MEDICAL REVIEW - SOUTHERN SECTION I
AUDITS AND INVESTIGATIONS
DEPARTMENT OF HEALTH CARE SERVICES

AIDS HEALTHCARE FOUNDATION

Contract Number: 11-88286

Audit Period: October 1, 2016
Through
September 30, 2017

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TABLE OF CONTENTS

I. INTRODUCTION 1

II. EXECUTIVE SUMMARY 2

III. SCOPE/AUDIT PROCEDURES 4

IV. COMPLIANCE AUDIT FINDINGS
Category 3 – Access and Availability of Care 6
Category 4 – Member's Rights 9
Category 5 – Quality Management 13

I. INTRODUCTION

AIDS Healthcare Foundation (Plan), founded in 1987, is a not-for-profit organization providing HIV treatment to more than 820,000 patients in 39 countries. Positive Healthcare is AIDS Healthcare Foundation Managed Care Division, which provides health care for Medi-Cal recipients in Los Angeles County.

The Plan is the first AIDS special needs plan in the country established in 1995 under a Federal Waiver from Department of Health and Human Services. The Plan expanded services to Florida in 2008. Positive Healthcare currently provides care to more than 7,000 people in California and Florida.

The Plan delivers care to Medi-Cal recipients, under the Primary Care Case Management (PCCM) contract, who have a prior AIDS diagnosis and at least 21 years of age. The Plan provides health care designed around the needs of people living with all stages of AIDS. The Plan covers primary care from doctors who are HIV specialists, routine doctor office visits, hospitalization, emergency and urgent care, outpatient services, individualized care from a Registered Nurse, and prescription drug services.

The Plan had a total average enrollment of 703 members for its Medi-Cal line of business for the audit period under review.

II. EXECUTIVE SUMMARY

This report represents the audit findings of the Department of Health Care Services (DHCS) medical review audit for the review period of October 1, 2016 through September 30, 2017. The onsite review was conducted from February 5, 2018 through February 15, 2018. The audit consisted of document review, verification studies, and interview with Plan personnel.

An Exit Conference was held on May 17, 2018 with the Plan. The Plan was allowed 15 calendar days from the date of the Exit Conference to provide supplemental information addressing the draft audit report findings.

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

The prior DHCS medical audit (for the period October 1, 2015 through September 30, 2016 with onsite review conducted from October 31, 2016 through November 10, 2016) was issued on August 29, 2017. This audit examined for compliance and to determine to what extent the Plan has implemented their CAP. The prior year CAP was closed as of October 20, 2017. Finding denoted as a repeat finding is an uncorrected deficiency substantially similar to that identified in the previous audit.

Category 1 – Utilization Management

No findings were noted during this audit period.

Category 3 – Access and Availability of Care

The Contract covers procedures for members to obtain routine specialty and first prenatal care appointments. The Contract states that members must be offered routine specialty care appointments within 15 business days and first prenatal appointments within two weeks upon request. The Plan's Provider Manual, Quick Reference Guide, and Membership Guide were not updated to reflect contract requirements for routine specialty care and first prenatal care appointments.

The Contract requires the provider directory to include the hours and days when each facility is open, if non-English languages are spoken, the telephone number to call after normal business hours, and identification of providers that are not accepting new patients. The Plan's Provider Directory does not list provider facility business hours and telephone numbers for primary and specialty care providers.

Category 4 – Member’s Rights

All Plan Letter (APL) 17-006 provides guidance to Medi-Cal managed care health plans (MCPs) regarding the application of new federal and existing state regulations for processing Grievances and Appeals. New federal regulations allow members to file a grievance at any time. Further, new federal regulations require members to request a State Hearing within 120 calendar days from the date of the Notice of Appeal Resolution (NAR) and file an appeal within 60 calendar days from the date of Notice of Action (NOA).

The Plan did not implement new federal regulations for processing Grievances and Appeals. The new federal regulation timeframes for filing a grievance and appeal were not updated in the Plan’s Membership Guide and website. Further, the State Hearing filing timeframe was not updated in Plan’s Membership Guide, website, and the “Your Rights” attachment.

