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

Contract Number: 11-88286

Audit Period: January 1, 2020
Through
December 31, 2020

Report Issued: June 11, 2021

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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 who have a prior diagnosis of Stage three HIV infection.

The Plan was established in California in 1995, under Federal Waiver from 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, X-ray, 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 five delegated groups and several vendors or subcontractors.

As of December 31, 2020, the Plan had 691 members of which 384 (56 percent) were Medi-Cal members and 307 (44 percent) were Medicare Dual Eligible members.

II. EXECUTIVE SUMMARY

This report presents the findings of the DHCS medical audit for the period of January 1, 2020 through December 31, 2020. The onsite review was conducted from February 8, 2021 through February 19, 2021. The audit consisted of document review, verification studies, and interviews with the Plan representatives.

An Exit Conference with the Plan was held on May 13, 2021. 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 May 28, 2021 the Plan submitted a response after the Exit Conference. The result of our evaluation of the Plan's response are reflected in this report.

The audit evaluated five performance categories: Utilization Management, Case Management and Coordination of Care, Access and Availability of Care, Members' Rights and Quality Management.

The prior DHCS medical audit for the period of January 1, 2019 through December 31, 2019 was issued on June 29, 2020. This audit examined the Plan's compliance with its DHCS contract. Documents submitted to DHCS in response to the prior year audit's Correction Action Plan were reviewed.

The summary of the findings by category is as follows:

Category 1 – Utilization Management

Category 1 includes procedures and requirements for the prior authorization appeal process.

The Plan is required to notify members receiving a Notice of Appeal Resolution (NAR) that they have an additional 120 days over and above the initial 120 days allowed to request a State Fair Hearing (SFH); however, the Plan did not comply with this requirement.

Category 2 – Case Management and Coordination of Care

Category 2 includes procedures and requirements for mental health and substance abuse services.

The Plan is required to ensure that a mental health screening of members is conducted by network Primary Care Providers (PCPs). However, the Plan did not have an effective policy and procedure for monitoring and tracking to ensure that mental health screening of members is conducted by network PCPs.

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 four NEMT and NMT providers in network were enrolled in the Medi-Cal Program or had an emergency approval from PED in accordance with All Plan Letters (APLs) requirements.

The Plan is required to ensure Physician Certification Statement (PCS) form is completed by member's treating physician; however, the Plan did not ensure the PCS form was completed by member's treating physician.

The Plan is required to cover and pay for all medically necessary NEMT and NMT covered service for members. In addition, California Code of Regulations (CCR), Title 28, section 1300.67.2.2 requires that Plans provide or arrange for the provision of covered health care services in a timely manner appropriate for the nature of the member's condition. Members did not get access to services in a timely manner due to systemic and persistent staff scheduling problems representing an identified but unresolved potential quality issue.

The Plan is required to establish and maintain a provider network, policies, procedures and quality assurance monitoring systems, and process sufficient to ensure transportation services are provided in a timely manner. The Plan did not have an effective monitoring process with transportation providers to provide services in a timely manner.

Category 4 – Member's Rights

No findings were noted for the audit period.

Category 5 – Quality Management

Category 5 includes procedures and requirements for the credentialing and recredentialing process.

The Plan is required to implement and maintain a system for the reporting of serious quality deficiencies that result in suspension or termination of a practitioner to the appropriate authorities. The Plan is required to implement and maintain policies and procedures for disciplinary actions. However, the Plan did not follow to completion their policies and procedures to report to the Credentialing and Peer Review Committee when a provider came under review by the Plan.

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 a virtual audit of the Plan from February 8, 2021 through February 19, 2021. 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 administrators and staff.

The following verification studies were conducted:

Category 1 – Utilization Management

Prior authorization requests: 21 prior authorization (11 medical and ten pharmacy) requests were reviewed for timeliness, consistent application of criteria, appropriateness of review, and communication of results to provider and members.

Prior authorization appeal procedures: The Plan had one appeal relating to medical services, which was reviewed for appropriateness and timeliness of decision making.

Category 2 – Case Management and Coordination of Care

Coordination of care and Individual Health Assessment (IHA) requirements: 11 medical records were reviewed to confirm coordination of care and fulfillment of IHA and Individual Health Education Behavior Assessment requirements.

Continuity of care: The Plan did not receive any request from members during the review period.

Category 3 – Access and Availability of Care

Emergency services and family planning claims: Eight emergency services claims were reviewed for appropriate and timely adjudication. The Plan did not have any family planning claims.

