MEDICAL REVIEW – SOUTHERN SECTION V
AUDITS AND INVESTIGATIONS
DEPARTMENT OF HEALTH CARE SERVICES

REPORT ON THE MEDICAL AUDIT OF

AIDS HEALTHCARE FOUNDATION
dba
POSITIVE HEALTHCARE CALIFORNIA

2022

Contract Number: 11-88286

Audit Period: January 1, 2021
Through
December 31, 2021

Dates of Audit: January 10, 2022
Through
January 21, 2022

Report Issued: July 14, 2022

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I. INTRODUCTION

AIDS Healthcare Foundation (AHF), founded in 1987, is a not-for-profit organization providing Human Immunodeficiency Virus (HIV) treatment. AHF dba Positive Healthcare California (Plan) provides specialty health care for Medi-Cal members in Los Angeles County.

The Plan was established in California in 1995, under Federal Waiver from the Department of Health and Human Services. The Department of Health Care Services (DHCS) entered into an agreement with the Plan in 2012. The Plan is the first Managed Care Program in the county for Medicaid members diagnosed with Acquired Immune Deficient Syndrome (AIDS). Effective July 1, 2019, the Plan transitioned into a full-risk Medi-Cal Managed Care plan in Los Angeles County. The Plan is a licensed Knox-Keene Health Care Service plan.

The Plan delivers care to eligible members who reside within their service area and are at least 21 years old with a diagnosis of stage three HIV infection.

The Plan provides health care services designed around the needs of people living with stage three HIV infection. The Plan has a comprehensive network of providers and offers the following contracted services: primary medical care (HIV specialists), specialty consultation, outpatient, radiology, laboratory, pharmaceutical, hospice, hospital inpatient and mental health. On July 1, 2019, hospice and hospital inpatient services were added to the Contract.

The Plan delivers services to members through delegated groups and vendors or subcontractors. The Plan has a network of eight delegated groups and several vendors or subcontractors.

As of December 31, 2021, the Plan had 685 members for its Medi-Cal line of business for the audit period under review.

II. EXECUTIVE SUMMARY

This report presents the findings of the DHCS medical audit for the period of January 1, 2021 through December 31, 2021. The review was conducted from January 10, 2022 through January 21, 2022. The audit consisted of document review, verification studies, and interviews with Plan representatives.

An Exit Conference with the Plan was held on June 14, 2022. The Plan was allowed 15 calendar days from the date of the Exit Conference to provide supplemental information addressing the draft audit report findings. On June 29, 2022 the Plan submitted a response. The results of our evaluation of the Plan's response are reflected in this report.

The audit evaluated five performance categories: Utilization Management (UM), Case Management and Coordination of Care, Access and Availability of Care, Members' Rights, Quality Management, and Administrative and Organizational Capacity.

The prior DHCS medical audit for the period of January 1, 2020 through December 31, 2020 was issued on June 11, 2021. This audit examined the Plan's compliance with its DHCS Contract. Documents submitted to DHCS in response to the prior year audit's Corrective Action Plan were reviewed.

The summary of the findings by category follows:

Category 1 – Utilization Management

Category 1 includes procedures and requirements for the Prior Authorization (PA) and appeal process.

The Plan's UM program is required to ensure it uses appropriate processes to review and approve the provision of medically necessary covered services and maintain a Medical Director whose responsibilities include ensuring that medical decisions are rendered by qualified medical personnel. The Plan did not ensure decisions were made by a qualified health care professional with appropriate clinical expertise in treating the condition and disease.

The Plan is required to comply with all current and applicable provisions of the Medi-Cal Provider Manual. The Plan did not ensure that its PA, concurrent review, and retrospective review included procedures to consider the requirements referenced in the Medi-Cal Provider Manual for coverage guidelines when making PA determinations.

