State of California—Health and Human Services Agency
Department of Health Care Services

JENNIFER KENT
DIRECTOR

EDMUND G. BROWN JR.
GOVERNOR

August 17, 2017

Elizabeth Gibboney
Partnership HealthPlan of California
4665 Business Center Drive
Fairfield, CA 94534

RE: Department of Health Care Services Medical Audit

Dear Ms. Gibboney:

The Department of Health Care Services (DHCS), Audits and Investigations Division conducted an on-site Medical Audit of Partnership HealthPlan of California, a Managed Care Plan (MCP), from January 30, 2017 through February 3, 2017. The survey covered the period of January 1, 2016 through December 31, 2016.

On August 14, 2017, the MCP provided DHCS with additional information regarding its Corrective Action Plan (CAP) in response to the report originally issued on June 15, 2017.

All items have been reviewed and found to be in compliance. The CAP is hereby closed. The enclosed report will serve as DHCS' final response to the MCP's CAP.

Please be advised that in accordance with Health & Safety Code Section 1380(h) and the Public Records Act, the final report will become a public document and will be made available on the DHCS website and to the public upon request.

If you have any questions, feel free to contact me at (916) 552-8946 or Farzaneh Aflatooni at (916) 319-8298.

Sincerely,

Jeanette Fong, Chief
Compliance Unit

Enclosures: Attachment A CAP Response Form

cc: Janelle Gilmore Contract Manager
Department of Health Care Services
Medi-Cal Managed Care Division
P.O. Box 997413, MS 4408
Sacramento, CA 95899-7413

ATTACHMENT A
Corrective Action Plan Response Form

Plan: Partnership HealthPlan of California

Audit Type: Medical Audit and State Supported Services **Review Period: 01/01/16 – 12/31/16**

MCPs are required to provide a CAP and respond to all documented deficiencies within 30 calendar days, unless an alternative timeframe is indicated in the letter. MCPs are required to submit the CAP via email in word format which will reduce turnaround time for DHCS to complete its review.

The CAP submission must include a written statement identifying the deficiency and describing the plan of action taken to correct the deficiency, and the operational results of that action. For deficiencies that require long term corrective action or a period of time longer than 30 days to remedy or operationalize, the MCP must demonstrate it has taken remedial action and is making progress toward achieving an acceptable level of compliance. The MCP will be required to include the date when full compliance is expected to be achieved.

DHCS will maintain close communication with the MCP throughout the CAP process and provide technical assistance to ensure the MCP provides sufficient documentation to correct deficiencies. Depending on the volume and complexity of deficiencies identified, DHCS may require the MCP to provide weekly updates, as applicable.

Deficiency Number and Finding	Action Taken	Supporting Documentation	Implementation Date* (*anticipated or completed)	DHCS Comments
1. Utilization Management				
1.4.1 **Acknowledgment Letters for Provider Appeals of Medical Utilization Management (UM) Denials** The Plan did not send acknowledgment letters for provider appeals of	1.4.1 **Acknowledgment Letters for Provider Appeals of Medical Utilization Management (UM) Denials** Policy # MCUP3037 was updated to reflect appropriate written communication to both the member and provider within 5 calendar days upon receipt of an	1.4.1 1. Policy MCUP3037: "After receipt of the request for appeal, the Plan will provide written acknowledgement to the member that	7/1/2017	**07/12/17** – The following documentation supports the MCP's efforts to correct this finding: -Updated P&P #MCUP3037, "Appeals/Expedited of UM Decisions for Medical Necessity Determination (Non Administrative)" (08/16/17) to show that the MCP sends acknowledgment letters