NEMT: Ten records were reviewed to confirm compliance with NEMT requirements.

NMT: 19 records were reviewed to confirm compliance with NMT requirements.

NEMT and NMT grievances: 26 records were reviewed for response to complainant and submission to the appropriate level of review.

Category 4 – Member's Rights

Grievance procedures: 27 grievances including eight quality of care, 18 quality of service, one exempt, and zero expedited; and 18 call logs 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: Three cases were reviewed for reporting, investigation, and remediation.

Credentialing and recredentialing: Ten newly contracted providers were reviewed for licensing and certification.

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

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

CATEGORY 1 - UTILIZATION MANAGEMENT

1.3	PRIOR AUTHORIZATION APPEAL PROCESS

1.3.1 Compliance with and Implementation of Supplement to APL 17-006

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 (PLs) and APLs issued by DHCS. (*Contract, Exhibit E, Attachment 2)*

Supplement to APL 17-006: *Emergency State Fair Hearing Timeframe Changes (03/2020),* states that during the COVID-19 public health emergency, Managed Care Health Plans (MCPs) must notify members receiving a NAR that they have an additional 120 days over and above the initial 120 days allowed to request a SFH. If an MCP is unable to include this temporary SFH rights information with the NAR at the time of the mailing, it must call the member at the time the NAR is being mailed to notify the member of the right to request a SFH within 240 days from the date of the NAR.

Finding: The Plan did not notify a member related to a NAR that they have an additional 120 days over and above the initial 120 days allowed to request a SFH; the Plan did not comply with this requirement.

In an interview, the Plan stated the Plan's Administrator and Compliance Department were aware of this APL Supplement via their usual monitoring process. The current finding indicates an apparent failure in Plan standard procedure for communicating APL and related information regarding NAR to the appropriate departments in their organization that would be integrated into the designated operations. The Plan was not certain of the exact root cause of this deficiency and apparently this may have been a combination of internal system control deficiency and unintentional human error related to the unusual "Supplement" nature of the APL communication during the pandemic.

Failure to notify members of APL's related information could negatively impact the appropriate care, service, and rights of members.

Recommendation: Develop and implement operating procedures and guidance to ensure members receive timely and accurate information about their rights.

CATEGORY 2 – CASE MANAGEMENT AND COORDINATION OF CARE

2.5	MENTAL HEALTH AND SUBSTANCE ABUSE

2.5.1 Mental Health Screening System

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 PLs and APLs issued by DHCS.
(Contract, Exhibit E, Attachment 2)

APL 17-018 Medi-Cal Managed Care Health Plan Responsibilities for Outpatient Mental Health Services (10/27/2017) states that the Plan is still obligated to ensure that a mental health screening of beneficiaries is conducted by network PCPs.

Plan's policy and procedure *CM 42 v3: PHC-CA Mental Health Services*, *(10/14/2020)* Mental Health Services Section 3(a), states that the Plan requires its network PCP to conduct mental health screening of its members. The Plan's Utilization Management Committee reviews data and provides oversight and feedback to facilitate improved quality operations.

Finding: Plan did not have an effective policy and procedure for monitoring and tracking to ensure that mental health screening of members is conducted by network PCPs.

During the interview, the Plan stated that network PCPs conducted mental health screening of members for mental disorders with Patient Health Questionnaire-2 (PHQ-2) and PHQ-9 tools as a part of IHA and follow-up visit. The Plan's staff stated that they track completion of the mental health screening assessment through billing "G Code".

A verification study consisted of a review of 11 members, six IHA and five follow-up visits from PCPs. All the screening records indicated the score of "0" for IHA and follow-up member visits. In addition, a score of "0" was found for members with psychiatric or without psychiatric disorders indicating that inadequate or no screening was performed by PCPs. The Plan stated that some PCPs failed to code the "G code" on billing claims. Based on information provided by the Plan, the procedure and monitoring system was not adequate.

Without a system in place to ensure that PCPs conduct mental health screening of members, members may not receive the services that they need.

Recommendation: Revise the process and monitoring system to ensure that PCPs conduct mental health screening of members.