The Plan shall ensure that reasons for decisions are clearly documented for PA, concurrent review**,** and retrospective reviews. The Plan did not clearly document reasons for its decisions on approved medical PAs. The Plan did not include any case notes, referenced guidelines or criteria, or insight into its medical decision making

process.

The Plan shall issue a Provider Manual regarding Medi-Cal services, including member rights information to file grievances and appeals and their requirements and timeframes for filing. The Plan did not include the timeframe of 60 calendar days from the date of the Notice of Action (NOA) for filing an appeal in the Provider Manual.

The Plan is required to maintain a system to ensure accountability for delegated quality improvement activities that at a minimum includes the continuous monitoring, evaluation and approval of the delegated functions. The Plan did not maintain a system to evaluate its delegate's functions. The Plan did not perform an annual audit of its delegate during the audit period.

Category 2 – Case Management and Coordination of Care

Category 2 includes procedures and requirements for substance abuse and alcohol treatment.

The Plan is required to maintain policies for identification, referral and coordination of care for members requiring alcohol or substance abuse treatment services. The Plan did not have policies and procedures for members requiring alcohol or substance abuse treatment services.

Category 3 – Access and Availability of Care

Category 3 includes procedures and requirements for the Non-Emergency Medical Transportation (NEMT), and Non–Medical Transportation (NMT).

The Plan is required to ensure its providers are enrolled in Medi-Cal or complete the emergency enrollment process through DHCS' Provider Enrollment Division (PED). The Plan did not ensure that 27 NEMT and two NMT providers in its network were enrolled in the Medi-Cal Program or had an emergency approval from PED.

Category 4 – Member's Rights

Category 4 includes procedures and requirements for the grievance process.

The Plan is required to resolve each grievance and provide notice to the member as quickly as the member's health condition requires, within 30 calendar days of receipt and notify the Member of the grievance resolution in a written member notice. The Plan did not resolve grievances within the 30 calendar days as required.

Category 5 – Quality Management

Category 5 includes procedures and requirements for the provider training process.

The Plan is required to conduct training for all providers within ten working days after the Plan places a newly contracted provider on active status. The Plan did not ensure new providers received training within the required timeframe.

Category 6 – Administrative and Organizational Capacity

Category 6 includes requirements to implement and maintain a health education system and compliance program.

The Plan is required to conduct, complete, and report the results of a preliminary investigation of suspected fraud or abuse to DHCS within ten working days of the date the Plan first becomes aware of such activity. The Plan did not report preliminary investigations of all suspected cases of fraud and abuse to DHCS within the required timeframe.

III. SCOPE/AUDIT PROCEDURES

SCOPE

The DHCS Medical Review Branch conducted the audit to ascertain that medical services provided to Plan members comply with federal and state laws, Medi-Cal regulations and guidelines, and the state Contract.

PROCEDURE

DHCS conducted the audit of the Plan from January 10, 2022 through January 21, 2022. The audit included a review of the Plan's Contract with DHCS, its policies for providing services, the procedures used to implement the policies, and verification studies of the implementation and effectiveness of the policies. DHCS reviewed the Plan's documents and interviewed the Plan's administrators and staff.

The following verification studies were conducted:

Category 1 – Utilization Management

Prior authorization requests: 30 PA (15 medical and 15 pharmacy) requests were reviewed for timeliness, consistent application of criteria, appropriateness of review, and communication of results to provider and members.

Category 3 – Access and Availability of Care

Emergency Services and Family Planning Claims: 20 emergency services claims were reviewed for appropriate and timely adjudication.

NEMT and NMT: 20 records were reviewed to confirm compliance with NEMT and NMT requirements.

Category 4 – Member's Rights

Grievance Procedures: 30 grievances including 15 Quality of Care (QOC), 15 Quality of Service (QOS), and three exempt were reviewed for timely resolutions, response to complainants, appropriate level of review and medical decision-making.

Category 5 – Quality Management

Potential Quality of Care Issues: One case was reviewed for reporting, investigation, and remediation.