Category 5 – Quality Management

The Contract requires the Plan to conduct training for all newly contracted providers within 10 working days of being placed on active status.

The Plan did not implement corrective action as stated in the prior year Corrective Action Plan (CAP). The Plan did not use the “Provider Orientation Grid” to document all new providers and dates they were provided with training. Additionally, the Plan did not monitor provider training through the “Provider Relations Key Performance Indicator Report” as stated in the CAP.

Due to the lack of monitoring, new providers did not receive training on a timely basis.

Category 6 – Administrative and Organizational Capacity

No findings were noted during this audit period.

III. SCOPE/AUDIT PROCEDURES

SCOPE

This audit was conducted by the Department of Health Care Services (DHCS) Medical Review Branch to ascertain that medical services provided to the Plan members comply with federal and state laws, Medi-Cal regulations and guidelines, and Primary Care Case Management contract.

PROCEDURE

DHCS conducted an on-site audit of the Plan from February 5, 2018 through February 15, 2018. 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. Documents were reviewed and interviews were conducted with the Plan administrators and staff.

The following verification studies were conducted:

Category 1 – Utilization Management

Prior Authorization Request: 27 medical and 9 pharmacy prior authorizations were reviewed for timeliness, consistent application of criteria, appropriateness of review, and communication of results to members and providers.

No appeal cases were reported for the audit period under review.

Category 3 – Access and Availability of Care

Emergency Service Claims: 3 emergency service claims were reviewed for appropriate and timely adjudication.

Category 4 – Member's Rights

Grievance Procedures: 7 grievances (1 Quality of Care and 6 Quality of Service) and 16 inquiries were reviewed for timely resolution, response to complainant, and submission to appropriate level for review.

No HIPAA cases were reported for the audit period under review.

Category 5 – Quality Management

Provider Training - 10 new provider training records were reviewed for timely provision of Medi-Cal Managed Care program training.

Category 6 – Administrative and Organizational Capacity

No fraud and abuse cases were reported for the audit period under review.

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

❖ COMPLIANCE AUDIT FINDINGS ❖	
PLAN: AIDS HEALTHCARE FOUNDATION	
AUDIT PERIOD: October 1, 2016 – September 30, 2017	DATE OF ONSITE AUDIT: February 5, 2018 – February 15, 2018

CATEGORY 3 – ACCESS AND AVAILABILITY OF CARE

3.1	APPOINTMENT PROCEDURES AND WAITING TIMES

Appointment Procedures:
Contractor shall implement and maintain procedures for Members to obtain appointments for routine care, Urgent Care, routine specialty referral appointments, prenatal care, and adult initial health assessments. Contractor shall also include procedures for follow-up on missed appointments.
PCCM Contract A.9.3.A

Members must be offered appointments within the following timeframes:

3. Non-urgent primary care appointments – within ten (10) business days of request;
4. Appointment with a specialist – within 15 business days of request;

PCCM Contract A.9.4.B

Prenatal Care:
Contractor shall ensure that the first prenatal visit for a pregnant Member will be available within two (2) weeks upon request.
PCCM Contract A.9.3.B

Waiting Times:
Contractor shall develop, implement, and maintain a procedure to monitor waiting times in the providers' offices, telephone calls (to answer and return), and time to obtain various types of appointments indicated in subparagraph A, Appointments, above.
PCCM Contract A.9.3.C

Provider Directory:

Contract requires the provider directory to include the hours and days when each facility is open, if non-English languages are spoken, the telephone number to call after normal business hours, and identification of providers that are not accepting new patients.
PCCM Contract A.13.4.D.4

SUMMARY OF FINDINGS:

3.1.1 Access Standards for Routine Specialty Care and Prenatal Care Appointments

The Contract requires the Plan to establish acceptable accessibility standards in accordance with Title 28, CCR, Section 1300.67.2.2, and as specified in the contract for timely appointments. The Plan shall communicate, enforce, and monitor providers' compliance with the standards. Members must be offered appointments for routine specialty care within 15 business days of request. First prenatal appointments must be offered within two weeks upon request.
(PCCM Contract A.9.3 (A) & (B))

Policy and Procedure PR 2.0: Access and Availability delineates the Contract requirement access standards for routine specialty care appointments should be available within 15 business days, and first prenatal appointment should be made available within 14 calendar days upon request.

