

DEPARTMENT OF
Managed Health Care
Help Center

DIVISION OF PLAN SURVEYS

1115 WAIVER

SENIORS AND PERSONS WITH DISABILITIES

**AND
RURAL EXPANSION**

**MEDICAL SURVEY REPORT OF
PARTNERSHIP HEALTHPLAN OF CALIFORNIA
A COUNTY ORGANIZED HEALTH SYSTEM**

DATE ISSUED TO DHCS: DECEMBER 7, 2015

**1115 Waiver SPD and Rural Expansion Medical Survey Report
Partnership HealthPlan of California
A County Organized Health System
December 7, 2015**

TABLE OF CONTENTS

EXECUTIVE SUMMARY	2
DISCUSSION OF POTENTIAL DEFICIENCIES	8
AVAILABILITY AND ACCESSIBILITY	8
MEMBER RIGHTS	11
APPENDIX A. MEDICAL SURVEY TEAM MEMBERS	21
APPENDIX B. PLAN STAFF INTERVIEWED	22
APPENDIX C. LIST OF FILES REVIEWED	23

EXECUTIVE SUMMARY

The California Department of Health Care Services (“DHCS”) received authorization (“1115 Waiver”) from the federal government to conduct mandatory enrollment of seniors and persons with disabilities (“SPD”) into managed care to achieve care coordination, better manage chronic conditions, and improve health outcomes. The DHCS then entered into an Inter-Agency Agreement with the Department of Managed Health Care (the “Department”)¹ to conduct health plan medical surveys to ensure that enrollees affected by this mandatory transition are assisted and protected under California’s strong patient-rights laws. Mandatory enrollment of SPDs into managed care began in June 2011.

Pursuant to Welfare and Institutions Code section 14005.27 and authorized under AB 1467, Medi-Cal managed care expanded to Medi-Cal beneficiaries residing in 28 rural California counties. The DHCS entered into an Inter-Agency Agreement with the Department² to perform medical surveys of each health plan participating in the Rural Expansion. Mandatory enrollment of Medi-Cal beneficiaries from Fee-For-Service into Medi-Cal managed care began in September 2013.

On December 9, 2014, the Department notified Partnership HealthPlan of California (the “Plan”) that its medical survey had commenced and requested the Plan to provide all necessary pre-on-site data and documentation. The Department’s medical survey team conducted the on-site portion of the medical survey from February 23, 2015 through February 27, 2015.

SCOPE OF MEDICAL SURVEY

As required by the Inter-Agency Agreements, the Department provides the 1115 Waiver SPD and Rural Expansion Medical Survey Report to the DHCS. The report identifies potential deficiencies in Plan operations supporting the SPD and Rural Expansion populations. This medical survey evaluated the following elements specifically related to the Plan’s delivery of care to the SPD and Rural Expansion populations as delineated by the DHCS-Partnership HealthPlan of California Contract, the Knox-Keene Act, and Title 28 of the California Code of Regulations³:

I. Utilization Management

The Department evaluated Plan operations related to utilization management, including implementation of the Utilization Management Program and policies, processes for effectively handling prior authorization of services, mechanisms for detecting under- and over-utilization of services, and the methods for evaluating utilization management activities of delegated entities.

¹ The Inter-Agency Agreement (Agreement Number 10-87255) was approved on September 20, 2011.

² The Inter-Agency Agreement (Agreement Number 13-90168) was approved on June 11, 2014.

³ All references to “Contract” are to the County Organized Health System, Geographic Managed Care, and Two-Plan contracts issued by the DHCS. All references to “Section” are to the Knox-Keene Act of the Health and Safety Code. All references to “Rule” are to Title 28 of the California Code of Regulations.

II. Continuity of Care

The Department evaluated Plan operations to determine whether medically necessary services are effectively coordinated both inside and outside the network, to ensure the coordination of special arrangement services, and to verify that the Plan provides for completion of covered services by a non-participating provider when required.