Credentialing and Re-credentialing: Five newly contracted and five re-credentialed providers were reviewed for licensing and certification.

New Provider Training: 15 newly contracted providers were reviewed for timely Medi-Cal Managed Care Program training.

Category 6 – Administrative and Organizational Capacity

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

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

CATEGORY 1 - UTILIZATION MANAGEMENT

1.2	PRIOR AUTHORIZATION REVIEW

1.2.1 Pre-Authorizations and Review Procedures

The Plan's UM program is required to ensure it uses appropriate processes to review and approve the provision of medically necessary covered services. (*Contract, Exhibit A, Attachment 5(1)*)

Contractor shall ensure that its pre-authorization, concurrent review and retrospective review procedures meet the following minimum requirement: Decisions to deny or to authorize an amount, duration, or scope that is less than requested shall be made by a qualified health care professional with appropriate clinical expertise in treating the condition and disease.
(Contract, Exhibit A, Attachment 5(2)(D))

The Plan shall maintain a Medical Director whose responsibilities include ensuring that medical decisions are rendered by qualified medical personnel.
(Contract, Exhibit A, Attachment 1(6)(A)(1))

The *2021 Positive Healthcare California (PHC) Utilization Management (UM) Program Description* stated that "Authorization Coordinators submit authorization requests with clinical supportive documentation for review by the UM Registered Nurse (RN) or Medical Director" and that UM RNs approved authorization services but if cases did not meet utilization review criteria then it would be the responsibility of the Medical Director.

Finding: The Plan did not ensure decisions to deny or authorize were made by a qualified health care professional with appropriate clinical expertise in treating the condition and disease.

In the verification study of 12 approved medical PAs, two were completed by a Licensed Vocational Nurse (LVN), four were completed by a Medical Assistant (MA), and four were completed by an authorization coordinator or UM administrative assistant. The file review showed minimal documentation for decision-making and there were no notes from qualified medical personnel. Examples of approved cases included:

- Surgical implantation of a neurostimulator electrode array (a device used to relieve pain by sending low levels of electricity into the spine. Placement requires surgery that can take up to two hours with a recovery time of 4-6 weeks).

- Electromyography nerve conduction study (a test involving small needles placed through the skin and into the muscle).
- A hip injection (a procedure where a needle is inserted into the hip to deliver medicine directly into the joint space) administered by a chiropractor, which is not a covered benefit by the provisions of the Medi-Cal Provider Manual.

During the interview, the Plan stated that the PA process included initial review by the Authorization Coordinator and a UM nurse. The Plan stated that it used McKesson's InterQual evidence based clinical criteria as guidelines which were built into the system to assist with UM decisions, but if requests did not meet medical necessity or were high cost, they would be sent to the Medical Director for review.

Additional documentation of clinical notes, guidelines or patient specific instructions to these individuals for UM reviews was requested from the Plan. A list of PA services allowed to be approved by coordinators, LVNs, or RNs was also requested. However, the Plan was not able to provide documentation.

If UM determinations are not made by qualified health care professionals, substandard medical care and patient harm might result from unnecessary procedures being approved or from inappropriate denials of medical services.

Recommendation: Develop and implement policies and procedures to ensure qualified health professionals render medical review decisions.

1.2.2 Criteria Used for Medical Prior Authorization Review

The Plan shall comply with all current and applicable provisions of the Medi-Cal Provider Manual, unless the Medi-Cal Provider Manual conflicts with this Contract, All Plan Letters (APL), and/or any applicable federal or state laws, regulations, in which case the specific terms of this Contract, the APL, or the applicable law will apply. *(Contract Exhibit E, Attachment 2(1)(E))*

The Plan shall ensure that there is a set of written criteria or guidelines for Utilization Review that is based on sound medical evidence, is consistently applied, regularly reviewed, and updated.
(*Contract, Exhibit A, Attachment 5, Provision 2, Paragraph C)*

Plan policy No. *UM 22.2 Authorization Referral Process, (Revised 11/01/2021)*, stated that for authorizations or adverse determination of service requests that are based on medical necessity, InterQual Clinical Utilization Review Criteria and State and Federal coverage guidelines are used to determine medical necessity and appropriateness of the requested service.

