Gavin Newsom, Governor
State of California
Health and Human Services Agency
DEPARTMENT OF MANAGED HEALTH CARE
980 9th Street, Suite 500
Sacramento, CA 95814
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March 29, 2024 **Via eFile**

Mr. Michael Weinstein, President
AIDS Healthcare Foundation
DBA: Positive Healthcare
6255 West Sunset Blvd., Suite 2100
Los Angeles, CA 90028

FINAL REPORT OF A ROUTINE EXAMINATION OF AIDS HEALTHCARE FOUNDATION, DBA: POSITIVE HEALTHCARE

Dear Mr. Weinstein:

Enclosed is the final report (Final Report) of a routine examination for the quarter ended March 31, 2023 of the fiscal and administrative affairs, including the claims settlement practices and provider dispute resolution mechanism, of AIDS Healthcare Foundation, dba: Positive Healthcare (Plan). The examination was conducted by the Department of Managed Health Care (Department) pursuant to Section 1382 of the Knox-Keene Health Care Service Plan Act of 1975.[1] The Department issued a preliminary report (Preliminary Report) to the Plan on December 21, 2023. The Department accepted the Plan's electronically filed responses (Responses) on February 11, 2024 and February 21, 2024.

The Final Report includes a description of the compliance efforts included in the Plan's Responses, in accordance with Section 1382(c).

Section 1382(d) states, "If requested in writing by the plan, the director shall append the plan's response to the final report issued pursuant to subdivision (c). The plan may modify its response or statement at any time and provide modified copies to the department for public distribution not later than 10 days from the date of notification from the department that the final report will be made available to the public. The addendum to the response or statement shall also be made available to the public."

[1] References to "Section" are to sections of the Knox-Keene Health Care Service Plan Act of 1975, as codified in California Health and Safety Code section 1340 et seq.

Please indicate within 10 days from the date of the Plan's receipt of this letter whether the Plan requests the Department to append its Responses. If so, please indicate which portions of the Plan's Responses should be appended, and electronically file copies of those portions excluding information held confidential pursuant to Section 1382(c). If the Plan requests the Department to append a brief statement summarizing the Plan's Responses or wishes to modify any information provided to the Department in its Responses, please provide an addendum no later than 10 days from the date of the Plan's receipt of this letter. Please file this addendum electronically via the corrective action plan (CAP) system within the Department's eFiling web portal at https://wpso.dmhc.ca.gov/secure/login/, as follows:

- From the main menu, select "eFiling."
- From the eFiling menu, select "Online Forms."
- From the Online Forms menu, select "Details" for "CAP # S23-R-432."
- Go to the "Messages" tab, then:
    - Select "Addendum to Final Report" (note this option will only be available for 10 days after the issuance of the Final Report).
    - Select the deficiency(ies) that are applicable.
    - Create a message for the Department.
    - Attach and upload all documents with the name "Addendum to Final Report."
    - Select "Send Message."

As noted in the attached Final Report, the Plan's compliance efforts described in the Responses did not fully resolve the deficiencies raised in the Preliminary Report issued by the Department on December 21, 2023. The Plan is required to respond to any request for corrective actions contained within the attached Final Report within 30 days of receipt of the Final Report unless stated otherwise. If the Plan fails to fully respond and/or resolve the deficiencies addressed in the Final Report, then a referral will be made to the Department's Office of Enforcement for appropriate administrative action.

The Plan is hereby advised that any violations listed in the Final Report may be referred to the Department's Office of Enforcement for appropriate administrative actions.

Please file the Plan's response electronically via the CAP system within the Department's eFiling web portal at https://wpso.dmhc.ca.gov/secure/login/, as follows:

- From the main menu, select "eFiling."
- From the eFiling menu, select "Online Forms."
- From the Online Forms menu, click on the "Details" for "CAP #S23-R-432."
- Go to the "Data Requests" tab, then:

- Click on the "Details" for each data request that does not have a status of "Complete."
- Follow the instructions and/or use the form shown to add the requested data (depending on the type of data requested: New Filing, Document Request, Claims Data, or Financial Statement Refile).

The Department will also send an e-mail to the Plan which contains a link to the CAP system for the Plan to file the response electronically.

