DHCS AUDITS AND INVESTIGATIONS

CONTRACT AND ENROLLMENT REVIEW DIVISION

LOS ANGELES SECTION

REPORT ON THE MEDICAL AUDIT OF AIDS HEALTHCARE FOUNDATION DBA POSITIVE HEALTHCARE CALIFORNIA FISCAL YEAR 2024-25

Contract Number: 23-30211

Audit Period: October 1, 2023 — September 30, 2024

Dates of Audit: November 4, 2024 — November 15, 2024

Report Issued: March 18, 2025

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I. INTRODUCTION

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

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

As of October 2024, the Plan had 533 Medi-Cal members.

II. EXECUTIVE SUMMARY

This report presents the audit findings of the DHCS medical audit for the period of October 1, 2023, through September 30, 2024. The audit was conducted from November 4, 2024, through November 15, 2024. The audit consisted of documentation review, verification studies, and interviews with the Plan's representatives.

An Exit Conference with the Plan was held on February 27, 2025. The Plan was allowed 15 calendar days from the date of the Exit Conference to provide supplemental information addressing the draft audit findings. On March 13, 2025, the Plan submitted a response after the Exit Conference. The evaluation results of the Plan's response are reflected in this report.

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

The prior DHCS medical audit for the period of October 1, 2022, through September 30, 2023, was issued on April 11, 2024. This audit examined the Plan's compliance with the DHCS Contract and assessed the implementation of the prior year 2023, Corrective Action Plan.

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

The summary of the findings by category follows:

Category 1 – Utilization Management

The Plan's UM program is required to ensure it uses appropriate processes to review and approve the provision of medically necessary covered services and maintain a Medical Director whose responsibilities include ensuring that medical decisions are rendered by qualified medical personnel. The California Business and Professions Code, section 2732 states, "No person shall engage in the practice of nursing, as defined in Section 2725, without holding a license which is in an active status issued under this chapter except as otherwise provided in this act…" The Plan did not ensure decisions were made by a qualified health care professional licensed in the State of California.

The Plan is required to notify members of a decision to deny, defer, or modify requests for prior authorization. The written communication shall include the telephone number

of the decision-maker responsible for the denial, delay, or modification or telephone number to the specific unit of the UM Department that handles provider appeals directly. The Plan did not provide the direct telephone number for the decision-maker responsible or telephone number to the specific unit of the UM Department that handles provider appeals directly for adverse benefit determinations in the Notice of Action (NOA) letters.

Category 2 – Case Management and Coordination of Care

There were no findings noted for this category during the audit period.

Category 3 – Access and Availability of Care

There were no findings noted for this category during the audit period.

Category 4 – Member's Rights

There were no findings noted for this category during the audit period.

Category 5 – Quality Management

There were no findings noted for this category during the audit period.

Category 6 – Administrative and Organizational Capacity

The Plan must have mechanisms, including an edit and reporting system, sufficient to ensure encounter data is complete, accurate, reasonable, and timely, as defined in state and federal law and All Plan Letters (APLs), prior to submission to the DHCS. The Plan is required to submit complete, accurate, reasonable, and timely encounter data. The Plan did not ensure that rendering provider information in submitted encounter data was accurate and complete.

III. SCOPE/AUDIT PROCEDURES

SCOPE

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

PROCEDURE

DHCS conducted an audit of the Plan from November 4, 2024, through November 15, 2024, for the audit period of October 1, 2023, through September 30, 2024. The audit included a review of the Plan's Contract with DHCS, policies and procedures for providing services, 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 Plan administrators and staff.

The following verification studies were conducted:

Category 1 – Utilization Management

Service Requests: A total of ten medical services requests (seven approved and three denied) were reviewed for timeliness, consistent application of criteria, and appropriate review.

Appeal Procedures: One of one appeal related to medical services was reviewed for appropriateness and timeliness of decision-making.

