DHCS AUDITS AND INVESTIGATIONS

CONTRACT AND ENROLLMENT REVIEW DIVISION

# REPORT ON THE FOCUSED AUDIT OF AIDS HEALTHCARE FOUNDATION DBA POSITIVE HEALTHCARE CALIFORNIA 2023

Contract Number: 11-88286

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

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

Report Issued: August 30, 2024

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# I. INTRODUCTION

## Background

In accordance with California Welfare and Institutions Code section 14456, the Department of Health Care Services (DHCS) may conduct additional reviews outside of the annual medical audit when DHCS determines there is good cause.

DHCS directed the Contract and Enrollment Review Division to conduct focused audits of all contracting Medi-Cal Managed Care Plans (Plans) to evaluate current Plans' performances in the areas of Behavioral Health and Transportation services.

These focused audits differ from DHCS' regular annual medical audits in scope and depth. The annual medical audits evaluate the Plan's organizational structures, policies and procedures, and systems for compliance with contractual requirements. The focused audits examined the operational issues that may hinder appropriate and timely member access to medically necessary care. The focused audit engagement formally commenced in January 2023, through December 2023.

For the Behavioral Health section, the focused audit evaluated the Plan's monitoring activities of specific areas such as Specialty Mental Health Services (SMHS), Non-Specialty Mental Health Services (NSMHS), and Substance Use Disorder Services (SUDS). The focused audit also reviewed potential issues that may contribute to the lack of member access and oversight to SMHS, NSMHS, and SUDS.

The focused audit conducted a more in-depth look at current Plan operations/practices for executing the delivery of transportation services. The audit examined potential causes for the systemic issues surrounding the Non-Emergency Medical Transportation (NEMT) and Non-Medical Transportation (NMT) services, specifically when transportation is delegated to a transportation broker.

AIDS Healthcare Foundation dba Positive Healthcare California (Plan), established in 1995 under the Federal Waiver Program, is a not-for-profit organization providing Human Immunodeficiency Virus (HIV) treatment. 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 to a full-risk AIDS specialty Medi-Cal Managed Care plan. The Plan is a licensed Knox-Keene Health Care Service plan.

The Plan provides specialty health care for Medi-Cal members, age 21 years old and over, in Los Angeles County. The Plan provides health care services designed around the

needs of people living with stage three HIV infection. The Plan has a network of providers offering the following contracted services: primary medical care (HIV specialists), specialty consultation, outpatient, radiology, laboratory, pharmaceutical, hospice, hospital inpatient and mental health. On July 1, 2019, hospice and hospital inpatient services were added to the Contract.

During the audit period, the Plan delegated behavioral health services to Magellan and transportation services to Call-the-Car and Lyft, transportation brokers.

As of September 2023, the Plan had 553 members for the Medi-Cal line of business.

# II. EXECUTIVE SUMMARY

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

An Exit Conference with the Plan was held on June 26, 2024. The Plan was allowed 15 calendar days from the date of the Exit Conference to provide supplemental information addressing the draft audit report findings. The Plan submitted a response after the Exit Conference. The results of the evaluation of the Plan's response are reflected in this report.

The focused audit evaluated the areas of performance for Behavioral Health and Transportation services.

The summary of findings by performance area follows:

## Performance Area: Behavioral Health

### Category 2 – Case Management and Coordination of Care:

- Specialty Mental Health Services
- Non-Specialty Mental Health Services
- Substance Use Disorder Services Category 3 – Access and Availability of Care

The Plan is required to coordinate care with the Mental Health Plan (MHP). The Plan is responsible for the appropriate management of a member's mental and physical health care. The Plan did not coordinate care with the MHP for appropriate management of member's mental and physical health care.

The Plan is required to have a Memorandum of Understanding (MOU) with the county MHP for coordination of Medi-Cal mental health services. The MOU requires oversight responsibilities for program oversight, quality improvement, and ongoing management of the MOU. The Plan's MHP did not participate in its mental health oversight program to meet quality improvement for mental health services.

The MOU between the Plan and MHP is required to have policies and procedures for the management of the member's care that ensure timely sharing of information. The Plan, and MHP, did not ensure timely exchange of medical information for the purposes of medical and behavioral health care coordination for the member.

# Performance Area: Transportation

## Category 3 – Access and Availability of Care

- Non-Emergency Medical Transportation
- Non-Medical Transportation

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

# III. SCOPE/AUDIT PROCEDURES

## SCOPE

This focused audit was conducted by the DHCS, Contract and Enrollment Review Division, to ascertain the medical services provided to Plan members complied with federal and state laws, Medi-Cal regulations and guidelines, and the State Contract.

