DEPARTMENT OF HEALTH CARE SERVICES
AUDITS AND INVESTIGATIONS
CONTRACT AND ENROLLMENT REVIEW DIVISION
LOS ANGELES SECTION

REPORT ON THE MEDICAL AUDIT OF

AIDS HEALTHCARE FOUNDATION DBA POSITIVE HEALTHCARE CALIFORNIA

2023

Contract Number:	11-88286
Audit Period:	October 1, 2022 through September 30, 2023
Dates of Audit:	November 27, 2023 through December 8, 2023
Report Issued:	April 11, 2024

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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 a 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 Immunodeficiency 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 areas and are at least 21 years old.

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, 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 a delegated group and vendors or subcontractors.

The Plan is not accredited by the National Committee of Quality Assurance for the Medi-Cal line of business.

As of September 1, 2023, the Plan had a total of 798 members as follows: 553 Medi-Cal and 245 Dual Special Needs Plan members.

II. EXECUTIVE SUMMARY

This report presents the findings of the DHCS medical audit for the period of October 1, 2022, through September 30, 2023. The review was conducted from November 27, 2023, through December 8, 2023. The audit consisted of document review, verification studies, and interviews with the Plan representatives.

An Exit Conference with the Plan was held on March 12, 2024. 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 March 28, 2024, the Plan submitted a response after the Exit Conference. The results of our evaluation of the Plan's response are reflected in this report.

The audit evaluated six 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, 2022, through September 30, 2022, was issued on March 23, 2023. The deficiencies identified in the audit report issued on July 14, 2022, and the implementation of the Corrective Action Plan were reviewed.

Findings denoted as repeat findings are uncorrected deficiencies substantially similar to those identified in the previous audit.

The summary of the findings by category is as follows:

Category 1 – Utilization Management

The Plan is required to have a set of written criteria or guidelines for utilization review that is based on sound medical evidence, is consistently applied, regularly reviewed, and updated, and reasons for decisions are clearly documented. The Plan did not clearly document guidelines or criteria used for prior authorization determinations.

The Plan is required to have policies and procedures to ensure decisions are based on the medical necessity of proposed health care services and are consistent with criteria or guidelines that are supported by clinical principles and processes. The Plan did not ensure that prior authorization determinations were based on medical necessity.

The Plan is required to notify members of a decision to deny, delay, or modify requests for prior authorization by providing a Notice of Action (NOA) to members and/or their authorized representative. The Plan did not notify members in writing of decisions to deny prior authorization requests.

Prior authorization requirements shall not be applied to emergency services, family planning services, preventive services, basic prenatal care, sexually transmitted disease services, and HIV testing. The Plan incorrectly applied prior authorization requirements to preventive services.

Category 2 – Case Management and Coordination of Care

The Plan is required to provide services to all members related to Mental Health and Substance Use Disorder (SUD). When a member's screening is positive, validated assessment tools should be used to determine if unhealthy alcohol use or SUD is present. In addition, brief interventions must include providing feedback to the member regarding screening and assessment results and discussing negative consequences that have occurred and the overall severity of the problem. The Plan utilized incomplete validated assessment tools for members with positive SUD screening results.

The Plan is required to coordinate care with the county Mental Health Plan (MHP) to deliver mental health care services to members. The Plan did not ensure the provision of coordination of care with Los Angeles County Department of Mental Health (LACDMH) in the delivery of Specialty Mental Health Services (SMHS) to members.

Category 3 – Access and Availability of Care

The Plan is required to ensure that the member must have an approved Physician Certification Statement (PCS) form authorizing Non-Emergency Medical Transportation (NEMT) by the provider. The Plan did not ensure PCS forms were approved before services were rendered.

The Plan and all subcontractors are required to maintain all the books, records, and documents for a minimum of ten years. The Plan did not maintain records for Non-Medical Transportation (NMT) services provided to members.

Category 4 – Member's Rights

The written record of grievances is required to be reviewed periodically by the Governing Body of the Plan, the Public Policy Body, and by an officer of the Plan or designee. The Plan did not ensure the Governing Body periodically reviewed the written record of grievances.

Category 5 – Quality Management

The Quality Improvement Committee (QIC) is required to meet at least quarterly but as frequently as necessary to demonstrate follow-up on all findings and required actions. The Plan did not ensure its Quality Management Committee (QMC) met at least quarterly in accordance with the Contract requirements.

Category 6 – Administrative and Organizational Capacity

Member encounter data must provide for the collection and maintenance of sufficient member encounter data to identify the provider who delivers any items or services to members. The Plan did not ensure that rendering provider information in submitted encounter data was accurate and complete.

III. SCOPE/AUDIT PROCEDURES

SCOPE

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

PROCEDURE

The audit was conducted from November 27, 2023, through December 8, 2023. 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 those policies. Documents were reviewed and interviews were conducted with the Plan administrators and staff.