CATEGORY 3 – ACCESS AND AVAILABILITY OF CARE

3.8	NON-EMERGENCY MEDICAL TRANSPORTATION NON-MEDICALTRANSPORTATION

3.8.1 Medi-Cal Enrollment of NEMT and NMT Providers

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 PLs and APLs issued by DHCS.
(Contract, Exhibit E, Attachment 2)

APL 19-004, *Provider Credentialing/Re-credentialing and Screening/Enrollment (06/12/2019),* states that the Final Rule extended the provider screening and enrollment requirements for all network providers. Part One of the APL related to the screening and enrollment requirements states that MCP network providers that have a state-level enrollment pathway must enroll in the Medi-Cal Program. State-level enrollment pathways are available through either DHCS PED or another State Department with a recognized pathway. MCPs have the option to develop and implement a Managed Care provider screening and enrollment process that meets the requirement of the APL.

Furthermore, the Medi-Cal Managed Care Program and MCPs must comply with statewide Medi-Cal Fee-For-Service enrollment standards and federal enrollment standards when verifying enrollment of providers through a state-level enrollment pathway or developing a provider enrollment pathway.

APL 20-004 Emergency Guidance for Medi-Cal Managed Care Health Care Plans in Response to COVID-19 (08/18/2020), states that the Plans that rely on DHCS PED must direct potential new providers to the process outlined in the DHCS guidance. Immediately upon successful completion of the emergency enrollment application process through PED, provider will receive an approval email message, and an approval letter in DHCS' Provider Application and Validation for Enrollment portal, stating that they have been granted enrollment for 60 days.

APL 17-004, Subcontractual Relationships and Delegation (04/18/2017), states that the Plans are responsible for ensuring that their subcontractors and delegated entities comply with all applicable state and federal laws and regulations; Contract requirements; reporting requirements; and other DHCS guidance including, but not limited to APLs. The Plan must have in place policies and procedures to communicate these requirements to all subcontractor and delegated entities.

The Plan's policy and procedure *CR 5: PHC-CA Transportation Provider Credentialing* (*12/02/2016),* states that the Plan provides client-specific guidelines during initial credentialing and continuous credentialing maintenance of transportation. In addition, transportation providers are required to meet Plan credentialing requirements prior to being approved to transport Plan members.

The Plan's policy and procedure *CR 6: PHC-CA Provider Screening and Enrollment (03/12/2018)*, states 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. The Plan does not enroll providers that are providing services pursuant to temporary Letter of Agreement, continuity of care arrangements, or an urgent or emergent basis.

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

The Plan has policies and procedures requiring NEMT and NMT network providers to be screened for Medi-Cal enrollment in accordance with APL requirements prior to contracting with the Plan. However, the Plan's staff, responsible for enrolling transportation providers, accepted the submission of the application to PED as confirmation of enrollment in the Medi-Cal program and did not follow the Plan's policy and procedure.

During the interview, the Plan's staff stated that all network providers were enrolled in the Medi-Cal program. However, review of 29 NEMT and NMT files determined that four providers who provided NEMT and NMT transportation services to members were not either enrolled in the Medi-Cal program yet, or did not have a confirmation email or letter from PED in accordance with APLs requirements.

Medi-Cal members may be subjected to substandard transportation services if a NEMT and NMT provider does not undergo the screening process to qualify as a Medi-Cal provider.

Recommendation: Implement policies, procedures, and monitor to ensure that network NEMT and NMT providers are screened and enrolled in Medi-Cal program per APL requirements.

3.8.2 NEMT Physician Certification Statement Form

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 PL and APLs issued by DHCS. *(Contract, Exhibit E, Attachment 2)*

APL 17-010, *Non-Emergency Medical and Non-Medical Transportation Services (07/17/2017)*, states Medi-Cal MCPs and transportation brokers must use a DHCS approved PCS form to determine the appropriate level of service for Medi-Cal members. Once the member's treating physician prescribes the form of transportation, the MCP cannot modify the authorization. In addition, each MCP must have a mechanism to capture and submit data from the PCS form to DHCS.

The Plan's policy and procedure *CM 43.v2: PHC-CA Transportation Benefit (08/5/2020)*, states that the Plan shall have a mechanism to capture and submit data from the PCS form to DHCS. Members can request a PCS form from their physician by telephone, electronically, or in person, or by another method established by the Plan.

The Provider Manual (07/01/2018), states that NEMT is covered when prescribed in writing by a physician, dentist, behavioral health provider etc. for an enrollee to obtain medically necessary covered services. Enrollees with the following conditions may qualify for wheelchair van transport when their provider submits a signed PCS form: members who suffer from severe mental confusion, members with paraplegia, dialysis recipients and members with chronic conditions who require oxygen but do not require monitoring.