III. Availability and Accessibility

The Department evaluated Plan operations to ensure that its services are accessible and available to enrollees throughout its service areas within reasonable timeframes, and are addressing reasonable patient requests for disability accommodations.

IV. Member Rights

The Department evaluated Plan operations to assess compliance with complaint and grievance system requirements, to ensure processes are in place for Primary Care Physician selection and assignment, and to evaluate the Plan's ability to provide interpreter services and communication materials in both threshold languages and alternative formats.

V. Quality Management

The Department evaluated Plan operations to verify that the Plan monitors, evaluates, takes effective action, and maintains a system of accountability to ensure quality of care.

The scope of the medical survey incorporated review of health plan documentation and files from the period of December 1, 2013 through November 30, 2014.

SUMMARY OF FINDINGS

The Department identified 4 potential deficiencies during the current medical survey.

2015 MEDICAL SURVEY POTENTIAL DEFICIENCIES

AVAILABILITY & ACCESSIBILITY	
#1	<p>The Plan does not ensure its network of primary care physicians are located within 30 minutes or ten miles of a member’s residence. DHCS-Partnership HealthPlan of California Contract, Exhibit A, Attachment 6 – Provider Network, Provision 7 – Time and Distance Standard.</p>
MEMBER RIGHTS	
#2	<p>The Plan’s responses to grievances involving a determination that the requested service is not a covered benefit do not consistently specify the provision in the contract, evidence of coverage, or member handbook that excludes the service. DHCS-Partnership HealthPlan of California Contract, Exhibit A, Attachment 14 – Member Grievance System, Provision 1 – Member Grievance System; Rule 1300.68(d)(5).</p>
#3	<p>The Plan does not consistently document that a reasonable effort was made to provide oral notice of resolution for expedited appeals. DHCS-Partnership HealthPlan of California Contract, Exhibit A, Attachment 14 – Member Grievance System, Provision 2(A) – Grievance System Oversight and Provision 6(E) – Responsibilities in Expedited Appeals.</p>
#4	<p>The Plan’s grievance acknowledgment letters do not consistently advise members of the grievance receipt date. DHCS-Partnership HealthPlan of California Contract, Exhibit A, Attachment 14 – Member Grievance System, Provision 1 – Member Grievance System and Provision 6(C) – Responsibility in Expedited Appeals; Rule 1300.68(d)(1); Rule 1300.68.01(a)(2).</p>

OVERVIEW OF THE PLAN'S EFFORTS TO SUPPORT SPD AND RURAL EXPANSION ENROLLEES

Access and Availability:

The Plan was established as a County Organized Health System (COHS) in 1994. In September 2013, the Plan expanded services from six core counties to an additional eight rural counties. This led to a rapid expansion of membership into already underserved areas of the state. The Plan's prior experience with providing services in underserved areas assisted the Plan with implementing innovative programs designed to address the shortage of providers. The Plan outlined the following efforts in its February 2015 document titled, "Documentation of PHC Activities to Provide Network Adequacy and Access to Care for Our Membership":

- Partnership HealthPlan of California has consistently contracted with all hospitals and providers willing to provide care to our members. We actively recruit providers through innovative programs specifically designed to recruit a network of high quality doctors. Programs include:
 - **Quality Coaching** – Partnership HealthPlan of California's Quality Improvement Program (QIP) offers financial incentives and technical assistance to Primary Care Providers, Hospitals and Pharmacies in order to make improvements in areas including, but not limited to: Chronic Disease Management, Patient Experience and Advance Care Planning[.]
 - **Quality Bonuses** – \$24 million was paid to Primary Care Providers, Hospitals and Pharmacies last year by Partnership HealthPlan of California as part of its Quality Improvement Program.
 - **Coleman Collaborative** – Partnership HealthPlan of California's Coleman Collaborative is an opportunity for contracted Primary Care Providers to improve appointment access, decrease no-show rate, reduce cycle time, and use team-based care and operational data to achieve true transformation.
 - **\$1 Million Innovation Grant** – Partnership HealthPlan of California's Local Innovation Grant will support new and innovative approaches utilized by organizations including Primary Care Providers, Hospitals, and Community Groups to improve access to primary and specialty care at the local level while building and maintaining effective partnerships with providers across all of Partnership HealthPlan of California's regions.
 - **Recruiter on Staff** – Due to Partnership HealthPlan of California's Northern Region being disproportionately effected by network issues, we have an experienced dedicated recruiter on staff in our Northern Region office.
 - **e-Consults** – PHC has entered into an agreement with e-Consults, a web-based specialty physician consultative program. Currently in pilot phase.

