COMPLIANCE ADVISORY COMMITTEE
Regular Meeting Minutes
Friday, July 12th, 2024
10:30 a.m. – 11:30 a.m.

Video Conference Call
and

1240 S. Loop
Road Alameda,
CA 94502

CALL TO ORDER

Committee Members Attendance: Byron Lopez, Richard Golfin III, Dr. Kelley Meade, Rebecca Gebhart

Remote: None

Committee Members Excused: None

1. CALL TO ORDER

The regular Compliance Advisory Committee meeting was called to order by Dr. Kelley Meade at 10:30 am.

2. ROLL CALL

A roll call was taken of the Committee Members, quorum was confirmed.

3. AGENDA APPROVAL OR MODIFICATIONS

There were no modifications to the agenda.

4. PUBLIC COMMENT (NON-AGENDA ITEMS)

None

5. CONSENT CALENDAR

a) June 14th, 2024, COMPLIANCE ADVISORY COMMITTEE MEETING MINUTES

Motion: A motion was made by Richard Golfin III and seconded by Byron Lopez to approve Consent Calendar Agenda Items.

Vote: Motion passed

Abstentions: Dr. Kelley Meade

6. COMPLIANCE MEMBER REPORTS

a) COMPLIANCE ACTIVITY REPORT

i. Plan Audits and State Regulatory Oversight

1. Compliance Dashboard

a. Summary: The 2024 DHCS audit started on June 17, 2024, and ended with an exit conference on June 28, 2024. During the exit conference, DHCS discussed twenty-three (23) different items they saw which may need correction. Since these are not yet officially issued findings, we have added them to the dashboard as self-identified so we can begin working on corrections for them. Then, when DHCS does issue their findings, if there are any of these twenty-three (23) on the final findings report, we will move them over to the State Audit Findings category. If any of these twenty-three (23) don't end up being on the final audit report, they will remain in the self-identified column, so we can continue to work to correct any identified deficiencies.

b. 2024 Routine Full Medical Survey (RMS) - Potential Findings

- Finding 1: Category 1.2 Prior Authorization Procedures: The Plan did not authorize referrals to transplant programs within 72 hours of the member's specialist identifying the member as eligible for Major Organ Transplant (MOT)
    - This finding is related to the state requirement that all MOT evaluations are processed within seventy-two (72) hours of receipt, even if not specifically indicated by the provider.
    - Policies and procedures (P&Ps) reflected correctly that we are to authorize within seventy-two (72) hours, however the standard operating procedure (SOP), did not align specifically with the policy and procedures.
    - SOPs have been updated, staff has been trained on the updated workflows, and we are currently following the process.
    - A new internal review process has been instituted within all departments that handle these referrals to make sure that all procedures align with the P&P moving forward
- Finding 2: Category 1.2 Prior Authorization Procedures: The Plan did not ensure all MOT procedures, including bone marrow, were performed in a medically approved center of excellence (COE) as described in APL 21-015
    - The P&Ps were accurate in that all of our MOT needed to be performed at a DHCS approved Center of Excellence (COE).
    - The SOPs did not include bone marrow transplant on that list. This has been corrected, and staff have been trained on the updated process.
    - The major issue was ensuring the paper trail of the process was being documented.
- Finding 3: Category 1.3 Prior Authorization Appeals: The Plan did not

obtain written consent from members prior to appeal when the provider filed the appeal in accordance with APL 21-011

  - Currently, the P&P states that we will try our best to get written consent from the member for an appeal, but if we do not, we will still process the appeal.
  - We will need to update the P&P, as well as the SOP, and then retrain staff on the updated process to ensure we get written consent from the member for an appeal.

