review Period 1/1/2021 - 3/31/2022*							INTERNAL AUDITS			
#	**Category**	**Deficiency**	**Corrective Action Plan (CAP)**	**Completion Date**	**Internal CAP Status**	**Department Responsible**	**Validation Status**	**State/Self Identified**	**Agency**	**Year**
			4. The plan will update the IHA P&P to reflect the updated workflows. Update 3/10/2023: Draft policy QI-124 completed, IVR outreach is pending DHCS approval of script. Upon DHCS approval we will continue to develop the process for IVR outreach and develop desktop procedures. Update 4/15/2023: The updated P&P was approved at Compliance Committee 3/21/2023 5. The plan will create a phone call campaign, create a script, and work with the state for approval. Update 3/10/2023: Awaiting DHCS approval of script. Update 6/9/2023: Final documents submitted to DHCS for review. Awaiting DHCS response. The Plan will continue to ensure accurate documentation of IHA outreach attempts via providers, by reviewing documentation as part of FSRs.							
5	CM	**R** (2.5.1) The Plan's MOU with the county MHP did not include the responsibility for the review of disputes between the Plan and the MHP.	1. The Alliance has made several updates to the MOU and incorporated APL 18-015, as well as APL 21-013 Dispute Resolution Process Between Mental Health Plans and Medi-Cal Managed Care Health Plans. The Alliance has had a series of meetings with the MHP to review redline changes to the MOU. The MHP is currently under review of the redline changes and will notify the Alliance when they can move forward with signing the MOU. The MHP MOU vetting process includes County Board of Supervisor (BOS) approval. Therefore, the Alliance is hoping to execute the MOU by the end of 2022.	12/31/2023	Completed	Provider Relations		State	DHCS	2022
6	Provider Relations	**R** (3.1.1) The Plan did not monitor the network providers' compliance with requirements for when appointments were extended.	1. The Provider Manual was edited to update the requirements, providers were advised in the Quarterly Provider Packet, and The Alliance Provider Representatives advised providers during PCP visits. Additionally, fax blasts were sent to providers regarding the updated requirements, and the Provider Education document was updated to reflect the requirements. 2. Edit P&P and Quality of Access Workflow to ensure all cases are reviewed by a QI Nurse. If a case is determined to be related to access, QI / A&A staff will review data for ED / Inpatient Stays as a result of delay in appointment. If the member does have an ED / IP Claim, the QI RN will then work the case up as a PQI / Quality of Care. This will be reviewed by the Medical Director and follow the PQI process. Finally, all QOA cases with available MRs will be reviewed to ensure the appropriate provider documentation. Update 03/10/2023: Policy QI-114 has been updated and is awaiting approval at committee Update 4/14/2023: P&P Q1-114 was approved at Compliance Committee 3/21/2023	3/21/2023	Completed	Provider Relations QI		State	DHCS	2022
7	Claims	(3.6.1) The Plan improperly denied emergency services claims.	1. Case #7 – The claim was paid on 8/11/2021. The vendor was notified of the finding on 5/19/2022 and asked to review their internal process to ensure that codes on claims are captured correctly. They acknowledged they reviewed their internal processes and stated that poor claim imaging may have cause the issue, but they will increase the resolution to help ensure better results in the future. 2. Case #20 –The vender was notified of the issue on 5/19/2022 and asked to review their internal process to ensure that dates on clams are captured correctly. They acknowledged they reviewed their internal processes and stated that poor claim imaging may have cause the issue, but they will increase the resolution to help ensure better results in the future. In addition, an edit was enhanced to ensure that the date range order is correct. 3. The claim was paid on 1/5/2022 correctly. The Claims Processor was shown the claim finding for review along with the correct workflow document that shows the correct process to help ensure moving forward this does not occur again. This workflow was also reviewed by the Claim Processor team and training occurred.	10/11/2022	Completed	Claims		State	DHCS	2022

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2022 DHCS AUDIT FINDINGS: *Audit Review Period 1/1/2021 - 3/31/2022*							INTERNAL AUDITS			
#	Category	Deficiency	Corrective Action Plan (CAP)	Completion Date	Internal CAP Status	Department Responsible	Validation Status	State/Self Identified	Agency	Year
8	Access and Availability	**R** (3.8.1) The Plan did not use PCS forms for NEMT services.	1. The Plan will educate providers on PCS requirements. Update 3/10/2023: Provider Alert PCS Form Reminder and Form was sent out to Providers in a fax blast on Tuesday, 12/27/22. 2. Refine PCS workflows to meet all regulatory requirements. Update 3/10/2023: Workflow updated. 3. The Plan will conduct staff trainings on process workflow changes. Update 4/15/2023: Training completed 1/31/2023. 4. The Plan will ensure that the transportation subcontractor trains their staff on the PCS process workflow changes. The transportation subcontractor will provide training materials and sign in sheets. Update 4/15/2023: Training completed 1/31/2023. 5. The Plan will develop reports on PCS form outcomes using both transportation subcontractor information and the Plan's process to obtain PCS forms. Update 4/15/2023: Reports developed and presented at UM Committee Q4 2022. 6. The Plan will monitor process workflows from the transportation subcontractor and the Plan to obtain missing PCS forms Update 4/15/2023: Reports developed and presented at UM Committee Q4 2022. 7. The Plan will analyze trends in provider practices and provide feedback to providers regarding PCS form requirements. Update 4/15/2023: Reports developed and presented at UM Committee Q4 2022, where trends analyzed. 8. The plan will evaluate whether to continue having the transportation subcontractor manage the PCS forms or take the direct management of PCS forms back into the Plan. Update 4/15/2023: Reports developed and presented at UM Committee Q4 2022. Will continue to analyze quarterly. 9. The Plan will provide a quarterly report to UM Committee Update 4/15/2023: Reports developed and presented at UM Committee Q4 2022.	4/1/2023	Completed	UM		State	DHCS	2022
9	Member Rights	**R** (4.1.1) The Plan did not send acknowledgement and resolution letters within the required timeframes.	1. The G & A Department Leadership and Quality Assurance Specialist will reference the daily reports to ensure the acknowledgment and resolution letters are sent timely 2. The Plan provided training to the Grievance & Appeals staff to review the regulatory requirements for mailing of acknowledgement and resolution letters. 3. The Quality Assurance Specialist will audit 5 appeals cases and 5 grievances cases per Grievance & Appeals Coordinator per month.	10/1/20222	Completed	G&A		State	DHCS	2022
10	Member Rights	**R** (4.1.2) The Plan did not send acknowledgement and resolution letters in threshold languages.	1. Updated our system of record to capture the dates the resolution letter was submitted for translation and the date it was mailed to the member. 2. The Plan provided training to the Grievance & Appeals staff on the updates made to the system of record. 3. The Quality Assurance Specialist will audit 5 appeals cases and 5 grievances cases per Grievance & Appeals Coordinator per month.	9/20/2022	Completed	G&A		State	DHCS	2022
11	Member Rights	(4.1.3) The Plan was not compliant with grievance extension letter timeframes; in some cases, it did not send extension letters for grievances that were not resolved within 30 calendar days and in other cases it did not resolve grievances by the estimated completion date specified in the extension letter	1. The Plan provided training to the Grievance & Appeals staff on the system updates to capture extension letters. 2. The Quality Assurance Specialist will audit 5 appeals cases and 5 grievances cases per Grievance & Appeals Coordinator per month. 3. Updated Policy & Procedure G&A- 003: Grievance and Appeals, Receipt, Review and Resolution. The policy will be sent to Committee for approval. Update 03/10/2023: Draft policy updated and awaiting approval at committee. Update 4/15/2023: P&P G&A-003 was approved at Compliance Committee on 3/21/2023	3/21/2023	Completed	G&A		State	DHCS	2022

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2022 DHCS AUDIT FINDINGS: *Audit Review Period 1/1/2021 - 3/31/2022*							INTERNAL AUDITS			
#	**Category**	**Deficiency**	**Corrective Action Plan (CAP)**	**Completion Date**	**Internal CAP Status**	**Department Responsible**	**Validation Status**	**State/Self Identified**	**Agency**	**Year**
12	Member Rights	**R** (4.1.4) The Plan did not thoroughly investigate and resolve grievances prior to sending resolution letters.	1. The Alliance will review resolution letters prior to mailing to the member. 2. The Alliance provided training to the Grievance & Appeals staff to ensure the resolution letter clearly addresses all of the member's concerns 3. The Quality Assurance Specialist will audit 5 appeals cases and 5 grievances cases per Grievance & Appeals Coordinator per month.	10/1/2022	Completed	G&A		State	DHCS	2022
13	Member Rights	**R** (4.3.1) The Plan did not report suspected security incidents or unauthorized disclosures of PHI to DHCS within the required timeframes.	The Plan has created an interdepartmental team to work in collaboration to develop a reporting process for timely submissions of possible HIPAA and FWA incidents to Compliance. Six points of entry for possible incidents have been identified. The team is utilizing technological improvements as well as developing staff training to be able to identify HIPAA and FWA incidents and the method for immediate reporting to compliance. Update 03/10/2023: Training created and provided to The Alliance staff; new referral tracking implemented and tool created.	3/10/2023	Completed	Compliance		State	DHCS	2022
14	Member Rights	(4.3.2) The Plan did not notify the DHCS Program Contract Manager and DHCS ISO of suspected security incidents or unauthorized disclosure of PHI or PI.	Due to human error, reporting to the three (3) entities at DHCS; DHCS Program Contract Manager, the DHCS Privacy Officer and the DHCS Information Security Officer was not completed for all possible HIPAA incidents. Reporting Policy CMP-013 has been updated to reflect the current reporting email address for possible HIPAA incidents to DHCS incidents@dhcs.ca.gov. This change was reviewed and approved by the Compliance Committee on 11/23/2021.	11/23/2021	Completed	Compliance		State	DHCS	2022
15	Fraud and Abuse	**R** (6.2.1) The Plan did not report preliminary investigations of all suspected cases of fraud and abuse to DHCS within 10 working days of the Plan receiving notification of the incident.	The Plan has created an interdepartmental team working in collaboration to develop a reporting process for timely submissions of possible HIPAA and FWA incidents to Compliance. Six points of entry for possible incidents have been identified. The team is utilizing technological improvements as well as developing staff training to be able to identify a possible incident for immediate reporting to compliance. At the initiation of the Reporting Process Enhancement, the FWA Specialist will conduct training designed for each department identified as a point of entry. The FWA Specialist will be responsible to track and monitor all privacy related referrals to the compliance department for timeliness. Update 03/10/2023: Training created and provided to The Alliance staff; new referral tracking implemented and tool created.	3/10/2023	Completed	Compliance		State	DHCS	2022

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2021 DMHC JOINT AUDIT FINDINGS : *Audit Review Period 11/1/2018 - 10/31/2020*							INTERNAL AUDITS			
#	**Category**	**Deficiency**	Corrective Action Plan (CAP)	Completion Date	Internal CAP Status	**Department Responsible**	**Validation Status**	**State/Self Identified**	**Agency**	**Year**
1	Grievances & Appeals	When the Plan has notice of a case requiring expedited review, the Plan does not immediately inform complainants of their right to contact the Department.	The Plan updated the process to state when a call is received by the Member Services Department and it is categorized as a potential expedite, the call is transferred to the Grievance & Appeals Department queue and the Clerk will provide the member with their DMHC rights.	5/3/2022	Completed	G&A		State	DMHC	2021
2	Grievances & Appeals	The Plan's online grievance submission procedure is not accessible through a hyperlink clearly identified as "GRIEVANCE FORM," does not allow a member to preview and edit the form before submission, and does not include the required disclosure.	The Plan has worked with our internal Information Technology (IT) Department to have the updates made to the website to include the GRIEVANCE FORM hyperlink, the edit/preview functionality and to update the disclosure statement. Exhibit 2A_Preview_Edit_Disclosure shows the updates on the testing site. Regarding the disclosure statement, the Plan identified an outdated version of the statement. The Plan has updated the disclosure statement so that it is in alignment with the verbiage from Knox-Keene (see attached Exhibit 2B_Knox-Keene).	8/11/2022	Completed	G&A		State	DMHC	2021
3	Grievances & Appeals	The Plan does not correctly display the statement required by Section 1368.02(b) in all required enrollee communications.	The Plan identified an outdated version of the statement. The Plan has updated the disclosure statement so that it is in alignment with the verbiage from Knox-Keene (see attached Exhibit 3A_Knox-Keene). Exhibit 3F will apply to both the appeals and grievance letters. The Plan's UM materials were likewise updated to reflect compliance with the verbiage. Revised Your Rights attachments for NOAs and NARs were implemented in TruCare on 1/18/2022. The Plan's Pharmacy templates are being drafted and copies will be provided on 12/30/2022 for the following: • 4A_GroupCare NOA template • 5A_ GroupCare NOA template • 6A_ Full Group Care Formulary/Template **12/30/2022**:Template letters completed and submitted to DMHC	12/30/2022	Completed	G&A Member Services UM Rx		State	DMHC	2021
4	Prescription (Rx) Drug Coverage	The Plan's prescription drug denial and modification letters to enrollees do not include accurate information about their grievance rights.	The plan will update/ensure prescription drug denial and modification letters to the enrollees include accurate information about their grievance rights. Templates are being drafted and copies will be provided on December 30, 2022.**12/30/2022:**Template letters completed and submitted to DMHC	12/30/2022	Completed	Rx		State	DMHC	2021
5	Prescription (Rx) Drug Coverage	The Plan does not inform enrollees of their right to seek an external exception request review in formulary exception request denial letters.	The plan will insert external exception request review in formulary exception request denial letters as seen below: "EXTERNAL REVIEWS You have the right to request an external review when the Alliance denies a prior authorization request for a drug that is not covered by the plan or for an investigational drug or therapy. A request for an external review will not prevent you from filing a Grievance or Independent Medical Review (IMR) with the California Department of Managed Health Care. You may request an external review through the Alliance contact information listed above." • Templates are being drafted and copies will be provided on December 30, 2022.**12/30/2022:**Template letters completed and submitted to DMHC	12/30/2022	Completed	Rx		State	DMHC	2021
6	Prescription (Rx) Drug Coverage	The Plan does not display its formularies in a manner consistent with the Department's standard formulary template.	The Plan will update formularies in a manner consistent with the Department's standard formulary template. **12/30/2022:** The formulary template has been updated.	12/30/2022	Completed	Rx		State	DMHC	2021