Category 2 – Case Management and Coordination of Care

There was no verification studies conducted for the audit review.

Category 3 – Access and Availability of Care

Non-Emergency Medical Transportation (NEMT): Ten records were reviewed to confirm compliance with NEMT requirements.

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

Category 4 – Member's Rights

Grievance Procedures: A total of 23 standard grievances (10 quality of care and 13 quality of service), 5 quality of service exempted grievances, and 6 inquiries were reviewed for timely resolutions, response to complainants, and submission to the appropriate level for review. There were no expedited grievances during the audit period.

Category 5 – Quality Management

Potential Quality Issues (PQI): Three PQI cases were reviewed for appropriate evaluation, investigation, and effective action taken to address improvements and remediation.

Category 6 – Administrative and Organizational Capacity

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

COMPLIANCE AUDIT FINDINGS

Category 1 – Utilization Management

1.2 Prior, Concurrent, and Retrospective Authorization Reviews

1.2.1 Qualified Healthcare Professional

The Plan shall maintain a full-time physician as Medical Director pursuant to California Code of Regulations (CCR), Title 22, section 53857 whose responsibilities shall include, but not be limited to, the following: Ensuring that medical decisions are rendered by qualified medical personnel. (*Contract, Exhibit A, Attachment I, 6.A.1*)

The Plan shall ensure that the prior authorization, concurrent review, and retrospective review procedures meet the following minimum requirements: qualified health care professionals supervise review decisions. (*Contract, Exhibit A, Attachment V, 2.B*)

No person shall engage in the practice of nursing, as defined in Section 2725, without holding a license which is in an active status issued under this chapter except as otherwise provided in this act. Every licensee may be known as a registered nurse and may place the letter "R.N." after their name." (*California Business and Professions Code, section 2732*)

Plan policy, *UM 22.8 PHC CA Authorization Referral Process* (revised 08/09/2024), stated that the Plan ensures that only a licensed health care professional (Medical Director and/or UM R.N.) reviews authorization requests that require the use of clinical judgement to determine medical necessity. Only a qualified health care professional with appropriate clinical expertise in treating the condition and disease makes decisions to deny (Medical Director only for denials) or to authorize (UM R.N.) an amount, duration, or scope less than requested. Only a physician holding an active, unencumbered state license may render an adverse determination. Requested health care services may be approved by UM staff who are not qualified health care professionals only when the UM staff is under the supervision of an appropriately licensed health care professional.

Finding: The Plan did not ensure decisions to authorize health care services were made by a qualified health care professional licensed in the State of California.

In a verification study, six out of ten samples reviewed did not demonstrate decisions were made by a qualified health care professional.

- Three samples were adjudicated by nurses licensed out of state, but not in California.
- Three other samples included UM decisions that should have been made by licensed personnel yet medical records lacked notes and signatures made by California-licensed qualified health care professionals.

Plan policy, *UM 22.8* stated that the Plan's licensed health care professional will supervise UM decisions by unlicensed staff; however, this policy does not detail how supervision is documented and if the supervisor's co-signature is required for these UM decisions.

According to the Plan's California Care organizational chart, the non-California-licensed nurses are included as part of the Plan's staff. The Plan stated in an interview that although the two nurses were not licensed in California, their decisions were supervised by the California-licensed staff. However, there were no notes in the member's medical records that demonstrated this supervision.

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

Recommendation: Revise and implement policies and procedures to ensure qualified health care professionals licensed in California render medical review decisions.