Member Evidence of Coverage (01/01/2020), states that a member is entitled to use NEMT when a member physically or mentally is not able to get to medical, dental, mental health and substance use disorder appointment by car, bus, train, or taxi. Before getting NEMT, member needs to request the service through the doctor and doctor will prescribe the correct type of transportation to meet the medical condition.

Finding: The Plan did not ensure member's treating physician completed the PCS form for NEMT services during the audit period in accordance with APL requirements.

During the review of ten verification study files for NEMT it was noted that the member's treating physician did not complete the PCS form provided in four files and six files did not have the form. The Plan's staff and member's treating physicians did not follow current procedures and APL requirements.

Without using the PCS forms as intended and required, the Plan cannot ensure that members receive the necessary and appropriate level of transportation services.

Recommendation: Implement policy and procedure, Provider Manual and APL to ensure that NEMT PCS form is completed by the member's treating physician.

3.8.3 Scheduling Transportation Services by the Plan Staff

The Plan is required to cover and pay for all medically necessary covered services for the member, including NEMT services, as provided for in Title 22 CCR, section 51323 (Medical Transportation Services), required by member to access Medi-Cal covered services.
(Contract, Exhibit A, Attachment 10)

CCR, Title 28, section 1300.67.2.2(c)(1), states that Plans shall provide or arrange for the provision of covered health care services in a timely manner appropriate for the nature of the enrollee's condition consistent with good profession practice. Plans shall establish and maintain provider network, policies, procedures, quality assurance monitoring systems, and process sufficient to ensure compliance with this clinical appropriateness standard.

APL 17-010, Non-Emergency Medical (NEMT) and Non-Medical Transportation (NMT) Services (07/17/2017), states the Plans are contractually required to meet timely access standards. The Plans that have a Knox-Keene license are also required to meet the timely access standards contained in CCR, Title 28, section 1300.67.2.2. The member's need for NMT and NEMT services do not relieve the Plans from complying with their timely access standard obligations.

The Plan's policy and procedure *CM 43 v2: PHC-CA (08/03/2020),* states that Registered Nurse Case Manager and/or Care Coordinator determines the best, safest, and most economical means of transportation based on the member's clinical condition.

The Plan's policy and procedure *CO 7 v3: PHC-CA Monitoring and Auditing (03/2020),* Section on Monitoring and Auditing Process states that the Plan monitors and tracks statistical data through claims, transportation invoices, and customer satisfaction surveys to ensure timely access standard of transportation is met.

Finding: The Plan did not have an effective process and monitoring system for its staff to provide transportation in a timely manner to members.

A verification study revealed systemic problems in the provision of transportation services. A review of 26 records revealed that 13 members did not get access to services in a timely manner, due to persistent appointment booking errors or wrong mode of transportation scheduled by the Plan's Member Services Department or call center.

The Plan identified staff scheduling errors in NEMT and NMT Potential Quality Issue (PQI) through call logs and grievance analysis. However, the documentation provided had insufficient information to support that the Plan's Quality Management Committee (QMC) fully implemented an effective procedure and monitoring system during the audit period to resolve the PQI issue related to the member's complaints with the Plan's staff transportation scheduling errors.

When the Plan makes persistent appointment booking errors or schedules the wrong mode of transportation, this can lead to delayed medical care and treatment for members.

Recommendation: Revise and implement an effective quality assurance process to ensure transportation access through accuracy of appointments and appropriate determination of transportation modes.

3.8.4 Monitoring of Timely Access Services of Transportation Providers

The Plan is required to cover and pay for all medically necessary covered services for the member, including NEMT services, as provided for in CCR, Title 22, section 51323 (Medical Transportation Services), required by member to access Medi-Cal covered services.
(Contract, Exhibit A, Attachment 10)

CCR, Title 28, section 1300.67.2.2(c) (1), states that Plans shall provide or arrange for the provision of covered health care services in a timely manner appropriate for the nature of the enrollee's condition consistent with good profession practice. Plans shall establish and maintain provider network, policies, procedures and quality assurance monitoring systems and process sufficient to ensure compliance with this clinical appropriateness standard.

APL 17-010, Non-Emergency Medical Transportation (NEMT) and Non-Medical Transportation (NMT) Services (07/17/2017), states that MCPs are responsible for ensuring their delegated entities and subcontractors comply with all applicable state and federal laws and regulations, contractual requirements, and other requirements set forth in DHCS guidance, including APLs. In addition, Medi-Cal MCPs must timely communicate these requirements to all delegated entities and subcontractors in order to ensure compliance.