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2021 DHCS JOINT AUDIT FINDINGS: *Audit Review Period 6/1/2019 - 3/31/2021*								INTERNAL AUDITS			
#	Category	Deficiency	Corrective Action Plan (CAP)	Risk Category (High, Medium, Low)	Completion Date	Internal CAP Status	Department Responsible	Validation Status	State/Self Identified	Agency	Year
1	UM	(1.2.1) The Plan did not have appropriate processes to ensure that limitations on speech therapy services would not be imposed. In addition to using Medi-Cal guidelines, the Plan used MCG as its evidence-based criteria to make decisions. MCG criteria dictates the amount of visits that can be approved based on a diagnosis and therefore imposes limits.	1. The Plan developed workflow outlining standard review process for speech therapy Prior Authorization (PA) requests, ensuring that no limitations on speech therapy would be imposed on members under age 21. 2. The Plan will conduct a current staff training on standard process, and include it in new staff training. Update 10/8/2021: Training complete 9/29/2021 3. The Plan will revise 10748 Daily Auth Denial report to incorporate service type to capture PA requests for Speech Therapy. Update 11/12/2021: The report request has been submitted, estimated completion is 11/15/2021. Update 12/10/2021: Report has been created and is being completed weekly.	Medium	Q1 2022	Completed	UM		State	DHCS	2021
2	UM	(1.2.2) The Plan did not ensure that a qualified health care professional reviewed dental anesthesia prior authorization requests which includes a review of clinical data. The Plan did not ensure the use of appropriate criteria/guidelines when reviewing dental anesthesia requests.	1. The Plan developed workflow outlining standard review process for dental anesthesia Prior Authorization (PA) requests. 2. The Plan will develop mitigation plan until auto auth programming is removed. Update 10/8/2021: Mitigation plan developed and put into place 9/29/2021 3. The Plan will conduct a staff training on the mitigation plan to identify and use standard UM review process for dental anesthesia (DA) and include it in new staff training. Update 10/8/2021 Training complete 9/29/2021 4. The Plan's UM and IT teams will collaborate to remove DA requests from Auto Authorization programming in TruCare (TC). Update 12/10/2021: DA requests have been removed from Auto Authorization programming in TruCare as of 10/1/2021 5. The Plan will develop a Tracking Report to capture and report on PA requests for Dental Anesthesia. Update 12/10/2021: The quarterly report (03127) Dental General Anesthesia Report will be utilized for monitoring 6. The Plan will monitor PA requests for Dental Anesthesia quarterly. Update 10/14/2022: PA requests for Dental Anesthesia are now being monitored quarterly 7. The Plan will report results quarterly to UMC. Update 10/14/2022: PA requests for Dental Anesthesia are now being tracked on a quarterly basis and was reported out at the Q1 2022 UM Committee	High	Q1 2022	Completed	UM		State	DHCS	2021
3	UM	(1.5.1) The Plan did not ensure the delegate met standards set forth by the Plan and DHCS. The Delegate inappropriately denied medical prior authorization requests.	1. The Plan will inform Delegate 1 of DHCS findings about inappropriately denied medical prior authorization requests. Update 11/12/2021: On 10/8/2021 a letter was sent to the delegate to advise of the audit findings. 2. The Plan will re-educate delegates on requirements for standard UM processes, including application of appropriate criteria guidelines. Update 11/12/2021: On 10/12/2021 a meeting was held with Delegate 1 leadership do educate on requirements for the standard UM process. 3. The Plan will audit Delegate 1's denied cases for appropriateness of denial elements using annual audit tool. Update 2/11/2022: The annual Delegate 1 delegation audit began 12/17/2021 and includes an audit of denied cases for appropriateness of denial elements. 4. The Plan will review denied cases at monthly Delegate 1 meeting for education. Update 2/11/2022: Denied cases are now being reviewed at the monthly Delegate 1 meeting for education. Update 5/13/2022: The Q1 2022 audit has commenced as of 5/5/2022. Update 08/09/2022: The Delegate 1 audit is in progress and is expected to be completed by 8/12/2022 Update 09/06/2022: The audit for Q2 2022 is in progress, preliminary findings have been submitted to Delegate 1. The audit for Q3 2022 is beginning. There will be four total quarters of reviews completed in order to close out this finding. 4/3/2023: Four quarters of the audit have been completed. Results under review. Update 6/9/2023: A Trend Report for 2022 Quarterly Focused Audit findings regarding medical necessity denials was issued to Delegate 1 along with the Final Report for their Annual Audit on 4/11/23. Delegate 1 CAP response due 6/16/2023. **Update 9/8/2023:** The 2022 CAP is ongoing. Delegate 1's CAP included updates to UM workflows, staff training, and internal audits. The CAP is in progress. Workflows, trainings, and internal audits have been completed and are under review by Alliance SMEs.	Medium	Q4 2023	Completed	UM		State	DHCS	2021
4	UM	(1.5.2) The Plan did not ensure the delegate met standards set forth by the Plan and DHCS. The delegate did not ensure that requests to see out of network providers were reviewed and decisions were made by a qualified health care professional. It did not include the decision-maker's name in the NOA.	1. The Plan will inform Delegate of DHCS findings about qualified health care professional did not always make decisions to deny or only authorized an amount, duration, or scope that was less than requested, and the lack of name and contact information on the NOA of the decision-maker. Update 11/12/2021: On 10/8/2021 a letter was sent to delegate to advise of the audit findings. 2. The Plan will re-educate delegates on standard UM requirement that only qualified health care professionals make decisions to deny or authorize an amount, duration, or scope that is less than requested, including out of network requests, and on the requirement to have the decision-makers' name and contact information on the NOA. Update 11/12/2021: The Alliance met with the delegate on 10/28/2021 to provide re-education. 3. The Plan will audit delegate's cases during the annual audit to ensure that only qualified health care professionals make decisions on denials and authorizations of the amount, duration, and scope less than requested, and contact information for the decision maker. Update 02/11/2022: The annual delegation audit started on 12/20/2021 and is in progress. The audit is expected to be completed on 4/1/2022. Update 09/09/2022: The delegate audit is in progress. And is expected to be completed by 9/23/2022	Medium	12/20/2021	Completed	UM Compliance		State	DHCS	2021

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#	Category	Deficiency	Corrective Action Plan (CAP)	Risk Category (High, Medium, Low)	Completion Date	Internal CAP Status	Department Responsible	Validation Status	State/Self Identified	Agency	Year
5	UM	**R** (1.5.3) The Plan did not ensure complete ownership and control disclosure information were collected from its delegates.	1. The Plan has updated its documentation, Provider Services Standard Operating Procedure – Ownership and Control Disclosure Reviews for Delegates, to include collecting required disclosures from the managing employees, or board of directors and senior management team in cases where the entity is a non-profit with no majority ownership and/or owned by physician shareholders.	Low	9/14/2021	Completed	Provider Network Vendor Management		State	DHCS	2021
6	UM	(1.5.4) The Plan did not ensure the written agreements with its delegates included the requirement to allow specified departments, agencies, and officials to audit, inspect, and evaluate the Plan's facilities, records, and systems related to good and services provided to Medi-Cal members.	1. The Plan is adding the Comptroller General in the Behavioral Health contract, Amendment 7. Update 11/12/2021: The Comptroller General was added to the contract, Amendment 7, as of 10/13/2021 2. The Plan is currently working with its delegate on a new contract and delegation agreement which will include the provision and requirement to allow governmental and specified agencies and officials to audit records and systems. Update 1/14/2022: The draft agreement has been completed and is expected to be fully executed in January 2022. Update 2/11/2022: Full execution of the draft agreement is still in progress. Update 09/09/2022: Full execution of the draft agreement is expected by the end of September 2022 3. The Plan will conduct a review of all of its delegated agreements and update the agreements to ensure that all of the language requirements are included. Update 1/14/2022: The agreement has been reviewed and updated. Update 2/11/2022: The Plan conducts annual oversight of its Delegates via an Annual Delegation Audit, as described in CMP-019 – Delegation Oversight. The Plan has updated its Compliance Audit tool to ensure the audit includes a review of the Delegation Agreement to confirm it contains the required language.	Medium	12/31/2022	Completed	Provider Network Vendor Management Compliance		State	DHCS	2021
7	UM	(1.5.5) The Plan did not have policies and procedures for imposing financial sanctions on its delegate and delegated entities.	1. The Plan has created a new Policy, CMP-030 Sanction and Escalation. This Policy describes the standards by which the Plan may impose sanctions against Delegated Entities (DE), providers and vendors for non-compliance or failure to comply with Corrective Actions Plan (CAP) deficiencies, or for breach of any material term, covenant or condition of an agreement and/or for failure to comply with applicable federal or state statutes, regulations, and rules. Update 12/10/2021: Policy CMP-030 was approved at Compliance Committee on 11/23/2021	Low	12/1/2021	Completed	Compliance		State	DHCS	2021
8	Case Management	**R** (2.1.1) The Plan did not conduct HRAs within the required timeframes for newly enrolled SPD members in 2019 and 2020.	1. The Plan revised the HRA process to track all incoming HRAs via a Log, documenting date of receipt. 2. The Plan revised current process for HRAs received past due to be entered into the system of record TruCare (TC) during the month of receipt. 2.a. The Plan updated workflows. 3. The Plan re-trained staff on the HRA process. 4. The Plan will monitor the Log weekly to ensure adherence to the new process. Update 10/8/2021: The log has been created and is being monitored weekly 5. The Plan will report outcomes up to UMC quarterly. Update 2/11/2022: As of the December UM Committee meeting, outcomes are now being reported at the UMC.	Low	12/31/2021	Completed	Case Management		State	DHCS	2021
9	Case Management	(2.1.2) The Plan did not ensure coordination of care in certain cases where EPSDT services were medically necessary.	1. The Plan will develop training on EPSDT PA requests to identify and refer members who need coordination of their care. Update 11/12/2021: Training developed 2. The Plan will provide training to UM and CM staff. Update 11/12/2021: Training completed for UM and CM staff 3. The Plan will create a reporting system to capture referrals to CM and the provision of care coordination. Update 11/12/2021: Reporting system to capture referrals has been created, change in reporting will be reflected mid-December 4. The Plan will report outcomes at UMC on a quarterly basis. Update 5/13/2022: Outcomes reported at January and March 2022 UMC Meetings.	Medium	5/13/2022	Completed	Case Management		State	DHCS	2021
10	Case Management	(2.2.1) The Plan did not ensure the completion of Individualized Care Plans for members enrolled in Complex Case Management.	1. The Plan revised its CCM ICP workflow and added the requirement that all staff complete ICPs for all members in CCM. 2. The Plan re-trained staff to complete ICPs for all members in CCM. 3. The Plan will revise its CM Aging Report to capture completion of ICPs for daily management and reporting outcomes. Update 10/8/2021: Aging report has been updated to capture completion of ICPs 4. The Plan will develop a monitoring workflow. Update 10/8/2021: The monitoring workflow has been completed 5. The Plan will routinely monitor completion of the ICPs. Update 10/8/2021: The log has been created and is being monitored weekly 6. The Plan will report outcomes at UMC quarterly. Update 09/09/2022: Monitoring of the ICPs is now being tracked and reported out quarterly at UM Committee.	Low	3/25/2022	Completed	Case Management		State	DHCS	2021

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11	Case Management	(2.2.2) The Plan did not ensure development of care plans in collaboration with the PCP.	1. The Plan re-trained staff on policy regarding developing care plans in collaboration with PCP. 2. The Plan will revise its CM Aging Report to capture the date the letter regarding Care Plans was sent to the PCP.10/8/2021: The CM Aging Report has been updated to capture the date the letter regarding Care Plans was sent to the PCP 3. The Plan will monitor, on an ongoing basis, the CM Aging Report to ensure CP letters are being sent to PCPs. Update 10/8/2021: Monitoring has begun, automation of this report is in progress 4. The Plan will report outcomes to UMC quarterly. Update 09/09/2022: Monitoring of the development of care plans with the PCP is now being tracked and reported out quarterly at UM Committee.	Low	3/25/2022	Completed	Case Management		State	DHCS	2021
12	Case Management	(2.2.3) The Plan did not conduct periodic evaluations to ensure the provision of complex case management based on the member's medical needs. The Plan did not implement procedures for monitoring time frame standards or maintaining monthly contact with members.	1. The Plan developed a workflow to maintain regular contact with members and ensure that the continuation of CCM is based on medical needs by using the Complex Criteria Checklist. 2. The Plan conducted staff training. 3. The Plan will revise its CM Aging Report to capture provision of CCM and maintaining monthly contact with member. 10/8/2021: The CM Aging Report has been revised to capture the provision of CCM and maintaining monthly contact with member 4. The Plan will monitor, on an ongoing basis, the CM Aging Report. 10/8/2021: Monitoring has begun, automation of this report is in progress 5. The Plan will report outcomes quarterly to UMC. Update 09/09/2022: Monitoring of the CM Aging Report is now being tracked and reported out quarterly at UM Committee.	Low	3/25/2022	Completed	Case Management		State	DHCS	2021
13	Case Management	(2.2.4) The Plan did not ensure that interdisciplinary team assessments were included in the updating of members' care plans. The Plan did not ensure timely documentation of the interdisciplinary team meeting notes.	1. The Plan created an additional column in the Complex Case Log to monitor timely entry of IDT Round note into system of record. 2. The Plan will develop a workflow for staff to include the IDT note in the updated care plans. Update 10/8/2021: The workflow has been updated to include the IDT note in the updated care plans. 3. The Plan will develop a monitoring workflow. Monitoring will be done on a bi-weekly basis. Update 9/9/2022: Monitoring is now being completed on a bi-weekly basis 4. The Plan conducted a staff training on the process. 5. The Plan will use Complex Case Log to monitor adherence to procedure. Update 11/12/2021: The Plan is now using the Complex Case Log to monitor adherence 6. The Plan will report outcomes quarterly to UMC. Update 09/09/2022: Monitoring of the IDT assessments is now being tracked and reported out quarterly at UM Committee.	Low	3/25/2022	Completed	UM		State	DHCS	2021
14	Case Management	(2.5.1) The Plan's MOU with the County MHP did not meet all the requirements specified in APL 18-015.	1. The Plan will conduct annual meetings with the County to ensure that the MOU is being updated (when appropriate). Update 1/14/2022: Due to staffing availability, the meeting with the County to review the MOU was not able to take place in December, and will be scheduled for early 2022. Update 2/11/2022: The first meeting with the county took place on 1/31/2022. 1.a. The Plan will develop meeting minutes to demonstrate topic of discussions. The Plan will submit meeting minutes to DHCS. Update 2/11/2022: Meeting minutes completed for first meeting on 1/31/2022. 2. The Plan's internal departments will work together to ensure clinical and quality components that are not present be updated in the MOU to reflect the requirements in APL-018. Update 2/11/2022: MOU has been updated to ensure clinical and quality components reflected.	Low	1/31/2022	Completed	Case Management Provider Network		State	DHCS	2021
15	Case Management	(2.5.2) The Plan's MOU with the County MHP did not specify policies, procedures, and reports to address quality improvements requirements specified in APL 18-015. The Plan did not conduct semi-annual calendar year reviews of referral and care coordination processes, generate semi-annual reports, or develop performance measures and quality improvement initiatives during the audit period.	1. The Plan will establish a cross-functional workgroup to develop specific P&Ps and QI performance metrics, in addition to referral and care coordination reports. Update 12/10/2021: The cross-functional workgroup was established and held it's first meeting on 10/20/2021. County JOMs will begin January 2022.	High	12/10/2021	Completed	Case Management Provider Network		State	DHCS	2021

