MEDICAL REVIEW – NORTHERN SECTION I
AUDITS AND INVESTIGATIONS
DEPARTMENT OF HEALTH CARE SERVICES

Partnership HealthPlan of California

Contract Number: 08-85215

Audit Period: January 1, 2016
Through
December 31, 2016

Report Issued: June 15, 2017

TABLE OF CONTENTS

I. INTRODUCTION

Partnership HealthPlan of California (the Plan) is a non-profit community based health care organization. The Plan is a County Organized Health System (COHS) established in 1994 in Solano County. The Plan is governed by a Board of Commissioners. The Board is comprised of locally elected officials, provider representatives, and patient advocates.

The Plan provides services to 14 Northern California counties: Del Norte, Humboldt, Lake, Lassen, Marin, Mendocino, Modoc, Napa, Shasta, Siskiyou, Solano, Sonoma, Trinity, and Yolo.

The Plan began operations in 1994 serving only Solano County. Between 1998 and 2011, Yolo, Sonoma, Marin, and Mendocino counties were added. On September 1, 2013, as part of the rural expansion, eight more counties were added: Del Norte, Humboldt, Lake, Lassen, Modoc, Shasta, Trinity, and Siskiyou.

As of October 24, 2016, the Plan had 570,953 Medi-Cal members, including 14 Healthy Kids members, distributed as follows:

- Del Norte* 11,333
- Humboldt* 52,038
- Lake* 29,752
- Lassen* 7,267
- Marin 37,743
- Mendocino* 36,772
- Modoc* 3,028
- Napa* 28,989
- Shasta* 60,869
- Siskiyou* 17,606
- Solano 114,138
- Sonoma 112,903
- Trinity* 4,612
- Yolo 53,903

*Rural to small counties in terms of total population size according to the *DHCS Network Adequacy Policy Proposal* dated February 2, 2017.

II. EXECUTIVE SUMMARY

This report presents the audit findings of the Department of Health Care Services (DHCS) medical audit for the period of January 1, 2016 through December 31, 2016. The onsite review was conducted from January 30, 2017 through February 3, 2017. The audit consisted of document review, verification studies, and interviews with Plan personnel.

An Exit Conference was held on May 4, 2017 with the Plan. The Plan was given the opportunity to provide supplemental information addressing the draft audit report findings.

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

The prior DHCS medical audit (for the period of January 1, 2015 through December 31, 2015, with onsite review conducted from January 25, 2016 through February 5, 2016) was issued on October 25, 2016. The corrective action plan (CAP) closeout letter was issued on January 20, 2017.

Category 1 – Utilization Management (UM)

The Plan did not send acknowledgment letters for provider appeals of medical UM denials. 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.

Category 2 – Case Management and Coordination of Care

The Plan's policy for Behavioral Health Treatment was based on a superseded All Plan Letter. Treatment plans did not clearly identify crisis, transition, and exit plans as required by the new All Plan Letter.

Category 3 – Access and Availability of Care

The Plan did not meet network adequacy requirements in its geographic service area consisting mostly of rural to small counties. The Plan has requested, but not received DHCS approval for an alternative time and distance standard.

The Plan denied claims for medically necessary covered services before California Children's Services (CCS) eligibility was confirmed. The Plan's process for handling claims with CCS-eligible diagnoses codes was to deny the claims and require CCS denial and provider resubmission before making payments.

The Plan did not meet the Contract requirement to include claim rejection reasons in written notification to providers for claims submitted with outdated or incorrect diagnosis codes.

Category 4 – Member Rights

Medical Director participation in the resolution of quality of care grievances was not documented.

The Plan's grievance system did not include sufficient oversight to ensure all expressions of dissatisfaction were captured and accurately reported. The Plan did not maintain an inquiry log to document all member and provider inquires. Approximately sixty-six percent of calls to the Plan's member services department were not logged and tracked.

Category 5 – Quality Management

No findings

Category 6 – Administrative and Organizational Capacity

No findings

III. SCOPE/AUDIT PROCEDURES

SCOPE

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

PROCEDURE

The onsite review was conducted from January 30, 2017 through February 3, 2017. 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 1 – Utilization Management

Prior authorization requests: 20 medical and 20 pharmacy prior authorization requests were reviewed for timeliness, consistent application of criteria, and appropriate review.

Appeal procedures: 24 prior authorizations appeals were reviewed for appropriate and timely adjudication.