The following verification studies were conducted:

Category 1 – Utilization Management

Prior Authorizations: A total of 34 medical authorizations, which included two concurrent and 32 denied and approved requests, were reviewed for timeliness, consistent application of criteria, appropriate review, and communication of results to providers and members. There was no retrospective, modified, expedited, or delegated requests.

Appeal Procedures: The Plan did not have any medical appeals for review for appropriateness and timeliness of decision making.

Category 2 – Case Management and Coordination of Care

Mental Health and SUD: 19 records were reviewed for appropriateness, completeness and timeliness of services provided.

Category 3 – Access and Availability of Care

NEMT and NMT: 20 records (ten NEMT and ten NMT) were reviewed to confirm compliance with transportation requirements for timeliness.

Category 4 – Member's Rights

Grievance Procedures: A total of 31 standard grievances (11 quality of care and 20 quality of service) were reviewed for timely resolution, response to complainant, and submission to the appropriate level for review. During the audit period, the Plan did not have exempt nor expedited grievances. In addition, 20 call inquiry logs were reviewed.

Category 5 – Quality Management

Potential Quality Issues: The Plan had two records which were reviewed to determine if effective action was taken to address needed improvement.

Category 6 – Administrative and Organizational Capacity

Encounter Data Review: Ten records were reviewed to verify the Plan's claims process and supporting documentation.

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

❖ COMPLIANCE AUDIT FINDINGS ❖

PLAN: AIDS Healthcare Foundation dba Positive Healthcare California

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CATEGORY 1 - UTILIZATION MANAGEMENT

1.2	PRIOR AUTHORIZATION REVIEW REQUIREMENTS

1.2.1. Documentation of Reasons for Medical Decisions

The Plan is required to ensure that its prior authorization, concurrent review**,** and retrospective review procedures meet the following minimum requirements: 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; Reasons for decisions are clearly documented. *(Contract, Exhibit A, Attachment 5, Provision 2C and 2D)*

Plan policy and procedure, UM 35.3 *PHC-CA Clinical Criteria and Guidelines,* (revised 07/22/2022), stated the following procedure: The Plan shall document utilization review criteria and guidelines utilized for organizational determinations providing clear rationale for denials that cite criteria.

Plan Standard Operating Procedure (SOP), 502.0 *AHF Second Level and Medical Director Review*, (revised 09/01/2022), stated that staff are to document criteria utilized to make determination when referring cases either to a Registered Nurse or the Medical Director for review.

Finding: The Plan did not clearly document guidelines or criteria used for prior authorization determinations.

A verification study of 34 prior authorization cases revealed that 20 cases had no documentation of the guidelines or criteria used to approve the requests. The Plan did not clearly document reasons for decisions on approved medical prior authorizations and did not include any referenced guidelines, criteria, or other insight into its medical decision-making process in its prior authorization case files.

The Plan, pursuant to its prior year Corrective Action Plan, updated its policy and procedure, *Clinical Criteria and Guidelines*; however, this procedure did not address documenting the rationale for decisions that are other than denials. In addition, SOP, *AHF Second Level and Medical Director Review* did not address documenting the reason for the decision on requests that can be approved by an authorization coordinator.

During the interview, the Plan stated that the criteria for the decision in these cases were not documented due to the staff not following policies and procedures despite training. Also, there appears to be a lack of monitoring of staff compliance with UM requirements.

This is a repeat of the prior year finding 1.2.3 Clear Documentation of Reasons for Medical Authorization Decisions.

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

Recommendation: Develop and implement policies and procedures to ensure the staff clearly documents reasons for all prior authorization decisions.

1.2.2. Authorization Decisions Based on Medical Necessity

The Plan is required to ensure that policies and procedures for authorization decisions are based on the Medical Necessity of a requested health care service and are consistent with criteria or guidelines supported by sound clinical principles. *(Contract, Exhibit A, Attachment 5, (1)(I)(1))*

The Plan is required to have written policies and procedures establishing the process by which the Plan reviews and approves, modifies, delays, or denies, based in whole or in part on medical necessity, requests of health care services. These policies and procedures shall ensure that decisions based on the medical necessity of proposed health care services are consistent with criteria or guidelines that are supported by clinical principles and processes. *(Health and Safety (H&S) code, section 1367.01b)*

Plan policy and procedure, UM 22.7 *PHC-CA Authorization Referral Process,* (revised 10/20/2023), stated that requested health care services may be approved by UM staff who are not qualified health care professionals only when: the UM staff is under the supervision of an appropriately licensed health professional; there are explicit UM criteria; and no clinical judgement is required.

The Plan's SOP, 502.0.0 *AHF Second Level and Medical Director Review,* (revised 09/01/2022), stated the categories of services that a first level non-clinician reviewer may approve include diagnostic services such as magnetic resonance imaging and

computed tomography scans, cardiac testing, sleep studies, or durable medical equipment under $500.

Finding: The Plan did not ensure that prior authorization determinations were based on medical necessity.