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16	Access	(3.1.1) The Plan did not enforce and monitor providers' compliance with the requirement to document when timeframes for appointments were extended.	1. The Plan revised P&P QI-107 to include appointment extension language and will be submitted to committee for approval. Update 11/12/2021: The P&P has been revised and is awaiting approval at committee on 11/23/2021. Update 12/10/2021: The policy was approved at Compliance Committee on 11/23/2021. 2. The Plan revised Timely Access Standards Provider Communication Sheet and will be submitted to committee for approval. Update 11/12/2021: The Timely Access Standards Provider Communication Sheet has been revised and is awaiting approval at committee on 11/18/2021. Update 12/10/2021: The Timely Access Standards Provider Communication Sheet was approved at HCQC on 11/18/2021.	Low	11/23/2021	Completed	QI		State	DHCS	2021
17	Access	(3.1.2) The Plan did not continuously review, evaluate and improve access to and availability of the first prenatal appointment.	1. The Plan revised P&P QI-107 to indicate current Access Standards for First Prenatal Appointment from 2 weeks from date of request to 10 days for PCP OB/GYN and 15 days from request for OB/GYN Specialty Care. P&P will be submitted to committee for approval. Update 11/12/2021: Awaiting clarification and further guidance from DHCS Contract Manager. Update 12/10/2021: QI-107 was approved at the Compliance Committee on 11/23/2021. 2. The Plan revised Timely Access Standards Provider Communications Sheet. Update 11/12/2021: Awaiting clarification and further guidance from DHCS Contract Manager. Update 12/10/2021: The Timely Access Standards Provider Communication Sheet was approved at HCQC on 11/18/2021. 3. The Plan will be implementing a tracking and trending report of First Prenatal PQIs. Update 11/12/2021: Awaiting clarification and further guidance from DHCS Contract Manager. Update 12/10/2021: The Tracking and Trending report of First Prenatal PQIs has been implemented	Medium	11/23/2021	Completed	QI		State	DHCS	2021
18	Access	(3.4.1) The Plan did not ensure standing referral determinations and processing were made within the required timeframes.	1. The Plan will develop a standing referral workflow. 11/12/2021: Standing referral workflow has been developed 2. The Plan will update The Alliance system of record for UM and CM, TruCare (TC) to add user define field in order to identify standing referral status to ensure correct TAT, which would include a reportable field for monthly reporting. Update 12/10/2021: TruCare has been updated to add the user defined field. 3. The Plan will revise TruCare (TC) to capture timeframes for processing Standing Referrals. Update 12/10/2021: The reporting TAT has been scheduled to begin in December, with the first report, containing December data, due in January. 4. The Plan will revise Authorization Aging report for day to day management and to report on timeframes for Standing Referrals. Update 01/14/2022: Revision of aging report complete 5. The Plan will conduct staff training on standard work for Standing Referrals. Update 01/14/2022: Staff training on standing referrals completed 11/16/2021 6. The Plan will monitor Standing Referral timeframes with the daily Authorization Aging report. 7. The Plan will report results quarterly to UMC. Update 09/09/2022: Standing referrals are now being tracked and reported on during UM Committee quarterly	High	3/25/2022	Completed	UM Case Management	Completed	State	DHCS	2021
19	Access	(3.6.1) The Plan improperly denied emergency services claims and family planning claims.	1. The Plan updated its monitoring report criteria to include a denial code (code:0630) which would allow us to identify claims prior to finalizing adjudication.	Low	3/26/2021	Completed	Claims IT (Config)		State	DHCS	2021
20	Access	(3.6.2) The Plan did not pay interest for family planning claims not completely reimbursed within 45 working days of receipt.	1. The Plan reviewed the issue thru Claims Processor & Specialist training to ensure staff understands the issue that resulted in no interest. The trainings were completed in May 2021.	Low	5/1/2021	Completed	Claims		State	DHCS	2021
21	Access	(3.8.1) The Plan did not ensure its transportation broker's NEMT providers were enrolled in the Medi-Cal program.	1. The Plan notified its transportation broker that remaining unenrolled NEMT providers need to complete PAVE application by 12/01/2021. Update 12/10/2021: The notification letter was sent to the transportation broker on 12/1/2021, 2. The Plan will audit transportation broker providers to ensure drivers are enrolled in the Medi-Cal program. This was last completed August 27, 2021. Monitoring will be conducted on an annual basis.	Low	12/31/2022	Completed	Vendor Management		State	DHCS	2021

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22	Access	(3.8.2) The Plan did not require PCS forms for NEMT services.	1. The Plan will require transportation broker to provide ongoing reports on rates of obtaining PCS forms from providers: Update 11/12/2021: UM Team working with Vendor Management and the transportation broker to obtain needed reports. Update 12/10/2021: The report was received from transportation broker on 10/28/2021. 2. The Plan will analyze trends in provider practices on a quarterly basis. Update 12/10/2021: The first report will be given at UMC in January 2022. Update 2/11/2022: Awaiting reports from the transportation broker 3. The Plan will educate providers on PCS requirements and provide data on their performance: Update 2/11/2022: Awaiting reports from the transportation broker 3.a. Provider newsletter. Update 2/11/2022: Awaiting reports from the transportation broker 3.b. Individual office contacts 4. The Plan will finalize process workflow to obtain missing PCS forms. Update 11/12/2021: UM Team working with Vendor Management and the transportation broker to obtain needed reports. Update 12/10/2021: The workflow has been finalized based on the reports received from the transportation broker 5. The Plan will conduct staff trainings on process workflow. Update 12/10/2021: Training was completed 11/8/2021. 6. The Plan will provide a quarterly report to UMC. Update 01/14/2021: Reporting will begin at UMC in Q1 2022. Update 2/11/2022: Awaiting reports from the transportation broker Update 09/09/2022: NEMT services are now being tracked and reported quarterly at the UM Committee.	Medium	12/31/2022	Completed	Vendor Management UM		State	DHCS	2021
23	Member Rights	(4.1.1) The Plan did not ensure that the medical director fully resolved QOC grievances prior to sending resolution letters.	1. The Plan updated G&A-003 Grievance and Appeals Receipt, Review and Resolution to include the process for the medical director's review and resolution of all levels of quality of care grievances prior to sending a resolution letter to members. The policy will be reviewed at the Health Care Quality Committee on November 18, 2021 and the Compliance Committee Meeting on November 23, 2021. Update 12/10/2021: G&A-003 was approved at the Compliance Committee meeting on 11/23/2021 2. The Plan will provide training to the medical directors to review G&A-003 Grievance and Appeals Receipt, Review and Resolution by November 30, 2021. Update 3/11/2022: Training was completed 1/12/2022	Medium	1/12/2022	Completed	G&A		State	DHCS	2021
24	Member Rights	(4.1.2) The Plan did not consistently implement its procedure for processing grievances. The Plan considered member's grievances resolved and classified as exempt without conducting investigation.	1. The Plan is updating its policy and procedures for processing Exempt Grievances to reflect its current process. The policy MBR-0024 will be reviewed at the Compliance Committee Meeting on November 23, 2021. Update 12/10/2021: MBR-024 was approved at Compliance Committee on 11/23/2021 2. The Plan will provide staff training by November 30, 2021. Update 1/14/2022: Training was completed 11/19/2021	Low	11/30/2021	Completed	Member Services		State	DHCS	2021
25	Member Rights	(4.1.3) The Plan did not send acknowledgement and resolution letters within the required timeframes. The Plan did not promptly notify the members that expedited grievances would not be resolved within the required timeframe.	1. The Plan provided training to the Grievance and Appeals staff to review G&A-003 Grievance and Appeals Receipt, Review and Resolution and G&A-005 Expedited Review of Urgent Grievances. The staff attested that they understood the requirements and will ensure that acknowledgement and resolution letters are sent within the required timeframes, and to also notify members when expedited grievances would not be resolved within the required timeframe.	Low	9/21/2021	Completed	G&A		State	DHCS	2021
26	Member Rights	(4.1.4) The Plan did not send acknowledgement and resolution letters in threshold languages.	1. The Plan provided training to the Grievance and Appeals staff to review G&A-001 Grievance and Appeals System Description and CLS-003 Language Assistance Services. The staff attested that they understood the requirements and will ensure that acknowledgement and resolution letters are sent to members in their threshold languages.	Low	9/21/2021	Completed	G&A		State	DHCS	2021
27	Member Rights	**R** (4.1.5) The Plan did not consistently resolve grievances prior to sending resolution letters.	1. The Plan provided training to the Grievance and Appeals staff to review G&A-001 Grievance and Appeals System Description. The staff attested that they understood the requirements and will ensure that grievances are fully resolved prior to sending resolution letters.	Low	9/21/2021	Completed	G&A		State	DHCS	2021
28	Member Rights	(4.3.1) The Plan did not report suspected security incidents or unauthorized disclosures of PHI to DHCS within 24 hours of discovery, did not provide an updated investigation report within 72 hours, and did not submit a complete report of the investigation within 10 working days.	1. To address staffing needs, the Plan has streamlined its Compliance Department and now has a dedicated staff member who focuses on Privacy. This FTE was hired on February 22, 2021. 2. The Plan reviewed and updated CMP-013 HIPAA Privacy Reporting to reflect the 24hr, 72hr and 10-day reporting requirements. This policy is scheduled to be reviewed and approved at the Compliance Committee on November 23, 2021. Update 12/10/2021: CMP-013 was approved at Compliance Committee on 11/23/2021	Low	11/30/2021	Completed	Compliance		State	DHCS	2021
29	Compliance	**R** (6.2.1) The Plan did not conduct and report preliminary investigations of all suspected cases of fraud and abuse to DHCS within ten working days.	1. The Plan has a dedicated staff member in the Special Investigations Unit (SIU) to focus on Fraud, Waste and Abuse FWA cases. This FTE was hired on 6/25/2021. 2. The plan updated CMP-002 to reflect reporting requirements. This policy is scheduled to be re-approved at the Compliance Committee on Nov 23, 2021. Update 12/10/2021: CMP-002 was approved at the 11/23/2021 Compliance Committee	Low	12/1/2021	Completed	Compliance		State	DHCS	2021
30	Compliance	(6.2.2) The Plan did not report recoveries of overpayments to DHCS annually.	After internal review, the Plan found that an update to CMP-002 was not necessary as the reporting of overpayments is addressed in CLM-008: Overpayment Recovery. The Plan has validated that reports were submitted appropriately to the Department.	Low	2/11/2022	Completed	Compliance		State	DHCS	2021
31	Claims	(SSS.1) The Plan did not distribute payments for state supported services claims within 90 calendar days as described in APL 19-013.	1. The Plan made changes to the claims system on 2/17/2021 and re-adjudicated all the previous claims paid incorrectly to pay the balance to the Prop 56 rate.	Low	2/17/2021	Completed	Claims		State	DHCS	2021
32	Claims	(SSS.2) The Plan did not pay interest for state supported services claims processed beyond the 90-calendar day timeframe specified in APL 19-013.	1. The Plan made changes to the claims system on 2/17/2021 and re-adjudicated all the previous claims paid incorrectly to pay the balance to the Prop 56 rate. The claim system was also updated to pay interest at the normal timeline of claims adjudicated after 45 work days from the received date.	Low	2/17/2021	Completed	Claims		State	DHCS	2021
33	Claims	(SSS.3) The Plan improperly denied state supported services claims.	1. As of 8/7/2020 the Plan reconfigured the system to no longer re-suspend the delegate's Non-Emergency Out of Area processed claims. In addition, the Claims workflow has been updated to accommodate the system change.	Low	8/7/2020	Completed	Claims		State	DHCS	2021

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34	Compliance	The Plan should have a policy and workflow for tracking discrimination grievances	1. The Plan has created the Special Cases Incident Log for tracking discrimination grievances 2. The Plan will update the policy and create a workflow regarding tracking of discrimination grievances. Update 12/1/2021: The policy has been created and was approved at the Compliance Committee on 11/23/2021	Medium	12/1/2021	Completed	Compliance		Self Identified	AAH	2021
35	Quality Management	The Plan should ensure that PQIs are appropriately classified (as QOS / QOA / QOC)	1. Sr. Dir. Of Quality and the QI Supervisor conduct quarterly audits of QOA and QOS case files 2. QOC files are reviewed and leveled by Quality Medical Director weekly	Low	2/28/2021	Completed	QM		Self Identified	AAH	2021