Finding: The Plan did not comply with requirements referenced in the Medi-Cal Provider Manual when rendering PA determinations. It made decisions using alternate criteria only.

A verification study of medical PAs showed that five out 15 cases were determined using InterQual criteria only. Review of files showed the following:

- In two cases, which were requests for chiropractic services, the Plan approved the requests but based on Medi-Cal criteria and the Plan's Evidence of Coverage (EOC), chiropractic services were not a covered benefit for these specific individuals.
- In another case, a device for pain control requiring surgery was approved but did not demonstrate medical necessity and would have been denied by provisions of the Medi-Cal Provider Manual.
- In a case for a request for a powered wheelchair, the file did not have the physical therapy evaluation required for approval based on the Medi-Cal Provider Manual.

During the interview, the Plan stated that it utilized McKesson's InterQual evidence based clinical criteria as initial guidelines and it was built into their health plan authorization management system. The Plan confirmed that it did not use the Medi-Cal Manual to determine whether the services requested were Medi-Cal benefits.

If the Plan does not reference Medi-Cal criteria when making medical determinations, there is a risk that members will be inappropriately denied or approved services which could lead to over and under-utilization, as well as poor health outcomes.

Recommendation: Implement policies and procedures to ensure the Plan references the Medi-Cal Provider Manual as required.

1.2.3 Clear Documentation of Reasons for Medical Authorization Decisions

The Plan shall ensure that reasons for decisions are clearly documented for prior authorization, concurrent review**,** and retrospective reviews.
(Contract, Exhibit A, Attachment (5)(2)(C))

The Plan's *Utilization Review Process Flows* outlined the PA review. If approved, the physician entered case notes. If denied, the physician documented clinical rationale. After the physician review, it was sent to a reviewer who reviewed the case summary page and sent the notification letter to the member and requesting provider.

Finding: The Plan did not clearly document reasons for its decisions on approved medical PAs.

The Plan did not include any case notes, referenced guidelines or criteria, or insight into its medical decision making process. The verification study revealed that 11 out of 12 approved medical PAs did not include documentation of the reasons for medical decisions or case notes. The following were approved with no documentation:

- Surgical implantation of a neurostimulator electrode array (a device used to relieve pain by sending low levels of electricity into the spine. Placement requires surgery that can take up to two hours with a recovery time of four to six weeks)
- Electromyography nerve conduction study (a test involving small needles placed through the skin and into the muscle)
- Epidural injection (a procedure to alleviate pain where a needle is inserted into the back to deliver medicine into the space around the spinal cord).

The Plan did not have policies and procedures in place for PA decision making other than the *AHF Utilization Review Process Flow*. Review of the verification study revealed that the Plan did not follow its own process of entering case notes.

During the interview, the Plan stated that review is done by an authorization coordinator and nurse. The Plan further explained that since they are a small Plan they communicate regularly; however, upon request of additional clinical notes or guidelines in support of approved PA decisions the Plan was unable to provide documentation.

If reasons for medical decision making are not clearly documented, it is difficult to ensure that guidelines and criteria are being adhered to or that clinical rationale for decisions are correct which could lead to poor decision making, substandard care, and ultimately patient harm.

Recommendation: Develop and implement policies and procedures to ensure decisions are clearly documented.

