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

Contract Number: 11-88286

Audit Period: January 1, 2019
Through
December 31, 2019

Report Issued: June 29, 2020

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I. INTRODUCTION

AIDS Healthcare Foundation, founded in 1987, is a not-for-profit organization providing Human Immunodeficiency Virus (HIV) treatment. AIDS Healthcare Foundation dba Positive Healthcare (Plan) provides health care for Medi-Cal recipients 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 country for Medicaid beneficiaries diagnosed with Acquired Immune Deficiency Syndrome (AIDS). The Plan became a fully insured Managed Care plan on July 1, 2019 as a qualified Knox-Keene Health Care Service Plan.

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

The Plan provides health care designed around the needs of people living with all stages of AIDS. The Plan covers physician services from doctors who are HIV specialists, hospital outpatient department services, laboratory and X-ray services, pharmaceutical services and prescribed drugs, skilled nursing facility care, preventive health care services, and mental health.

The Plan had a total average membership of 693 members for its Medi-Cal line of business for the audit period under review.

II. EXECUTIVE SUMMARY

This report presents the findings of DHCS medical audit, for the period of January 1, 2019 through December 31, 2019. DHCS conducted the onsite review from February 4, 2020 through February 13, 2020. The audit consisted of document review, verification studies, and interviews with Plan representatives.

The audit evaluated six categories of performance: 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 October 1, 2017 through September 30, 2018) was issued on May 22, 2019. This audit examined the Plan's compliance with DHCS contract and assessed implementation of its prior year's Corrective Action Plan (CAP).

An Exit Conference with the Plan was held on May 28, 2020. DHCS allowed the Plan 15 calendar days from the date of the Exit Conference to provide supplemental information addressing the draft audit report findings. On June 12, 2020, the Plan submitted a response after the Exit Conference. The results of DHCS evaluation of the Plan's response are reflected in this report.

The summary of the findings by category is as follows:

Category 1 – Utilization Management

The Plan is required to integrate UM activities into the Quality Improvement System (QIS). The Plan did not integrate UM activities, such as integrating reports on the review of the number and types of appeals, denials, deferrals, and modifications into QIS for both medical and pharmacy prior authorizations.

The Plan is required to use the revised Notice of Action (NOA) /Notice of Appeal Resolution (NAR) and "Your Rights" attachments contained in the All Plan Letter (APL) 17-006. The Plan became a Knox-Keene plan on July 1, 2019. Therefore, the Plan is required to use the "Your Rights" attachment for Knox-Keene licensed plans. However, the Plan sent members and prescribers the NOA/NAR with the incorrect "Your Rights" attachment for non-Knox-Keene licensed plans for all pharmacy prior authorization decisions made on and after July 1, 2019.

The Plan is required to ensure appropriate processes are used to review and approve Medically Necessary Covered Services and that reasons for decisions in respect to its preauthorization and review procedures are clearly documented. The Plan denied a pharmacy prior authorization without medical necessity review by a qualified physician or pharmacist.

The Plan is required to notify the requesting provider of any decision to deny, approve,

modify, delay a service authorization request, to authorize a service in an amount, duration, or scope that is less than requested. Plan's decisions must be communicated to the provider initially by telephone or facsimile, and then in writing. The Plan failed to send written pharmacy prior authorization notice to prescribing providers.

Category 2 – Case Management and Coordination of Care

The Plan is required to ensure that an Initial Health Assessment (IHA) for adult members is performed within 120 calendar days of enrollment. The Plan failed to ensure the completion of the IHA within the required timeframe.

The Plan is required to use a DHCS approved Physician Certification Statement (PCS) form to determine the appropriate level of service for Medi-Cal members before providing Non-Emergency Medical Transportation (NEMT) services. The Plan did not use and complete the PCS form to determine the appropriate level of service before providing NEMT services.

The Plan is required to ensure its NEMT providers are enrolled in the Medi-Cal Program. The Plan did not ensure its NEMT provider was enrolled in the Medi-Cal Program.

The Plan is required to provide members with pre-existing provider relationships who make a Continuity of Care (COC) request the option to continue treatment for up to 12 months with an out-of-network Medi-Cal provider. The Plan must begin to process the request within five working days following the receipt of the request. Each COC request must be completed within 30 calendar days from the date the Plan received the request; 15 calendar days if the member's medical condition requires more immediate attention; or three calendar days if there is risk of harm to the member. The Plan did not ensure that members' requests for COC are processed and completed within the required timeframes.