ALAMEDA ALLIANCE FOR HEALTH
COMPLIANCE DASHBOARD

2020 DHCS STATE AUDIT FINDINGS - *Audit Review Period: 10/01/2018 - 9/30/2020*					INTERNAL AUDITS						
#	Category	Deficiency	Corrective Action Plan (CAP)	Completion Date	Internal CAP Status	Department Responsible	Validation Status	State/Self Identified	Agency	Year	Status
1	Claims	The Plan denied payment to a contracted hospital for continued treatment of Plan members with chronic medical conditions. The Plan did not provide for all medically necessary covered services for members	1. The Plan and the hospital renegotiated its hospital agreement with an effective date of February 1, 2021. The Alliance and the hospital agreed to a step down approach where The Alliance will authorize care at the appropriate level and work in conjunction with the hospital toward an appropriate discharge. The rate paid by Plan will be equal to the medical surgical rate. Please see Section 3.6 Utilization Management of The Alliance and hospital Contract Amendment. 2. The Plan and the hospital have a meeting set up for 4/6/2021 at 3:30 PM. The goal of this meeting is to finalize the cases in arbitration and any other outstanding claims. Update 5/14/21 The legal team is continuing to review which claims to pay. Update 6/11/21 The Alliance is working with the provider on evaluating and assessing the claims from the audit. Senior level discussions are in process between the hospital and the Alliance. Update 10/8/2021 The Plan paid the hospital for all claims in Arbitration on the 7/22/2021 check run. The hospital had some additional claims they wanted reviewed and we met on 7/27/2021 to review them. The Plan agreed to pay these claims, as well, and they were paid out on the 8/25/2021 and 9/1/2021 check runs. Update 5/13/2022: DHCS advised The Alliance they consider the findings of this audit closed as of 4/19/2022	9/1/2021	Completed	UM / Claims		State	DHCS	2020	Completed
2	UM	The Plan did not apply written criteria for each concurrent review of continued long term acute care (LTAC) services throughout members' hospital stays	1. The Plan reviewed and revised the following P&P: a. UM-003 Concurrent Review and Discharge Planning Process to reflect frequency of reviews throughout the members' hospital stay, including after a NOA is sent, and the use of standard Utilization Review procedures. Policy and Procedure will be approved at the HCQC on 5/20/2021. b. The Plan's standard review procedures include applying written criteria for each review. The Plan's standard utilization review procedures are reflected in Plan's P&P UM-057 and in UM-054 Notice of Action. 2. The Plan will train its Utilization Management staff involved in the Concurrent Review process of the change. The training will be documented with training materials and attendance records. Update 5/14/21: Training was completed on 3/31/21 3. The Plan will audit the Concurrent review process after Q2 2021 to ensure that process are followed and implemented accordingly. Update 5/14/21: Manual audit in place, automated report in development. Update 7/9/2021: Manual tracking continues, nearing completion of automated report. Update 10/8/2021: Manual tracking continues, awaiting completion of automated report 4. The Plan will report the results of the Concurrent review process to the UM Committee on a quarterly basis, starting Q4 2021. Update 10/8/2021: First report to UMC on 8/24/2021. 100% compliance. Update 12/10/2021: The most recent audit concluded in November with a passing score for each factor reviewed. The results were reported at the UM Committee on 12/3/2021. Update 04/08/2022: The most recent audit encompassed NOA letters from January and February 2022 with a passing score for each factor reviewed. The results were reported at the UM Committee on 03/25/2022. Update 5/13/2022: DHCS advised The Alliance they consider the findings of this audit closed as of 4/19/2022	3/25/2022	Completed	UM		State	DHCS	2020	In Progress
3	UM	The Plan did not document that qualified physicians reviewed all denials of continued long term acute care (LTAC) services throughout members' hospital stays	1. The Plan reviewed and revised the following P&P: a. UM-003 Concurrent Review and Discharge Planning Process to reflect frequency of reviews throughout the members' hospital stay, including after a NOA is sent, and the use of standard Utilization Review procedures. Policy and Procedure will be approved at the HCQC on 5/20/2021. b. The Plan's standard review procedures include applying written criteria for each review. The Plan's standard utilization review procedures are reflected in Plan's P&P UM-057 and in UM-054 Notice of Action. 2. The Plan will train its Utilization Management staff involved in the Concurrent Review process of the change. The training will be documented with training materials and attendance records. Update 5/14/21: Training was completed on 3/31/21 3. The Plan will audit the Concurrent review process after Q2 2021 to ensure that process are followed and implemented accordingly. Update 5/14/21: Manual audit in place, automated report in development. Update 7/9/2021: Manual tracking continues, nearing completion of automated report. Update 10/8/2021: Manual tracking continues, awaiting completion of automated report 4. The Plan will report the results of the Concurrent review process to the UM Committee on a quarterly basis, starting Q4 2021. Update 10/8/2021: First report to UMC on 8/24/2021. 100% compliance. Update 11/12/2021: The results of the next quarterly audit will be presented at the November UM Committee. Update 12/10/2021: The results of the next quarterly audit will be reported at the December UM Committee.	3/25/2022	Completed	UM		State	DHCS	2020	In Progress

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			Update 04/08/2022: The most recent audit encompassed NOA letters from January and February 2022 with a passing score for each factor reviewed. The results were reported at the UM Committee on 03/25/2022. Update 5/13/2022: DHCS advised The Alliance they consider the findings of this audit closed as of 4/19/2022								
4	UM	The Plan did not notify members and the hospital of continued denial of long term acute care (LTAC) services through NOA letters and "Your Rights" attachments for each concurrent review throughout the members' hospital stays	1. The Plan reviewed and revised the following P&P: a. UM-003 Concurrent Review and Discharge Planning Process to reflect frequency of reviews throughout the members' hospital stay, including after a NOA is sent, and the use of standard Utilization Review procedures. Policy and Procedure will be approved at the HCQC on 5/20/2021. b. The Plan's standard review procedures include applying written criteria for each review. The Plan's standard utilization review procedures are reflected in Plan's P&P UM-057 and in UM-054 Notice of Action. 2. The Plan will train its Utilization Management staff involved in the Concurrent Review process of the change. The training will be documented with training materials and attendance records. Update 5/14/21: Training was completed on 3/31/21 3. The Plan will audit the Concurrent review process after Q2 2021 to ensure that process are followed and implemented accordingly. Update 5/14/21: Manual audit in place, automated report in development. Update 7/9/2021: Manual tracking continues, nearing completion of automated report. Update 10/8/2021 Manual tracking continues, awaiting completion of automated report 4. The Plan will report the results of the Concurrent review process to the UM Committee on a quarterly basis, starting Q4 2021. Update 10/8/2021: First report to UMC on 8/24/2021. 100% compliance. Update 11/12/2021: The results of the next quarterly audit will be presented at the November UM Committee. Update 12/10/2021: The most recent audit concluded in November with a passing score for each factor reviewed. The results were reported at the UM Committee on 12/3/2021. Update 04/08/2022: The most recent audit encompassed NOA letters from January and February 2022 with a passing score for each factor reviewed. The results were reported at the UM Committee on 03/25/2022. Update 5/13/2022: DHCS advised The Alliance they consider the findings of this audit closed as of 4/19/2022	3/25/2022	Completed	UM		State	DHCS	2020	In Progress
5	UM	The Plan provided unclear information about the Plan's decision for denial of long term acute care (LTAC) services in the only NOA letters that were issued to members and the Hospital. Letters contained inaccurate information about denied dates and requesting providers.	1. The automated section of the NOA letter generated by the Plan's system of record, TruCare, was incorrectly configured and displayed inaccurate information about the requesting LTAC provider and the dates of denial. The Plan's system of record, TruCare, was re-configured to display the correct dates and correct requesting provider in the automated portion of the NOA letters. 2. The Plan's In-Patient Utilization Management Leadership will continue to audit the NOA letters to ensure that they contain accurate information and meet the regulatory requirements. Update 5/15/2021: Identified deficiencies have been added to the audit tool and audits of inpatient NOA letters are currently taking place. 3. The Plan will report the results of NOA letter audit at Utilization Management Committee on a quarterly basis, starting Q3 2021. Update 7/9/2021: Manual tracking continues, report will be provided starting in Q3 2021 Update 10/8/2021: Manual tracking continues, awaiting completion of automated report. First report to UMC on 8/24/2021. 100% compliance. Update 11/12/2021: The results of the next quarterly audit will be presented at the November UM Committee. Update 12/10/2021: The most recent audit concluded in November with a passing score for each factor reviewed. The results were reported at the UM Committee on 12/3/2021. Update 04/08/2022: The most recent audit encompassed NOA letters from January and February 2022 with a passing score for each factor reviewed. The results were reported at the UM Committee on 03/25/2022. Update 5/13/2022: DHCS advised The Alliance they consider the findings of this audit closed as of 4/19/2022	3/25/2022	Completed	UM		State	DHCS	2020	In Progress

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#	Category	Deficiency	Corrective Action Plan (CAP)	Completion Date	Internal CAP Status	Department Responsible	Validation Status	State/Self Identified	Agency	Year	Status
6	Delegation	The Plan did not ensure the Delegate met standards set forth by the Plan and DHCS. The Delegate did not ensure that concurrent review denials were reviewed and made by a qualified physician. It did not send NOA letters with "Your Rights" information for denial of services that occurred after initial denial. It did not include the decisions maker's name in the initial and only NOA sent to providers.	1. The Plan's revised policy UM-003 Concurrent Review and Discharge Planning Process and the revised process expectations were shared with Delegate on 3/26/2021. 2. The Plan will require the Delegate to do the following: a. Adopt the Plan's policies, to reflect that the concurrent review denials are reviewed and made by a qualified physician, that the clinical case is reviewed using the regulatory requirements on a regular cadence after the initial denial, that NOA letters with "Your Rights" information are sent after every subsequent review, and that the decision-maker's name is on each NOA. Update 6/11/2021 The Alliance's Health Care Services is working with the delegate to update the policies. b. Provide evidence of policy and procedure approval. Update 7/9/2021: Delegate has provided evidence that the revised policy was approved on 6/23/2021 c. Train its staff on the new Concurrent review process. Update 7/9/2021: Delegate states they are developing the training for their staff and are on track to provide the documents to The Alliance. Update 9/10/2021: Staff training completed, training documents provided. d. Provide evidence of the training, including the training materials and the attendance records. Update 9/10/2021: Delegate provided attestations to show training completed 6/23/2021 3. The Plan will audit the Delegate on a quarterly basis to ensure that the process is implemented, starting at the end of Q3 2021, and report the results of the audit at the Plan's UM Committee on a quarterly basis. Update 10/8/2021: Q3 2021 audit completed 9/29/2021, and initial audit results provided to the Delegate; final audit report will be issued to the Delegate by 10/13/2021. Update 11/12/2021: The next quarterly audit is scheduled for 12/17/2021. Update 04/08/2022: The next quarterly audit is scheduled to be completed in May 2022 4. At annual Delegate oversight audits, concurrent reviews and letters will be examined to ensure compliance. Update 11/12/2021: The next annual Delegation Oversight Audit is scheduled for February 2022. Concurrent reviews and letters will be reviewed at that time. Update 04/08/2022: The next quarterly audit is scheduled to be completed in May 2022. Update 5/13/2022: DHCS advised The Alliance they consider the findings of this audit closed as of 4/19/2022. Update 5/13/2022: The delegate does not have any cases that meet the criteria for audit for Q1 2022. DHCS advised The Alliance they consider the findings of this audit closed as of 4/19/2022. Update 07/08/2022: The Alliance is currently in the process of quarterly delegate audit. Update 09/09/2022: The quarterly delegate audit is in progress and is expected to be completed by October 2022. Update 10/14/2022: The quarterly delegate audit has been completed, there were no findings. This audit will be closed and the findings noted by DHCS will continue to be reviewed during the annual audit.	9/23/2022	Completed	UM		State	DHCS	2020	In Progress
7	Delegation	The Plan did not ensure the Delegate met standards set forth by the Plan and DHCS. The Delegate denied medically necessary services.	1. The Plan's revised policy UM-003 Concurrent Review and Discharge Planning Process and the revised process expectations were shared with Delegate on 3/26/2021. 2. The Plan will require the Delegate to do the following: a. Adopt the Plan's policies, to reflect that the concurrent review denials are reviewed and made by a qualified physician, that the clinical case is reviewed using the regulatory requirements on a regular cadence after the initial denial, that NOA letters with "Your Rights" information are sent after every subsequent review, and that the decision-maker's name is on each NOA. Update 6/11/2021 The Alliance's Health Care Services is working with the delegate to update the policies. b. Provide evidence of policy and procedure approval. Update 7/9/2021: Delegate has provided evidence that the revised policy was approved on 6/23/2021 c. Train its staff on the new Concurrent review process. Update 7/9/2021: Delegate states they are developing the training for their staff and are on track to provide the documents to The Alliance. Update 9/10/2021: Staff training completed, training documents provided. d. Provide evidence of the training, including the training materials and the attendance records. Update 9/10/2021: Delegate provided attestations to show training completed 6/23/2021 3. The Plan will audit the Delegate on a quarterly basis to ensure that the process is implemented, starting at the end of Q3 2021, and report the results of the audit at the Plan's UM Committee on a quarterly basis. Update 10/8/2021: Q3 2021 audit completed 9/29/2021, and initial audit results provided to the Delegate;	9/23/2022	Completed	UM		State	DHCS	2020	In Progress

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2020 DHCS STATE AUDIT FINDINGS - *Audit Review Period: 10/01/2018 - 9/30/2020*					INTERNAL AUDITS						
#	Category	Deficiency	Corrective Action Plan (CAP)	Completion Date	Internal CAP Status	Department Responsible	Validation Status	State/Self Identified	Agency	Year	Status
			final audit report will be issued to the Delegate by 10/13/2021. Update 11/12/2021: The next quarterly audit is scheduled for 12/17/2021. Update 04/08/2022: The next quarterly audit is scheduled to be completed in May 2022 4. At annual Delegate oversight audits, concurrent reviews and letters will be examined to ensure compliance. Update 11/12/2021: The next annual Delegation Oversight Audit is scheduled for February 2022. Concurrent reviews and letters will be reviewed at that time. Update 04/08/2022: The next quarterly audit is scheduled to be completed in May 2022. Update 5/13/2022: The delegate does not have any cases that meet the criteria for audit for Q1 2022. DHCS advised The Alliance they consider the findings of this audit closed as of 4/19/2022. Update 07/08/2022: The Alliance is currently in the process of quarterly delegate audit. Update 09/09/2022: The quarterly delegate audit is in progress and is expected to be completed by October 2022. Update 10/14/2022: The quarterly delegate audit has been completed, there were no findings. This audit will be closed and the findings noted by DHCS will continue to be reviewed during the annual audit.								