Category 2 – Case Management and Coordination of Care

Behavioral Health Treatment: 75 files were reviewed.

IHA: Nine medical records were reviewed.

CCM: Five medical records were reviewed.

Category 3 – Access and Availability of Care

Claims: 20 emergency services and 11 family planning claims were reviewed for appropriate and timely adjudication.

Category 4 – Member Rights

Grievance procedures: 35 grievances were reviewed for timely resolution, response to complainant, and submission to the appropriate level for review.
HIPAA: All 10 HIPAA related cases reported during the audit period were reviewed for appropriate reporting and processing.

Category 5 – Quality Management

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

Category 6 – Administrative and Organizational Capacity

Fraud and Abuse: All six suspected fraud and abuse cases reported during the audit period were reviewed for appropriate reporting and processing.

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

CATEGORY 1 - UTILIZATION MANAGEMENT

1.4 PRIOR AUTHORIZATION APPEAL PROCESS

Appeal Procedures:
There shall be a well-publicized appeals procedure for both providers and Members.
COHS Contract A.5.2.E

SUMMARY OF FINDINGS:

1.4.1 **Acknowledgment Letters for Provider Appeals of Medical Utilization Management (UM) Denials**

The Plan is required to implement and maintain a member grievance system in accordance with *CCR, Title 28, § 1300.68* (*Contract, Exhibit A, Attachment 14 (1)*). A grievance is defined as a written or oral expression of dissatisfaction regarding Plan or provider services, including quality of medical care concerns, and should include requests for appeals made by an enrollee or their representative (*CCR, Title 28, § 1300.68 (a)(1)).* Thus, appeals are technically grievances and subject to regulations applicable to grievances.

The Plan is required to provide a written acknowledgment within five calendar days of receipt of a grievance advising the complainant of receipt, date of receipt, name of the Plan representative to be contacted, their telephone number and address *(California Health and Safety Code 1368, (a), (4),(A),(B), (i, ii, iii*) and *CCR, Title 28 § 1300.68 (d)(1)).* These requirements pertain to appeals as well.

Plan policy #: *CGA-019, Medi-Cal Appeals Process*, states that an acknowledgement letter must be issued within five calendar days of receipt of an appeal unless the appeal is resolved within five calendar days in which case the resolution letter serves as the acknowledgement letter.

The Plan's Member Complaint, Appeal and Hearing Information sheet informs members about filing grievances and appeals. It states that the members will receive an acknowledgement letter within five calendar days of grievance receipt. The letter is to give the name and contact information of the Plan staff handling the grievance.

The Plan did not send acknowledgment letters for provider appeals of medical UM denials. The DHCS Grievance Questionnaire answers indicated that acknowledgment letters were sent to providers and members for grievances submitted by providers on behalf of members. 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.

Therefore, there is no accurate verification of appeals receipt by the complainant(s) and of the name, title, phone number, and address of the Plan representative who is responsible. Acknowledgment letters provide written and verifiable documentation of timely appeals receipt for members and providers advocating for members. Acknowledgment letters keep the provider and member informed of appeals resolutions, provides the required name, title, phone number, and address of the responsible Plan representative, provides an estimated date of resolution, and delineates State Fair Hearing and other rights.

RECOMMENDATION:

1.4.1 Develop and implement a process to send acknowledgment letters, including all required information, for appeals of medical UM denials.

CATEGORY 2 – CASE MANAGEMENT AND COORDINATION OF CARE

2.3 BEHAVIORAL HEALTH TREATMENT

COHS Contract E.A.10.5
Services for Members under Twenty-One (21) Years of Age
Contractor shall cover and ensure the provision of screening, preventive and Medically Necessary diagnostic and treatment services for Members under 21 years of age, including Early and Periodic Screening, Diagnosis and Treatment (EPSDT) Supplemental Services. Contractor shall inform Members that EPSDT services are available for Members under 21 years of age, as well as how to access services.