1.3	APPEAL PROCEDURES

1.3.1 Appeal Timeframe Information for Providers

The Plan shall issue a provider manual to the contracting and subcontracting providers of healthcare services that includes information and updates regarding Medi-Cal services, policies and procedures, statutes, regulations, telephone access and special requirements, and the member grievance, appeal, and State Fair Hearing process. The provider manual shall include member rights information including member's right to file grievances and appeals and their requirements and timeframes for filing. *(Contract, Exhibit A, Attachment (7)(4)(B))*

Timeframes for filing appeals are delineated in the DHCS Contract, as well as in the federal law. Members must file an appeal within 60 calendar days from the date of the NOA. *(APL 21-011, Grievance and Appeal Requirements, Notice and "Your Rights" Templates (08/31/2021))*

Positive Healthcare (PHC) California Provider Manual (7/1/2018) stated "A Provider, on behalf of a member, may appeal a Utilization Management decision to deny or modify a requested service." It did not include the timeframe for filing an appeal.

Finding: The Plan did not include the timeframe of 60 calendar days from the date of the NOA for filing an appeal in the Provider Manual.

During the interview, the Plan could not explain how the omission of the timeframe occurred.

If the timeframe to request an appeal is not included in the Provider Manual, this may prevent providers from filing an appeal on the member's behalf in a timely manner and ultimately lead to members' inability to exercise their rights and receive timely medically necessary care.

Recommendation: Revise the Provider Manual to include the 60 calendar day timeframe to file an appeal.

1.5	DELEGATION OF UTILIZATION MANAGEMENT

1.5.1 Annual Oversight of a Delegated Entity

The Plan shall maintain a system to ensure accountability for delegated quality improvement activities that at a minimum includes the continuous monitoring, evaluation and approval of the delegated functions.
(*Contract, Exhibit A, Attachment 4(6)(B)(3)*)

Plan policy *No.UM 99.0 PHC-CA UM Vendor Delegation Oversight, (*Revised 12/3/2019) stated that delegated entities will be reviewed no less than annually*.* In addition, the Plan developed the *Delegation Oversight Evaluation Tool* and *Delegation Assessment Checklist* to assist them in evaluation of their delegates.

Plan's Delegation Agreement stated that the "Plan will oversee delegation by performing audits at least annually". The delegate provides health care services, including behavioral health, mental health, and substance abuse services.

Finding: The Plan did not maintain a system to evaluate its delegated functions. The Plan did not follow its procedures to perform an annual audit of its delegate during the audit period.

During the interview, the Plan stated that it had not conducted an annual delegation audit since entering into a Contract with its delegate in 2019. The Plan also stated that it did not implement the Delegate Oversight Evaluation Tool or the Delegation Assessment Checklist because they were re-evaluating the value of the current tool. The Plan stated that due to staffing issues they were unable to complete an annual delegation audit and had been focused on monitoring. The monitoring included communication through quarterly Joint Operational Meetings (JOM) and biweekly Inter-Collaborative Team (ICT) meetings.

Without evaluation, the Plan cannot ensure that its delegate is complying with standards set forth by contract requirements.

Recommendation: Implement policies and procedures to ensure annual oversight audits of delegate are conducted to ensure the delegate meets the standards set forth.

2.5.1 Alcohol or Substance Abuse Treatment

Plan is required to have policies and procedures for identification, referral and coordination of care for members requiring alcohol or substance abuse treatment services.
(Contract, Exhibit A, Attachment 18(11)(F))

Medi-Cal Managed Care Health Plans (MCP) must offer members with brief behavioral counseling interventions as specified by the Preventive Services Medi-Cal Provider Manual to reduce Alcohol Misuse. MCPs must also maintain policies and procedures to ensure that providers in primary care settings offer and document alcohol misuse screening services. MCPs are responsible for ensuring that their delegate and subcontractors comply with all the applicable state and federal laws and regulations, contract requirements and other DHCS guidance.
(APL 18-014, Alcohol Misuse, Screening and Behavioral Interventions in Primary Care (08/14/2018))

MCPs must provide Alcohol and Drug Screening, Assessment, Brief Interventions and Referral to Treatment (SABIRT) services for members 11 years of age and older including pregnant women. MCPs are responsible for ensuring that their delegate and subcontractors comply with all the applicable state and federal laws and regulations, contract requirements and other DHCS guidance. These requirements must be communicated by each MCPs to subcontractors and network providers.
(APL 21-014, Alcohol and Drug Screening, Assessment, Brief Interventions and Referral to Treatment (SABIRT) (10/11/2021))

Finding: The Plan does not have policies and procedures for identification, referral, and coordination of care for members requiring alcohol or substance abuse treatment services.