Category 3 – Access and Availability of Care

The Plan is required to give written notice of termination of a contracted provider to affected members within 15 calendar days. The Plan's policy did not include the requirements for sending affected members a written notice of termination of a contracted pharmacy provider within 15 calendar days.

Category 4 – Member's Rights

The Plan is required to submit copies of all grievances alleging discrimination against members to DHCS for review and appropriate action. The Plan failed to submit copies of grievances alleging discrimination to DHCS.

The Plan is required to implement and maintain procedures to ensure that grievances

are resolved at the appropriate level. The Plan is required to submit all grievances and appeals related to medical Quality of Care (QOC) issues to the Medical Director for action. However, the Plan's QOC grievances did not document the Medical Director's, or a health care professional with clinical expertise in treating beneficiary's condition, review and final decision.

Category 5 – Quality Management

No findings noted for the audit period.

Category 6 – Administrative and Organizational Capacity

No findings noted for the audit period.

III. SCOPE/AUDIT PROCEDURES

SCOPE

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

PROCEDURE

DHCS conducted an on-site audit of the Plan from February 4, 2020 through February 13, 2020. 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 Plan documents and interviewed the Plan administrators and staff.

The following verification studies were conducted:

Category 1 – Utilization Management

Prior authorization review requirements: 12 medical and 14 pharmacy prior authorization files were reviewed for timeliness, consistent application of criteria, appropriateness of review, and communication of results to members and providers.

The Plan had no prior authorization appeals during the review period.

Category 2 – Case Management and Coordination of Care

IHA: 28 medical records were reviewed for documentation, timely completion, and fulfillment of all required IHA components.

Complex Case Management: 19 medical records were reviewed to evaluate the performance of services.

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

Non-Medical Transportation (NMT): Six claims were reviewed to confirm compliance with NMT requirements.

COC: 20 files were reviewed for timeliness and appropriateness of COC request determination.

Category 3 – Access and Availability of Care

Emergency Services and Family Planning Claims: 15 emergency service claims were reviewed for appropriate and timely adjudication. The Plan had no family planning claims during the review period.

Category 4 – Member's Rights

Grievance Procedures: 23 grievances (11 QOC, 11 Quality of Service, and one exempt) were reviewed for timely resolution, response to complainant, and appropriate level of review and medical decision-making.

The Plan had no Health Insurance Portability and Accountability Act (HIPAA) cases reported during the review period.

Category 5 – Quality Management

Provider Training: Ten new provider files were reviewed for timely Medi-Cal Managed Care training.

Category 6 – Administrative and Organizational Capacity

Fraud and Abuse Reporting: Three cases were reviewed for appropriate reporting of all suspected fraud and/or abuse to DHCS within the required timeframes.

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

❖ COMPLIANCE AUDIT FINDINGS (CAF) ❖
PLAN: AIDS Healthcare Foundation DBA Positive Healthcare
AUDIT PERIOD: January 1, 2019 through December 31, 2019 **DATE OF AUDIT:** February 4, 2020 through February 13, 2020

CATEGORY 1 - UTILIZATION MANAGEMENT

1.1	UTILIZATION MANAGEMENT PROGRAM

1.1.1 Integrating Reports of Utilization Management Activities Into the Quality Improvement System

The Plan is responsible for ensuring that the UM program includes the integration of UM activities into the QIS. The Plan is required to include a process to integrate reports on review of the number and types of appeals, denials, deferrals, and modifications for review by the appropriate QIS staff. (*Contract, Exhibit A, Attachment 5(1)(G)*)

Plan policy UM 23.2*, PHP/ PHC Under/ Over Utilization Review* (revision date: November 28, 2018*),* stated the Plan's UM Committee shall review the analysis of the data and present through either direct report to Quality Management or through Subcommittee Report to Quality Management Committee (QMC).

Finding: DHCS auditor reviewed the QMC meeting minutes and found that the minutes did not indicate the prior authorization break down and analysis of the types of appeals, denials, deferrals, and modifications. The Plan did not fully demonstrate integration of UM activities into the QIS for continuous improvement of the UM program and processes.