Questions or problems related to the electronic transmission through the CAP system should be directed to the Office of Financial Review administrative support team at 916-255-2345 or by e-mail at ofr_admin@dmhc.ca.gov.

The Department will make the Final Report available to the public in 10 days from the Plan's receipt of this letter. The Final Report will be located at the Department's web site at http://www.dmhc.ca.gov/LicensingReporting/ViewFinancialExaminationReports.aspx.

If there are any questions regarding the Final Report, please contact me at 916-403-9518 or by e-mail at Marcia.Davis@dmhc.ca.gov.

Sincerely,

SIGNED BY

Marcia Davis
Corporation Examiner IV, Supervisor
Office of Financial Review
Division of Financial Oversight

cc: Sandra Holzner, Compliance Officer, AIDS Healthcare Foundation
Pritika Dutt, CPA, Deputy Director, Office of Financial Review
Jennifer Clark, Supervising Examiner, Division of Financial Oversight
Nyamsuren Sanjaa, Examiner, Division of Financial Oversight
Elissa Nesmith, Examiner, Division of Financial Oversight
Sheena Tran, Attorney, Office of Plan Licensing
Chris Wordlaw, Staff Services Manager III, Office of Plan Monitoring
Chad Bartlett, Staff Services Manager II, Help Center

STATE OF CALIFORNIA
DEPARTMENT OF MANAGED HEALTH CARE

OFFICE OF FINANCIAL REVIEW
DIVISION OF FINANCIAL OVERSIGHT

FINAL REPORT OF A ROUTINE EXAMINATION

OF

AIDS HEALTHCARE FOUNDATION
DBA: POSITIVE HEALTHCARE

FILE NO. 933 0432

DATE OF FINAL REPORT: MARCH 29, 2024

SUPERVISING EXAMINER: JENNIFER CLARK

OVERSIGHT EXAMINER: MARCIA DAVIS

EXAMINER-IN-CHARGE: NYAMSUREN SANJAA

FINANCIAL EXAMINERS:

GETACHEW TAREKE

SULLY WONG-GUERRERO

DANIEL FLORES

BACKGROUND INFORMATION FOR AIDS HEALTHCARE FOUNDATION
DBA: POSITIVE HEALTHCARE

Date Plan Licensed:	December 1, 2005
Organizational Structure:	AIDS Healthcare Foundation, dba: Positive Healthcare (Plan) is a nonprofit health care organization. The Plan provides medical care for people affected by Human Immunodeficiency Virus or living with the Acquired Immune Deficiency Syndrome. The Plan files financial statements with the Department on a consolidated basis with other entities controlled by the Plan. The Plan is affiliated with several entities and performs administrative services for some affiliates pursuant to written administrative services agreements.
Type of Plan:	The Plan operates as a full-service health care service plan and provides services to Medicare and Medi-Cal members under contracts with the Centers for Medicare and Medicaid Services and the California Department of Health Care Services, respectively.
Provider Network:	The Plan provides health care through a network of outpatient health care centers, pharmacies, primary care and specialty physicians, hospitals and clinics, mental health providers and facilities, and other ancillary providers.
Plan Enrollment:	The Plan reported total enrollment of 1,439 as of March 31, 2023.
Service Area:	Los Angeles and San Bernardino counties, and the cities of San Francisco and Oakland.
Date of Prior Final Routine Examination Report:	March 5, 2020

FINAL REPORT OF A ROUTINE EXAMINATION OF AIDS HEALTHCARE FOUNDATION DBA: POSITIVE HEALTHCARE

This is the final report (Final Report) for the quarter ended March 31, 2023 of a routine examination of the fiscal and administrative affairs, including the claims settlement practices and provider dispute resolution mechanism, of AIDS Healthcare Foundation, dba: Positive Healthcare (Plan). The examination was conducted by the Department of Managed Health Care (Department) pursuant to Section 1382 of the Knox-Keene Health Care Service Plan Act of 1975.[1]

The Department issued a preliminary report (Preliminary Report) to the Plan on December 21, 2023. The Department accepted the Plan's electronically filed responses (Responses) on February 11, 2024 and February 21, 2024.

This Final Report includes a description of the compliance efforts included in the Plan's Responses to the Preliminary Report, in accordance with Section 1382(c). The Plan's Responses are noted in italics within this Final Report.