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ALAMEDA ALLIANCE FOR HEALTH
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2020 DMHC STATE AUDIT FINDINGS - *Audit Review Period: 1/01/2019 - 9/30/2019*					INTERNAL AUDITS						
#	**Category**	**Deficiency**	**Corrective Action Plan (CAP)**	**Completion Date**	**Internal CAP Status**	**Department Responsible**	**Validation Status**	**State/Self Identified**	**Agency**	**Year**	**Status**
1	Grievances & Appeals	The Plan failed to accurately and consistently identify grievances received by telephone. Coverage Dispute issues were processed as an exempt grievance and not a standard grievance as required.	The G&A current procedures appropriately process coverage disputes as a standard grievance. Member Services will provide a refresher staff training of the procedures by 3/31/2020 to ensure coverage disputes are processed appropriately. Update as of 4/10/2020 Refresher training for benefits coverage disputes was completed on 3/12/2020.	3/12/2020	Completed	Member Services/ G&A	✓	State	DMHC	2020	Completed
2	Grievances & Appeals	The Plan does not consistently provide immediate notification to complainants of their right to contact the Department regarding expedited appeals.	G&A staff training was conducted to review regulations on 1/30/2020. G&A application was updated to include a new log type for expedited DMHC rights notification that was implemented on 2/6/2020.	2/6/2020	Completed	G&A	✓	State	DMHC	2020	Completed
3	UM	The Plan does not include the statement required by Section 1363.5(c) when disclosing medical necessity criteria for UM decisions.	Cover sheet being created in the TruCare system for all requests by providers for clinical criteria used to adjudicate requests. Creation of tracking log, workflow and training to be completed by 3/31/2020. Update as of 4/10/2020: Tracking log workflow and training completed as of 3/12/2020.	3/12/2020	Completed	UM	✓	State	DMHC	2020	Completed
4	Access to Emergency Services	The Plan does not provide all non-contracting hospitals in the state with Plan contact information needed to request authorization of post-stabilization care. DMHC expects the onus to be on the Plan to reach out to the hospitals and notices should be mailed at least annually.	The Plan is working with the Hospital Association to assist in sending out the notices to non-contracted hospitals. Update as of 6/12/2020: Notices were mailed to non-contracted hospital providers on May 26.	5/31/2020	Completed	Provider Relations	✓	State	DMHC	2020	Completed
5	Access & Availability	The Plan failed to adequately review and address access issues as part of its quality assurance (QA) program.	The QI Team and Member Services team perform an annual training to ensure that the appropriate process is followed. The Alliance is working on additional training to ensure the appropriate referral of PQIs. All access-related exempt grievances are compiled in a track and trend report and referred to Quality Improvement via the Access and Availability Sub-Committee	4/30/2020	Completed	Quality Management	✓	State	DMHC	2020	Completed
#	**Category**	**Deficiency**	**Corrective Action Plan (CAP)**	**Completion Date**	**Internal CAP Status**	**Department Responsible**	**Compliance Internal Audit**	**State/Self Identified**	**Agency**	**Year**	**Status**
1	Quality Assurance	The Plan failed to ensure that all potential quality of care issues were identified and processed in accordance with its Quality Assurance (QA) Program. Cases were found to misclassified and include documentation issues.	1. RN Staff In-Service on PQI definition, classification, review, processing and documentation conducted by Quality Sr. Director on 2/7/2020. 2. Deleted "Not a PQI" from classification drop down selections. 3. All new PQI submissions are reviewed and classified (as QOS/QOA/QOC) by Quality Director. 4. RN PQI Classification IRR conducted by Quality Director on 2/25/2020. 5.Department wide IRR Conducted by Medical Director on 2/27/2020 6.Quality Director to process all QOAs and QOSs 7. Medical Director is auditing random sample of QOA and QOS cases processed by nurse management staff as of 4/6/2020. 8. Quality Director to conduct weekly auditing of RN documentation of all QOCs as of 3/5/2020. 9. Medical Director continues to level and audit all QOC cases 10. Ongoing weekly team meeting continues to ensure case discussion and review Update as of 4/30/2020: QI team has completed all steps listed above.	4/30/2020	Completed	Quality Improvement	✓	Self Identified	AAH	2020	Completed
2	UM	The Plan does not consistently provide enrollees with a clear and concise reason for denials based in whole or in part on medical necessity.	Quality checklist for review of NOA letters for all requirements prior to being sent out to be developed, then train staff, by 3/31. Quality checks of all NOAs by management before sending out continues. Weekly review by external consultants continue with MDs to improve decision notices. Update as of 4/10/2020: NOA checklist training and implementation done as of 4/2/2020. Weekly review by external consultants continues.	4/2/2020	Completed	UM	✓	Self Identified	AAH	2020	Completed
3	UM	In letters to providers denying or modifying requested services on the basis of medical necessity, the Plan does not include a direct telephone number or extension of the professional responsible for the decision. The peer to peer process to improve its oversight and tracking process.	Phone numbers in all UM template letters being checked for accuracy and corrected in TruCare as needed. Standardized tracking workflow of Peer to Peer communication is being developed, trained and implemented by 3/31/2020. Update as of 4/10/2020: Training and tracking implemented as of 3/12/2020.	3/12/2020	Completed	UM	✓	Self Identified	AAH	2020	Completed

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2019 DMHC AUDIT FINDINGS - *Audit Review Period: 10/1/2017-9/30/2019*					INTERNAL AUDITS						
#	Category	Deficiency	Corrective Action Plan (CAP)	Completion Date	Internal CAP Status	Department Responsible	Validation Status	State/Self Identified	Agency	Year	Status
1	Payment Accuracy	Three out of 50 late paid claims (a compliance rate of 94 percent). This deficiency was caused by the Plan using the incorrect date to calculate interest on improperly denied and reprocessed claims. Three out of 30 high dollar claims. The deficiency was caused by the Plan not paying interest on a claim improperly denied for missing authorization when the independent practice association (IPA) authorized services but did not forward the authorization to the Plan, and underpaying claims due to processor error.	Late Claims – processing errors identified in this finding are attributable to human error by one specific individual. The incorrect handling was addressed verbally with the employee at the time of the audit. Refresher training on CLM-001 Claims Processing, CLM-003 Emergency Services Claims Processing and Claims Change Alert Clean Claim Interest Workflow was completed on March 13, 2020 to ensure that all staff who handles adjustments are using the appropriate received date for adjusted claims. Update 5/1/2020: At the Department's request, the Plan created a report to identify claims where the incorrect received date was used on an adjusted claim. The report was provided to the Department on 4/21/2020. The identified claims have been adjusted and the report has been updated to add the check date, check # and the amount of interest and penalties paid. Current policies and procedures do not require changes and meet compliance requirements. High Dollar Claims – processing errors identified in this finding are attributable to human error. Refresher training on CLM-001 Claims Processing and Claims Change Alert - Clean Claim Interest Workflow was completed on 3/13/2020 to ensure that all staff who handles adjustments are using the appropriate received date for adjusted claims.	4/29/2020	Completed	Claims	✓	State	DMHC	2019	Completed
2	Incorrect Claim Denials	Claims were improperly denied and should have been paid in three out of 50 denied claims (a compliance rate of 94 percent). The deficiency was caused by the Plan not re-processing retro enrollment, incorrectly denying a claim as duplicate and a system configuration issue that incorrectly denied claims as not the financial responsibility of the Plan.	Retro Eligibility Denial – The Plan's Claims management is working with its Information Technology/Analytics Department to create a retroactive eligibility report to identify claims that were denied correctly at the time of processing, but may be impacted due to the retroactive reinstatement of eligibility. Once the report is completed, the Plan will make sure to adjudicate any claims found to be improperly denied since 5/29/2018, and provide evidence that the claims were adjudicated appropriately. Update 5/1/2020: Report was put into production on 5/1/2020 and will be run weekly. Claims is working with IT to identify impacted claims from 5/29/2018-9/30/2019 and will adjust impacted claims and provide the final spreadsheet to the Department by 5/15/2020. Division Of Financial Responsibility (DOFR) Denial - this issue was identified as a configuration error for one specific service, and corrected in October 2019 prior to the audit. Update 5/1/2020: At the Department's request, the Plan created a report to identify claims where the service had been denied incorrectly. The report was provided to the Department on 4/21/2020. The identified claims are being adjusted and should be complete by 5/15/2020. The report will then be updated to add the check date, check # and the amount of interest paid. Duplicate Denial - duplicate claims refresher training on HS-004 Duplicate Claims was completed on 3/13/2020 for all staff that handles adjustments. Due to the unique cause of this non-system related error, a remediation report cannot be run.	~~4/15/2020~~ 5/15/2020	Completed	Claims	✓	State	DMHC	2019	Completed
3	Clear & Accurate Denial Explanation	Plan provided an incorrect denial explanation in three out of 50 denied claims (a compliance rate of 94 percent).	The Plan reviewed the deficient cases and found that the three denial errors identified in the audit were related to Division of Financial Responsibility (DOFR) issues. The Plan will review the services where there are DOFR conflicts, come to agreement with the delegates, and make any required configuration changes to the system. Update 5/1/2020: System changes for the delegate were completed and put into production on 4/16/2020. The claims were originally denied correctly as the responsibility of another delegate but contained an additional incorrect message that they were forwarded to delegate. These claims do not need to be re-adjudicated and re-denied again. Due to the Coronavirus Pandemic, meetings with delegate have been put on hold. The Plan has updated the system to correct the configuration with out of area office visits that was identified during the audit. At the Department's request, the Plan created a report to identify claims where these services had been denied incorrectly. The report was provided to the Department on 4/21/2020. The identified claims are being adjusted and should be complete by 5/15/2020. The report will then be updated to add the check date, check # and the amount of interest paid.	~~6/30/2020~~ 5/15/2020	Completed	Claims	✓	State	DMHC	2019	Completed

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#	**Category**	**Deficiency**	**Corrective Action Plan (CAP)**	**Completion Date**	**Internal CAP Status**	**Department Responsible**	**Validation Status**	**State/Self Identified**	**Agency**	**Year**	**Status**
4	Change in Plan Personnel	Plan shall within five days, file an amendment when there are changes in personnel of the plan. Plan did not file the Board of Governors changes for three members.	The Plan has updated its internal procedures to ensure key personnel requirements are met. The Plan implemented a monthly quality check capturing any changes with the Plan's Board of Governor member seats. The Plan's Compliance team staff completed updated training for key personnel filing procedures on March 30, 2020. As of 3/31/2020, the Plan has also completed updates to the filings for three Board members as requested: Member 1: DMHC Filing #20201241 Member 2: DMHC Filing #20200184/#20201243 Member 3: DMHC Filing #20200644	4/1/2020	Completed	Compliance	✓	State	DMHC	2019	Completed
5	Control over Mailroom Claims Processing	Plan does not have sufficient control over its mailroom claims processing as the mailroom staff does not stamp the date of receipt on paper claims. In addition, the Plan's mailroom staff does not count the number of claims sent to vendors for further processing, impeding the Plan's ability to reconcile the number of claims received and processed.	The Plan has an established process for receiving claims in its onsite mailroom for capturing receipt dates. The Plan performs quality checks for reconciliations of claims count scanned and received to ensure all claims are captured for processing. The Plan has daily logs of professional and facility claims received and scanned. The logs have the original claim count, the claim count successfully scanned, the rejected claim count and the merged claim count. The Plan utilizes the daily log counts to perform reconciliation when the files are received and loaded. Included with the CAP response is the weekly reconciliation sample report and sample logs of claims as evidence of this quality internal control process for counting the number of claims.	4/1/2020	Completed	Support Services/ Claims	✓	State	DMHC	2019	Completed