The Plan's SOP, 502.0 *AHF Second Level and Medical Director Review*, allows for non-clinicians to approve services without any documentation of medical necessity. The SOP stated that the categories of services that a first level non-clinician reviewer may approve include diagnostic services such as magnetic resonance imaging and computed tomography scans, cardiac testing, sleep studies, or durable medical equipment under $500. However, there were no associated requirements for approval, such as diagnosis code or other clinical information that would demonstrate the medical necessity for the requested service.

In a verification study, three of 34 prior authorization cases indicated that services were approved without clinical documentation to support medical necessity.

In an interview, the Plan confirmed that non-clinicians may approve services in accordance with SOP, 502.0 *AHF Second Level and Medical Director Review,* without any requirements for clinical documentation or any corresponding diagnosis codes. Furthermore, the Plan's Medical Director acknowledged that there is no medical necessity review done at the first level review for authorization determinations. If these cases are approved there is no additional review.

Without ensuring medical necessity is met for approved procedures, the risks of patient harm and fraud, waste, or abuse are increased.

Recommendation: Develop and implement policies and procedures to ensure that prior authorization determinations including approvals are based on medical necessity.

1.2.3. Written Notification of Prior Authorization Decisions

The Plan is required to notify members of a decision to deny, delay, or modify requests for prior authorization, in accordance with the Code of Federal Regulations (CFR), Title 42, section 438.210(c) and California Code of Regulations (CCR), Title 22, sections 51014.1 and 53894 by providing a Notice of Action (NOA) to Members and/or their authorized representative, regarding any denial, delay or modification of a request for approval to provide a health care service. (*Contract, Exhibit A, Attachment 13 (7) (A))*

The Plan's records, including any NOA, shall meet the retention requirements described in Exhibit E, Attachment 2, Provision 20, Audit. *(Contract, Exhibit A, Attachment 5 (2)(I))*

Responses regarding decisions to deny, delay, or modify health care services requested by providers prior to, retrospectively, or concurrent with the provision of health care services to members shall be communicated to the member in writing, and to providers initially by telephone or facsimile, except with regard to decisions rendered retrospectively, and then in writing, and shall include a clear and concise explanation of the reasons for the Plan's decision, a description of the criteria or guidelines used, and the clinical reasons for the decisions regarding medical necessity. (*H&S code, section 1367.01(h)(4))*

Plan policy and procedure, UM 22.7 *PHC-CA Authorization Referral Process,* (revised 10/20/2023), stated that the UM Department communicates decisions to modify, delay or deny health care services (adverse determinations) to members in writing, and to providers initially by telephone or facsimile, except regarding decisions rendered retrospectively, and then in writing. In addition, it includes a clear and concise explanation of the reasons for the decision, a description of the criteria or guidelines used, and the clinical reasons for the decisions regarding medical necessity. The appropriate DHCS-standardized NOA template, accompanied by the DHCS-standardized NOA "Your Rights" template, is utilized for this communication.

Finding: The Plan did not notify members in writing of decisions to deny prior authorization requests.

A verification study showed that in three of six denied prior authorization requests, the Plan did not send members written notices to inform them of the denials.

Plan policy and procedure, *Authorization Referral Process* was not consistently followed by staff during the audit period.

During the interview, the Plan acknowledged that there was a defect in its eQSuite software system that prevented the generation of NOA letters for administrative denials, such as in cases where the denial was due to lack of medical information. In another case, the Plan confirmed that the NOA letter had been voided and could not be retrieved from the system. Despite a request during the interview, the Plan was unable to provide evidence that the NOA letter was sent to the member to inform them of their appeal and state fair hearing rights.

If the Plan does not notify members in writing of decisions to deny prior authorization requests, this can lead to adverse health effects since members will not receive

information on their right to appeal for a reconsideration of covered and medically necessary services.

Recommendation: Implement policies and procedures to ensure that the Plan notifies members in writing of decisions to deny prior authorization requests.

1.2.4. Prior Authorization for Preventive Services

Prior authorization requirements shall not be applied to emergency services, family planning services, preventive services, basic prenatal care, sexually transmitted disease services, and human immunodeficiency virus (HIV) testing. *(Contract, Exhibit A, Attachment 5(2)(H))*

Plan policy and procedure, UM 21.3 *PHC-CA Access to Self-Referred Covered Services,* (revised 10/05/2023), listed covered services available to members without prior authorization, including primary care visits and urgent or emergency care services.

Plan policy and procedure, CM 44.2 *PHC-CA Adult Preventive Services,* (revised 03/23/2023), stated that members are to receive preventive services identified as United States Preventive Services Task Force "A" and "B" recommendations in accordance with their individual risk factors.

Finding: The Plan incorrectly applied prior authorization requirements to preventive services.

During the audit period, the Plan applied prior authorization requirements for preventive services such as low dose computed tomography scans for lung cancer screening and colonoscopies for colon cancer screenings. A verification study identified five out of 34 files where prior authorization was incorrectly applied to preventive cancer screening services.