- Finding 4: Category 1.3 Prior Authorization Appeals: The Plan did not send updated non-discrimination notice with tagline to appeal notification as described in APL 21-004
  - For every written communication that is sent in Grievance and Appeals (G&A), we have to provide Member's Rights and attach the Non-Discrimination Notice and Language Assistance Guidelines.
  - Updates were made by the State in 2021 and 2022, and Alliance systems were not updated with the appropriate updated enclosures for the Members Rights documents. We are working on updating those enclosures in our systems.
- Finding 5: Category 2.1 California Childrens Services (CCS): The Plan did not monitor CCS referral program pathways to identify members who may be eligible for CCS
  - We do have a dedicated team at the Alliance to support our coordination with CCS in this particular finding, there are multiple referral pathways to go to the CCS program.
  - One of them is referrals identified for the Plan and we have a very solid referral tracking mechanism for any Plan initiated referral.
  - There are also other provider pathways to refer to CCS, so our external provider community can also refer directly to CCS, however we don't have as streamlined of a process to monitor those types of referrals.
  - Currently there is a retrospective review where we receive reports from the county CCS office telling us who all of the people are that have been referred, but we want to be more proactive in identifying when the provider is referred directly to CCS.
  - Since we want to know who has been referred, we have been updating our processes to monitor that specific referral pathway, and we're going to be working very closely with our CCS partners to make sure that we can streamline that process.

    Question: What gap exactly was the finding specific to cause? As you illustrated, there are lots of ways to access the services through CCS and the referral pathways.

    Answer: The gap was our lack of ability to know exactly when a provider made a direct referral to CCS.

Follow Up Question: How do we fixed that?

Answer: We tried to have that oversight by having our CCS county partners submit what they call a SAR report. That was not a proactive enough approach.

Discussion: We are going to be working with our CCS partners on solutions and on a more proactive approach as opposed to these reports. Exploring more upstream approaches while not overburdening our partners with more administrative costs.

- Finding 6: Category 2.1 Initial Health Assessment (IHA): The Plan did not ensure reasonable member outreach attempts for the IHA document
    - There have been three major steps implemented to ensure outreach:
        - IVR calls: We call every individual who is new to the Plan, who is eligible for an IHA, and encourage them to call their primary care provider and then obtain the appropriate appointment.
        - New Member Orientation: We offer new Alliance members a new member orientation, however not all members choose to participate.
        - Mailers and Phone Calls: All new members get various mailers and phone calls directly, in an attempt to connect them with their primary care provider and get the IHA within 120 days
    - DHCS requested multiple types of case files, and within those case files they requested to see documentation of the above three items. That information has been submitted as evidence of reaching out to new members.
- Finding 7: Category 2.1 Initial Health Assessment (IHA): The Plan did not ensure the provision of Initial Health Assessments for members
    - This is a repeat finding
    - There are six major steps being taken:
        - Multiple webinars
        - Chart audits
        - Outreach and IVR calls
        - Program around non-utilizers
        - Outreach calls to children as well as members over the age of 50
        - Providing a provider guide

        Question: What is our most successful outreach method?

Answer: Direct phone calls. We are not allowed to use a text method for outreach.

- Finding 8: Category 2.1 Initial Health Assessment (IHA): The Plan did not ensure the provision of blood lead screenings for pediatric members
    - Within the pediatric population the appropriate provision of blood lead screening is a specific concern for the department.
    - They pulled five (5) pediatric case files and we took some time to look at each of those files. In those cases, blood lead screening was completed.
        - Three of them had screening results
        - Two of them were documented in the medical record as being ordered.
        - This information was also submitted to DHCS
- Finding 9: Category 2.1 Initial Health Assessment (IHA): The Plan did not ensure the member outreach attempts were conducted and documented for IHAs for pediatric members
    - DHCS specifically called out the pediatric population for findings six (6) and seven (7). We perform the same pieces that I talked about in those two findings for our pediatric population; IVR calls direct phone calls to the parents, tip sheets, P4P program.
- Finding 10: Category 2.3 Behavioral Health Therapy (BHT): The Plan did not ensure timely access to Behavioral Health Therapy services
    - We have been extremely successful in meeting the metrics that we wanted to meet when we brought these services in-house.
    - We have seen a fourfold increase in our mental health utilization, almost a twofold increase in our behavioral health therapy utilization. We are providing care to more members.
    - The penetration rate is going up, meaning the number of members in the medical population who are utilizing mental health and BHT services in the look back period.
    - We had an increase in utilization and tripling of the staff, as well as support from senior leadership and Board of Governors, however, in the lookback period, we did have a large number of members awaiting their comprehensive diagnostic evaluations and services, in part due t a large backlog we received from our previous mental health delegate, that we were not aware of.
    - We are expanding the network, increasing services and access to services and we're seeing the improvements and increases in utilization.
    - This finding, and the next, is fair and expected given what we have seen in the past. We are aggressively working on improvements, as these services are important and we want to

provide them timely.