The Provider Manual states that specialty care appointments should be available within 30 calendar days upon request. The Provider Manual does not list the number of days to obtain an appointment for first prenatal visit. The Quick Reference Guide for Providers does not list the first prenatal appointment standard. The Membership Guide does not include appointment availability days for routine specialty care nor first prenatal appointments.

The Provider Manual, Quick Reference Guide, and Membership Guide were not updated to reflect the contract requirement access standards for routine specialty care and first prenatal appointments. The Plan acknowledged the information was not included. The Plan did not have a process in place to ensure that manuals and guides are updated. This may result in delay of care if providers and members are not notified of the required access standards.

3.1.2 Provider Directory

The Contract requires the provider directory to include the hours and days when each facility is open, if non-English languages are spoken, the telephone number to call after normal business hours, and identification of providers that are not accepting new patients.
(PCCM Contract A.13.4.D.4)

The printed and online Provider Directory does not list the business hours for some of the primary care providers. The telephone numbers and/or business hours were not listed for some of the specialty providers. The Plan's website includes a provider search engine. However,

business hours are also missing for some providers within the Plan's website provider search engine.

The Provider Directory is printed twice a year while the online provider directory is updated monthly. However, the Plan did not have a process in place to ensure the provider directory includes the required items from the contract. The Plan stated they are working on an ongoing validation element with the Credentialing Department to get updated provider information and will redefine the directory content. The IT Department will correct data being pulled and once the updated file is approved, it will be included in the provider directory.

Due to the Plan's lack of process to ensure an updated directory, members may not be able to contact provider facilities.

RECOMMENDATIONS:

3.1.1 Update the appointment availability access standards for routine specialty care and first prenatal care in the Provider Manual, Quick Reference Guide, and Membership Guide.

3.1.2 Update the printed and online Provider Directory to include provider facility business hours and telephone numbers for primary and specialty care providers.

CATEGORY 4 – MEMBER'S RIGHTS

4.1	GRIEVANCE SYSTEM

Member Grievance System and Oversight:
Contractor shall implement and maintain a Member Grievance system in accordance with Title 28, CCR, Section 1300.68 and 1300.68.01, Title 22, CCR, Section 53858, Exhibit A, Attachment 13, Provision 4, Paragraph D, item 12), and 42 CFR 438.420(a)-(c). Contractor shall resolve each grievance and provide notice to the Member as quickly as the Member's health condition requires, within 30 calendar days from the date Contractor receives the grievance. Contractor shall notify the Member of the grievance resolution in a written member notice.
PCCM Contract A.14.1

Contractor shall implement and maintain procedures…to monitor the Member's Grievance system and the expedited review of grievances required under Title 28 CCR Sections 1300.68 and 1300.68.01 and Title 22 CCR Section 53858.
PCCM Contract A.14.2

Contractor shall maintain, and have available for DHCS review, grievance logs, including copies of grievance logs of any sub-contracting entity delegated the responsibility to maintain and resolve grievances. Grievance logs shall include all the required information set forth in Title 22 CCR Section 53858(e).
PCCM Contract A.14.3.A

ALL PLAN LETTER 17-006: Grievance and Appeal Requirements and Revised Notice Templates and "Your Rights" Attachments:
Effective July 1, 2017, All Plan Letter (APL) 17-006, provides Medi-Cal managed care health plans (MCPs) with clarification and guidance regarding the application of new federal and existing state regulations for processing Grievances and Appeals.

Grievance Timeframes for Filing:
Timeframes for Filing Grievances are delineated in both federal and state regulations. While existing state regulations establish a timeframe of at least 180 calendar days from the date of the incident subject to the beneficiary's dissatisfaction, new federal regulations allow Grievances to be filed at any time. MCPs shall adopt the standard which is least restrictive to beneficiaries and allow Grievances to be filed at any time.