A review of the Plan policies and Provider Manual showed no information stating that preventive care is exempt from prior authorization. Plan policy and procedure, *Access to Self-Referred Covered Services* did not include preventive services in this policy. In addition, the Plan policy and procedure for *Adult Preventive Services* did not state that these services are exempt from prior authorization requirements. Similarly, the Plan's 2018 and 2024 Provider Manuals did not include preventive services in the list of services exempt from prior authorization.

During the interview, the Plan stated that preventive services did not require prior authorization and that the Plan has a form letter to notify when a service does not require prior authorization. However, the verification study files showed that the notification letters for preventive services did not indicate an exemption from prior authorization. Instead, they indicated the application of prior authorization procedures and formal approval.

When prior authorization is required for preventive services, it may create a barrier for members to obtain necessary screenings in a timely manner, potentially delaying appropriate medical diagnosis and treatment.

Recommendation: Revise and implement policies and procedures to ensure that the Plan does not apply prior authorization to preventive services.

CATEGORY 2 – CASE MANAGEMENT AND COORDINATION OF CARE

2.5	MENTAL HEALTH AND SUBSTANCE USE DISORDER

2.5.1 Alcohol and Substance Use Disorder Validated Assessment Tools for Positive Screening

The Plan is required to provide services to all members related to Mental Health and Substance Use Disorder (SUD). *(Contract Exhibit A, Attachment 10, provision 6 D)*

When a screening is positive, validated assessment tools should be used to determine if unhealthy alcohol use or SUD is present. Validated alcohol and drug assessment tools may be used without first using validated screening tools. Validated assessment tools include, but are not limited to:

- National Institute on Drug Abuse-Modified Alcohol, Smoking and Substance Involvement Screening Test
- Drug Abuse Screening Test 20
- Alcohol Use Disorders Identification Test

For members with brief assessments that reveal unhealthy alcohol use, brief misuse counseling should be offered. Appropriate referral for additional evaluation and treatment, including medications for addiction treatment, must be offered to members whose brief assessment demonstrates probable Alcohol Use Disorder or SUD. *(All Plan Letter (APL) 21-014, Alcohol and Drug Screening, Assessment, Brief Interventions and Referral to Treatmen*t)

Plan policy and procedure, UM 34.6 V *PHC-CA Substance Use Disorder Treatment Services,* (revised 10/13/23), stated the following:

- When a screening is positive, validated assessment tools such as Drug Abuse Screening Tool and Alcohol Use Disorders Identification Test should be used to determine if a SUD is present.
- When a screening is positive, validated assessment tools should be used to determine if unhealthy alcohol use or SUD is present.
- The Plan provides appropriate referrals for additional evaluation and treatment.
- Also, the Plan provides brief interventions, which include: Providing feedback to the member regarding screening and assessment results; Discuss consequences which may have occurred due to substance use and the overall severity of the problem; Assess members for readiness to change or

motivation to engage in treatment services, if appropriate.

Finding: The Plan utilized incomplete validated assessment tools for members with positive SUD screening results.

The Plan has a *Specialty Mental Health Services* (*SMHS), Non-Specialty Mental Health Services (NSMHS), and Substance Use Disorder Services (SUDS) End-to-End Care Management Workflow* that outlined the intake and screening for alcohol and SUD. The Assessment process reflected in the workflow required the following: Registered Nurse Case Team Manager (RNCTM) to complete the Health Risk Assessment Tool, Patient Health Questionnaire (PHQ)-2 and PHQ-9. Then, the member is referred to appropriate Behavioral Health Services (Delegated group or Department of Mental Health (DMH)). The validation process requires RNCTM to confirm that the member is receiving behavioral health services and is engaged in care. However, this workflow did not incorporate a process for conducting a validated assessment and brief intervention procedure for members who were screened positive for alcohol use or SUD.

A review of verification files revealed five out of 19 samples indicated that members were screened with positive SUD using the Cut, Annoyed, Guilty and Eye AID Screening Tool included in the Health Risk Assessment (HRA). There were incomplete validated assessments for members with positive SUD screening during the audit period. A review of the Plan documentation and verification files indicated that the Plan's procedures were deficient in determining unhealthy alcohol use or SUD.

During the interview, the Plan staff stated that alcohol and SUD screening are embedded in the HRA and its procedure is to screen during the HRA within 45 days, annually, and if required it can be repeated. A review of the HRA and Alcohol Use Disorder Identification Test C+2 tools contained incomplete validated assessment questionnaires.

When the Plan utilizes incomplete validated assessment tools for members with a positive screening result, it may lead to missed opportunities to engage members in treatment services.

Recommendation: Implement policies and procedures to ensure the Plan utilizes complete validated assessment tools for members with positive alcohol and SUD screening.