ALL PLAN LETTER 15-025 Responsibilities for Behavioral Health Treatment Coverage for Children Diagnosed with Autism Spectrum Disorder
The MCP is responsible for the provision of EPSDT supplemental services to include medically necessary Behavioral Health Treatment (BHT) services such as Applied Behavior Analysis (ABA) and other evidence-based behavioral interventions that develop or restore, to the maximum extent practicable, the functioning of a member with Autism Spectrum Disorder (ASD). The MCP must ensure all children, including children with ASD, receive EPSDT screenings designed to identify health and developmental issues, including ASD, as early as possible. When a screening exam indicates the need for further evaluation of a child's health, the child must be referred for medically necessary diagnosis and treatment without delay. The MCP is required to:
1. Inform members that EPSDT services are available for members under 21 years of age
2. Provide access to comprehensive screening and prevention services in accordance with the most current Bright Futures periodicity schedule
3. Provide access to comprehensive diagnostic evaluation based upon recommendation of a licensed physician and surgeon or a licensed psychologist for treatment of ASD including all medically necessary services, including but not limited to, BHT services
5. Ensure appropriate EPSDT services are initiated in accordance with timely access standards as set forth in the contract
6. Ensure coverage criteria for BHT are met.

For individuals diagnosed with ASD who are under the age of three with a rule out or provisional ASD diagnosis, or those diagnosed with an intellectual disability, the MCP must ensure appropriate referrals are made to the Regional Center and Special Education Local Plan Area (SELPA) for Regional Center services and supports and/or special education services, respectively.

MCP Approved Treatment Plan
MCPs must ensure that BHT services are medically necessary and are provided and supervised under an MCP-approved behavioral treatment plan developed by a contracted (or other form of agreement between the MCP and provider) and MCP-credentialed "qualified autism service provider," as defined by H&S Code Section 1374.73(c)(3) and the MCQMD ALL PLAN LETTER 15-025, Responsibilities for Behavioral Health Treatment Coverage for Children Diagnosed with Autism Spectrum Disorder.
BHT services must be provided under a behavioral treatment plan that has measurable goals over a specific timeline for the specific beneficiary being treated and developed by a qualified autism service provider. The behavioral treatment plan must be reviewed, revised and/or modified no less than once every six months by a qualified autism service provider.

Continuity of Care (APL 15-025)
MCPs must ensure continuity of care in accordance with existing contract requirements, ALL PLAN LETTER 15-025, and Health & Safety Code Section 1373.96 for the provision of BHT services.

Delegation Oversight (APL 15-025)
The MCP must ensure that delegates comply with all applicable state and federal laws and regulations, contract requirements, and DHCS guidance, including APLs for the provision of BHT services

SUMMARY OF FINDINGS:

2.3.1 **Behavioral Health Treatment (BHT) Plan Requirements**

The Plan is required to cover medically necessary BHT services for members under 21 years of age diagnosed with Autism Spectrum Disorder (ASD) or for members under 3 years of age with a provisional diagnosis. (*Contract, Amendment 32, Exhibit A, Attachment 10 (5)(F)*)

On July 7, 2014, the Centers for Medicare and Medicaid Services released guidance regarding the coverage of BHT services. On September 15, 2014, the Department of Health Care Services (DHCS) issued an interim All Plan Letter (APL) 14-011 providing guidance on BHT services. DHCS issued APL 15-025 on December 3, 2015, superseding APL 14-011. During this time, the Department of Developmental Services Regional Centers (RCs) were funding BHT services. Starting in February 2016, in concert with DHCS and RCs, the Plan began funding BHT services and accepting the RCs members for BHT.

Plan policy #: *MPUP3126, Autism Spectrum Disorder (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.

RECOMMENDATION:

2.3.1 Revise and implement policies and procedures to meet current Contract and All Plan Letter requirements.

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, children's preventive periodic health assessments, and adult initial health assessments. Contractor shall also include procedures for follow-up on missed appointments.
COHS Contract A.9.3.A

Members must be offered appointments within the following timeframes:
c) Non-urgent primary care appointments – within ten (10) business days of request;
d) Appointment with a specialist – within 15 business days of request;
COHS Contract A.9.3.A.2

Prenatal Care:
Contractor shall ensure that the first prenatal visit for a pregnant Member will be available within 10 business days upon request.
COHS 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 Subprovision A, Appointments, above.
COHS Contract A.9.3.C

SUMMARY OF FINDINGS:

3.1.1 **Network Adequacy Requirements**

The Plan is required to maintain a network of primary care physicians (PCP) that are located within 30 minutes or ten (10) miles of a member's residence unless the Plan has a DHCS approved alternative time and distance standard. (*Contract, Exhibit A, Attachment 6 (7))*

The Plan is required to arrange for a member to receive timely care as necessary for their health condition if timely appointments within the time and distance standards required are not available. The Plan shall refer members to, or assist members in locating, available and accessible contracted providers in neighboring service areas for obtaining health care services in a timely manner. (*Contract, Amendment 19, Exhibit A, Attachment 9 (3)(A)(4)*)

The Plan is required to ensure that members are offered appointments for covered health care services within a time period appropriate for their condition and that members must be offered appointments for Non-urgent primary care appointments within ten (10) business days of request. (*Contract, Amendment 19, Exhibit A, Attachment 9 3(A)(1) and (2)(c)*)

The Plan did not meet these 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.