1.2.2 Decision Maker Contact Information

The Plan shall notify members of a decision to deny, defer, or modify a request for prior authorization, in accordance with CCR, Title 22, section 53894 by providing written notification to members and/or the authorized representative, regarding any denial, deferral or modification of a request for approval to provide a health care service. This notification must be provided as specified in California Health and Safety Code, section 1367.01. *(Contract, Exhibit A, Attachment 13)*

For decisions based in whole or in part on medical necessity, the written NOA must contain, among other criteria, the name and direct telephone number or extension of the decision-maker. If the Plan can substantiate through documentation that effective processes are in place to allow the provider the ability to easily contact the decision-maker through means other than a direct phone number (e.g., telephone number to the specific unit of the UM Department that handles provider appeals directly), a direct

telephone number or extension is not required. (*APL 21-011, Grievance and Appeals Requirements, Notice and Your Rights Templates*)

Any written communication to a physician or other health care provider of a denial, delay, or modification of a request shall include the name and telephone number of the health care professional responsible for the denial, delay, or modification. The telephone number provided shall be a direct number or an extension, to allow the physician or health care provider the ability to easily contact the professional responsible for the denial, delay, or modification. *(Health and Safety Code, section 13607.01(h)(4))*

Plan policy, *UM 22.8 PHC CA Authorization Referral Process* (revised 08/09/2024*),* stated that any written communication to a physician or other health care provider of a denial, delay, or modification of a request includes the name and telephone number of the health care professional responsible for the denial, delay, or modification. The telephone number provided is a direct number or an extension, to allow the physician or health care provider the ability to easily contact the professional responsible for the denial, delay, or modification.

Finding: The Plan's NOA letters to the providers did not contain the direct telephone number for the decision-maker or the specific unit of the UM Department responsible for adverse benefit determinations.

A verification study found three out of three prior authorization denials in which the corresponding NOA letters did not contain all required information. All three letters contained a general Plan number. However, the general Plan number is not the direct telephone number for the decision-maker or the specific unit of the UM Department that handles provider appeals directly. The Plan did not provide in the NOA letters a direct telephone number that is consistent with policies and procedures, contractual requirements, and federal regulations.

A review of the Plan's NOA letter template showed that the boilerplate layout contained fillable fields for Medical Director's signature, Medical Director's name, and Medical Director's telephone number. However, the Plan's NOA letters did not include the direct telephone number for the Medical Director as required by APL 21-011.

In an interview, the Plan stated that its interpretation of the NOA letter criteria met the contractual requirements. The Plan stated that listing the general telephone number was adequate to meet the NOA letter requirements. However, this statement contradicts

with the APL 21-011, requirement to include the telephone number of the decision-maker or the specific unit of the UM Department that handles provider appeals directly.

If NOA letters do not include the direct number of the Plan's decision-maker, it can limit the provider's ability to easily contact the decision-maker. This can result in the delayed submission of appeals for medically necessary services and lead to poor health outcomes.

Recommendation: Implement policies and procedures to ensure that NOA letters contain the direct telephone number for the decision-maker.

COMPLIANCE AUDIT FINDINGS

Category 6 – Administrative and Organizational Capacity

6.3 Encounter Data

6.3.1 Encounter Data Reporting

The Plan is required to submit complete, accurate, reasonable, and timely encounter data. *(Contract, Exhibit A, Attachment III, 2.1.2)*

The Plan must have mechanisms, including an edit and reporting system, sufficient to ensure encounter data is complete, accurate, reasonable, and timely, as defined in state and federal law and APLs, prior to submission to the DHCS. *(Contract, Exhibit A, Attachment III, Section 2.1.2)*

Plan policy, *MC IT 2.4 PHC CA Encounter Data Submissions for Managed Care* (revised 09/19/2024), stated that the Compliance Officer or designee and the Associate Director of Electronic Data Interchange and Data Analytics or designee review Quality Measures for Encounter Data reports, Monthly Encounter Data reports, and Quarterly Stoplight reports, and other internal reports related to completeness, accuracy, reasonability, and timeliness measures. On a regular basis, the plan shall review sample claims with procedure code(s) 99211, identify providers who are not submitting rendering provider information per the Medi-Cal billing manual and inform providers of non-compliance.

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

The verification study revealed that in six out of ten samples the encounter data information submitted to the DHCS was inaccurate.