- Finding 11: Category 2.3 Behavioral Health Therapy (BHT): The Plan did not ensure provision of BHT services
    - Just as in finding ten (10), we have been successful in meeting the metrics since we brought the services in house. The same challenges are seen, and corrections are being put in place, for this finding.
- Finding 12: Category 2.3 Behavioral Health Therapy (BHT): The Plan did not ensure care coordination for members needing BHT services.
    - The BH team is working to be able to demonstrate that we have closed the coordination of care gap that is identified.
    - This is a theme that we heard in a most recent audit as well that the expectation from DHCS is that we will be actively facilitating coordination of care between the county and treating providers and in this case it would be also between BHT providers and the referring pediatricians.
- Finding 13: Category 2.4 Continuity of Care: The Plan did not ensure the notice of action (NOA) letters regarding continuity of care (CoC) denials were clear and concise.
    - Continuity of care processes fall under the Utilization Management (UM) pathways, similar to how we would process any type of authorization.
    - If there is an adverse benefit, we would have to send a Notice of Action letter (NOA). One of the file samples that we submitted, the language in the NOA that explained the reason for the denial wasn't as clear as we wanted it to be. The auditor specifically mentioned some double negative language in the actual letter, so that has been corrected now and we are continuing to reevaluate those types of documentation.
    - We have weekly and monthly work groups to make sure our communication to our members and our providers are clear and concise.
- Finding 14: Category 3.1 Access: The Delegate subcontractor placed members on appointment waitlists and did not provide timely appointments.
    - This is in the PCP realm, and at a joint operating meeting (JOM) with Alameda Health Systems (AHS) a wait list AHS had for primary care office visits and specialty office visits, particularly those of ophthalmology, gastroenterology, was brought forward.
    - Independently, one of the CHCN clinics, Tiburcio Vasquez, also mentioned delays in primary care visits, meaning waitlists for members who are waiting to get in to see a primary care provider.
    - The department was curious about what steps we were taking

to address those wait lists. In regards to access there are many items. For AHS, there are two we'd like to highlight specifically:

- We provide a host of surveys, provider education around what are the appropriate timely access requirements, and we monitor potential quality issues.
- We look at grievances. The positive result is that the number of grievances around access for both AHS particularly and CHCN, Tiburcio Vasquez, has gone down.

  - We acknowledge the wait times and regularly meet with AHS and discuss these waitlists and appropriate access.

- Finding 15: Category 3.1 Access: The Plan did not monitor appointment wait times and appointment availability for specialists and behavioral health specialists
  - There are multiple timely access requirements from the State, one of which is the requirement to monitor appointment wait times and availability for specialists and for behavioral health specialists. The way we do that is through a survey called the CG Caps survey.
  - It's about a 30-question survey and we send out approximately 60,000 surveys a year.
  - The survey has been sent out for many years, and that is how we have looked at access around these requirements this year.
  - We included the behavioral health providers in this specific survey, however, in order to do so, we had to modify the survey. It was edited and sent to Compliance for review. Compliance sent it to DHCS, which took several months to approve the survey. This caused a delay in sending out the survey.
  - The survey has now been approved. The survey was then done in Q2 2024, and we will have the results in Q3 2024.
- Finding 16: Category 4.1 Grievance Resolution: The Plan did not ensure the decision maker for grievances involving clinical issues was a healthcare expert with clinical expertise for the condition as described in APL 21-011
  - The auditors noted that there was not a strong clinical review for quality of care grievances. Auditors discussed the lack of clinical review while reviewing the medical records and provider responses and noted that the clinical reviews were not in the final resolution letters.
  - We are working on creating an SOP for quality of care grievances, and we are working with the Chief Medical Officer to create a more robust clinical review for our quality care grievances.
- Finding 17: Category 4.1 Grievance Resolution: The Plan did not

completely resolve quality of care and quality of service grievances

  - These are the cases which were closed without a complete resolution, for example, for the cases where the member called in and had a grievance against access to care, saying that there wasn't enough specialists within a specific specialty, we would respond that we do have more specialist, and the information is in our provider directory, which is not a complete resolution.
  - A complete resolution is to obtain a timely appointment for that member, however, those cases were closed without getting a timely appointment for the member.
  - Retraining will be needed to resolve this finding.