- Partnership HealthPlan of California values our relationship our providers. Throughout the community we are celebrated and held in high regard for our payment incentive programs, efficient working relationship and historic community partnerships. It is because of this hard work that 95 percent of our core county providers said they are overall satisfied with Partnership HealthPlan of California.
- In response to historic network problems, Partnership HealthPlan of California has developed and implemented a tele-health pilot program. In contracting with TeleMed2U Partnership HealthPlan of California has successfully provided necessary care to members in our rural regions while increasing member access to specialty care providers through this new exciting technology. The TeleMed2U network of physicians are fully credentialed to practice in California and have at least 10 years of experience.
- Often times, members in our rural areas prefer to see a provider outside of their resident county due to access issues or personal preference for a specific provider. Partnership HealthPlan of California not only allows cross county appointments for members in our rural areas (when appropriate), but will also provide transportation services when needed.

In addition to the initiatives described above, the Plan also has a robust Care Coordination Program to assist members with accessing appropriate medical services.

Mental Health Services:

The Plan's collaboration with Beacon is perhaps the Plan's most notable effort to address the mental health needs of the SPD and Rural Expansion populations. As of January 1, 2014, the Plan was required to provide mental health services for Medi-Cal managed care members with mild to moderate psychological conditions. With the increase in membership due to the rural expansion, the Plan was tasked with developing a provider network to coordinate benefits in eight additional counties.

The Plan distributed a request for proposal to potential vendors in November 2013. In January 2014, the Plan selected Beacon, a National Committee for Quality Assurance (NCQA) accredited and nationwide behavioral health organization. A letter of agreement was put into place. Delegated functions to Beacon included claims processing, telephone access and triage services, credentialing, quality management, case management, etc.

Beginning January 1, 2014, with the exception of the Plan's Kaiser members, Beacon administered mental health benefits to the Plan's Medi-Cal membership having mild to moderate psychological conditions. Members with more moderate to severe psychological conditions received services from the respective counties. Beacon worked closely with the eight rural expansion counties to distinguish mild/moderate from moderate/severe conditions to minimize members potentially going back and forth between the counties and the Plan to receive mental health services. Referrals sources included the members themselves, PCPs, mental health workers, or Plan representatives. To assist with the referral process, screening tools for adults

and children were developed using the State's criteria. Information was disseminated through trainings conducted in each of the counties and dispute resolution processes were developed to account for anticipated disagreements in severity.

What was unique about the collaboration between Beacon and the Plan was that select Beacon employees, including the Program Director and case management staff, worked onsite from the Plan's headquarters in Fairfield, CA. This arrangement allowed for in-person consultations, weekly rounds, and facilitation of better coordination of care for members. All of Beacon's California operations are otherwise managed through their service center in Orange County and can be accessed through an 800 number.

The Plan and Beacon initially met on a weekly basis and gradually transitioned to monthly meetings. Delegation oversight and performance-based discussions occurred at each meeting where topics such as network adequacy, clinical quality of care, and access and availability were discussed. Grievances were addressed on a quarterly basis as well. Overall, operations have been successful with full collaboration and coordination by the Plan, Beacon, counties, hospitals, and providers.

Grievances & Appeals:

The Plan consistently provides timely written responses to member grievances. In many cases, the Plan is able to resolve and send out resolution letters within five calendar days of receipt of the grievance, well within the 30-calendar day required timeframe.

DISCUSSION OF POTENTIAL DEFICIENCIES

AVAILABILITY AND ACCESSIBILITY

Potential Deficiency #1: The Plan does not ensure its network of primary care physicians are located within 30 minutes or ten miles of a member's residence.