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2019 DHCS AUDIT FINDINGS - *Audit Review Period: 6/1/2018-5/31/2019*						INTERNAL AUDITS						
#	Category	Deficiency	Corrective Action Plan (CAP)	Repeat Finding (Yes/No)	Completion Date	Internal CAP Status	Department Responsible	Validation Status	State/Self Identified	Agency	Year	Status
1	UM Delegation	The Plan did not ensure a delegate complied with all contractual and regulatory requirements. The delegate required PA for an initial visit with a mental health provider to determine if the member had mild-to-moderate mental health issues, which the contract does not allow.	The Alliance scheduled a meeting with the delegate to discuss the findings and will put a corrective action plan in place. Update as of 12/5/2019: The delegate has revised policy, and submitted to The Alliance for review. The Alliance will review and discuss changes with the delegate on the next Operations call. Update as of 1/8/2020: Plan reviewed documents and agree with the changes for member self-referral process. Discussing with DHCS prior to final CAP submission.	No	1/8/2020	Completed	Utilization Management	✓	State	DHCS	2019	Completed
2	UM Delegation	The Plan did not ensure a delegate complied with all contractual and regulatory requirements. The delegate required a two-step prior authorization (PA) process for BHT services, which is allowed, but did not send written notification when it denied services at the first step. The delegate did not consistently apply criteria for approving BHT.	The Alliance scheduled a meeting with the delegate to discuss the findings and will put a corrective action plan in place. Update as of 12/5/2019: The delegate has revised policy, and submitted to The Alliance for review. The Alliance will review and discuss changes with the delegate on the next Operations call. Update as of 1/8/2020: Plan reviewed documents and still have open items not documented. Plan will be meeting with the delegate to discuss criteria and procedures for further documentation needed. Update as of 2/7/2020: Met with the delegate to review their criteria and approval process. Requested policy language changes to meet the regulatory requirements. Policy was approved by Committee on 1/27/20. Updated CAP response submitted to DHCS on 2/7/2020.	No	2/7/2020	Completed	Utilization Management	✓	State	DHCS	2019	Completed
3	UM Delegation	(1.1.3) The Plan did not review ownership and control disclosure information for their Utilization Management (UM) delegates	The Plan will ensure that its delegated providers complete the Ownership and Control disclosure forms. The Plan will create a tracking log and document any follow up attempts made with the delegate to ensure accuracy. Update as of 12/2/2019: PR has created a tracking log and is working on a desktop procedure.	Yes	1/1/2020	Completed	Provider Services	✓	State	DHCS	2019	Completed
4	UM Delegation	The Plan did not ensure receipt of all contractual and regulatory reports during the audit period.	The Plan will conduct staff retraining of delegation reporting procedures to ensure all are tracked and monitored for receipt and review. Update as of 12/5/2019: Staff training was conducted on 12/3/2019.	Yes	12/1/2019	Completed	Compliance	✓	State	DHCS	2019	Completed
5	UM Delegation	The Plan's oversight of its delegate did not identify unclear NOA letters, and incorrect appeal and SFH information	The Alliance scheduled a meeting with the delegate to discuss the findings and will put a corrective action plan in place. Update as of 12/5/2019: The delegate has developed on a new process regarding NOA letters, appeal rights and SFH Information. The Alliance will review and discuss changes with the delegate on the next Operations call. Update as of 1/8/2020: Plan reviewed documents and agreed with changes of procedure checklist and training materials.	No	1/15/2020	Completed	Utilization Management		State	DHCS	2019	Completed
6	Referral Tracking process	The Plan did not track all approved PAs; the specialty referral tracking process did not include modified PAs and in-network approved services.	The UM Department is working with analytics to expand the routine referral tracking report to include all approved authorizations. Update as of 12/5/19: Clarity is being sought from DHCS on the scope of specialty referral tracking. Update as of 1/8/20: An updated referral tracking report is being developed to include all decision types and specialty services that require authorization. Update as of 2/7/20. Updated report sample generated and submitted to DHCS. Working with Analytics to create routine report that captures all needed data elements. Update as of 3/5/2020 UM met with Analytics to create the routine report capturing all needed elements. Report is in development. Update as of 5/8/20 Specialty Tracking Report has been created by Analytics, including all required elements, and will now be routinely reported quarterly through UMC and HCQC. Reported at HCQC on 5/21/20. Update as of 6/12/20: Report sent to HCQC on 5/21/20 and reviewed at UMC at 5/29/20.	Yes	5/21/2020	Completed	Utilization Management	✓	State	DHCS	2019	Completed
7	Prior Authorizations	A review of PA data showed non-qualified Plan staff denied retrospective cases for administrative reasons other than non-eligibility for membership. The Plan denied retrospective service requests without review by a medical director if the provider submitted the request more than 30 days after the service delivery date, or if requests did not meet Plan-imposed conditions. The Plan's contract did not specify submission timeframes or other conditions that, if not met, allowed eliminating medical necessity review of retrospective requests for covered services.	Policy and procedure UM-001 Utilization Management will be updated to comply with the contractual requirements. Workflows will be updated to have all retrospective requests reviewed by a medical director. Workflows have been updated to have all retrospective requests reviewed by a medical director. Update as of 12/5/2019: Clarity is being sought from DHCS on allowing a time limit of 30 days. Update as of 1/8/2020: Plan received clarity from DHCS and is updating internal procedures. Update as of 2/7/2020: P&Ps updated to reflect that only an MD can deny retro PA requests. P&Ps approved at HCQC on 1/16/2020.	Yes	1/16/2020	Completed	Utilization Management	✓	State	DHCS	2019	Completed
8	Prior Authorizations	(1.2.2) The Plan did not ensure it used appropriate processes to review and approve medically necessary covered services when it did not ensure that qualified medical personnel rendered medical decisions. Dependent practitioners reviewed, assessed and approved requests for continued hospital stays	The process for ensuring LVNs perform only within their scope of practice was updated and implemented on 10/2/2019. Additional changes to the UM systems to better track the change in process are being developed. Update as of 12/5/2019: Changes to the UM systems to better track the RN oversight role with the LVNs completed. Other Managed Medi-Cal plans have LVNs performing UM. Clarity is being sought from DHCS on the use of LVNs in UM. Policies and procedures and job descriptions are being reviewed to be aligned with the updated oversight process. Update as of 1/8/2020: Plan received clarity from DHCS and updated procedures for RN oversight.	No	1/8/2020	Completed	Utilization Management	✓	State	DHCS	2019	Completed
9	Prior Authorizations (UM and Rx)	The Plan's notice of action (NOA) letters did not follow specifications in Health and Safety Code Section 1367.01. Provider letters in medical cases did not include the decision makers' direct phone number or contained the incorrect number. Letters did not explain the reasons for the denial. Pharmacy NOAs were not concise.	Accurate phone numbers for the decision makers are on the NOA, monitoring will be conducted through internal audits. UM NOA template letters were updated and implemented on 11/4/2019, internal auditing will be conducted monthly to ensure that the letters are clear and concise and explain the reasons for denial. Pharmacy NOA template letters were updated and implemented in April 2019, internal auditing will be conducted at least monthly to ensure that the letters are clear and concise and explain the reasons for denial. The pharmacy team also meets with the PBM on a weekly basis to optimize PA review process, NOA letter language and reasons for denial.	Yes	11/4/2019	Completed	Utilization Management /Pharmacy		State	DHCS	2019	Completed

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#	Category	Deficiency	Corrective Action Plan (CAP)	Repeat Finding (Yes/No)	Completion Date	Internal CAP Status	Department Responsible	Validation Status	State/Self Identified	Agency	Year	Status
10	Prior Authorizations	The Plan did not ensure that all contracting practitioners were aware of the procedures for orthotic items; the Plan provided inaccurate information about authorization requirements for orthotic items	The Alliance's Authorization Grid will be updated to include the accurate information about authorization requirements for orthotics. The updated grid will be uploaded on the website. Update as of 12/5/2019: A meeting will be scheduled the week of 12/9 to discuss changes. Update as of 1/8/2020: Meeting was conducted and PA grid will be updated to reflect corrections. Update as of 2/7/2020. PA grid is being updated for all services requiring PA, so that MDs do not receive repeat communication about changes to the PA grid. Orthotics will be included in the comprehensive update. Update as of 3/5/2020 Prior Auth requirement for Orthotics was added to the PA grid on the Provider Portal	No	3/2/2020	Completed	Utilization Management	✓	State	DHCS	2019	Completed
11	Appeals	The Plan's appeal notification letters did not comply with contractual regulations. NAR letters were not clear or concise, and contained inaccurate information	The G&A staff will attend additional training to review contractual regulations. Internal audits will be conducted monthly by the manager or director to monitor compliance. Update as of 12/5/2019: Training conducted on 11/14/2019.	No	11/22/2019	Completed	G&A		State	DHCS	2019	Completed
12	Case Management & Care Coordination - HRAs	The Plan did not follow the specified timeframes required for completion of the HRAs for newly enrolled SPD members. The Plan did not ensure that HRAs were completed within 45 calendar days of enrollment for those identified by the risk stratification mechanism as higher risk, and within 105 calendar days of enrollment for those identified as lower risk.	HRA tracking had been implemented in early 2019, and continues at present. HRAs are sent out within the required timeframes. Robo calls are made to low risk members to encourage them to complete and send in the HRA within the timeframe. Direct calls are made by CM staff on high risk members to encourage them to complete and send in the HRA within the timeframe. A tracking log is kept to ensure that the required timelines are met.	No	9/16/2019	Completed	Case Management		State	DHCS	2019	Completed
13	Case Management & Care Coordination - Initial Health Assessment (IHA)	The Plan did not ensure that all providers documented all required components of an IHA. Preventive services identified as USPSTF "A" and "B" recommended services were not provided, or status of these recommended services was not documented	The QI Department revised its provider medical record request letter to include: all categories that support IHA completion; a hyperlink and/or copy of the SHA/IHEBA form; and sample documentation of a compliant SHA/IHEBA. Providers were re-educated on the SHA/IHEBA requirements.	No	9/30/2019	Completed	Quality		State	DHCS	2019	Completed
14	Complex Case Management (CCM)	2.2.1 The Plan did not implement its monitoring of the CCM program to address member needs. The Plan did not close its CCM cases after 90 days, or present them at Case Rounds as stated in its policy	Existing aging reports are being utilized by the Case Management Department in CCM Rounds to ensure that members' cases are either reviewed and closed, or extended past 90 days.	Yes	10/14/2019	Completed	Case Management	✓	State	DHCS	2019	Completed
15	Access & Availability	3.1.1 The Plan did not maintain an accurate provider directory.	The Plan will continue to verify 10 providers per week and has added the following two processes to continuously maintain an accurate provider directory: 1. Provider Data Comparison to manually review provider data received from our delegates started September 2019 and 2. Provider Data Validation Yearly Project to review directly contracted providers who appear in the Provider Directory. In addition, the Provider Relations Department includes a Provider Demographic form in all provider quarterly packets and work with providers to obtain the completed forms during provider visits.	Yes	11/1/2019	Completed	Provider Services	✓	State	DHCS	2019	Completed
16	Emerg Family Planning Claims/SSS	The Plan paid non-contracted family planning services at less than the Medi-Cal Fee-For-Service rate. The Plan's claim system misclassified non-contracted family services as non-billable. The Plan is required to pay all covered family planning services regardless if these services are contracted with the Plan.	This finding is specific to one provider based on the list of services identified in the contract. No other provider was impacted by this issue. The claims system has been re-configured to reimburse services as follows: * services listed in the provider contract will be reimbursed at the contracted rate * covered Medi-Cal services not listed in the contract will be reimbursed at 100% of the prevailing Medi-Cal rate	No	9/5/2019	Completed	Claims	✓	State	DHCS	2019	Completed
17	Emerge Family Planning Claims	The Plan did not inform members of the correct minor consent provision for family planning services in its Evidence of Coverage (EOC).	The Plan has updated its 2020 EOC to include the appropriate minor consent provisions. The EOC was submitted to DHCS for review and approval on 10/7/2019.	No	10/7/2019	Completed	Compliance	✓	State	DHCS	2019	Completed
18	Access to Pharm Services	The Plan did not monitor the provision of drugs prescribed in emergency situations.	The Pharmacy Department is working with the PBM to create routine monitoring reports of drugs prescribed in emergency situations. Update as of 1/8/20: Internal meeting was conducted to ensure requirements are clear and next steps for updating policy and monitoring reports. Update as of 2/11/2020: Draft P&P and monitoring log have been created and are under review. Update as of 4/10/2020: The P&P and monitoring log were approved at the most recent P&T Committee meeting.	Yes	3/17/2020	Completed	Pharmacy	✓	State	DHCS	2019	Completed
19	Grievances	4.1.1 The Plan did not document review and final resolution of clinical grievances by a qualified health care professional	The G&A workflow for Quality of Care review was updated and implemented on 4/15/2019 to include the CMOs review and final resolution.	Yes	4/15/2019	Completed	G&A	✓	State	DHCS	2019	Completed
20	Grievances	4.1.2 The Plan's grievance system did not capture all complaints and expressions of dissatisfaction reported by members.	The G&A staff will attend additional training to review contractual regulations. Internal audits will be conducted monthly by the manager or director to monitor compliance. Update as of 12/5/2019: Training was conducted on 11/14/2019.	No	11/22/2019	Completed	G&A		State	DHCS	2019	Completed
21	Grievances	The Plan's grievance system did not capture all complaints and expressions of dissatisfaction filed through Plan providers.	The Plan provided training to its delegated entities of the Plan's grievance process to ensure the Plan's system receives and resolves all complaints of dissatisfaction. Clinics will be trained by the delegate to ensure that the Alliance is capturing all complaints. Update as of 1/8/2020: Medical group provided training sign in sheet. The delegate is working on next steps of educating providers. Update as of 2/7/2020: the delegate provided an attestation to complete its provider training by the end of Q1 2020. Update as of 4/10/2020: Meeting medical group week of 4/6 to discuss implementation. Update as of 4/20/2020: Process for forwarding complaints received by medical group has been implemented as of 4/20/2020.	Yes	~~3/31/2020~~ 5/1/2020	Completed	G&A/Provider Services/ Compliance	✓	State	DHCS	2019	Completed
22	Grievances	4.1.4 The Plan sent member resolution letters without completely resolving all complaints.	The G&A staff will attend additional training to review contractual regulations. Internal audits will be conducted monthly by the manager or director to monitor compliance. Update as of 12/5/2019: Training was conducted on 11/14/2019.	Yes	11/22/2019	Completed	G&A		State	DHCS	2019	Completed