During the interview, DHCS auditor discussed the QMC meeting minutes with the Plan staff. The Plan acknowledged the number and types of appeals, denials, deferrals, and modifications were not included in the QMC meeting minutes.

The Plan did not fully implement policy UM 23.2 to present the required information to the QMC. As a result, the Plan may miss opportunities for improvement of their UM program.

Recommendation: Revise and implement policy to ensure integration of UM activities to include breakdown and analysis reports on the number and types of appeals, denials, deferrals, and modifications for the appropriate QIS. Ensure the documentation of the integration in QMC for continuous improvement.

1.2	PRIOR AUTHORIZATION REVIEW REQUIREMENTS

1.2.1 Non-Knox-Keene "Your Rights" Notice

The Plan is required to mail a NOA, a formal letter informing a member that a medical service has been denied, deferred, or modified. A NOA must include all of the following: the member or provider's right to file an appeal; the member's right to request a State Fair Hearing; and procedures for exercising the member's rights to appeal or grieve. (*Contract, Exhibit A, Attachment 14(4)(A))*

The Plan is required to use the revised NOA/NAR and "Your Rights" attachments contained in *APL 17-006* for Knox-Keene licensed plans. The Plan is required to comply with additional state laws [under *Health and Safety (H&S) Code, section 1368.02*] and include verbatim language required in all notices sent to beneficiaries regarding grievance and appeal requirements. This required paragraph is incorporated into the templates and requires no action by the Plan. (*APL 17-006)*

Finding: The Plan became a Knox-Keene plan on July 1, 2019. As such, the Plan shall use the "Your Rights" attachment for Knox-Keene licensed plans on and after July 1, 2019. DHCS auditor examined 14 pharmacy prior authorization decisions to verify Plan compliance. DHCS auditor found that the Plan sent members and prescribers the NOA/NAR with the "Your Rights" attachment for non-Knox-Keene licensed plans in 11 pharmacy prior authorization decisions made on and after July 1, 2019.

Plan policy PH.10, *Coverage Determinations & Redeterminations for Drugs and Therapeutic Devices* (effective October 2018), did not address the need to use the "Your Rights" attachment for Knox-Keene licensed plans.

Two causes led to this finding. First, the Plan did not revise its pharmacy prior authorization policy to send members and prescribers the Knox-Keene "Your Rights" notice on and after July 1, 2019. Additionally, the Plan did not perform periodic review to ensure compliance with Contract requirements and *APL 17-006* regarding grievance and appeal requirements.

When a Plan provides members with incorrect information about their rights, it could delay their care and negatively affect their health outcomes.

Recommendation: Revise and implement policy and procedures to ensure use of Knox-Keene "Your Rights" notice. Furthermore, revise Plan's pharmacy prior authorization system to send members and prescribers the Knox-Keene "Your Rights" notice. Perform periodic review of the NOA/NAR letters issued to ensure compliance with DHCS requirements.

1.2.2 Pharmacy Prior Authorization Lacked Medical Necessity Review

The Plan shall ensure that its pre-authorization review procedures have qualified health care professionals to "supervise review decisions, including service reductions, and a qualified physician will review all denials that are made, whole or in part, on the basis of medical necessity. For purposes of this provision, the review of the denial of a pharmacy prior authorization may be by a qualified physician or contractor's pharmacist." *(Contract, Exhibit A, Attachment 5(2)(A))*.

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, updated for its pre-authorization, concurrent review, and retrospective review procedures. *(Contract, Exhibit A, Attachment 5(2)(B)(C) & (D))*.

The Plan's formulary is required to be comparable to the Medi-Cal Fee For Service (FFS) list of contract drugs, except for drugs carved out through specific contract agreements. (*Contract, Exhibit A. Attachment 10(6)(F)(2))*

According to California State Plan under Title 19 of the Social Security Act, under Section 3.1. Amount, Duration and Scope of Services: Categorically Needy, Attachment 3.1-A.1. Medicaid Program: Requirements Relating to Covered Outpatient Drugs for Categorically Needy, the Medi-Cal Program covers agents used for anorexia, weight loss, or weight gain. All drugs in this category are potential benefits, subject to medical necessity.