In addition, APL states that the Plans are contractually required to meet timely access standards. The Plans that have a Knox-Keene license are also required to meet the

timely access standards contained in CCR, Title 28, section 1300.67.2.2. The member's need for NMT and NEMT services do not relieve the Plans from complying with their timely access standard obligations.

The Plan's policy and procedure *CO 7 v3: PHC-CA Monitoring and Auditing* (*03/26/2020),* Section on Monitoring and Auditing Process, states that the Plan monitors the vendor and tracks statistical data on claims, transportation invoices, and customer satisfaction surveys to ensure timely access standard of transportation is met.

The Plan's policy and procedure *CM 43 v2: PHC-CA Transportation Benefits (08/03/2020),* states that the Plan will provide delegation oversight of its transportation vendors and ensure these delegated entities comply with all applicable states and federal laws and regulations, contractual requirements, and other requirements set forth in DHCS guidance, including APLs.

Finding: The Plan did not have an effective process to monitor transportation providers to ensure services are provided in a timely manner.

During the audit, the Plan identified NEMT and NMT provider PQI. The Plan identified PQI through call logs and member grievance analysis. The PQI related to the provider was discussed in QMC meeting minutes dated March 2020. Documentation provided had insufficient information to support that the Plan developed an effective quality assurance process to handle PQI related to transportation provider. Review of 26 grievance verification files revealed that eight files still had similar complaints related to transportation drivers not picking up members in a timely manner and cancelling appointments at the last minute.

When the Plan does not fully implement a system to address and monitor member complaints related to transportation providers, it potentially leads to a delay in member's care and treatment.

Recommendation: Revise, implement, and monitor effective procedures to address the provision of timely access transportation with providers.

CATEGORY 5 – QUALITY MANAGEMENT

5.3	PROVIDER QUALIFICATIONS - CREDENTIALING AND RECREDENTIALING

5.3.1 Credentialing and Recredentialing Process for Providers under Concern

The Plan is required to implement and maintain written policies and procedures concerning the initial credentialing, recredentialing, recertification, and reappointment of network providers developed by the Department in accordance with Code of Federal Regulations, Title 42, 438.214 and APL 16-012. The Plan is required to ensure that the responsibility for recommendations regarding credentialing decisions will rest with a credentialing committee or other peer review body.

In addition, the Plan is required to implement and maintain a system for the reporting of serious quality deficiencies that result in suspension or termination of a practitioner to the appropriate authorities. The Plan is required to implement and maintain policies and procedures for disciplinary actions including, reducing, suspending, or terminating a practitioner's privileges.
(Contract, Exhibit A, Attachment 4.12)

The Plan's policy and procedure *CR 3 v1: PHC-CA Peer Review (01/15/2019),* states that the Plan conducts peer review based upon evidence-based standards of care for all practitioners as a part of the overall Quality Improvement Plan in order to focus on the quality and appropriateness of member care and services. For example, provider may be taken through peer review process that includes but is not limited to the following: professional misconduct, substance abuse, quality of care issue etc. Peer Review Committee focuses on the quality of care and monitoring of medical staff member's practice. Through review, clinical privileges can be immediately suspended or restricted where the failure to take such action may result in an imminent danger to the health of the individual. Findings and recommendations from the Peer Review and Credentialing Committee are communicated to the individual contracted practitioner under review and provided to QMC via quarterly updates or more urgently if necessary.

The Plan's policy and procedure *CR 4 v1- PHC-CA 805 Reporting of Adverse Action (11/26/2019),* states that the Medical Board of California, and National Practitioner Data Bank has imposed legal requirements for reporting certain actions related to the Credentialing and Peer Review processes. The Plan has a process to file Form 805 to

the Medical Board for specific disciplinary cause or reason: A Medical Disciplinary cause or reason is an aspect of the practitioner's competence or professional conduct which is reasonably likely to be detrimental to patient safety or to the delivery of patient care. Such conduct includes that which affects, or could adversely affect, the health or welfare of a patient.

Finding: The Plan did not follow to completion their policies and procedures to report to the Credentialing and Peer Review Committee when a provider came under review by the Plan.