During the interview, the Plan disclosed that it delegates Behavioral Health Services to Magellan. The Plan provided two policies; however these policies did not directly address substance use and alcohol misuse. The Plan and its delegate acknowledged that there were no Substance Use Disorder (SUD) and alcohol misuse policies and procedures.

Without policies and procedures in place, members may not receive appropriate SUD and alcohol misuse services.

Recommendation: Develop and implement policies and procedures for identification, referral, and coordination of care for members requiring alcohol or substance abuse treatment services.

CATEGORY 3 – ACCESS AND AVAILABILITY OF CARE

3.8	NON-EMERGENCY MEDICAL TRANSPORTATION NON-MEDICALTRANSPORTATION

3.8.1 NEMT and NMT Provider Enrollment

The Plan is required to comply with all applicable provisions of the California Medicaid State Plan and any current and applicable amendments thereto. In addition, the Plan is required to comply with all existing final Policy Letters and APLs issued by DHCS. *(Contract, Exhibit E, Attachment 2(1)(C) & 2(1)(D))*

MCP network providers that have a state-level enrollment pathway must enroll in the Medi-Cal program. State-level enrollment pathways are available either through the DHCS PED or another state department with a recognized enrollment pathway. MCPs have the option to develop and implement a managed care provider screening and enrollment process that meets the requirements of this APL, or MCPs may direct their network providers to enroll through a state-level enrollment pathway. *(APL 19-004, Provider Credentialing/Re-credentialing and Screening/Enrollment (06/12/2019))*

Plan policy *No*. *CR 6: PHC-CA Provider Screening and Enrollment (Revised 09/24/2021)*, stated that the Plan maintains a provider screening and enrollment process designed to meet the requirements of DHCS and to ensure all Plan providers are enrolled in the Medi-Cal program.

Finding: The Plan did not ensure that contracted NEMT and NMT providers were enrolled in the Medi-Cal Program.

Review of a list of all vendors revealed that 29 (27 NEMT and two NMT) out of 121 vendors were not enrolled in the Medi-Cal program.

During the interview, the Plan explained that some transportation vendors choose not to enroll while others were still in the process of enrolling. The Plan has monthly informal meetings with their contracted vendor to monitor the enrollment of vendors into the Medi-Cal program. The Plan has a policy and procedure in place, however it was not fully implemented.

Medi-Cal members may be subject to substandard transportation services if a provider does not undergo the enrollment process to be eligible as a Medi-Cal provider.

This is a repeat of prior year finding **3.8.1. Medi-Cal Enrollment of NEMT and NMT Providers.**

Recommendation: Implement policy and procedures to monitor and ensure NEMT and NMT providers in the Plan's network are enrolled in the Medi-Cal program.

CATEGORY 4 – MEMBER'S RIGHTS

4.1	GRIEVANCE SYSTEM

4.1.1 Grievance Resolution

The Plan is required to provide a notice of resolution to the member as quickly as the member's health condition requires, within 30 days of receipt. The Plan shall notify the member of the resolution in a written member notice.
(Contract, Exhibit A, Attachment 14(1)(B))

Member grievances shall be resolved within 30 days of the member's submittal of a written grievance or if the grievance is made verbally, it shall be resolved within 30 days of the written record of the grievance.
(CCR, Title 22, section 53858(g)(1))