Contractual/Statutory/Regulatory Reference(s): DHCS-Partnership HealthPlan of California Contract, Exhibit A, Attachment 6 – Provider Network, Provision 7 – Time and Distance Standard.

DHCS-Partnership HealthPlan of California Contract, Exhibit A, Attachment 6 – Provider Network

7. Time and Distance Standard

Contractor shall maintain a network of Primary Care Physicians that are located within 30 minutes or ten (10) miles of a Member's residence unless the Contractor has a DHCS approved alternative time and distance standard.

Documents Reviewed:

- Policy MP PR #201: PCP Availability and Capacity Policy and Procedure (09/10/14)
- Policy MP PR #201A: Network Availability Standards Policy and Procedure (09/10/14)
- Policy MP PR #205: Monitoring of PCP Accessibility of Services Policy and Procedure (09/10/14)
- Policy MPQP1023: Access Standards (03/19/14)
- DMHC Onsite Request #6a: Geo Access Monitoring of PCP Network Summary Report (2014)
- DMHC Onsite Request #6b: Documentation of PHC Activities to Provide Network Adequacy and Access to Care for Our Membership (February 2015)
- DMHC Onsite Request #6c: Geo Access Reporting – PHC Primary Care, Specialty Care, Hospital Network (2014)

Assessment: DHCS-Partnership HealthPlan of California Contract, Exhibit A, Attachment 6, Provision 7 requires the Plan to maintain a network of Primary Care Physicians (PCPs) that are located within 30 minutes or ten miles of a member's residence unless the Plan has a DHCS approved alternative time and distance standard. The Plan's policy, MP PR #201: PCP Availability and Capacity Policy and Procedure, reinforces this requirement and on page 1 states, "PHC is responsible for monitoring PCP access and availability on an annual basis.... The PCP availability standard is defined below: 1 PCP office site located within 30 minutes or 10 miles of member's residence."

To assess compliance with this standard, the Department reviewed the Plan's 2014 GeoAccess Monitoring of PCP Network Summary Report. The report directly addresses the Plan's compliance with ensuring that one PCP is available within ten miles of a member's residency in each of the Plan's six original core counties as well as eight rural expansion counties. However, the report does not address whether the Plan's PCP network is located within 30 minutes of a member's residence. Page 1 of the report states the following summary of findings:

Findings: PHC manages medical care for members that reside, for the most part, in very rural areas with limited access to medical services. The Plan ensures we contract with primary care providers in all towns and cities within a county. *Members are often residing in areas where the average distance to a primary care office significantly exceeds the 10 mile radius standard.* The Plan assists members with transportation when medically indicated per our Plan policies. [Emphasis added.]

The report then goes on to describe whether the standard was specifically met in each of the Plan’s six original core counties and eight rural expansion counties that it serves. However, the report indicates that the standard was met in only one⁴ core county and one⁵ rural expansion county. By contrast, the standard was only “generally met” in five⁶ core counties and seven⁷ rural expansion counties. The report further identifies specific areas within each county where the standard was not met, where members have to travel anywhere from 11 to 46 miles to access a PCP. See Tables 1 and 2 below.

TABLE 1
PCP within 10 Miles – Core Counties

COUNTY	STANDARD MET	DISTANCE
Marin	No	14-18 miles
Mendocino	No	14-27 miles
Napa	Yes	≤10 miles
Solano	No	17-19 miles
Sonoma	No	12-18 miles
Yolo	No	12-30 miles

TABLE 2
PCP within 10 Miles – Rural Expansion Counties

COUNTY	STANDARD MET	DISTANCE
Del Norte	No	19-21 miles
Humboldt	No	12-26 miles
Lake	Yes	≤10 miles
Lassen	No	12-46 miles
Modoc	No	16-30 miles
Shasta	No	11-33 miles
Siskiyou	No	11-30 miles

⁴ Napa

⁵ Lake

⁶ Marin; Mendocino; Solano; Sonoma; Yolo

⁷ Del Norte; Humboldt; Lassen; Modoc; Shasta; Siskiyou; Trinity

Trinity	No	11-34 miles
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In addition to providing the 2014 Geo Access Monitoring of PCP Network Summary Report, the Plan presented the Department with two additional documents for consideration: 1) Geo Access Reporting and 2) Documentation of PHC Activities to Provide Network Adequacy and Access to Care for Our Membership.