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medical UM denials. The appeals verification study found that acknowledgment letters were not sent to providers or members for provider appeals of adverse UM decisions, but were sent for grievance-related appeals and pharmacy UM appeals.	appeal by a provider on behalf of a member. Appeal letter created to be sent to Providers and members. Policy #MCUP3037 was approved by DHCS within the Grievance and Appeals deliverable.	is dated and postmarked within five (5) calendar days of receipt of the appeal." 2. UM Appeal Acknowledgment Letter template.		to the members and the providers when they receive provider appeals on behalf of a member (page 2, section B.2.a). -Sample of Appeal Acknowledgment Letter that includes a cc to the member and provider. -"Desktop Procedure for Appeal Acknowledgment Letters" which indicates that the MCP's HS/UM Appeal Coordinator will generate the acknowledgment letter and send it out to both the member and provider. -"Appeal Acknowledgment Letter In-Service" and corresponding sign-in sheet (04/20/17) as evidence that MCP trained staff on sending acknowledgment letters to providers when providers file an appeal on behalf of a member. **This finding is closed.**
2. Case Management and Coordination of Care				
2.3.1 **Behavioral Health Treatment (BHT) Plan Requirements** Plan policy #: *MPUP3126, Autism Spectrum Disorder*	2.3.1 **Behavioral Health Treatment (BHT) Plan Requirements** Policy MPUP3126 has been updated to include information from APL15-025.	2.3.1 1. Updated Policy #MPUP3126. 2. Agenda from Provider meeting dated June 13,	July 1, 2017	**07/07/17** – The following documentation supports the MCP's efforts to correct this finding: -Updated P&P, "#MPUP3126, Autism Spectrum Disorder (ASD) Behavioral Health Treatment (BHT) (06/21/17)

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(ASD) Behavioral Health Treatment (BHT), Latest Approval Date: 09/21/2016, was based on the superseded APL 14-011 and did not meet all of the required elements that the treatment plan must have as specified in APL 15-025. The Plan's policy and procedures did not clearly identify crisis, transition, and exit plans to its treatment plan requirements. A treatment plan without the required elements may delay the child's transitioning to the next level of needed care. The verification study confirmed that treatment plans did not include APL 15-025's additional requirements. Forty-five treatment plans did not include clearly identified crisis plans and 44 did not include exit plans.	Providers have been educated concerning the change in requirements per APL15-025. Roundtable discussion included: Providers must add the following to treatments plans effective immediately: • Transition plan, and who is responsible • Crisis Plan and who is responsible • Exit Plan and criteria We advised that the plans must be child specific, address specific behavior, and include parental notification.	2017.		which was amended to incorporate treatment plan requirements in accordance with DHCS APL 15-025. The plan requires crisis, transition, and exit plans to be included into the treatment plans. (Page 4, Section 2.i and m) -Meeting Agenda (06/13/17) as evidence that providers were trained on BHT policy changes. Clarification email (07/12/17) further reiterates that providers were specifically trained on including the following components in BHT treatment plans: transition plan, crisis plan, and exit plan. **07/20/17** – The following additional documentation submitted supports the MCP's efforts to correct this deficiency: -Two samples care plans (05/31/17; 06/25/17) which clearly incorporate evidence of crisis and transition/exit plans. **This finding is closed.**