The Plan is hereby advised that any violations listed in the Final Report may be referred to the Department's Office of Enforcement for appropriate administrative action.

The Department examined the Plan's financial report filed with the Department for the quarter ended March 31, 2023, as well as other selected accounting records and controls related to the Plan's various fiscal and administrative transactions.

The Department's findings are presented in this Final Report as follows:

Part I.	Financial Statements
Part II.	Calculation of Tangible Net Equity
Part III.	Compliance Issues

The Plan is required to respond to any request for corrective actions contained herein within the timelines specified in this Final Report.

[1] References to "Section" are to sections of the Knox-Keene Health Care Service Plan Act of 1975, as codified in California Health and Safety Code section 1340 et seq. References to "Rule" are to regulations promulgated pursuant to the Knox-Keene Health Care Service Plan Act of 1975 contained within title 28 of the California Code of Regulations.

PART I. FINANCIAL STATEMENTS

The Department's examination did not result in any adjustments or reclassifications to the Plan's financial statements for the quarter ended March 31, 2023, as filed with the Department. A copy of the Plan's financial statements can be viewed by selecting "AIDS Healthcare Foundation" on the second drop-down menu of the Department's financial statement database available at http://wpso.dmhc.ca.gov/fe/search/#top.

No response is required to this Part.

PART II. CALCULATION OF TANGIBLE NET EQUITY (TNE)

Net Worth as reported by the Plan as of quarter ended March 31, 2023	$1,741,620,521
Less: Intangible Assets and Goodwill – Net	23,987,955
Less: Unsecured Affiliate Receivables	810,618,001
TNE	907,014,565
Required TNE	76,195,965
TNE Excess per Examination	$830,818,600

The Plan was in compliance with the TNE requirements of Rule 1300.76 as of March 31, 2023.

No response is required to this Part.

PART III. COMPLIANCE ISSUES

A. CLAIMS SETTLEMENT PRACTICES – "UNFAIR PAYMENT PATTERN"

Section 1371.37 prohibits a health care service plan from engaging in an unfair payment pattern and defines certain claim settlement practices as an "unfair payment pattern."

Rule 1300.71(a)(8) defines an "unfair payment pattern" or "demonstrable and unjust payment pattern" as any practice, policy, or procedure that results in repeated delays in the adjudication and correct reimbursement of provider claims.

The Department's examination found that the Plan engaged in demonstrable and unjust payment patterns and unfair payment patterns for the three-month period ended March 31, 2023, as follows:

1. PAYMENT ACCURACY, INCLUDING INTEREST AND PENALTIES – REPEAT DEFICIENCY

Section 1371 and Rule 1300.71(i)(2) and (j) require a health care service plan, if the plan is a health maintenance organization, to reimburse uncontested claims no later than 45 working days after the date of receipt of the claim by the plan. If an uncontested claim is not reimbursed within 45 working days after receipt, interest accrues at the rate of 15 percent per annum, beginning with the first calendar day after the 45-working day period. A plan that fails to automatically include any interest due in its payment of the claim must also pay a fee of $10 to the claimant.

Rule 1300.71(a)(8)(K) describes a demonstrable and unjust payment pattern as the failure to reimburse at least 95 percent of complete claims with the correct payment including the automatic payment of all interest and penalties due and owing over the course of any three-month period.

Rule 1300.71.38 requires a health care service plan to establish a fast, fair and cost effective dispute resolution mechanism to process and resolve contracted and non-contracted provider disputes in accordance with Section 1371 and Rule 1300.71.

The Department's examination disclosed that claims were not reimbursed accurately, including automatic payment of interest and penalties, in the following claims samples:

- Six out of 50 claims resulting from provider dispute resolutions (PDRs). This deficiency was noted in the following PDR samples: 11, 12, 28, 29, 43, and 46. The deficiency primarily occurred because interest was not paid on overturned PDRs. The Department infers with 90 percent confidence that the true compliance rate is between 78.43 percent and 93.67 percent, with the upper bound being less than the required 95 percent compliance rate.