Appeal Timeframes for Filing:
Existing federal allow beneficiaries 90 days from the date on the (Notice of Action) NOA to file an Appeal. However, new federal regulations require beneficiaries to file an Appeal within 60 calendar days from the date of the NOA. MCPs shall adopt the 60 calendar day timeframe in accordance with the new federal regulations. Beneficiaries must also exhaust the MCP's Appeal process prior to requesting a State Hearing.

State Hearing Timeframes for Filing:
Existing federal regulations and state laws currently require beneficiaries to request a State Hearing within 90 days from the date of the Notice of Action (NOA). However, new federal regulations require beneficiaries to request a State Hearing within 120 calendar days from the date of the Notice of Appeal Resolution (NAR), which informs the beneficiary that the Adverse Benefit Decision has been upheld.

<u>SUMMARY OF FINDINGS:</u>

4.1.1 Grievance Timeframes

The All Plan Letter (APL) 17-006, effective July 1, 2017, provides Medi-Cal managed care health plans (MCPs) with clarification and guidance regarding the application of new federal and existing state regulations for processing Grievances and Appeals. New federal regulations allow members to file a grievance at any time.

Policy and Procedure Number RM 201: The PHC California Member Grievance Process state that a member may file a grievance anytime following any incident or action that is the subject of his/her dissatisfaction. A member may submit a written grievance by using the Plan's grievance form available at all primary care provider locations or file a verbal grievance through the Plan's Member Services Department.

The Membership Guide and the Plan's website state that a member may file a grievance up to 180 days following an incident. The Membership Guide and the Plan's website were not updated to reflect the federal requirements. The Plan was aware of the APL but had not updated the information to adhere to the new federal requirements. The Plan did not have a process in place to update guide and website to conform to new federal requirements. This may result in members not filing grievances due to the misinformation listed in the Membership Guide and the Plan's website.

4.1.2 Appeal Timeframes

The All Plan Letter 17-006, effective July 1, 2017, states new federal regulations require members to file an appeal within 60 calendar days from the date of the Notice of Action (NOA).

Policy and Procedure Number UM 24: The PHC Adverse Benefit Determination Appeal Process states that a member may file an appeal within 60 calendar days of a denial of service or payment.

The Membership Guide and the Plan's website states that members can appeal an action within 90 calendar days of receipt of the health plan's notice about the action. The Membership Guide and the Plan's website were not updated to reflect the federal requirements. Plan was aware of the APL but had not updated information to adhere to the new federal requirements. The Plan did not have a process in place to update guide and website to conform to new federal requirements. This may result in members not filing an appeal timely due to the misinformation listed in the Membership Guide and the Plan's website.

4.1.3 State Hearing Timeframes

The All Plan Letter 17-006, effective July 1, 2017, states new federal regulations require members to request a State Hearing within 120 calendar days from the date of the Notice of Appeal Resolution (NAR), which informs the member that the Adverse Benefit Decision has been upheld.

Policy and Procedure Number UM 24: The PHC Adverse Benefit Determination Appeal Process states that if a member and/or their representative want a State Hearing, it must be requested within 120 days from the date of the Notice of Appeal Resolution (NAR).

The Membership Guide, the Plan's website, and the "Your Rights" attachment sent to members states that members have the right to ask for a Medi-Cal Fair Hearing at any time within 90 days from the date on the Plan's letter about the result of the grievance. The Membership Guide, the Plan's website, and the "Your Rights" attachment were not updated to reflect the federal requirements. The Plan was aware of the APL but had not updated information to adhere to the new federal requirements. This may result in members not requesting a State Hearing due to the misinformation listed in the Membership Guide and the "Your Rights" attachment. The Plan did not have a process in place to update guide, website, and "Your Rights" attachment to conform to new federal requirements.

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RECOMMENDATIONS:

4.1.1 Update the grievance filing timeframe in the Membership Guide and the Plan’s website.

4.1.2 Update the appeals timeframe in the Membership Guide and the Plan’s website.

4.1.3 Update the State Hearing filing timeframe in the Membership Guide, the Plan’s website, and the “Your Rights” attachment.