The Geo Access Reporting document acknowledges that members who live in rural areas may have to travel beyond ten miles to seek PCP services, but does not address whether the Plan is able to meet the 30-minute time standard as required by the DHCS. The document reiterates that the Plan contracts with PCPs in towns and cities within each county and describes further efforts taken to mitigate access issues. On page 1, it states:

The Plan has engaged in a number of initiatives to address access issues for our members.... In addition to the innovative initiatives, PHC has a robust Care Coordination program that assists members and providers with access to appropriate medical services and care. PHC continuously monitors access to care through a variety of methods including but not limited too [sic]: member complaints and grievances, the annual 3NA survey, provider and community based organization input and feedback from PHC Care Coordination department.

The Documentation of PHC Activities to Provide Network Adequacy and Access to Care for Our Membership document additionally describes the challenges that the Plan has faced in providing services to members in rural areas and similarly outlines various programs that the Plan has initiated to address these issues. Some of these efforts include having a dedicated recruiter on staff in the Northern Region to address network issues, offering quality bonuses and incentives to PCPs, participating in the Coleman Collaborative, entering into an agreement with e-Consults, implementing a tele-health pilot program, and providing transportation services across counties based on member preference.

Despite the challenges the Plan faces and efforts the Plan has undertaken to minimize access concerns for its members, in onsite interviews, the Plan indicated that it had not sought out alternative time and distance standards.

Conclusion: DHCS-Partnership HealthPlan of California Contract, Exhibit A, Attachment 6, Provision 7 requires the Plan to maintain a network of PCPs that are located within 30 minutes or ten miles of a member's residence unless the Plan has a DHCS approved alternative time and distance standard. The Plan did not provide any information as to whether it is able to meet the 30-minute standard. In addition, the Plan's 2014 GeoAccess Monitoring of PCP Network Summary Report indicates that in five of six core counties, and seven of eight rural expansion counties, this standard was not met and identifies areas where members have to travel anywhere from 11 to 46 miles to access a PCP. Despite the Plan's efforts to address access issues for its members, there was no documentation to support that the Plan had sought out or obtained a DHCS approved alternative time and distance standard. Therefore, the Department finds the Plan in violation of this contractual requirement.

MEMBER RIGHTS

Potential Deficiency #2: The Plan's responses to grievances involving a determination that the requested service is not a covered benefit do not consistently specify the provision in the contract, evidence of coverage, or member handbook that excludes the service.

Contractual/Statutory/Regulatory Reference(s): DHCS-Partnership HealthPlan of California Contract, Exhibit A, Attachment 14 – Member Grievance System, Provision 1 – Member Grievance System; Rule 1300.68(d)(5).

DHCS-Partnership HealthPlan of California Contract, Exhibit A, Attachment 14 – Member Grievance System

1. Member Grievance System

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).

Rule 1300.68(d)(5)

Plan responses to grievances involving a determination that the requested service is not a covered benefit shall specify the provision in the contract, evidence of coverage or member handbook that excludes the service.

Documents Reviewed:

- Policy CGA-003: Medi-Cal Member Grievance System (03/20/13)
- Standard Grievances & Appeals files (45 SPD Core; 44 SPD Rural; 29 Non-SPD Rural)
- Expedited Appeals files (10 SPD Core; 5 SPD Rural; 6 Medi-Cal Rural)

Assessment: Rule 1300.68(d)(5) requires the Plan's responses to grievances involving a determination that the requested service is not a covered benefit to specify the provision in the contract, evidence of coverage, or member handbook that excludes the service.