- In two out of six samples the rendering provider stated in the medical records was not the same as the rendering provider listed in the encounter data. Furthermore, the rendering provider identified in the medical record was not enrolled in the Medi-Cal program.
- In one of the six samples the medical record did not identify a verifiable rendering provider. Only the first name of the provider was listed.
- For three of the six samples, the Plan did not provide supporting documents to verify the rendering providers.

As part of the Corrective Action Plan to the prior audit deficiency (6.3.1 Encounter Data Reporting) the Plan revised policy, MC IT 2.4 PHC CA Encounter Data Submissions for Managed Care (revised 09/19/2024) and implemented quarterly audits. In an interview, the Plan stated that monthly and quarterly audits are conducted to sample encounter data accuracy. Review of the Plan's audit reports for accuracy showed the Plan found claims that listed the physician provider as the rendering provider while the medical record showed that a non-physician provider (Physician Assistant/ Nurse Practitioner) performed the service. However, the Plan did not address the encounter data inaccuracies.

When the Plan does not report accurate provider information in encounter data, the DHCS will not have the right foundation for tracking the quality of care, monitoring population health, and making informed financial decisions.

This is a repeat finding of the 2023 audit finding 6.3.1 Encounter Data Reporting Review.

Recommendation: Revise and implement policy and procedure to ensure the accuracy of the encounter data reporting for rendering provider information.

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REPORT ON THE MEDICAL AUDIT OF AIDS HEALTHCARE FOUNDATION DBA POSITIVE HEALTHCARE CALIFORNIA FISCAL YEAR 2024-25

Contract Number: 23-30243

Contract Type: State Supported Services

Audit Period: October 1, 2023 — September 30, 2024

Dates of Audit: November 4, 2024 — November 15, 2024

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I. INTRODUCTION

This report presents the results of the audit of AIDS Healthcare Foundation dba Positive Healthcare California (Plan) compliance and implementation of the State Supported Services contract number 23-30243 with the State of California. The State Supported Services Contract covers abortion services with the Plan.

The audit covered the period of October 1, 2023, through September 30, 2024. The audit was conducted from November 4, 2024, through November 15, 2024, which consisted of a document review and verification study with the Plan administration and staff.

An Exit Conference with the Plan was held on February 27, 2025. No deficiencies were noted during the review of the State Supported Services Contract.

COMPLIANCE AUDIT FINDINGS

State Supported Services

The Plan is required to provide, or arrange to provide, to eligible members the following State Supported Services: Current Procedural Terminology Codes: 59840 through 59857 and Center for Medicare & Medicaid Services Common Procedure Coding System Codes: X1516, X1518, X7724, X7726, and Z0336. These codes are subject to change upon the Department of Health Care Services implementation of the Health Insurance Portability and Accountability Act of 1996 electronic transaction and code set provisions. *(State Supported Services Contract, Exhibit A)*

Plans must cover abortion services, as well as the medical services and supplies incidental or preliminary to an abortion, consistent with the requirements outlined in the Medi-Cal Provider Manual. Managed Care Plans and their network providers and subcontractors are prohibited from requiring medical justification, or imposing any utilization management or utilization review requirements, including prior authorization and annual or lifetime limits, on the coverage of outpatient abortion services. However, non-emergency inpatient hospitalization for the performance of an abortion may require prior authorization under the same criteria as other medical procedures. (*All Plan Letter 24-003, Abortion Services*)

Plan policy, *UM 36.1 PHC-CA Abortion Services* (revised 08/09/2024), stated the Plan covers abortion services, as well as medical service and supplies incidental or preliminary to an abortion, consistent with the requirements detailed in the Medi-Cal Provider Manual; the network providers and any subcontractors are prohibited from requiring medical justification or imposing any utilization management or utilization review requirements, including prior authorization and annual or lifetime limits, on the coverage of outpatient abortion services.

Finding: No deficiencies were identified in this audit.

Recommendation: None.