2.5.2 Care Coordination

The Contract stated the Memorandum of Understanding (MOU) is required to specify, the respective responsibilities of the Plan and the MHP in delivering Medically Necessary Covered Services and Specialty Mental Health Services (SMHS) to members. The MOU shall address protocols for the delivery of SMHS, including the MHP's provision of clinical consultation to the Plan for members being treated by the Plan for mental illness; Protocols and procedures for the exchange of medical records information, including procedures for maintaining the confidentiality of medical records. *(Contract Exhibit A, Attachment 12*, Provision 3A)

The Plan and county MHPs must implement procedures to deliver care and coordinate services for all members. *(CFR, Title 42, section 438.208(b))*

The Plan is required to coordinate with MHPs to facilitate care transitions and guide referrals for members receiving NSMHS to transition to an SMHS provider and vice versa, ensuring that the referral loop is closed and the new provider accepts the care of the member. Such decisions should be made via a member centered shared decision-making process. *(APL 22-005, No Wrong Door for Mental Health Services Policy)*

The MOU section related to coordination of care stated the Plans are required to provide medical case management and cover and pay for all medically necessary Medi-Cal covered physical health care services for a member receiving SMHS. The Plan is required to coordinate care with the MHP. *(APL 22-006, Medi-Cal Managed Care Health Plan Responsibilities for Non-Specialty Mental Health Services)*

The MOU between the Plan and LACDMH, (effective 07/01/2019), contained a description of the coordination of care and collaboration agreements as noted in, but are not limited to the following:

- An Interdisciplinary Team will be assigned to coordinate a member's care when necessary, as determined by mutually agreed upon protocols.
- There will be a facilitation of continuity of care, including shared treatment plans for members receiving both the Plan and the MHP's mental health services.
- Both parties will have assigned staff available to each other during their hours of operation.

Plan policy and procedure, CM 97.2 *PHC-CA Exchange of information with the LACDMH to Facilitate Care Coordination of Mental Health and Substance Use Disorder Treatment,* (revised 08/31/2023), stated the Plan shall maintain a process for members to access all Non-Specialty Mental Health and Substance Use Disorder covered

services, including coordinated care for all SMHS and SUD services and provide referrals including mechanisms to track completion of follow up visits, to the county MHP. In addition, the Plan shall ensure care coordination with LACDMH as follows: To carry out the provision of all medically necessary covered services; When the Plan is determined to be responsible for covered BHS, the Plan shall initiate, provide, and maintain ongoing care coordination as mutually agreed upon in the MOU with the LACDMH; Transition of care is provided for members transiting to or from the Plan or LACDMH.

Finding: The Plan did not ensure the provision of coordination of care with LACDMH in the delivery of SMHS to members.

The Plan did not implement its policies and procedures for the provision of coordination of care to deliver SMHS to members, including the implementation of MOU elements. The Plan did not furnish:

- Documentary evidence showing that after referring a member for SMHS, the Plan reaches out to the LACDMH or accepts and monitors the LACDMH's reports.
- Documentary evidence showing compliance with MOU components such as: coordination of care between the Plan and LACDMH.

Plan policy and procedure, *PHC-CA Exchange of information with the LACDMH to Facilitate Care Coordination of Mental Health and Substance Use Disorder Treatment* for coordination of care between the Plan and the LACDMH was not implemented. In addition, no communication occurred between the LACDMH and the care coordination team for members who were referred by the Plan to LACDMH or members who directly self-referred to LACDMH during audit period.

In an interview, the Plan stated that it notifies members to self-refer to the LACDMH to obtain SMHS. In addition, the last member communication the Plan had with LACDMH staff was in December 2022, and it did not have an assigned staff from LACDMH to communicate members' care.

When the Plan does not ensure the provision of coordination of SMHS to members, this may lead to delayed or missed mental health services resulting in poor mental health outcomes.

Recommendation: Implement policies and procedures to ensure the Plan and LACDMH are coordinating SMHS to members.

CATEGORY 3 – ACCESS AND AVAILABILITY OF CARE

3.8	NON-EMERGENCY MEDICAL TRANSPORTATION NON-MEDICALTRANSPORTATION

3.8.1 Physician Certified Statement

The Plan is required to comply with all existing final Policy Letters and APLs issued by DHCS. *(Contract Exhibit E, Attachment 2)*

The Plan is required to ensure that the member must have an approved PCS form authorizing NEMT by the provider. For Medi-Cal managed care health plan (MCP) covered services requiring recurring appointments, MCPs must provide authorization for NEMT for the duration of the recurring appointments, not to exceed 12 months. (*APL 22-008, Non-Emergency Medical and Non-Medical Transportation Services and Related Travel Expenses)*

Plan policy and procedure, CM 43.7 *PHC-CA Transportation Benefit,* (revised 06/29/2023), stated the Plan must have a completed and executed PCS form on file for all NEMT services that require prior authorization. The members must have an approved PCS form authorizing NEMT by the provider. The PCS form must be completed by the provider requesting NEMT services for the member.

Finding: The Plan did not ensure PCS forms were approved before NEMT services were rendered.

The Plan did not consistently apply its policy, *PHC-CA Transportation Benefit* requiring completed PCS forms before rendering NEMT services. A review of verification study cases revealed that in two out of ten NEMT sampled, the PCS forms were completed after services were rendered. In one case, the service date was March 13, 2023, while the PCS form certified the period from March 15, 2023, two days after the NEMT service was provided. In another case, the service date was March 17, 2023, while the PCS form was incomplete and signed on November 16, 2023.