## PROCEDURE

On November 3, 2022, DHCS informed Plans that it would conduct focused audits to assess performance in certain identified high-risk areas. The focused audit was concurrently scheduled with the annual medical audit of the Plans. The focused audit scope encompassed the following sections:

- Behavioral Health - SMHS, NSMHS, and SUDS
- Transportation – NEMT and NMT services

The audit was conducted from November 27, 2023, through December 8, 2023. The audit included a review of the Plan's 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 Plan administrators and staff.

The following verification studies were conducted:

### Category 2 – Case Management and Coordination of Care

SMHS: No samples were available to evaluate care coordination with the county MHP and compliance with All Plan Letter (APL) requirements.

NSMHS: Ten samples were reviewed to evaluate care coordination with the county MHP and compliance with APL requirements.

SUDS: Four samples were reviewed to evaluate compliance with APL requirements.

### Category 3 – Access and Availability of Care

NEMT: Ten samples were reviewed to evaluate compliance with APL requirements.

NMT: Ten samples were reviewed to evaluate compliance with APL requirements.

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

# COMPLIANCE AUDIT FINDINGS

## Performance Area: Behavioral Health – SMHS, NSMHS, and SUDS

### Category 2 – Case Management and Coordination of Care

#### 2.1 Care Management and Care Coordination

The Plan is required to coordinate care with the MHP. The Plan is responsible for the appropriate management of a member's mental and physical health care, which includes, but is not limited to, medication reconciliation and coordination of all medically necessary, contractually required Medi-Cal covered services, including mental health services, both within and outside the Plan's provider network. (*APL 22-006 Medi-Cal Managed Care Health Plan Responsibilities for Non-Specialty Mental Health Services)*

The Plan's MOU must address policies and procedures for management of the member's care for both Plan and MHP, including but not limited to screening, assessment and referral, medical necessity determination, care coordination, and exchange of medical information. (APL 18-015 Memorandum of Understanding Requirements for Medi-Cal Managed Care Plans)

The Plan's MOU (effective 07/01/2019 – 06/30/2024) between the Plan and MHP, Los Angeles County Department of Mental Health (LACDMH), states that the Plan and MHP shall have written policies and procedures to address a process for assignment of an interdisciplinary team to coordinate a member's care as determined by mutually agreed upon protocols. The team, composing of representatives from Department of Mental Health, Department of Public Health, Substance Abuse Prevention and Control, and the Plan have oversight responsibility for provision of screening, assessment, referrals, care management, care coordination and authorization of Medi-Cal mental health services to eligible members.

Plan policy CM 42.4, PHC-CA Mental Health Services (revised 08/31/2023), states that the Plan maintain a process for members to access all NSMH and SUD covered services, including coordinated care for all SMHS and SUDS and provide referrals including mechanisms to track completion of follow up visits, to the county MHP and Drug Medi-Cal or Drug Medi-Cal Organized Delivery System services. The Plan procedure is to ensure care coordination with LACDMH.

Plan policy PR 22.0, PHC-CA Specialty Mental Health Services through County Mental Health Plan (revised 03/08/2023), states that the Plan is responsible for the provision of case management and care coordination for all medically necessary services a member needs.

**Finding:** The Plan did not coordinate care with the MHP for appropriate management of members mental and physical health care for members accessing SMHS.

The Plan did not have the MHP's participation in oversight responsibility for the provisions of SMHS, including the screening, assessment, referrals, care management, care coordination and authorization. Therefore, it is not certain if the Plan was aware if any of the members were receiving SMHS.

Furthermore, the Plan responded to the SMHS verification sample request by initially providing inaccurate information; specifically, it provided information on NSMHS instead. Through the interview, it was discovered that the Plan was not aware of any SMHS cases and that the initial request was incorrectly categorized. As a result, a verification study to ensure mental health treatment was appropriately managed and coordinated for members could not be conducted.

During the interview, the Plan stated that it did not have any MHP-assigned liaison for care coordination and care management for potential members accessing SMHS. As a result, the Plan had no direct communication with the county MHP to facilitate coordination of care for members seeking or receiving SMHS.

Without care management and coordination between the Plan and MHP, members accessing SMHS may experience disruption in receiving the appropriate health care.

**Recommendation:** Revise and implement policies and procedures to ensure the Plan coordinates care with the MHP for the appropriate coordination of member's mental and physical health care.