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3. Access and Availability of Care				
3.1.1 **Network Adequacy Requirements** The Plan did not meet network adequacy requirements in its geographic service area consisting mostly of rural to small counties. The Plan did not meet the time and distance standard in eight rural to small counties and the PCP appointment timeliness standard (new adult patient only) in four of the eight rural to small counties.	3.1.1 **Network Adequacy Requirements** Due to the extremely rural and frontier geographic areas where there are no PCPs within the time and distance standards, PHC applied and is awaiting notice from DHCS regarding alternative access standards that were submitted in December 2016. In the meantime, PHC continues its efforts to: 1) assist primary care offices in recruiting physicians, physician assistants, and nurse practitioners; 2) offer trainings to primary care offices to optimize efficiencies in patient workflow; and 3) offer contracts to existing and new non-contracted PCPs who are Medi-Cal approved. The plan is currently conducting the Third Next Available (3NA) Appointment Survey, will compare the results to the 2016 results and develop initiatives designed to improve appointment findings based on the 2017 results.		Ongoing	**07/24/17** – The following documentation supports the MCP's ongoing efforts to correct this finding: -A report "Initiatives focused on Access and Availability" (January of 2016) as evidence that MCP has focused on a number of initiatives to improve primary and specialty access and availability. -A document "Improving Access to Specialty Care" as evidence of MCP's ongoing efforts to increase access and to specialty care (e.g., Marin Community Health Centers – Orthopedic Clinic, Shasta Community Health Centers – Telehealth, Regional Referral Coordinator Roundtable). -Various Access Committee Meeting minutes (02/28/16; 08/05/16; 11/04/16) as evidence of MCP's ongoing documented efforts and discussion to improve specialty access (e.g.,Telehealth and eConsult, etc.). -Internal Quality Improvement Committee (IQIC) meeting minutes (10/11/16) as evidence that MCP has conducted a 3NA Survey (Third Next Available Survey) to evaluate timely

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				access to appointments. -Quality and Utilization Advisory Committee meeting minutes (11/16/16) as evidence that MCP has discussed the result of 3NA Survey (Third Next Available Survey). **08/14/17** – The following additional documentation submitted supports the MCP's efforts to correct this deficiency: -Several meeting minutes from Primary Care Access Workgroup (January 2017 through May 2017). Meeting minutes document ongoing recruitment efforts of the plan to expand its provider network to address access issues. **This finding is closed.**
3.5.1 **Potential Carved-Out Services Claims** The Plan denied claims for medically necessary covered services before CCS eligibility was confirmed. The Plan's process for handling claims with CCS-eligible diagnoses codes was to deny the claims and	3.5.1 **Potential Carved-Out Services Claims** 1. Updated Claims Operating Instruction Memorandum 026pp 2. Changed system configuration to remove CCS edits as of 6/21/17. All emergent/urgent service claims will pay as PHC responsibility.	3.5.1 1. Attached copy of Claims Operating Instruction Memorandum 026pp dated 6/21/17. 2. EOPs showing the adjustment of 2016 audit	6/21/17	**07/07/17** – The following documentation supports the MCP's efforts to correct this finding: -Updated P&P, "CL#26pp, Medi-Cal Emergent/ Urgent Care Claims" (04/01/17) which indicates that claims received on or after 06/21/17, the MCP will no longer check for possible CCS financial responsibility on emergent/urgent care claims. Claims will

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require CCS denial and provider resubmission before making payments. This was evidenced by the verification study and confirmed during interviews. By denying claims for medically necessary covered services before CCS eligibility is confirmed, the Plan is not fulfilling its contractual responsibility to pay for services that have been provided, as the burden to ensure payment falls on the providers to resubmit claims for those services.		samples.		no longer be pended for review. (Page 2, Section II.D) -Evidence that for the two deficient cases cited in the report, MCP retroactively reimbursed CCS for payment. -Email correspondence (05/19/17) describing the MCP's process for retroactively reimbursing CCS for past claims denied. MCP response indicates that for claims denied since 01/01/17, MCP is re-adjudicating each claim and is working with the CCS offices and informing providers of the process. **07/20/17** – The following additional documentation submitted supports the MCP's efforts to correct this deficiency: -Updated P&P CL#18h, "California Children Services (CCS) (effective 07/01/17) which specifies that MPC will continue to provide all necessary medical coverage to CCS members until their eligibility is confirmed by CCS office (page 1, section II). In addition, the P&P includes a section on a procedure to ensure compliance which indicates that MCP will run monthly reports to audit CCS denied claims (page 2, section III.C).