During the interview, the Plan stated that the Member Services Department did not ensure the PCS forms were on file before allowing for the scheduling of NEMT services. Additionally, the UM Department, did not verify PCS forms, maintain a PCS Form

Tracker, and follow the Plan's policies and procedures of quarterly submission of PCS Form Tracker reports to the UM Committee for monitoring purposes.

After the interview, the Plan's Member Services Department resubmitted an NEMT log that included a column indicating the PCS form verification status. This highlighted that several provided NEMT services were missing PCS forms. The UM Department explained that the failure to obtain and verify PCS forms for the sampled cases was due to the physician's limited availability and the Member Services Department's leadership change.

Without obtaining PCS forms before providing NEMT trips, the Plan cannot determine the appropriate level of service for Medi-Cal members.

Recommendation: Implement policies and procedures to ensure PCS forms are approved before the NEMT services are rendered to the member.

3.8.2 Maintaining NMT Service Records

The Plan and all subcontractors are required to maintain all of the books, records, and documents for a minimum of ten years from the final date of the Contract period or from the date of completion of any audit, whichever is later. *(Exhibit E, Attachment 2, provision 20B)*

The Plan and subcontractor must retain and are required to retain the data, information, and documentation for a period of no less than ten years. (*CFR, Title 42, section 438.416)*

Plan policy and procedure, CM 43.7 *PHC-CA Transportation Benefit,* (revised 06/29/2023), stated if an NMT request comes through Member Services, the Transportation Coordinator verifies the member to be going to or returning home from a medical appointment, medical facility, pharmacy, etc., that will render or has rendered a Medi-Cal covered service.

The Plan's documentation and monitoring process noted in *Workflows for NEMT and NMT Services* stated that all relevant information, including member and service details, is recorded in NEMT logs by the Member Services Transportation Coordinator. The Director of Member Services and their designee (Supervisor, Manager of Member Services) monitor the log for completion, and logs are maintained and monitored to ensure compliance.

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Finding: The Plan did not maintain records for NMT services provided to members.

A review of two out of ten NMT verification study files indicated that the Plan was missing records to support the existence and accuracy of services provided. For the two sampled files, the NMT log indicated that trips were completed by the Plan; however, there were no call documentation or invoices available to support that these trips were rendered.

A review of the policy and procedure, *PHC-CA Transportation Benefit* indicated that the Plan's Member Services Department is mandated to maintain detailed records of all transportation services, including trip status, dates, service type, and any related information, for documentation and reporting purposes; however, review of verification files indicated that procedures were not followed by the staff as there were two missing records.

During the interview, the Plan confirmed that for the two sampled files, NMT services were provided, and payments were made to the contracted provider. The Plan acknowledged that it did not maintain records and documents for these trips due to entry errors.

The absence of documentation may hinder DHCS from verifying the validity of services rendered to the member.

Recommendation: Implement policies and procedures to ensure NMT records are maintained for services provided to members.

CATEGORY 4 – MEMBER'S RIGHTS

4.1	GRIEVANCE SYSTEM

4.1.1 Grievance Records Oversight

The Plan is required to implement and maintain procedures for grievances and the expedited review of grievances required under CFR, Title 42, sections 438.402, 406, and 408, CCR, Title 28, sections 1300.68 and 1300.68.01, and CCR, Title 22, section 53858. *(Contract, Exhibit A, Attachment 14(2))*

The Grievance and Appeal System is required to operate in accordance with all applicable federal regulations, state laws, and state regulations. The Plan must maintain a written record for each grievance and appeal received by the Plan. The record of each grievance and appeal must be maintained in a log with information such as a description of the complaint or problem and action taken to investigate and resolve the grievance or appeal. The written record of grievances and appeals is required to be reviewed periodically by the Governing Body of the Plan, the Public Policy Body, and by an officer of the Plan or designee. The review is required to be thoroughly documented. *(APL 21-011, Grievance and Appeal Requirements, Notice and "Your Rights" Templates)*

A written record shall be made for each grievance received by the Plan, including the date received, the Plan representative recording the grievance, a summary or other document describing the grievance, and its disposition. The written record of grievances shall be reviewed periodically by the Governing Body of the Plan, the Public Policy Body created pursuant to CCR, Title 28, section 1300.69, and by an officer of the Plan or his designee. This review shall be thoroughly documented. *(CCR, Title 28, section 1300.68 (b)(5))*

Plan policy and procedure, RM 7.4 *PHC-CA Enrollee Grievance Process,* (revised 09/13/2023), stated a written record is maintained for each grievance. Grievance documentation captures all the elements required to be reported in accordance with state and federal reporting requirements. The monitoring section stated that grievance data are submitted periodically to the Executive Oversight Committee (EOC) for review and to the Pubic Policy Body.

Finding: The Plan did not ensure the Governing Body periodically reviewed the written record of grievances.