Finding: The Plan denied a pharmacy prior authorization without medical necessity review by a qualified physician or pharmacist. DHCS auditor examined 14 pharmacy prior authorization decisions to verify Plan compliance. DHCS auditor found that the Plan denied a request for Contrave®, which is Food and Drug Administration approved as an adjunct to a reduced-calorie diet and increased physical activity for chronic weight management in adults, as excluded from Plan coverage. Because Contrave® is a drug used for weight loss, the Plan should have evaluated this drug request for medical necessity. The Medi-Cal FFS list of contract drugs covers agents used for anorexia, weight loss, or weight gain when these agents are medically necessary. However, the Plan's formulary did not cover agents used for anorexia, weight loss, or weight gain when these agents are medically necessary.

The Plan did not know the Medi-Cal program provides medical necessity coverage for drugs used for anorexia, weight loss, or weight gain. Additionally, the Plan's policy PH 2.2, *California Formulary Policy* (effective January 1, 2018) did not identify the medical necessity review procedures for drugs used for anorexia, weight loss, or weight gain are covered. Lastly, the Plan did not train its pharmacy prior authorization staff to review

medical necessity requests for drugs used for anorexia, weight loss, and weight gain.

When the Plan incorrectly denies requests for covered drugs that are medically necessary, the member does not receive the medically necessary medication.

Recommendation: Revise and implement policy and procedures to ensure proper handling of medical necessity reviews for drugs used for anorexia, weight loss, or weight gain. Properly train pharmacy prior authorization staff to review medical necessity requests for drugs used for anorexia, weight loss, or weight gain. Lastly, update Plan formulary with its Pharmacy Benefit Manager, to ensure proper claims adjudication.

1.2.3 Written Notification to Prescribing Providers

The Plan must notify the requesting provider of any decision to deny, approve, modify, or delay a service authorization request, to authorize a service in an amount, duration, or scope that is less than requested. The notice to the provider may be verbal or in writing. (*Contract, Exhibit A, Attachment 5(1)(I))*

Furthermore, the decisions to approve, modify, or deny requests by providers for authorization prior to, or concurrent with, the provision of health care services to enrollees must be communicated to the requesting provider within 24 hours of the decision. 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 enrollees must be communicated to providers initially by telephone or facsimile and then in writing. (*H&S Code, section 1367.01(h)(3) and (4))*

Plan's decisions must be communicated to the provider initially by telephone or facsimile, and then in writing. (*APL 17-006*)

Finding: The Plan did not communicate the decisions to prescribing providers initially by telephone or facsimile, and then in writing. DHCS auditor examined 14 pharmacy prior authorization decisions to verify Plan compliance. The Plan did not communicate their decision for pharmacy prior authorization request to prescribing providers in three out of 14 samples.

The Plan explained that the Plan's staff monitored for facsimile failure daily and reached out to the prescribing providers for alternative notification. However, the Plan was not able to provide documentation to support that an alternative notification was provided and therefore the Plan did not call or send written notification to prescribing providers.

The Plan's policy PH 10.3, *Coverage Determinations & Redeterminations for Drugs and Therapeutic Devices* (effective October 2018), did not identify the procedures for

handling unsuccessful facsimile communication to prescribing providers.
In addition, the Plan did not implement a quality assurance process to ensure alternative provider notification took place when facsimile communication failed.

The Plan did not send the written pharmacy prior authorization notice to prescribing providers. This causes prescribing providers to not be aware of the denied pharmacy prior authorization requests and impairs members' ability to initiate an appeal.

Recommendation: Revise and implement policy and procedures to ensure the Plan's pharmacy prior authorization decisions are communicated to the prescribing provider initially by telephone or facsimile, and then in writing.