The percentage of members residing in counties, deemed as rural to small counties in terms of total population size by the *DHCS Network Adequacy Policy Proposal* dated February 2, 2017, within the time and distance standard and the average days of the third next available appointments for non-urgent primary care are as follows:

County	**Percentage of members residing within 30 minutes/10 miles from a PCP Office**	**Average Primary Care (New Adult Patient) Third Next Available Appointment (Standard: 10 business days *(or 14 days)* for non-urgent PCP appointment)**
Del Norte	77%	**26.3 days**
Humboldt	91%	**17.5 days**
Lake	98%	**17.9 days**
Lassen	65%	**24 days**
Mendocino	88%	13.2 days
Modoc	82%	8 days
Napa	98%	13.3 days
Shasta	96%	11.4 days
Siskiyou	83%	**14.5 days**
Trinity	87%	2.7 days

Sources: Plans' 2016 PCP Geo-Access Reports and 2016 3rd Next Available (3NA) Appointment Survey

The Plan implemented various access improvement initiatives to ameliorate the access challenges inherent with an expansive, rural geographic service area and limited PCP availability. These initiatives include:

- Funding PCP recruitment in 2014-16, which according to Plan resulted in 103 new providers for all of its 14 counties.
- A pilot program to allow a fee-for-service payment model for PCPs.
- Contracting with a consultancy firm to assist PCPs who could improve operational strategies to match appointment supply and demand, reduce backlogs, and optimize the patient care.

The Plan has requested, but not received DHCS approval for an alternative time and distance standard.

RECOMMENDATION:

3.1.1 Implement and monitor access initiatives to improve compliance with network adequacy requirements.

3.5 EMERGENCY SERVICES AND FAMILY PLANNING CLAIMS

Emergency Service Providers (Claims)
Contractor is responsible for coverage and payment of emergency services and post stabilization care services and must cover and pay for emergency services regardless of whether the provider that furnishes the services has a contract with the plan.
COHS Contract A.8.12.A

Contractor shall pay for Emergency Services received by a Member from non-contracting providers.
COHS Contract A.8.12.C

At a minimum, Contractor must reimburse the non-contracting emergency department and, if applicable, its affiliated providers for Physician services at the lowest level of emergency department evaluation and management CPT (Physician's Current Procedural Terminology) codes, unless a higher level is clearly supported by documentation, and for the facility fee and diagnostic services such as laboratory and radiology.
COHS Contract A.8.12.D

For all non-contracting providers, reimbursement by Contractor or by a subcontractor who is at risk for out-of-plan Emergency Services, for properly documented claims for services rendered on or after January 1, 2007 by a non-contracting provider pursuant to this provision shall be made in accordance with provision 4, Claims Processing, above, and 42 USC Section 1396u-2(b)(2)(D).
COHS Contract A.8.12.E

Contractor shall cover emergency medical services without prior authorization pursuant to Title 28 CCR Section 1300.67(g)(1).
COHS Contract A.9.6.A

Family Planning (Claims)
Contractor shall reimburse non-contracting family planning providers at no less than the appropriate Medi-Cal FFS rate….
COHS Contract A.8.8

Claims Processing
Contractor shall pay all claims submitted by contracting providers in accordance with this provision, unless the contracting provider and Contractor have agreed in writing to an alternate payment schedule.

A. Contractor shall pay all claims submitted by contracting providers in accordance with this provision….Contractor shall comply with 42 USC Section 1396a(a)(37) and Health and Safety Code Sections 1371 through 1371.39.
B. Contractor shall pay 90 percent of all clean claims from practitioners who are in individual or group practices or who practice in shared health facilities, within 30 days of the date of receipt and 99 percent of all clean claims within 90 days. The date of receipt shall be the date Contractor receives the claim, as indicated by its date stamp on the claim. The date of payment shall be the date of the check or other form of payment….