- Finding 18: Category 4.1 Grievance Resolution: The Plan did not ensure resolution letters contained clear and concise explanations for quality of care and quality of service decisions
  - The grievance and appeals resolution letters were not clearly written. They were identified during the audit. There were not a lot, but there were some that were confusing.
  - The Plan will provide staff training for coordinators, and we are also considering a template to help standardize the letters to make it easier for the member to read the letter.
- Finding 19: Category 4.1 Grievance Resolution: The Plan did not send updated non-discrimination and language assistance information with grievance letters
  - This is the same as the appeal finding.
  - We have updated our enclosures for the current non-discrimination notice and the language assistance tagline, and it is being updated in the system.
- Finding 20: Category 4.2 Cultural and Linguistic Services (CLS): The Plan did not monitor the linguistic performance of vendors that provider interpreter services
  - Documentation has been submitted to DHCS regarding the monitoring of our interpreter quality.
  - We do an annual review of interpreter qualifications for our three interpreter vendors.
  - We also do surveys with both our providers and our members asking about quality of interpreters to help us look for trends that might be a cause for response or action.
  - We've been looking at PQIs and grievance and appeals and have not noticed any concerns, which is why we only used an annual update on their assessment processes.
  - We will review reports submitted to the state and we'll implement some new monitoring processes that we hope will meet that need.

- Finding 21: Category 4.3 Confidentiality: The Plan did not notify DHCS within 24 hours of a breach or HIPAA incident
    - This is an ongoing process of improvement for the Plan for education and training for all member facing departments that may receive a possible HIPAA incident or breach, and making sure that information gets to the Privacy Office so it can be reported within 24 hours of the time of discovery.
- Finding 22: Category 6.2 Fraud, Waste, and Abuse: The Plan does not have a regular method of reviewing services have been delivered by network providers or received by members
    - Currently services are reviewed through the Fraud, Wast FWA process and includes referrals from various departments throughout AAH, including Grievance and Appeals, Case Management, and Quality.
    - We also have a proactive way of reviewing services, which is through a vendor called Health Care Fraud Shield (HCFS). They review our claims data for outlier providers. We meet with HCFS monthly to review the outliers that have been identified and if needed, we will open cases to research them further.
    - This potential finding would involve adding additional processes. Aside from the methods that we currently use to review that services have been delivered by providers and received by members as billed. We are looking into process improvements which includes exploring options for more routine checks on PCP services for our members.
- Finding 23: Category 3.6 State Supported Services: The Plan did not distribute minimum payments for State Supported Services claims as described in APL 23-015
    - We have five (2) cases that the State was concerned about in terms of abortion services or state supported services that we had not paid the full Proposition 56 rate.
    - In all five (5) cases it was due to modifiers
        - In three (3) of those five (5) cases, the claims were facility claims with the UA modifier, which is not the actual abortion service, but the surgical trays that the facility provided for the service. In these cases, the claims for the abortion services we're paid under the correct rate, but under a different claim by the provider.
        - In the remaining two (2) cases, the claims that they were looking at were modifier fifty-one (51), which indicates multiple services and per medical guidelines those rates are to be reduced by at least 50%. In this case, we actually paid them their contracted rate, which was a little bit higher than the 50%. In any case, we paid the minimum required.

- Since we believe these payments were correct, we sent the information to DHCS. We will see if they remove this potential finding from the final findings they issue.

c. 2023 Focused Medical Survey – Preliminary Findings

- The discussion of the 2023 Focused Medical Survey Preliminary Findings will be tabled for the next Compliance Advisory Committee, in September, due to time.

b) MEDI-CAL PROGRAM UPDATES

- No Updates

7. COMPLIANCE ADVISORY COMMITTEE BUSINESS

a) None

8. STAFF UPDATES

a) None

9. UNFINISHED BUSINESS

a) None

10. STAFF ADVISORIES ON COMPLIANCE BUSINESS FOR FUTURE MEETINGS

a) None

11. ADJOURNMENT

Dr. Kelley Meade adjourned the meeting at 11:34 am.