❖ COMPLIANCE AUDIT FINDINGS (CAF) ❖
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CATEGORY 2 – CASE MANAGEMENT AND COORDINATION OF CARE

2.1	INITIAL HEALTH ASSESSMENT

2.1.1 Completion of Initial Health Assessment

The Plan is required to ensure that an IHA for adult members is performed within 120 calendar days of enrollment. (*Contract, Exhibit A, Attachment 10(4)*)

An IHA is a comprehensive assessment that is completed during the member's initial encounter(s) with a selected or assigned Primary Care Physician (PCP), appropriate medical specialist, or non-physician medical provider and must be documented in the member's medical record. The IHA enables the member's PCP to assess and manage the acute, chronic, and preventive health needs of the member. All new members must have a complete IHA within 120 calendar days of enrollment. If the member requests or the Plan initiates a change in their PCP within the first 120 days of enrollment and the IHA has not yet been completed, the IHA must be completed by the newly assigned PCP within the established timeline for new members. (*Plan Letter 08-003)*

Plan policy CM 33, *PHC Initial Health Assessment* (revision date: December 2, 2019), stated that members are provided an IHA by the member's PCP within 120 calendar days of enrollment.

Finding: The Plan did not monitor to ensure completion of IHA within 120 calendar days by a PCP as required. DHCS auditor reviewed 14 member's IHA records and found that the Plan did not monitor completion of IHA by PCP. The Plan used a monitoring report to track IHA completion. However, the monitoring report indicated "N/A" for members' identify as having a completed IHA. The Plan stated the "N/A" was because the Plan did not have an electronic method to verify IHA completion.

During the interview, Plan stated that they do not have a procedure to monitor IHA completion within the required timeframe.

Without monitoring IHA completion, the Plan cannot ensure that each member completed IHA within the 120-calendar day timeframe, which can delay member's care.

Recommendation: Revise and implement policy and procedures for monitoring and ensuring the completion of IHA within 120 calendar days of enrollment.

2.4	NON-EMERGENCY MEDICAL TRANSPORTATION NON-MEDICAL TRANSPORTATION

2.4.1 Completion of Physician Certification Statement Form

The Plan is required to comply with all existing final Policy Letters issued by Med-Cal Managed Care Division (MMCD) incorporated into the Contract. All Policy Letters issued by MMCD subsequent to the effective date provide clarification of the Plan's obligations pursuant to the Contract, and may include instructions regarding implementation of mandated obligations pursuant to changes in state or federal statutes, regulations, or pursuant to judicial interpretation. *(Contract, Attachment E, Exhibit 2(1)(D))*

The Plan and its subcontracted 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 Plan cannot modify the authorization. (*APL 17-010*)

Plan policy CM 43.2, *PHC Transportation Benefit* (revision date: December 2, 2019), stated "NEMT PCS Form – The Plan and its transportation vendors will use the AIDS Healthcare Foundation approved PCS form to determine the appropriate level of service for Medi-Cal members. The PCS form must be completed before NEMT can be prescribed or provided."

Finding: The Plan did not complete a PCS form before providing NEMT services to members. DHCS auditor reviewed ten NEMT files and found that the Plan did not complete a PCS form in all ten files. In addition, the Plan did not follow its policy and procedures, which states the PCS form must be completed before NEMT can be prescribed or provided. Neither the DHCS nor Plan's approved PCS form was used.

The Plan explained that its computer system for arranging NEMT services contains components required in the PCS form. Therefore, the Plan did not complete the PCS form before providing NEMT services to members. However, the computer system only included some of the required components of the PCS form.

Without a completed PCS form from the treating physician, the appropriate level of service for members may not be determined; therefore, the members' medical transportation needs may be compromised.

Recommendation: Implement policies and procedures to ensure the use of DHCS approved PCS form and ensure that PCS forms are completed before NEMT services are provided.

2.4.2 Medi-Cal Program Enrollment of Non-Emergency Medical Transportation Provider

The Plan is required to comply with all existing final Policy Letters issued by MMCD incorporated into the Contract. All Policy Letters issued by MMCD subsequent to the effective date provide clarification of the Plan's obligations pursuant to the Contract, and may include instructions regarding implementation of mandated obligations pursuant to changes in state or federal statutes, regulations, or pursuant to judicial interpretation. *(Contract, Attachment E, Exhibit 2(1)(D))*

Effective June 12, 2019, *APL 19-004, Provider Credentialing/Re-credentialing and Screening/Enrollment*, supersedes *APL 17-019* which states the Plan is required to screen and enroll all network providers. The Plan's network providers that have state-level enrollment pathway must enroll in the Medi-Cal program. State-level enrollment pathways are available either through DHCS Provider Enrollment Division or another State Department with a recognized enrollment pathway. Alternatively, the Plan has the option to develop and implement a Managed Care provider screening and enrollment process that meets the requirement of this APL. The Plan may screen and enroll network providers in a manner that is substantively equivalent to DHCS' provider enrollment process. (*APL 19-004*)

Finding: The Plan did not ensure that its NEMT provider was enrolled in the Medi-Cal program as required by *APL 19-004*. DHCS auditor reviewed ten NEMT records for compliance. The records indicated the Plan had only one NEMT provider for providing services to Medi-Cal members. The NEMT provider was not enrolled in the Medi-Cal program.