COHS Contract A.8.4

Time for Reimbursement. A plan and a plan's capitated provider shall reimburse each complete claim, or portion thereof, whether in state or out of state, as soon as practical, but no later than thirty (30) working days after the date of receipt of the complete claim by the plan or the plan's capitated provider, or if the plan is a health maintenance organization, 45 working days after the date of receipt of the complete claim by the plan or the plan's capitated provider, unless the complete claim or portion thereof is contested or denied, as provided in subdivision (h).
CCR, Title 28, Section 1300.71(g)

SUMMARY OF FINDINGS:

3.5.1 **Potential Carved-Out Services Claims**

The Plan is required to continue to provide all medically necessary covered services for the member's California Children's Services (CCS) eligible condition until CCS eligibility is confirmed (*Contract, Amendment 19, Exhibit A, Attachment 11 (10)(A)(4)*)

If the local CCS program does not approve eligibility, the Plan remains responsible for the provision of all medically necessary covered services to the member. If the local CCS program denies authorization for any service, the Plan remains responsible for obtaining the service, if it is medically necessary, and paying for the service if it has been provided. (*Contract, Amendment 19, Exhibit A, Attachment 11 (10)(A)(6))*

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 require CCS denial and provider resubmission before making payments. This was evidenced by the verification study and confirmed during interviews.

The Plan did not pay two claims based on possible CCS-eligible medical conditions for members whose CCS eligibility status was unknown at the time these claims were adjudicated and for which the local CCS office subsequently determined were not eligible for CCS services.

For the first claim (emergency services provided on July 28, 2016), the Plan sent a denial letter to the provider on August 22, 2016. The denial letter indicated that: these services may be for a CCS-eligible condition, the Plan is not responsible for payment, referred this provider to the appropriate county CCS office, and the provider may resubmit this claim "in the event CCS determines this service does not meet their eligibility criteria." On November 7, 2016, the local CCS determined the member was ineligible for CCS services as of May 20, 2016.

For the second claim (emergency services provided on September 1, 2016), the Plan sent a denial letter to the provider on October 3, 2016. The denial letter contained the same standard notification language as the first claim. The local CCS denied the provider's Service Authorization Request (SAR) on October 17, 2016 for the same services claimed to the Plan, indicating that the member "does not have a CCS-eligible seizure condition per California Code of Regulations, Title 22, Section 41517.3 regarding nervous system disorders."

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.

3.5.2 **Claim Denial Reasons in Remittance Advice or Denial Letter**

The Plan is required, upon rejecting a claim from a health care provider, to disclose the specific rationale used in determining why the claim was rejected. (*Health and Safety Code §1399.55*)

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 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.

Providers need to know why claims are denied in order to resubmit corrected claims and receive payment for medically necessary covered services provided to members. Including denial reasons in remittance advices sent to providers will also lead to improved encounter data completeness and accuracy.

RECOMMENDATIONS:

3.5.1 Develop and implement a process that will ensure medically necessary covered services are covered until CCS eligibility is confirmed.

3.5.2 Research, correct, and verify that the claim payment system includes claim denial reasons in written notification to providers.

CATEGORY 4 – MEMBER 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 (except Subdivision 1300.68(c)(g) and (h)), 1300.68.01(except Subdivision 1300.68.01(b) and (c)), Title 22 CCR Section 53858, Exhibit A, Attachment 13, Provision 4, paragraph D.13, and 42 CFR 438.420(a)(b) and (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.
COHS 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…. (as required by Contract)
COHS 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).
COHS Contract A.14.3.A

SUMMARY OF FINDINGS:

4.1.1 Medical Director Documentation of Quality of Care Grievance Participation

The Plan must maintain a full-time physician as Medical Director whose responsibilities include resolution of grievances related to medical quality of care (*Contract, Exhibit A, Attachment 1 (6)(E)*). The Plan must appoint a physician as Medical Director, with responsibilities including resolution of medically related grievances and active participation in the functioning of the Plan grievance procedures (*CCR, Title 22, § 53246, Medical Director*).

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.

Although the Plan refers most quality of care grievances to the Quality Improvement Department (as part of the potential quality issues process) which includes physician involvement, the grievance system is a separate and distinct process with its own requirements and regulations. Documenting Medical 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.