CATEGORY 5 – QUALITY MANAGEMENT

5.2	PROVIDER QUALIFICATIONS

Credentialing and Re-credentialing:
Contractor shall develop and maintain written policies and procedures that include initial credentialing, recredentialing, recertification, and reappointment of Physicians including Primary Care Physicians and specialists in accordance with the MMCD, Credentialing and Recredentialing Policy Letter, MMCD Policy Letter 02-03. Contractor shall ensure those policies and procedures are reviewed and approved by the governing body, or designee. Contractor shall ensure that the responsibility for recommendations regarding credentialing decisions will rest with a credentialing committee or other peer review body.
PCCM Contract A.4.13

Standards:
All providers of Covered Services must be qualified in accordance with current applicable legal, professional, and technical standards and appropriately licensed, certified or registered. All providers must have good standing in the Medicare and Medicaid/Medi-Cal programs and a valid National Provider Identifier (NPI) number. Providers that have been terminated from either Medicare or Medicaid/Medi-Cal cannot participate in Contractor's provider network.
PCCM Contract A.4.13.A

Medi-Cal Managed Care Provider Training:
Contractor shall ensure that all providers receive training regarding the Medi-Cal Managed Care program in order to operate in full compliance with the Contract and all applicable Federal and State statutes and regulations. Contractor shall ensure that provider training relates to Medi-Cal Managed Care services, policies, procedures and any modifications to existing services, policies or procedures. Contractor shall conduct training for all providers within ten (10) working days after the Contractor places a newly contracted provider on active status.
PCCM Contract A.7.*5*

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PLAN: AIDS HEALTHCARE FOUNDATION	
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Delegated Credentialing:
Contractor may delegate credentialing and recredentialing activities. If Contractor delegates these activities, Contractor shall comply with Provision 6. Delegation of Quality Improvement Activities…
PCCM Contract A.4.13.B

Disciplinary Actions:
Contractor shall 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. Contractor shall implement and maintain policies and procedures for disciplinary actions including reducing, suspending, or terminating a practitioner's privileges. Contractor shall implement and maintain a provider appeal process.
PCCM Contract A.4.13.D

Medi-Cal and Medicare Provider Status:
The Contractor will verify that their subcontracted providers have not been terminated as Medi-Cal or Medicare providers or have not been placed on the Suspended and Ineligible Provider list. Terminated providers in either Medicare or Medi-Cal/Medicaid or on the Suspended and Ineligible Provider list, cannot participate in the Contractor's provider network.
PCCM Contract A.4.13.E

SUMMARY OF FINDINGS:

5.2.1 New Provider Training

The Contract requires the Plan to ensure that all providers receive training regarding the Medi-Cal Managed Care program in order to operate in full compliance with the contract and all applicable Federal and State statutes and regulations. The Plan shall conduct training for all providers within ten (10) working days after the Plan places a newly contracted provider on active status.
(PCCM Contract A.7.5)

Policy and Procedure Number PR3: Provider Training and Education states that the Plan's Provider Relations Department shall provide orientations for new providers within ten (10) working days of active status. The Provider Relations Department shall maintain records of provider orientations/trainings, education, and Provider Manual distributions. Provider Relations will monitor the new provider orientations on a quarterly basis to ensure they are being conducted within the required time frame. Monitoring will be conducted by comparing the credentialing new provider report with the Contract Inventory grid.

The verification study disclosed that nine new providers did not receive the new provider training within ten (10) working days of being placed on active status. The Provider Orientation Summaries which are used to document the training provided, did not have the in-service dates for eight providers. Provider orientation packets were mailed out to eight providers and there was no documentation to support when the orientation packets were mailed by the Plan and when the providers received them.

The Plan explained they did not implement the Provider Orientation Grid and the Provider Relations Key Performance Indicator Report as indicated on the Corrective Action Plan, did not monitor provider training, and the training requirements were not met. The Plan encountered staffing and organization challenges including having only one Provider Representative to conduct all the new provider training. The Plan is currently working on improving their monitoring system to ensure that new providers receive training on a timely basis. Due to the lack of monitoring, the Plan cannot ensure that providers will be compliant with contractual requirements.

This is a repeat finding.

RECOMMENDATIONS:

5.2.1 Monitor provider training to ensure new providers receive training within ten (10) working days of being placed on active status.