- Five out of 30 high dollar claims. The deficiency was noted in the following high dollar samples: 2, 6, 15, and 23. The deficiency occurred because the Plan priced claims using the Medi-Cal APR DRG Pricing Calculator for Effective Dates of Admission on or after 7/1/21 rather than the Medi-Cal APR DRG Pricing Calculator for Effective Dates of Admission on or after 7/1/22.

The Plan's failure to reimburse claims accurately, including automatic payment of interest and penalties, is a repeat deficiency, as this issue was previously noted in the Department's final report dated March 5, 2020, for the quarter ended June 30, 2019. This examination disclosed that the Plan's compliance efforts in response to the prior final report did not achieve the necessary levels of compliance with the Section and Rules cited.

The Preliminary Report required the Plan to explain why the corrective actions implemented to resolve the deficiency of failure to reimburse claims accurately, including automatic payment of interest and penalties, as identified in the Department's prior examination, were not effective in ensuring ongoing compliance.

In addition, the Plan was required to submit a detailed corrective action plan (CAP) that included the following:

a. Policies and procedures, including internal claims audit procedures, implemented to ensure claims are paid accurately, including interest and penalties. When applicable, clean and redlined versions were to be submitted to clearly identify revisions made to policies and procedures as a result of the examination.

b. Date the policies and procedures were implemented.

c. Training materials and the date(s) training was conducted to ensure claim processors are aware of and comply with the requirements of the above Section and Rules.

d. Identification of all claims paid inaccurately including interest and penalties from March 5, 2020 (date of last exam) through the date the corrective action is implemented by the Plan.

e. Evidence that additional payments, interest, and penalties as appropriate, were paid retroactively for the claims identified in paragraph "d" above. This evidence is to include an electronic data file/schedule (Excel or Access) that identifies the following:

    - Claim number
    - Date of service
    - Date original claim received
    - Date new information received
    - Total billed
    - Original amount paid
    - Date original amount paid
    - Additional amount paid as a result of remediation
    - Date additional amount paid
    - Amount of original interest paid
    - Amount of additional interest paid as a result of remediation
    - Date additional interest paid
    - Number of late days used to calculate interest
    - Check number for additional claim payment
    - Provider name
    - ER or Non-ER indicator

The data file is to provide the details of all claims remediated, including claims corrected during the course of the examination, and should include the total number of claims, total original claim payments, additional claim payments, and the total additional interest and penalties paid as a result of remediation.

f. Management position(s) responsible for overseeing the CAP, and a description of the monitoring system implemented to ensure ongoing compliance.

The Plan was required to provide a response to the Department within 45 days of receipt of the Preliminary Report. If the Plan was not able to complete the CAP or portions of the CAP within 45 days, the Plan was required to submit a timeline with its response that committed the Plan to complete the CAP within 90 calendar days of receipt of the Preliminary Report. If the Plan was not able to meet this timeframe, it was required to provide a justification for the delay and request approval by the Department for the proposed timeline for completion of the CAP. The Plan was also required to submit monthly status reports to the Department until the CAP was completed.

The Plan responded to the Department's Preliminary Report as follows:

The Plan's prior corrective actions were partially successful in ensuring interest was applied automatically to clean claims but did not thoroughly address monitoring and controls for claims that require manual intervention.

As a result, starting January 8, 2024, the Plan began the process of reviewing claims. Further, starting January 10, 2024, the Plan began reviewing and updating existing policies and procedures, standard operating procedures, job aids, and training materials for claims processing with a target completion date of April 1, 2024. The Plan intends to implement the policies and procedures by May 1, 2024. Further, the training materials for examiners are under review and scheduled training is pending but is expected to be completed by June 1, 2024.

The Plan is working internally with Information Technology and Claims Management to identify inaccurately paid claims to be reviewed and reprocessed for accurate payment, including interest and penalties from March 5, 2020 through present.

The Plan has made specific efforts on high dollar and PDR identifications. All Inpatient high dollar claims are being manually reviewed to confirm the appropriate APG-DRG Pricing tool was used. Inaccurately paid claims identified will be reprocessed and the Plan will provide a report of evidence for additional payments. All paid PDRs are being manually reviewed to confirm accurate payment, interest, and penalties are applied. Any inaccurately paid claims identified will be reprocessed. The Plan will provide a report of evidence for additional payments. Claims identified as "paid inaccurately" will be submitted with evidence of additional payment, interest, and penalties as appropriate. The target completion date is April 1, 2024.