4.1.2 Documenting and processing expressions of dissatisfaction

The Plan is required to implement and maintain procedures to monitor the Member Grievance System and the expedited review of grievances. (*Contract, Exhibit A, Attachment 14 (2)*) The Plan is required to have procedures for systematic aggregation and analysis of the grievance data and use for Quality Improvement. (*Contract, Exhibit A, Attachment 14 (2)(C)*)

The Plan is required to have procedures to ensure that the grievances are reported to an appropriate level, i.e., medical versus health care delivery issues. (*Contract, Exhibit A, Attachment 14 (2)(D)*) The Plan is required to have procedures to ensure the participation of individuals with authority to require corrective action. Grievances related to medical quality of care issues shall be referred to the Plan's Medical Director. (*Contract, Exhibit A, Attachment 14 (2)(E)*)

The Plan is required to maintain, and have available for DHCS review, grievance logs, including copies of grievance logs of any subcontracting entity delegated the responsibility to maintain and resolve grievances. (*Contract Exhibit A, Attachment 14 (3)(a)*)

A grievance is defined as a written or oral expression of dissatisfaction. Where the Plan is unable to distinguish between a grievance and an inquiry, it shall be considered a grievance. (*CCR, Title 28, § 1300.68 (a)(1)*)

Grievances received over the telephone that do not involve medical necessity and that are resolved by the close of the next business day are exempt from the requirement to send a written acknowledgment and response. The Plan is required to maintain a detailed log of exempt grievances to be periodically reviewed by the Plan. (*CCR, Title 28, § 1300.68 (d)(8)*)

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 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. Member services staff estimated that the call center receives 1,000 calls per day. The Plan reported 284,680 calls received during the audit period in the call center reports submitted to DHCS Managed Care Quality and Monitoring Division (MCQMD). 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.

Member services staff use 50 call codes and 16 were considered exempt grievance codes. Member services department forwarded 96,943 (96,766 exempt grievances for these 16 codes and 177 non-exempt grievances) to the grievance department. Only 824 grievances (exempt and non-exempt) and appeals were reported to DHCS MCQMD.

Not capturing and reviewing all calls for expressions of dissatisfaction could result in overlooked and unresolved grievances, improper categorization, and potential quality issues.

RECOMMENDATIONS:

4.1.1 Develop and implement procedures that will ensure documentation of Medical Director involvement in all quality of care grievances.

4.1.2 Develop, implement, and oversee procedures that will ensure all expressions of dissatisfaction, are captured, classified and reviewed for proper classification and reporting.

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

Partnership HealthPlan of California

Contract Number: 08-85222
State Supported Services

Audit Period: January 1, 2016
Through
December 31, 2016

Report Issued: June 15, 2017

TABLE OF CONTENTS

INTRODUCTION

This report presents the audit findings of Partnership HealthPlan of California (the Plan) State Supported Services contract No. 08-85222. The State Supported Services contract covers contracted abortion services.

The onsite audit was conducted from January 30, 2017 through February 3, 2017. The audit period was January 1, 2016 through December 31, 2016 and consisted of document review and interviews with Plan personnel.

An Exit Conference was held on May 4, 2017 with the Plan.

❖ COMPLIANCE AUDIT FINDINGS (CAF) ❖	
PLAN: Partnership HealthPlan of California	
AUDIT PERIOD: January 1, 2016 - December 31, 2016	DATE OF AUDIT: January 30, 2017 - February 3, 2017

STATE SUPPORTED SERVICES CONTRACT REQUIREMENTS

Abortion
Contractor agrees to provide, or arrange to provide, to eligible Members the following State Supported Services:
Current Procedural Coding System Codes: 59840 through 59857*
HCFA Common Procedure Coding System Codes: X1516, X1518, X7724, X7726, Z0336*

**These codes are subject to change upon the Department of Health Services' (DHS') implementation of the Health Insurance Portability and Accountability Act of 1996 (HIPAA) electronic transaction and code sets provisions. Such changes shall not require an amendment to this Contract.*
State Supported Services Contract Exhibit A.1

SUMMARY OF FINDINGS:

The Plan paid 186 abortion services claims and denied 18 during the audit period. These 18 claims were denied for routine reasons including claims submitted more than a year after the dates of service, duplicate claims, or claims forwarded to a capitated payor.

Based on our review of the Plan's policies, member and provider information materials, grievance reports, and above analysis, we found that the Plan has materially complied with the terms of the State Supported Services Contract.