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23	Quality Program	The QIPD did not list the individuals' qualifications, which was inconsistent with Plan policy.	The 2019 Annual Quality Improvement Program Description (QIPD) was revised to include the leadership positions and their qualifications (Licensure, Education, Work Exp) The program description was presented and approved in the July 18, 2019 Health Care Service oversight committee.	No	7/18/2019	Completed	Quality	✓	State	DHCS	2019	Completed
24	Provider Training	The Plan did not ensure provider training was conducted within 10 working days	During the last review period of June 2017 through May 2018, the Plan acknowledged deficiencies in the NPO process to be corrected by the end of December 2018. Since January 2019, the plan is meeting its goal of conducting training with the 10 day working timeframe 100% of the time.	Yes	1/1/2019	Completed	Provider Services	✓	State	DHCS	2019	Completed
25	Fraud, Waste, and Abuse (FWA)	The Plan did not conduct preliminary investigations of all suspected cases of fraud and abuse.	FWA reporting procedures will be revised to include the preliminary investigation details to DHCS within 10 working days. Staff training of the revised procedure will be completed by 12/01/2019. Update as of 12/5/2019: Staff training will be conducted on 12/11/2019 to review the updated procedure. Update as of 1/8/2020: Staff training was conducted on 12/11/2019	Yes	12/11/2019	Completed	Compliance		State	DHCS	2019	Completed
26	Fraud, Waste, and Abuse (FWA)	The Plan did not investigate all suspected fraud and abuse incidents promptly. The Plan did not conduct a preliminary or follow-up investigation of 4 of 12 suspected fraud and abuse cases until two to six months after it became aware of the incidents.	FWA reporting procedures will be revised to include the preliminary investigation details to DHCS within 10 working days. All cases will be resolved and closed within 90 days of receipt. Staff training of the revised procedure will be completed by 12/01/2019. Update as of 12/5/2019: Staff training will be conducted on 12/11/2019 to review the updated procedure. Update as of 1/8/2020: Staff training was conducted on 12/11/2019	Yes	12/11/2019	Completed	Compliance		State	DHCS	2019	Completed
27	Fraud, Waste, and Abuse (FWA)	The Plan's compliance officer did not develop and implement fraud, waste, and abuse policies and procedures	The Plan's designated compliance officer will develop and attest to all new and updated policies and procedures prior to committee review.	No	12/13/2019	Completed	Compliance	✓	State	DHCS	2019	Completed
28	State Supportive Services Claims	The Plan did not forward all misdirected claims within 10 working days.	The post-adjudication script that adds the forwarding action was corrected and deployed.	No	7/11/2019	Completed	IT/ Claims	✓	State	DHCS	2019	Completed

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#	**Category**	**Deficiency**	**Corrective Action Plan (CAP)**	**Completion Date**	**Internal CAP Status**	**Department Responsible**	**Validation Status**	**State/Self Identified**	**Agency**	**Year**	**Status**
1	Utilization Management (UM) Program	1.1.1 The Plan did not continuously update and improve its UM program during the audit period.	The Plan's policy and procedure UM-001 includes the annual review process of the UM program. The 2018 UM program was approved by Committee timely this year on 3/20/2018. The Plan will continue to update its UM program annually and track for a timely approval by Committee.	3/31/2018	Completed	Utilization Management	✓	State	DHCS	2018	Completed
2	Prior Authorizations	1.2.1 The Plan did not conduct IRR testing to evaluate the consistency of UM criteria application during the audit period.	The Plan has implemented an IRR testing policy and procedure to ensure clinical staff is evaluated on an annual basis to ensure consistency in decision making and criteria application. - UM/Appeals IRR conducted on 5/25/2018 - Pharmacy IRR conducted on 12/17/2018 Update as of 1/31/2019: IRR testing for Health Care Services (Pharmacy & UM) has been completed as of 1/31/2019.	12/17/2018	Completed	Utilization Management/ Pharmacy	✓	State	DHCS	2018	Completed
3	Prior Authorizations	1.2.2 The Plan did not use appropriate processes to determine medical necessity for PA requests. The Plan's UM staff used outdated criteria and criteria that did not meet the case details.	The Plan has updated its policy and procedure to ensure the Plan's criteria is reviewed at least annually. IRR testing of clinical staff is completed annually to ensure consistency in decision making and criteria application. - UM/Appeals IRR conducted on 5/25/2018 - Pharmacy IRR conducted on 12/17/2018 Update as of 1/31/2019: IRR testing for Health Care Services (Pharmacy & UM) has been completed as of 1/31/2019.	12/17/2018	Completed	Utilization Management	✓	State	DHCS	2018	Completed
4	Prior Authorizations	1.2.3 The Plan denied retrospective service requests for medical services without documentation of a qualified health care professional's review for medical necessity.	The Plan updated its policy and procedure for the retrospective authorization request process to include details of the review process. The P&P and workflow will be reviewed and approved on 1/17/2019. Staff training will then be conducted on 1/22/2019. Update as of 1/31/2019: Updated P&P and workflow retro authorization request processes were approved at HCQC on 1/17/2019. Staff training was conducted on 1/29/2019.	1/22/2019	Completed	Utilization Management	✓	State	DHCS	2018	Completed
5	Prior Authorizations	1.2.4 The Plan did not respond to pharmacy requests within 24 hours or one business day.	The Plan monitors pharmacy authorization request timeframes by a daily aging report. Staff training of the turnaround timeframe requirements was provided on 10/02/2018. Update as of 1/07/2019: The Plan has determined that timeframe requirements were not consistently met due to a lack of coverage on weekends and holidays. The Plan has updated its Pharmacy Benefit Management contract to include coverage for weekends and holidays as of 12/1/2018. Staff training of the updated procedures will be completed by 1/22/2019. Update as of 1/31/2019: Staff training was completed on 1/23/2019.	1/22/2019	Completed	Pharmacy	✓	State	DHCS	2018	Completed
6	Prior Authorizations	1.2.5 The Plan's NOA letters were not clear and concise, or at sixth grade reading level.	Update as of 3/5/2019: Continuing internal audits revealed issues with how TruCare generates letters, leading to potentially confusing language for members. A team is working on a plan to mitigate the issues. Once the TruCare issues are resolved, staff will be retrained on the mitigation procedures. In the meantime, audits continue to ensure that the language is clear and concise and a process for final review before sending out is being developed. The updated timeline for completion is 4/30/2019. Update as of 4/10/2019: Denial rationale language has been updated. Staff training was completed on 3/29/2019.	4/30/2019	Completed	Utilization Management/ Pharmacy		State	DHCS	2018	Completed
7	Prior Authorizations	1.2.6 The Plan provided incorrect appeal, grievance, and state fair hearing information in translated pharmacy member notifications. The translated "Your Rights" attachments did not follow the required format.	The Plan will update its pharmacy member notifications to ensure the translated versions are in the required format with updated member rights information by 1/25/2019. Update as of 2/4/2019: Updated translated versions of the "Your Rights" attachments have been provided to the Pharmacy Benefits Manager. Update as of 2/19/2019: Updated translated versions of the "Your Rights" attachments have been placed into production by the Pharmacy Benefits Manager.	1/25/2019	Completed	Pharmacy	✓	State	DHCS	2018	Completed
8	Prior Authorizations	1.2.7 The Plan provided conflicting information to providers about podiatry benefits, which required PA; it therefore did not communicate to providers the services that required PA.	The Plan will be updating its Prior Authorization Grid and Provider Training Presentation to include clear communication of the prior authorization process including clarification of the podiatry benefit. Update as of 1/07/2019: The Plan will be updating its prior authorization grid and provider training materials by 1/25/2019. Update as of 1/31/2019: The PA Grid and Provider Training Presentation have been updated. The PA Grid and updated Provider Manual have been posted to the Plan website.	1/25/2019	Completed	Utilization Management	✓	State	DHCS	2018	Completed
9	Referral Tracking process	1.3.1 The Plan did not track authorized PAs to completion and inform providers of the referral tracking process.	The Plan has updated its referral tracking policy and procedure. Routine reporting has been developed to track authorization PAs to completion. The Plan's provider manual has been updated to include information on the Plan's referral tracking process for providers. Update as of 1/07/2019: The Plan will be uploading the provider manual to the website by 1/25/19. Update as of 1/31/2019: The updated Provider Manual has been posted to the Plan website.	1/25/2019	Completed	Utilization Management	✓	State	DHCS	2018	Completed

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#	Category	Deficiency	Corrective Action Plan (CAP)	Completion Date	Internal CAP Status	Department Responsible	Validation Status	State/Self Identified	Agency	Year	Status
10	Appeal	1.4.1 The Plan did not ensure health care professionals with appropriate clinical expertise in treating the member's condition resolved pharmacy appeals. The Plan allowed the Pharmacy Director to resolve appeals for medication requests instead of requiring a clinical professional with expertise in treating the member's condition.	The Plan updated its appeal procedures to reflect MD review for final decision for pharmacy appeals on 09/26/2018 and conducted staff training on 10/30/2018.	10/30/2018	Completed	Health Care Services	✓	State	DHCS	2018	Completed
11	Appeal	1.4.2 The Plan did not translate acknowledgement and resolution appeal letters into the required threshold languages.	The Plan's appeal policies and procedures in place are compliant with the translation requirements. Staff training refresher of translation of letters was conducted on 10/30/2018.	10/30/2018	Completed	Grievance & Appeals	✓	State	DHCS	2018	Completed
12	Appeal	1.4.3 The Plan did not update its provider manual to include the new timeframes for filing a state fair hearing that became effective July 1, 2017.	The Plan updated its provider manual on 12/25/2018 to include the correct new SFH filing timeframes. Update as of 1/07/2019: The Manual is scheduled to be uploaded on our website on 1/25/2019. Update as of 1/31/2019: The updated Provider Manual has been posted to the Plan website.	1/25/2019	Completed	Grievance & Appeals/ Provider Relations	✓	State	DHCS	2018	Completed
13	Delegation Oversight	1.5.1 The Plan did not collect and review ownership and control disclosure information for their UM delegates.	The Plan's subcontractor policy & procedure addresses the ownership and control disclosure information requirements. Update as of 1/07/2019: The Plan has requested ownership and control disclosure information of its UM delegates as of 1/4/2019. Update as of 1/30/2019: All forms from the Plan's UM delegates have been received as of 1/31/2019 with the exception of the Plan Pharmacy Benefits Manager (PBM). Update as of 3/6/2019: All forms from the Plan's UM delegates have been received.	3/15/2019	Completed	Provider Relations	✓	State	DHCS	2018	Completed
14	Delegation Oversight	1.5.2 The Plan did not require corrective action for all identified deficiencies as a part of their annual oversight audits.	The Plan updated its corrective action plan policy and procedure on 11/8/2018 to ensure all identified deficiencies are a part of annual audits such as policy and procedure deficiencies. UM annual delegation audits conducted for 2018 reflect the policy and procedure deficiencies in the corrective action.	11/8/2018	Completed	Compliance	✓	State	DHCS	2018	Completed
15	Delegation Oversight	1.5.3 The Plan did not continuously monitor and evaluate the functions of its UM delegates. The Plan did not ensure receipt of all contractual and regulatory reports during the audit period.	The Plan has updated its monitoring of UM delegates to ensure all contractual and regulatory reports are being tracked for review. The Plan's delegation reporting tracking log has been updated to document all UM delegation reporting. Update as of 1/7/2019: The Plan will update the desktop procedure and conduct staff training on the monitoring process by 1/22/2019. Update as of 1/31/2019: The Plan completed staff training on 12/20/2018.	1/22/2019	Completed	Compliance	✓	State	DHCS	2018	Completed
16	Initial Health Assessment (IHA)	2.4.1 The Plan did not ensure that new members receive an IHA within 120 days from enrollment. The Plan's IHA completion records were inaccurate.	The Plan updated its procedures to monitor IHA completion and validate the procedure codes. Medical record auditing procedures will be conducted to monitor IHA completion and conduct validity testing. Update as of 1/07/2019: The Plan completed the audit and is completing the summary report for Committee by 1/17/2019.	1/17/2019	Completed	Quality Management	✓	State	DHCS	2018	Completed
17	Complex Case Management (CCM)	2.5.1 The Plan did not implement its policy and did not consistently monitor its CCM program.	The Plan monitors its daily aging report to ensure compliance with its CCM program.	12/1/2018	Completed	Health Services	✓	State	DHCS	2018	Completed
18	Complex Case Management (CCM)	2.5.2 The Plan did not ensure PCP participation in the provision of CCM services to each eligible member.	The Plan's updated CCM policy and procedure includes a process for PCP participation. The PCP Input Form was implemented for use on 5/31/2018.	5/31/2018	Completed	Health Services	✓	State	DHCS	2018	Completed
19	Access & Availability	3.1.1 The Plan did not initiate and implement steps to monitor wait times for providers to answer members' telephone calls.	The Plan will be updating its policy and procedure to include the telephone wait times standards for answering and returning calls. The Plan will monitor wait times for providers and answering member telephone calls through a quarterly survey. Update as of 1/31/2019: The Plan has updated its P&P to include all wait time standards. The Plan conducted a survey in January 2019 to assess and monitor wait times as required.	1/31/2019	Completed	Quality Management	✓	State	DHCS	2018	Completed
20	Access & Availability	3.1.2 The Plan did not maintain an accurate and complete provider directory.	The Plan implemented an audit process of the provider directory. The Plan expanded its annual audit for its Pharmacy Benefit Manager (PBM) to include monitoring its provider data included in the directory. Update as of 1/30/2019: Provider Directory Data P&P and desktop procedure for internal auditing have been updated.	2/28/2019	Completed	Provider Services/ Pharmacy	✓	State	DHCS	2018	Completed