The Plan's National Director of Managed Care Operations and Program Development/ Plan Administrator are responsible for overseeing the CAP and ensuring ongoing compliance.

The Department finds that the Plan's compliance efforts are not fully responsive to the corrective action required since the Plan did not complete the actions required by the Department.

The Department approves the Plan's proposed date of April 1, 2024 to identify the underpaid claims and provide evidence of additional payment. The Department also approves the Plan's proposed date of May 1, 2024 and June 1, 2024 respectively to update the policies and procedures and complete the necessary training.

The Plan is required to submit monthly status reports to the Department until the CAP is completed.

B. AMENDMENTS TO PLAN APPLICATION

Section 1352(a) and Rule 1300.52 require all plans to file an amendment with the director within 30 days after any change in the information contained in its application, other than financial or statistical information. Rule 1300.52.4 sets forth the standards for filing amendments.

1. ADMINISTRATIVE SERVICE AGREEMENTS

Section 1351(d) requires a health plan applicant to provide a copy of any contract made, or to be made, between the applicant and any person or organization agreeing to perform an administrative function for the plan.

Rule 1300.51(d)(F)(2) requires all applicants to provide a copy of each contract with affiliated persons, principal creditors, and providers of administrative services.

Rule 1300.51(d)(N)(1) requires all applicants provide a copy of each contract which applicant has for administrative or management services, or consulting contracts, or which applicant intends to have for the health plan.

The Department's examination disclosed that the Plan failed to file with the Department its claims processing agreements with Catalyst Solutions and Change Healthcare.

The Preliminary Report required the Plan to file the abovementioned administrative service agreements as an amendment using the Department's eFiling system. In addition, the Plan was required to implement corrective actions to ensure administrative service agreements are filed with the Department pursuant to the applicable Section and Rules, describe the corrective actions taken to the Department, state the date of implementation, and identify the management position(s) responsible for implementation and ensuring ongoing compliance.

The Plan responded that the Administrative Service Agreement (ASA) for Catalyst Solutions and Change Healthcare were filed with the Department on January 30, 2024. Those filings are currently under review by the Department.

Further, the Plan implemented a corrective action on January 30, 2024, and updated the internal report reminder to perform an annual review of all ASAs to ensure they are correctly filed with the Department. The Compliance Officer in collaboration with the Plan Administrator is responsible for ensuring all ASAs are appropriately filed with the Department.

The Department finds that the Plan's compliance effort is responsive to the deficiency cited and corrective action required. Therefore, no further response is required.

2. CHANGES IN PLAN PERSONNEL – REPEAT DEFICIENCY

Section 1352(c) and Rule 1300.52.2 state, in part, that a plan shall, within five days, file an amendment when there are changes in personnel of the plan. Changes in personnel refer to the addition or deletion of a director, trustee, principal officer, general partner, general manager or principal management persons, or persons occupying similar positions, or performing similar functions, or a substantial and material change in the duties or any such person.

The Department's examination disclosed that the Plan did not file a personnel change within the required five days for a Board Member. The Board Member was nominated and accepted to the Board of Directors during the Board meeting on January 12, 2022.

The Preliminary Report required the Plan to electronically file a new amendment to report the personnel change with the Department. The cover page was to state that it is filed as a result of the recent financial examination. The Plan was required to provide evidence in its response to this Preliminary Report that the filing was submitted to the Department.

In addition, the Plan was required to implement corrective actions to ensure changes in key personnel are filed with the Department within five days pursuant to the above Section and Rule, describe the corrective actions taken to the Department, state the date of implementation, and identify the management position(s) responsible for

implementation and ensuring ongoing compliance.

The Plan filed an amendment to report the personnel changes on April 19, 2024. Further per the response, the Plan implemented a corrective action on August 29, 2023 and updated the Compliance Policy and Procedures to ensure key personnel changes are filed with the Department within the required timeframe. The Compliance Officer is responsible for notifying the Department and ongoing compliance.

The Department finds that the Plan's compliance effort is responsive to the deficiency cited and corrective action required. Therefore, no further response is required.