The state's established timeframe is 30 calendar days. MCP's must comply with the state's established timeframe of 30 calendar days for grievance resolution. Even though federal regulations allow for a 14-calendar day extension for standard and expedited appeals, this allowance does not apply to grievances.
(APL 21-011, Grievance and Appeal Requirements, Notice and "Your Rights" Templates (08/31/2021))

Plan Policy *No. RM7: PHC-CA Member Grievance Process (11/08/21)* stated that the Plan shall expeditiously notify members of decisions, but no more than 30 days after the receipt of the grievance. If the member requests an extension, or if there is a justified need for information and documentation in which a delay is in the best interest of the member, PHC may extend the 30 day timeframe up to an additional 14 days after immediately notifying the member in writing of the reasons for the delay.

Finding: The Plan did not resolve grievances within the required 30 calendar days.

The verification study identified that 24 out of 30 standard grievances, including 12 QOC and 12 QOS, were not resolved within the required timeframe. The verification study revealed that the Plan resolved grievances within 42 - 43 days.

During the interview the Plan attributed the delay in grievance resolutions due to delays in receiving replies from vendors, incomplete responses, or obtaining required medical documentation.

Delays in resolving grievances related to clinical or QOC issues could adversely impact member health outcomes.

Recommendation: Revise and implement policy and procedures to be consistent with APL requirements and ensure grievance resolutions are sent to members within the required timeframe.

❖ COMPLIANCE AUDIT FINDINGS (CAF) ❖
PLAN: AIDS Healthcare Foundation dba Positive Healthcare California
AUDIT PERIOD: January 1, 2021 through December 31, 2021 **DATE OF AUDIT: January 10, 2022 through January 21, 2022**

CATEGORY 5 – QUALITY MANAGEMENT

5.3	PROVIDER QUALIFICATIONS – PROVIDER TRAINING

5.3.1 New Provider Training

The Plan shall conduct training for all network providers within ten working days after the Contractor places a newly contracted network provider on active status. *(Contract, Exhibit A, Attachment 7(5)(A))*

Plan policy *No. PR 3: PHC-CA Provider Training and Education (Revised 11/11/2021),* stated the Plan shall provide orientations for new providers within ten working days of Contract activation status.

Finding: The Plan did not ensure new providers received training within ten business days after placing the contracted providers on active status. The Plan did not define the active status date in its policies and procedures.

The verification study identified four providers that did not receive the training within the required timeframe and three providers without evidence of training completion.

The Plan did not maintain proper record keeping of provider training log to ensure new providers completed the required training.

Without ensuring the proper training, new providers will be unaware of covered services and requirements of the Medi-Cal program.

Recommendation: Update Plan policy to define the active status date and develop a process to ensure all providers receive training within ten working days.

6.2	FRAUD AND ABUSE

6.2.1 Fraud and Abuse Reporting

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

Plan policy *CO 400: Standard Operating Procedure (SOP) (Revised 09/27/2019),* stated the Plan shall report to DHCS all cases of suspected fraud, and/or abuse has occurred by subcontractors, members, providers, or employees. The Plan shall conduct, complete, and report to DHCS the results of a preliminary investigation of the suspected fraud and/or abuse within ten working days of the date that the Plan first becomes aware of such activity.

Finding: The Plan did not report preliminary investigations of suspected cases of fraud and abuse to DHCS within ten working days.

During the provider training review the Plan discovered that an employee participated in unethical behavior forging orientation dates to appear in compliance with Contract requirements. This issue was discovered during the Plan's internal review which caused a delay in provider training log and verification study files. The Plan conducted an investigation and the employee was terminated; however the incident was not reported to DHCS.

If the Plan does not conduct prompt investigations of suspected incidents, it could delay the detection and later prevention of actual fraud, waste, and abuse.

Recommendation: Implement policies and procedures to ensure preliminary investigations of suspected cases of fraud and abuse are reported within the required timeframe.