DHCS reviewers noted that an in-network provider was listed on the Plan's Fraud and Abuse Log submitted for the audit. During the interview, the Plan's Compliance Manager and Special Investigation Unit (SIU) Manager explained that the Plan identified this provider under review from the 2020 National Health Care Fraud and Opioid Takedown database. Information indicated that this provider had been indicted with intent to defraud a health care program. The SIU Manager performed an impact analysis with no finding of apparent exposure to the Plan, DHCS, or members. The Plan filed Form MC609 for the provider under review. However, the case was not forwarded to the Plan's Credentialing Department nor addressed in Peer Review Committee as required by the Plan's contract, policies, and procedures.

The Plan did not have effective internal controls to ensure that there was a complete and consistent process for providers who are under review for possible misconduct.

A lack of internal controls related to credentialing can lead to inadequate oversight of the Plan's provider network and increase the risk for possible member harm when members receive care from practitioners who are under investigation.

Recommendation: Develop and implement procedural controls to ensure that the Plan's credentialing process appropriately addresses providers who have come under concern to the Plan due to an investigation, disciplinary action, or sanctions.

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

Contract Number:	20-10355 State Supported Services
Audit Period:	January 1, 2020 Through December 31, 2020
Report Issued:	June 11, 2021

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I. INTRODUCTION 1

II. COMPLIANCE AUDIT FINDINGS 2

I. INTRODUCTION

This report presents the review of AIDS Healthcare Foundation dba Positive Healthcare California's (Plan) compliance and implementation of the State Supported Services contract with the State of California. The Contract covers abortion services contracted with the Plan.

The onsite audit was conducted from February 8, 2021 through February 19, 2021. The audit covered the review period from January 1, 2020 through December 31, 2020. It consisted of document reviews and interviews with the Plan staff.

The Plan delivers care to eligible beneficiaries who reside within their service area and are at least 21 years old with Acquired Immunodeficiency Syndrome (AIDS) diagnosis.

An Exit Conference with the Plan was held on May 13, 2021. There were no deficiencies found for the review period on the Plan's State Supported Services.

❖ COMPLIANCE AUDIT FINDINGS (CAF) ❖

PLAN: AIDS Healthcare Foundation dba Positive Healthcare California

AUDIT PERIOD: January 1, 2020 Through December 31, 2020
DATE OF AUDIT: February 8, 2021 Through February 19, 2021

STATE SUPPORTED SERVICES CONTRACT REQUIREMENTS

The Plan agrees to provide, or arrange to provide, to eligible members the following State Supported Services based on the following codes:

- Current Procedural Terminology Coding System: 59840 through 59857
- Health Care Finance Administration Common Procedure Coding System Codes: X1516, X1518, X7724, X7726, and Z0336

In addition, the services areas covered under this contract between Department of Health Care Services (DHCS) and the Plan are specified in the Primary Contract. *(State Supported Services Contract Exhibit A)*

The Plan and DHCS are bound by all applicable terms and conditions of the Primary Contract including all applicable amendments to the Primary Contract. *(State Supported Services Contract Exhibit E)*

All Plan Letter (APL) 15-020, Abortion Services (dated: 09/15/2015), states that the Plan is responsible to provide members timely access to abortion services. Plans that provide physician services must not require medical justification and/or prior authorization for outpatient abortion services.

The *Member Handbook/Evidence of Coverage* lists the following family planning services offered to members: pregnancy testing, family planning visits, and all Food and Drug Administration approved birth control. Family planning services are provided to members of childbearing age to enable them to determine the number and spacing of children and no referral is required for sensitive services outside of the Plan's Network.

The Plan's *Provider Manual* informs providers that members have the right to receive family planning services outside of their health plan's network and through any family planning provider without prior authorization.

The Plan's policy *CL 13, PHC-CA State Supported and Proposition 56 Claims Processing (Revised: 11/18/2020),* states that the Plan reimburses State Supported Services pursuant to contractual requirements based on DHCS APL 15-020 requirements for abortion services. The Plan maintains appropriate procedure codes per Medi-Cal guidelines for appropriate claims processing.

❖ COMPLIANCE AUDIT FINDINGS (CAF) ❖
PLAN: AIDS Healthcare Foundation dba Positive Healthcare California
AUDIT PERIOD: January 1, 2020 Through December 31, 2020 **DATE OF AUDIT: February 8, 2021 Through February 19, 2021**

Request for verification study revealed that the Plan did not have any claims related to the State Supported Services during the audit period.

Based on review of the Plan's policy, member and provider information materials, and staff interviews, no deficiencies were noted for the audit period.

Recommendation: None.