## 2.2 Mental Health Oversight and Quality Improvement

The Plan is required to have an MOU with the county MHP for coordination of Medi-Cal mental health services. The MOU requires oversight responsibilities to include the Plan mental health Medi-Cal oversight team comprised of representatives of the Plan and MHP responsible for program oversight, quality improvement, and ongoing management of the MOU. *(APL 18-015 Memorandum of Understanding Requirements for Medi-Cal Managed Care Plans)*

The Plan's MOU (effective 07/01/2019 – 06/30/2024) with LACDMH states that the Oversight Committee, consisting of Plan and MHP, shall provide program oversight of the multidisciplinary behavioral health care management team. The Oversight Committee shall address quality improvement requirements for mental health services including, but not limited to:

- Regular meetings, as agreed upon by the Plan and MHP, to review the referral and care coordination process.
- No less than semi-annual calendar year reviews of referral and care coordination processes to improve quality of care.
- Performance measures and quality improvement initiatives to be determined as required by regulatory and accredited governing bodies.

**Finding:** The Plan did not have the MHP participate in its mental health oversight program to meet quality improvement for mental health services.

The Plan was unable to provide any documentation during the review period to demonstrate the Plan and MHP held any regular joint-oversight committee meetings to continuously address quality improvement requirements. The oversight includes review of care management, referral process, and care coordination process by the multidisciplinary behavioral health care management team.

During the interview, the Plan stated that it did not have any MHP liaison within the review period. The Plan indicated multiple reach-out attempts to the MHP were made to obtain a liaison. The Plan provided a string of electronic mail communication with the MHP; however, the communication and the Plan statements were after the review period and not related to obtaining a liaison.

Subsequently, the Plan did not have the policy and procedure for the MHP's participation and regular joint-meetings in the oversight effort, and quality improvement, for the delivery of mental health services.

Without established collaboration between the Plan and MHP, there may be potential missed opportunities in referral, care coordination and management, which may result in the delay of members receiving appropriate health care.

**Recommendation:** Execute and implement MOU to establish an oversight committee to address quality improvement for mental health services.

## 2.3 Exchange of Medical Information

The Plan's MOU must address policies and procedures for management of the member's care for both Plans and MHPs, including but not limited to screening, assessment and referral, medical necessity determination, care coordination, and exchange of medical information. *(APL 18-015 Memorandum of Understanding Requirements for Medi-Cal Managed Care Plans*)

The Plan and county MHP are required to have policies and procedures that ensure timely sharing of information. The policies and procedures should describe agreed-upon roles and responsibilities for sharing protected health information for the purposes of medical and behavioral health care coordination; such information may include, but is not limited to, beneficiary demographic information, diagnosis, treatment plan, medications prescribed, laboratory results, referrals, and discharges to and from inpatient and crisis services, and known changes in condition that may adversely impact the member's health and/or welfare. *(APL 18-015 Memorandum of Understanding Requirements for Medi-Cal Managed Care Plans, Attachment 2)*

Plan policy, *CM 97, PHC-CA Exchange of information with the LACDMH to Facilitate Care Coordination of Mental Health and Substance Use Disorder Treatment* (revised 05/31/2020), states the purpose is to ensure access to Behavioral Health Services for the Plan members by outlining the method of exchanging member information with the county MHP. The Plan shall ensure care coordination with LACDMH, county MHP, to carry out the provisions of all medically necessary covered services.

**Finding:** The Plan, and MHP, did not ensure timely exchange of medical information for the purposes of medical and behavioral health care coordination for the member.

The Plan was not able to provide evidence of mutual exchange of information between the Plan and county MHP, as delineated in the MOU, to ensure that any members seeking SMHS receive coordinated care.

During the interview, the Plan stated that it solely relied on members receiving SMHS to inform the Plan of their care instead of receiving medical information from the county MHP for purposes of care coordination. The Plan relied on member information because it stopped receiving from the county MHP.

A request for evidence was made to substantiate the Plan's statements in the interview regarding the stoppage of data sharing from the county MHP. In response, the Plan provided non-related documentation from DHCS regarding claims data. Furthermore, the Plan did not respond to an inquiry regarding the last time medical information was exchanged between the Plan and the county MHP.

Failure to exchange timely medical information may result in members experiencing a lack of coordination of care, potentially impacting their health outcomes.

**Recommendation**: Implement policies and procedures to ensure the Plan and MHP, follow agreed-upon policies and procedures for exchange of medical information.