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				This finding is closed.
3.5.2 **Claim Denial Reasons in Remittance Advice or Denial Letter** The Plan's remittance advices sent to providers did not include denial reasons for claims submitted with outdated or incorrect diagnosis codes. Four verification study claims were denied with no remittance advice explanation due to providers submitting claims with invalid diagnosis codes related to the transition from ICD-9 to ICD-10. One verification study claim was denied with no remittance advice explanation due to the provider submitting an incorrect diagnosis code. All four claims	3.5.2 **Claim Denial Reasons in Remittance Advice or Denial Letter** 1. IT created an exception report to validate system updates of explanation codes to the EOPs. 2. Adjusted and reissued the EOPs for the audited claims. **07/14/17 Updated Response:** In response to DHCS finding on claims with missing remarks, the following steps have been put in place: A. IT department has created a report (IT Exception Report) that compares AMISYS claim Explanation (EX) codes to the current HIPAA compliant EX code matrix. Any EX code not found on the matrix will generate to this report for claims staff resolution.	3.5.2 1. Copy of exception report 2. EOPs reissued for the claims audited	EOP run 6/21/17	**07/07/17** – The following documentation supports the MCP's efforts to correct this finding: -Evidence that for the five deficient cases cited in the report, MCP retroactively resubmitted remittance advice explanation for denials (the appropriate denial code and corresponding explanation was included). -EOP Exception Report (06/30/17) as evidence that the plan's current practice is to run a report to ensure that codes are included with each EOP. **07/14/17** – The following additional documentation submitted supports the MCP's efforts to correct this deficiency: -MCP's written response clarifying that prior to each check run, the Exception Report is generated. When data is present on the report, staff must manually update the EOP to input a remark code. When no data is present on the report, all claims on the EOP have

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included the denial reasons within the Plan's claim payments system, but these reasons were not included in the remittance advices sent to the providers. The Plan has referred these cases to their information technology department to research and ensure correction.	B. Report will be generated prior to each check run, currently each Wednesday and Friday. C. Designated staff will receive notification of report via email. D. When data is present on the report: - Claims configuration staff will review the claim, EX code and assign a HIPAA code. - Update the EXCode Matrix and MAPA-Adjustment Reason and RA Remark code for EX code Crosswalk spreadsheets. - Send the updated spreadsheets to EDI with a request for a priority update in order for the EOP to have the remark code. E. When no data is present on the report, it means all the claims on the EOP			a remark code. **This finding is closed.**

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	have a remark code. - Save a copy of the report - No additional action is necessary PHC Claims department has developed an Operating Instruction Memo regarding the above process and currently being finalized.			
4. Members' Rights				
4.1.1 **Medical Director Documentation of Quality of Care Grievance Participation** Medical Director participation in the resolution of quality of care grievances was not documented. There was no written Medical Director documentation in 12 quality of care grievances. There was written documentation of involvement in two cases but this was unrelated to the actual grievance resolution. Documenting Medical	4.1.1 **Medical Director Documentation of Quality of Care Grievance Participation** All quality of care grievances are reviewed by a Plan Medical Director in conjunction with the Grievance Clinical Lead as of 7/3/2017. During the initial review of a grievance, the GCL will do the following: • Make clinical vs. non-clinical determination • Refer Case to appropriate Medical Director • Identify expedited grievances and alert	4.1.1 Per Policy CGA024: All quality of care grievances are reviewed by a GCL and submitted to the CMO or his/her physician designee for review within a timeframe which is appropriate for the nature of the member's condition. If there is a potential safety issue determined by the	7/3/2017	**07/07/17** – The following documentation supports the MCP's efforts to correct this finding: -Updated P&P, "CGA-024, Medi-Cal Member Grievance System" (06/21/17) which describes the MCP's new process as of 07/03/17 of funneling quality of care grievances to the Medical Director through the Grievance Clinical Lead (GLC) who logs all cases. In addition, the MCP has an IRR process to validate whether the GCL consistently categorizes QOC grievances and 10 cases are reviewed per quarter by the CMO. **08/01/17** – The following additional documentation submitted supports the MCP's efforts to correct this deficiency:

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Director involvement during quality of care grievance resolution ensures that time sensitive quality issues are promptly addressed by a Medical Director with clinical expertise in the area of concern.	Medical Director • Document the Medical Directors comments in the case prior to sending to the appropriate department to have reviewed as a potential quality issue (PQI). **08/01/17** updated response to clarify the MCP's IRR process: 20 random samples will be selected quarterly (beginning July 2017 for Q22017). • 10 non-PQI referral cases – to determine whether the decision to not refer the case to QI as PQI was appropriate. • 10 clinical vs. non-clinical. o 5 clinical cases – to determine whether the categorization of a grievance (clinical) was	GCL or Quality Improvement RN, documentation of the issue will be reviewed by the QI Department.		-Job description of the "Grievance Clinical Lead" indicating that the GCL reviews all grievances and appeals for clinical components and provides clinical oversight to grievance staff. Email response (08/01/17) from MCP indicates that this person has a Bachelor's degree in Nursing. -Email response (08/01/17) which provides more details on the MCP's IRR process to ensure that the GCL consistently forwards all QoC grievances to the Medical Director for review. **This finding is closed.**

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	appropriate. o 5 non-clinical cases – to determine whether the categorization of a grievance (non-clinical) was appropriate. All 20 samples will be provided to the CMO or designee for review. Response regarding the sample from CMO would be reported out during the following quarter during the Quality and Grievance Committee meetings.			
4.1.2 **Documenting and processing expressions of dissatisfaction** The Plan's grievance system did not include sufficient oversight to ensure all expressions of dissatisfaction were captured and accurately reported. The Plan receives grievances primarily through the	4.1.2 **Documenting and processing expressions of dissatisfaction** Member Services has implemented an intake form that captures all instances of expressed dissatisfaction both standard and exempt grievances and will be captured in our Grievance and Appeal case management system (Everest). All inquiries will be captured by Call Center system remark codes.	4.1.2 1. Documenting Inquiries MS38C-02.pdf (details inquiry tracking process) 2. NR/SR Documenting Inquiries Training Sign-in Sheet (To show evidence that call center staff were trained	4.1.2 Implementation of the new intake form was conducted **6/30/2017**, implementation of the Inquiry documentation process was conducted **5/9/2017.**	**07/07/17** – The following documentation supports the MCP's efforts to correct this finding: -Desktop process MS38C-02, "Documenting Inquiries" (05/23/17) which describes the inquiry tracking process that MCP has created for the call center staff to record, log and track all the oral and written requests made by members that are not grievances. "Inquiry remarks" (or codes) are inputted into the MCP's electronic system.

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member services department call center. The Plan did not have a method to capture all potential expressions of dissatisfaction such as call log, inquiry log, or call reports to allow for reviewing, tracking and monitoring. Sixty-six percent (187,737 of 284,680) of the calls were not logged and tracked. Member services staff only documented calls needing follow-up or for which they deemed were exempt or non-exempt grievances. The Plan did not keep track of or review the remaining inquiries.	Grievance reports along with the inquiry log(s) should satisfy call tracking concerns.	on the new process) 3. MS Policy 344 (Calls out in section VI. 'Monthly Evaluations-Evaluating Phone Performance' how calls are reviewed for documentation accuracy)		-Member Services Sign-In Sheets (05/12/17 – 05/17/17) as evidence of training ("Documenting Inquiries") provided by MCP on the new inquiry documentation process. -P&P MP 344, "Department Standards and Performance Evaluation" (08/09/16) as evidence that MCP conducts monthly performance evaluations by assessing 5 calls per month for each MSR to ensure that calls are documented appropriately (which would include accuracy of categorization/codes used). **This finding is closed.**

Submitted by: Dina M. Cuellar **Date: 7/7/2017**
Title: Director of Regulatory Affairs