The Plan was aware of the APL requirements; however, the Plan was not aware that the enrollment requirements applied to NEMT providers. Therefore, the Plan did not require its NEMT provider to enroll with the Medi-Cal program. Furthermore, the Plan did not have policies and procedures to ensure their NEMT providers are enrolled in the Medi-Cal program.

Medi-Cal members can be subject to inadequate and unsafe transportation conditions if the NEMT provider does not undergo the screening process to qualify as a Medi-Cal provider.

Recommendation: Develop and implement policy to require NEMT providers to enroll in the Medi-Cal program and monitor to ensure that all NEMT providers are enrolled.

2.5	CONTINUITY OF CARE

2.5.1 Processing and Completing Requests for Continuity of Care

The Plan is required to give members with pre-existing provider relationships who make a COC request to continue treatment for up to 12 months with an out-of-network Medi-Cal provider. The Plan must begin to process the request within five working days following the receipt of the request. Each COC request must be completed within the following timelines: 30 calendar days from the date the Plan received the request; 15 calendar days if the member's medical condition requires more immediate attention; or three calendar days if there is risk of harm to the member. (*APL 18-008*)

Plan policy MS 16*, Continuity of Care* (revision date: January 16, 2019), stated that the Plan provides COC for 12 month period. Furthermore, the Plan shall ensure that new enrollees experience no break in services or care coordination while transitioning to the Plan. However, Plan policy does not include timeframes for processing member requests.

Finding: The Plan did not monitor to ensure members requests for COC are processed and completed within the timeframes as required by *APL 18-008*. Review of the Plan's COC files indicated the Plan did not have procedures for processing member's COC requests within the required timeframes.

During the interview, the Plan acknowledged that they do not have a process to monitor and ensure member's COC requests are completed within the required timeframes.

Without procedures for timely completion of member's requests for COC, the members may experience a delay or interruption of medically necessary services.

Recommendation: Revise and implement policy to include all required timeframes to ensure member's requests for COC is in accordance to *APL 18-008*.

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CATEGORY 3 – ACCESS AND AVAILABILITY OF CARE

3.4	ACCESS TO PHARMACEUTICAL SERVICES

3.4.1 Member Notification on Pharmacy Provider Termination

The Plan is required to notify members in writing of any changes in the availability or location of covered services, or any other changes in information listed in Code of Federal Regulations (CFR), Title 42, 438.10(f)(4), at least 30 calendar days prior to the effective date of such changes. In the event of an emergency or other unforeseeable circumstances, the Plan is required to provide notice of the emergency or other unforeseeable circumstance to DHCS as soon as possible. The notification must also be presented to and approved in writing by DHCS prior to its' release. (*Contract, Exhibit A, Attachment 13(5))*

Effective July 5, 2016, the Plan is required to make a good faith effort to give written notice of termination of a contracted [pharmacy] provider, within 15 calendar days after receipt or issuance of the termination notice, to each enrollee who received his or her primary care from, or was seen on a regular basis by the terminated [pharmacy] provider. Therefore, the revised CFR, Title 42, section 438(f)(1) amends the Contract requirements and applies to this audit. (*CFR, Title 42, section 438.10(f)(1))*

Finding: The Plan policy PH 1.4, *Guidelines for Provision of Pharmaceutical Services* (effective January 1, 2018) did not identify the procedures for pharmacy terminations. Moreover, the Plan's policy also did not specify that the Plan shall send affected member a written notice of termination of a contracted pharmacy provider within 15 calendar days after receipt or issuance of the termination notice. Therefore, the Plan's policy did not comply with Contract requirement and CFR, Title 42, section 438.10(f)(1).