The Plan's Governing Body delegates it functions to the EOC.

Plan policy and procedure, *PHC-CA Enrollee Grievance Process* did not address presenting of the written record of grievances to the EOC for review.

A review of committee meeting minutes indicated that the Plan did not have documentation to support that the EOC conducted a review of the written records of grievances. The Plan did not ensure that committees followed the APL requirements and policies and procedures.

During the interview, the Plan acknowledged that the EOC did not review the written record of grievances during the audit period due to the oversight of the staff.

When the Plan's Governing Body or EOC does not periodically review the written record of grievances, this may result in the Plan's inability to make timely interventions to remedy problems identified and provide quality of care and services to members.

Recommendation: Implement policies and procedures to ensure that the Governing Body periodically reviews the written record of grievances.

❖ COMPLIANCE AUDIT FINDINGS ❖
PLAN: AIDS Healthcare Foundation dba Positive Healthcare California
AUDIT PERIOD: October 1, 2022, through September 30, 2023 **DATES OF AUDIT: November 27, 2023, through December 8, 2023**

CATEGORY 5 – QUALITY MANAGEMENT

5.1	QUALITY IMPROVEMENT SYSTEM

5.1.1. Quality Management Committee

The Quality Improvement Committee (QIC) is required to meet at least quarterly but as frequently as necessary to demonstrate follow-up on all findings and required actions. *(Contract, Exhibit A, Attachment 4 (4) (B))*

Plan policy and procedure, QM 1.4 *PHC-CA Quality Improvement Program,* (revised 10/27/2023), stated that, at the very minimum, the QMC meets on a quarterly basis (The QMC functions as the Plan's QIC). The QMC reviews highlights of the quality improvement activities quarterly and identifies opportunities for improvement.

The Plan's *2023 Quality Management Committee (QMC) Charter* stated that the committee is to meet at least quarterly.

Finding: The Plan did not ensure its QMC met at least quarterly in accordance with the Contract requirements.

The Plan did not fully implement its policies and procedures requiring its QMC to meet quarterly. The Plan's QMC only met twice during the audit period, on December 12, 2022, and March 27, 2023.

During the interview, the Plan was asked whether a QMC meeting was held around June 2023. The Plan stated that the QMC did not meet at that time because of absentee members. In addition, in a written response, the Plan stated that the QMC's next meeting was scheduled for December 11, 2023. Therefore, the Plan only had two QMC meetings scheduled during the audit period.

When the Plan's QMC does not meet on a regular basis, the Plan may miss opportunities to identify and act upon quality improvement issues in a timely manner, which may result in members receiving substandard care.

Recommendation: Implement policies and procedures to ensure that the QMC meets at least quarterly to maintain oversight of its Quality Improvement Program and to fulfill the Contract requirements.

CATEGORY 6 – ADMINISTRATIVE AND ORGANIZATIONAL CAPACITY

6.3	ENCOUNTER DATA REVIEW

6.3.1 Encounter Data Reporting

The Plan is required to implement policies and procedures for ensuring complete, accurate, reasonable, and timely submission of encounter data to DHCS for all items and services furnished to a member under the Contract, whether directly or through subcontracts or other arrangements, including capitated Providers. *(Contract, Exhibit E, Attachment 3, 2(B))*

The Plan is required to maintain a Management Information System that collects and reports encounter data to DHCS in compliance with CFR, Title 42, section 438.242, and pursuant to applicable DHCS APLs. *(Contract, Exhibit A, Attachment 3, 2.A)*

Member encounter data must provide for the following: Collection and maintenance of sufficient member encounter data to identify the provider who delivers any items or services to members; Submission of member encounter data to the state at a frequency and level of detail to be specified by Centers for Medicare and Medicaid Services and the State, based on program administration, oversight, and program integrity needs. *(CFR, Title 42, section 438.242 (c)(1) and (2))*

Unless otherwise specified in the Contract, the Plan is required to comply with all current and applicable provisions of the Medi-Cal Provider Manual, unless the Medi-Cal Provider Manual conflicts with the Contract, APLs, and/or any applicable federal or state laws, regulations, in which case the specific terms of the Contract, the APL, or the applicable law will apply. *(Contract, Exhibit E, Attachment 3, 1.D(2) and 1.E)*

Reimbursement for services rendered by a Physician Assistant (PA) can be made only to the employing physician, organized outpatient clinic or hospital outpatient department. Providers must indicate the appropriate PA modifier “U7” in conjunction with the Healthcare Common Procedure Coding System (HCPCS) or Current Procedural Terminology code when the service was performed by a PA. In addition to this PA modifier, the modifier code “99” may also apply to PA services, creating a multiple modifier condition. *(Medi-Cal Provider Manual - Billing and Reimbursement, non ph 3; Page updated: March 2023)*

Plan policy and procedure, MC IT 2.2 *PHC-CA Encounter Data Submission for Managed Care,* (revised 09/07/2023), stated the Plan shall ensure the completeness, accuracy, reasonability, and timeliness of all subcontractor encounter data regardless of whether a subcontractor is reimbursed on a fee-for-service or capitated basis. In addition, the Compliance Officer or designee and the Associate Director of Electronic Data Information and Data Analytics or designee review Quality Measures for Encounter Data Reports, Monthly Encounter Data Reports, Quarterly Stoplight Reports, and other internal reports related to completeness, accuracy, reasonability, and timeliness measures.