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21	Emergency & Family Planning Claims	3.5.1 The Plan denied emergency room (ER) service and family planning (FP) claims containing procedures that normally require prior authorization outside of an ER or FP setting.	The Plan updated its system configuration to ensure ER and FP claim procedure codes were updated and will not be denied for services not being authorized. Monitoring reports have been implemented to review any claims denied incorrectly that are adjusted the following week.	11/30/2018	Completed	Claims	✓	State	DHCS	2018	Completed
22	Emergency & Family Planning Claims	3.5.2 The Plan did not pay the greater of $15 or 15 percent interest annually for emergency service claims not reimbursed within 45 working days of receipt.	The Plan updated its system to ensure interest is paid based on the greater of the $15 or 15 percent interest annually for emergency services not reimbursed timely. Update as of 1/07/2019: The Plan will run a pre-payment monitoring report prior to each check run to ensure interest is paid based on the greater of the $15 or 15% per annum for emergency services claims not adjudicated timely. Update as of 1/31/2019: The Plan's pre-payment monitoring report process is now in place prior to each check run to ensure interest is paid accurately for emergency services claims when interest is required. All claims identified on the weekly report are manually adjusted as needed prior to payment to providers.	1/25/2019	Completed	Claims	✓	State	DHCS	2018	Completed
23	Emergency & Family Planning Claims	3.5.3 The Plan improperly denied family planning claims for out of network, non-contracted providers. These claims were denied based on edits in the Plan's claims system and subsequent review by claims analysts.	The Plan provided staff training on 6/11/2018 to ensure FP claims edits for out of network claims are reviewed and not inappropriately denied. Monitoring reports have been implemented to review any claims denied incorrectly. Any claims identified as denied incorrectly are adjusted the following week manually.	12/31/2018	Completed	Claims	✓	State	DHCS	2018	Completed
24	Emergency & Family Planning Claims	3.5.4 The Plan did not disclose the specific rationale used in determining why claims are rejected.	Update as of 3/6/2019: The Plan will send via fax blast to the provider network training materials for reading remittance advice forms from Alliance claims by March 31. The training materials will also be included in all provider quarterly packets by May 31, 2019. Update 4/8/2019: The training guide created by the Claims director for providers has been sent to the entire Alliance network via fax as of 4/1/2019; the guide was also posted to the Alliance website as of 4/1/2019. The guide is currently also being hand-delivered by the Provider Relations team via the 2nd quarter provider packets.	4/1/2019	Completed	Claims	✓	State	DHCS	2018	Completed
25	Emergency Pharmacy Provisions	3.6.1 The Plan did not ensure the provision of sufficient amounts of drugs prescribed in emergency situations.	The Plan updated its policy and procedure to ensure emergency provisions of drugs are prescribed in emergency situations. The monitoring report was updated to include all supply claims to ensure members have access to medically necessary drugs.	12/11/2018	Completed	Pharmacy	✓	State	DHCS	2018	Completed
26	Grievances	4.1.1 The Plan's process omitted medical director review of QOC grievances prior to sending resolution letters.	The Plan updated its grievance procedures and letters to include MD review for quality of care grievances. Update as of 1/7/2019: Implementation will be completed by 3/31/2019 once RN staff are on board and trained on the updated process. Update as of 3/5/2019: Health Care Services has successfully recruited one nurse, and is in the process of filling the remaining vacancy. Update as of 4/10/2019: Training is to be completed by 4/11/2019. The checklist for standard and expedited grievances has been updated. Update as of 5/8/2019: The review process for QOC grievances was implemented on 4/15/2019.	4/15/2019	Completed	Health Care Services	✓	State	DHCS	2018	Completed
27	Grievances	4.1.2 The Plan sent member resolution letters without completely resolving all complaints.	The Plan updated its grievance procedure to include a process for resolving all complaints and resolutions resolved outside the 30 day timeframe. Staff training was conducted on 7/17/2018.	7/17/2018	Completed	Grievance & Appeals		State	DHCS	2018	Completed
28	Grievances	4.1.3 The Plan did not update its provider manual to include the new timeframes for filing grievances that became effective July 1, 2017.	The Plan updated its Provider Manual on 12/25/2018 to include the correct new grievance filing timeframes. Update as of 1/07/19: The Manual is scheduled to be uploaded on our website on 1/25/2019. Update as of 1/25/2019: The Plan has posted the updated Provider Manual to its website.	1/25/2019	Completed	Grievance & Appeals/ Provider Relations	✓	State	DHCS	2018	Completed
29	Grievances	4.1.4 The Plan's grievance system did not capture and process all complaints and expressions of dissatisfaction	The Plan provided training to its delegated entities of the Plan's grievance process to ensure the Plan's system receives and resolves all complaints of dissatisfaction. New provider orientation materials and the provider manual will include education materials of the Plan's grievance process for new and existing providers. Update as of 1/7/2019: The Plan will be uploading the provider manual to the website by 1/25/19. Update as of 1/25/2019: The Plan has posted the updated Provider Manual to its website.	1/25/2019	Completed	Grievance & Appeals/ Provider Relations	✓	State	DHCS	2018	Completed
30	HIPAA	4.3.1 The Plan did not report the discovery of PHI breaches to the DHCS Information Security Officer.	The Plan updated its procedures to ensure reporting of PHI incidents are reported to all DHCS contacts including the DHCS Information Security Officer. Staff training on updated procedures was conducted on 8/22/2018 and 10/3/2018.	10/3/2018	Completed	Compliance	✓	State	DHCS	2018	Completed
31	HIPAA	4.3.2 The Plan did not report all suspected security incidents or unauthorized disclosures of PHI to DHCS within 24 hours of discovery.	The Plan updated its procedures and tracking log to ensure monitoring of reporting to DHCS occurs timely. Staff training on updated procedures was conducted on 8/22/2018 and 10/3/2018.	10/3/2018	Completed	Compliance	✓	State	DHCS	2018	Completed
32	Provider Training	5.2.1 The Plan did not ensure provider training was conducted within 10 working days.	The Plan monitors its tracking log to ensure provider training is conducted within 10 working days. Staff training of the required timeframe was conducted on 12/17/2018.	12/31/2018	Completed	Provider Services	✓	State	DHCS	2018	Completed

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33	Provider Training	5.2.2 The Plan did not specify in its written agreement provider training responsibilities for two delegated entities.	The Plan updated its contract with the two delegated entities to ensure provider training requirements. Update 12/31/2018: The Plan has updated its contract with one of the delegates to include delegation of provider training requirements. The other delegate's contract is in progress to be finalized. Estimated time for contract to be completed is 2/28/2019. Update as of 3/4/2019: The remaining delegate has agreed to the provider training responsibilities; the final contract will be signed once the delegate agrees to terms for non-related items. Update as of 8/5/2019: Both delegates involved in the finding delegation agreements were updated. Another delegate's contract still needs to be finalized.	6/30/2019	Completed	Provider Services	✓	State	DHCS	2018	Completed
34	Provider Training	5.2.3 The Plan did not ensure training materials provided by two delegated entities included information on Plan policies, procedures, services, and member rights and responsibilities.	The Plan's delegated entities have updated their training materials to include the required information. Update 12/31/2018: The Plan is currently working with the delegate to incorporate this information. Target date for materials to be updated is 1/31/19. Update as of 1/30/2019: Both delegates have revised their training materials to include member rights and responsibilities, grievances and services.	1/31/2019	Completed	Provider Services	✓	State	DHCS	2018	Completed
35	Fraud, Waste, and Abuse (FWA)	6.3.1 The Plan did not conduct and report preliminary investigations of all suspected cases of fraud and abuse to DHCS within 10-working days.	The Plan updated its fraud and abuse policy and procedure as of 7/17/2018 to ensure timely reporting of incidents to DHCS. Staff training on updated procedures was conducted on 7/17/2018. The Plan updated its monitoring tracking log to monitor the reporting timeframe requirement.	7/17/2018	Completed	Compliance	✓	State	DHCS	2018	Completed
36	Fraud, Waste, and Abuse (FWA)	6.3.2 The Plan did not conduct prompt and complete investigations of all suspected fraud and abuse incidents.	The Plan updated its fraud and abuse policy and procedure as of 7/17/2018 to investigate all suspected incidents and update DHCS until the case closure. Standardized investigation form for documentation was implemented as of 7/17/2018. Staff training on updated procedures was conducted on 7/17/2018.	7/17/2018	Completed	Compliance	✓	State	DHCS	2018	Completed

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37	State Supportive Services	SSS.1 The Plan denied state supported services (SSS) claims containing procedures that normally require prior authorization outside of a SSS setting. These claims were denied based on edits in the Plan's claims system and review by claims analysts; the Plan's process did not include exceptions for FP or ER services.	The Plan updated its system configuration to ensure SSS claim procedure codes were updated and will not be denied for services not being authorized. Monitoring reports have been implemented to review any claims denied incorrectly that are adjusted the following week.	11/30/2018	Completed	Claims	✓	State	DHCS	2018	Completed
38	State Supportive Services	SSS.2 The Plan did not disclose the specific rationale used in determining why claims are rejected.	The Plan's Remittance Advice (RA) includes the specific rationale for claims denials. Denial codes can be applied at the Header level, line level or both. The Plan's claims processing system edits each claims and assigns all denial or informational codes that are applicable to the claim. Update as of 1/31/2019: The Plan will provide training to providers to ensure comprehension concerning the remittance advice set-up. Update as of 3/6/19: The Plan will send via fax blast to the provider network training materials for reading remittance advice forms from Alliance claims by March 31. The training materials will also be included in all provider quarterly packets by 5/31/2019. Update 4/8/2019: The training guide created by the Claims director for providers has been sent to the entire Alliance network via fax as of 4/1/2019; the guide was also posted to the Alliance website as of 4/1/2019. The guide is currently also being hand-delivered by the Provider Relations team via the 2nd quarter provider packets.	4/1/2019	Completed	Claims	✓	State	DHCS	2018	Completed
1	Prior Authorizations	Authorizations were auto-approved for hospital.	Effective 9/17/2018, the Plan started to review and impose standard UM authorization guidelines for hospital authorizations.	9/17/2018	Completed	Utilization Management	✓	Self Identified	AAH	2018	Completed
2	Appeal	The Plan's expedited appeals checklist does not include a reminder to call the member when the case is de-escalated from urgent to routine.	The expedited appeals checklist has been updated. Staff training will be conducted by 10/1/2018. Checklist includes requirements of De-expedited: Decision to de-expedite must be made within 24 hours. Send ack letter within 3 calendar days notifying of priority change and right to contact DMHC. Follow standard appeal process. If 24 hour TAT is not met, proceed with expedited appeal.	10/1/2018	Completed	Grievance & Appeals	✓	Self Identified	AAH	2018	Completed
3	Delegation Oversight	Some authorization cases included many errors with subcontractor's notices of actions. Plan oversight of authorizations and notices is in process.	Reestablished bi weekly meetings with subcontractors and conducted monthly focused file audit which included NOAs, conducted clinical case rounds for overturned appeals. The plan will continue to monitor during annual audit review process. The Plan will be terminating services subcontractor and consuming this function to review authorization effective 4/1/2019.	12/1/2018	Completed	Utilization Management	✓	Self Identified	AAH	2018	Completed
4	Care Coordination	The Plan did not annually review the County MOU for CCS services.	Update 9/27/2019: MOUs have transitioned to Provider Services. Provider Services is in discussion with the county on review MOUS, including CCS. Update as of 12/2/2019: The MOUs have been transitioned to the Provider Services team. The MOU was executed with an effective date of 8/1/2019	8/1/2019	Completed	Provider Services	✓	Self Identified	AAH	2018	Completed
5	Care Coordination	The Plan did not annually review the County MOU for Early intervention/development disabilities.	Update 9/27/2019: MOUs have been transitioned to Provider Services. Provider Services is in discussion with the county on review MOUS, including EI/DD services. Update as of 12/2/2019: The Plan is currently working on developing a full county MOU to include services for early intervention and development disabilities services Update 7/10/2020: The MOU was sent to the County for review on6/16/2020. Update 10/9/2020: The County has accepted the Alliance's edits and the MOU is currently under review for final approval with the County. Update 11/10/2020: The County has cancelled the November 3rd meeting. This agenda item will be carried over to the December 15th docket. **Update 5/14/2021**: The MOU was approved by the county board on 4/6/2021.	~~2/28/20~~ TBD	Completed	Provider Services	✓	Self Identified	AAH	2018	Completed
6	Initial Health Assessment (IHA)	The Plan did not have a process for validating the procedure codes used for IHA completion.	P&P will be updated to include the detail of the process for annual validation and codes. The validated for this year will occur prior to 11/1/2018. Update 11/6/2018: Codes were validated and updated by QM department.	11/1/2018	Completed	Quality Management	✓	Self Identified	AAH	2018	Completed
7	Initial Health Assessment (IHA)	The Plan does not have a system in place for monitoring member's missed appointments.	Missed appointments are identified during the Medical Record Review that is part of a FSR. The criteria for missed primary care appointments and outreach efforts, which is part of DHCS's tool. The FSR review nurse evaluates this information and if a deficiency is identified the provider is educated on the importance of outreaching to the member and that documentation of the outreach attempts is required.	11/26/2019	Completed	Quality Management	✓	Self Identified	AAH	2018	Completed
8	Access & Availability	The Plan did not monitor appointment wait times.	Policy and procedure is in place for monitoring appointment wait time standards. Standardized process for monitoring and corrective action plan in place as of 9/20/2018.	9/20/2018	Completed	Quality Management	✓	Self Identified	AAH	2018	Completed
9	Grievances	Some exempt grievance cases were not resolved within the next business day timeframe (applied to 1-3 cases).	Policies and procedures in place are compliant with the exempt grievance resolution timeframe requirements. Staff training refresher of resolving all exempt grievances by close of next business day was conducted on 10/12/2018.	10/12/2018	Completed	Member Services	✓	Self Identified	AAH	2018	Completed
10	Quality Improvement	Reporting of the HCQC was not consistently reported to the Board.	The Chief Medical Officer will provide HCQC summary updates to the Board starting in November. The meeting minutes will be included in the Board materials.	11/9/2018	Completed	Quality Management	✓	Self Identified	AAH	2018	Completed
11	Utilization Management	The Plan did not routinely review overturned UM denials for trends & to develop plans for intervention where needed.	The Plan will pull reporting of UM denial trends that will be presented at the UM committee. The first UM committee for presenting the overturn UM denial trends at UM committee will be on 9/28/2018. These findings will be presented to the HCQC and subsequently to the Board of Governors.	9/28/2018	Completed	Utilization Management	✓	Self Identified	AAH	2018	Completed

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12	Utilization Management	The Plan did not have a clear process for peer-to-peer clinician discussions concerning denied services.	Steps Plan took or will take to correct deficiency: 1.Plan develop a desktop procedure on peer to peer discussion by 9/14/2018. 2. Plan to train physicians and pharmacists of desktop procedure and when and how to document peer-to-peer clinician discussions by 9/26/2018. 3.Plan has started a weekly meeting with physicians and pharmacist for peer to peer discussions as of 7/17/2018.	9/26/2018	Completed	Utilization Management	✓	Self Identified	AAH	2018	Completed