During the interview, the Plan was not aware of the Contract requirement and requirements set forth in CFR, Title 42, section 438.10(f)(1) regarding provider terminations and timely written member notice of termination of a contracted provider applies to pharmacy providers.

The Plan's failure to identify procedures to terminate network pharmacies and to send affected members timely written notice of termination of a contracted pharmacy provider may adversely affect member health outcomes.

Recommendation: Revise and implement policy and procedures to address pharmacy provider termination and the need to send affected members timely written notification of pharmacy termination to comply with amended federal regulation. Develop a quality assurance process to ensure the Pharmacy Benefit Manager complies with amended federal regulation.

CATEGORY 4 – MEMBER'S RIGHTS

4.1	GRIEVANCE SYSTEM

4.1.1 Submit Copies of All Grievances Alleging Discrimination to DHCS

The Plan is required to submit copies of all grievances alleging discrimination against members or eligible beneficiaries because of race, color, national origin, creed, ancestry, religion, language, age, marital status, sex, sexual orientation, gender identity, health status, physical or mental disability, or identification with any other persons or groups defined in California Penal Code 422.56. The Plan is required to forward the grievance to DHCS for review and appropriate action. (*Contract, Exhibit E, Attachment 2(28)(C)*)

Finding: The Plan did not submit copies of grievances alleging discrimination to DHCS for review and appropriate action as required by the Contract. DHCS auditor reviewed 23 grievance files for appropriate action and identified a grievance complaint alleging discrimination reported by a member; however, the case was not submitted to DHCS.

During interviews, the Plan stated that they misunderstood the requirement; the Plan thought cases were submitted to DHCS if incidents alleging discrimination resulted in a denial of services to members. However, the Plan's policy RM 7*, Member Grievance Process* (revision date: August 23, 2019), did not identify procedures for submitting copies of grievances alleging discrimination to DHCS at all.

By not submitting grievances alleging discrimination, DHCS will not have the opportunity to review and implement appropriate action.

Recommendation: Revise and implement policy to include procedures to submit copies of grievances alleging discrimination against a member, or eligible member, to DHCS for review and appropriate action.

4.1.2 Documentation of Medical Director Involvement in the Resolution of Quality of Care Grievances

The Plan is required to implement and maintain procedures to monitor the member's grievance system and the expedited review of grievances required under California Code of Regulations (CCR), Title 28, sections 1300.68 and 1300.68.01 and CCR, Title 22, section 53858. The Plan shall maintain procedure to ensure that the grievance submitted is reported to an appropriate level. Any grievance involving the appeal of a denial based on lack of medical necessity; appeal of a denial of a request for expedited

resolution of a grievance; or an appeal that involves clinical issues are required to be resolved by a health care professional with appropriate clinical expertise in treating the member's condition or disease. (*Contract, Exhibit A, Attachment 14(2)(D))*

The Plan is required to immediately submit all grievances and appeals related to medical QOC issues to the Plan's Medical Director for action. (*APL 17-006*)

Plan policy RM 7.0, *PHC-CA Member Grievance Process* (revision date: August 23, 2019*)* stated, "Grievances related to medical issues shall be discussed with the Medical Director or designee. All grievances regarding medical QOC, including but not limited to, an appeal of a denial or an appeal that involves clinical issues, are immediately submitted to the Medical Director for action."

Finding: The Plan used a Complaint, Grievance and Appeal Investigation Case Form (ICF) to document the review and resolution by the Medical Director. However, the Medical Director did not complete the Medical Director Clinical Review and Medical Director's Determination section on the ICF for ten out of 11 QOC grievances.

The Plan explained that QOC grievances are reviewed during their weekly "Medical Administration" meetings with the participation of the Plan's Medical Director and/or Medical Consultant staff. The Plan believed that the meeting was sufficient review of QOC grievances. Therefore, the Medical Director did not complete the required sections on the ICF.

Without the documentation by a health care professional with appropriate clinical expertise treating the member's condition or disease, the member's grievance complaint with clinical aspects may not be properly resolved and therefore may adversely affect the member's health.

This is a repeat finding from prior year's audit, 4.1.1 Medical Quality of Care Grievances.

Recommendation: Ensure implementation of policy and procedures to document the Medical Director's involvement in the review and resolution of all QOC grievances.