Finding: The Plan did not ensure that rendering provider information in its submitted encounter data was accurate and complete.

A verification study revealed that in three out of ten samples, the rendering provider information in encounter data submitted to DHCS was inaccurate and incomplete. These were the issues identified:

- In one of the samples, according to the medical record, a service was rendered by a PA and reviewed and signed off by a physician. However, a different physician's name was reported in the encounter data.
- In three samples, the encounter data did not contain appropriate PA modifiers "U7" or "99" to indicate these services were rendered by PAs.

Plan policy and procedure, *PHC-CA Encounter Data Submission for Managed Care* does not include the requirements for reporting rendering provider information for verification purposes. Furthermore, this policy does not include the requirement to apply the Medi-Cal Provider Manual requirements to report the appropriate PA modifiers "U7" or "99" to indicate that these services were rendered by PAs.

The Plan provided a written response stating that the Medi-Cal Provider Manual directs billing for services rendered by PA under physician supervision, allowing subcontractors to list supervising physicians as the rendering providers in encounter data instead of the PA. A review of three out of ten cases indicated that HCPCS modifier U7 and 99 was missing to indicate that care was provided by a PA per the Provider Manual instructions. The Plan did not follow the Provider Manual billing instructions to completeness when submitting encounter data report related to services provided by rendering providers.

When the Plan does not report accurate and complete provider information in encounter data, DHCS will not have the right foundation for tracking healthcare quality and costs, monitoring population health and affordability trends, and identifying gaps in care.

Recommendation: Revise and implement policies and procedures to ensure the accuracy and completeness of encounter data reports related to rendering provider information.

DEPARTMENT OF HEALTH CARE SERVICES
AUDITS AND INVESTIGATIONS
CONTRACT AND ENROLLMENT REVIEW DIVISION
LOS ANGELES SECTION

REPORT ON THE STATE SUPPORTED SERVICES AUDIT OF

AIDS HEALTHCARE FOUNDATION dba POSITIVE HEALTHCARE CALIFORNIA

2023

Contract Numbers: 20-10355 and 22-20459

Audit Period: October 1, 2022 through September 30, 2023

Dates of Audit: November 27, 2023 through December 8, 2023

Report Issued: April 11, 2024

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I. INTRODUCTION

This report presents the results of the audit of AIDS Healthcare Foundation dba Positive Healthcare California (Plan) compliance and implementation of the State Supported Services Contract with the State of California. The Contracts cover abortion services with the Plan.

The audit covered the review period from October 1, 2022, through September 30, 2023. The audit was conducted from November 27, 2023, through December 8, 2023, and consisted of documentation review and interviews with the Plan staff.

The Plan delivers care to eligible members who reside within their service area and are at least 21 years old with an acquired immunodeficiency syndrome diagnosis.

An Exit Conference with the Plan was held on March 12, 2024. No deficiencies were noted during the review period.

❖ COMPLIANCE AUDIT FINDINGS ❖

PLAN: AIDS Healthcare Foundation dba Positive Healthcare California

AUDIT PERIOD: October 1, 2022, through September 30, 2023
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STATE SUPPORTED SERVICES

The Plan is required to provide, or arrange to provide, to eligible members the following State Supported Services: Current Procedural Terminology (CPT) Codes: 59840 through 59857 and Center for Medicare & Medicaid Services (CMS) Common Procedure Coding System Codes: X1516, X1518, X7724, X7726, and Z0336 *(State Supported Services Contract, Exhibit A)*

Abortion services are a covered benefit in the Medi-Cal program as a Physician Service. The Plan is required to cover abortion services, as well as the medical services and supplies incidental or preliminary to an abortion, consistent with the requirements. The Plan and network providers and subcontractors are prohibited from requiring medical justification or imposing any utilization management or utilization review requirements, including prior authorization and the coverage of outpatient abortion services. *(All Plan Letter (APL) 22-022, Abortion Services)*

Plan policy and procedure, *UM 36.0 PHC-CA Abortion Services* (revised 01/19/2023), stated the Plan covers abortion services, as well as medical service and supplies incidental or preliminary to an abortion, consistent with the requirements detailed in the Medi-Cal Provider Manual; the network providers and any subcontractors are prohibited from requiring medical justification in accordance with APL 22-022 requirements.

The Plan maintains a list of CPT and CMS Common Procedure Coding System codes required for pregnancy termination that the Plan's Claims Department uses for claims processing.

A request for verification study revealed that the Plan did not have any claims related to State Supported Services during the audit period. A review of documentation and interviews indicated no deficiencies were noted during the audit period.

Recommendation: None.