To assess compliance with these standards, the Department reviewed a random sample of standard grievances and appeals files, as well as expedited appeals files, for the following populations: 1) SPDs in the core counties, 2) SPDs in the rural expansion counties, and 3) non-SPDs in the rural expansion counties. The Department identified all grievances and appeals involving benefit determinations and isolated those files for review. The Department's findings yielded similar results for all three populations and it was determined that the Plan's resolution letters did not consistently specify the provision in the contract, evidence of coverage, or member handbook that excludes the service. Rather, the resolution letters instead advised the member that he/she could request a copy of the applicable benefit provision without ever disclosing the actual provision. The deficient files are presented below, as well as in Tables 3, 4, and 5, for each of the respective populations.

1. Core Counties – SPD

- *Standard Grievances and Appeals:*

The Department reviewed 29 standard grievances and appeals that involved a determination that the service was not a covered benefit. All 29⁸ files (100%) failed to specify the provision in the contract, evidence of coverage, or member handbook that excludes the service.

- *Expedited Grievances and Appeals:*

The Department reviewed two expedited appeals that involved a determination that the service was not a covered benefit. One file⁹ (50%) failed to specify the provision in the contract, evidence of coverage, or member handbook that excludes the service.

2. Rural Expansion Counties – SPD

- *Standard Grievances and Appeals:*

The Department reviewed 16 standard grievances and appeals that involved a determination that the service was not a covered benefit. Three¹⁰ of 16 files (19%) failed to specify the provision in the contract, evidence of coverage, or member handbook that excludes the service.

- *Expedited Grievances and Appeals:*

The Department reviewed two expedited appeals that involved a determination that the service was not a covered benefit. Both files¹¹ (100%) failed to specify the provision in the contract, evidence of coverage, or member handbook that excludes the service.

3. Rural Expansion Counties – Non-SPD

- *Standard Grievances and Appeals:*

The Department reviewed 18 standard grievances and appeals that involved a determination that the service was not a covered benefit. 15¹² of 18 files (83%) failed to specify the provision in the contract, evidence of coverage, or member handbook that excludes the service.

- *Expedited Grievances and Appeals:*

The Department reviewed four expedited appeals that involved a determination that the service was not a covered benefit. Three¹³ of four files (75%) failed to specify the provision in the contract, evidence of coverage, or member handbook that excludes the service.

TABLE 3
Benefit Determination Grievances – Core Counties (SPD)

⁸ Files: 1; 2; 3; 5; 6; 8; 10; 11; 12; 13; 14; 16; 17; 18; 19; 21; 23; 24; 25; 26; 27; 30; 34; 36; 38; 41; 43; 44; 45.

⁹ File: 2.

¹⁰ Files: 2; 13; 18.

¹¹ Files: 3; 4.

¹² Files: 1; 4; 5; 6; 7; 10; 16; 17; 20; 21; 22; 23; 24; 26; 27.

¹³ Files: 2; 4; 6.

FILE TYPE	NUMBER OF FILES REVIEWED	ELEMENT	COMPLIANT	DEFICIENT
Standard G&A	29	Plan's response specifies the provision in the contract, evidence of coverage, or member handbook	0 (0%)	29 (100%)
Expedited Appeals	2	Plan's response specifies the provision in the contract, evidence of coverage, or member handbook	1 (50%)	1 (50%)

TABLE 4
Benefit Determination Grievances – Rural Expansion Counties (SPD)

FILE TYPE	NUMBER OF FILES REVIEWED	ELEMENT	COMPLIANT	DEFICIENT
Standard G&A	16	Plan's response specifies the provision in the contract, evidence of coverage, or member handbook	13 (81%)	3 (19%)
Expedited Appeals	2	Plan's response specifies the provision in the contract, evidence of coverage, or member handbook	0 (0%)	2 (100%)

TABLE 5
Benefit Determination Grievances – Rural Expansion Counties (Non-SPD)

FILE TYPE	NUMBER OF FILES REVIEWED	ELEMENT	COMPLIANT	DEFICIENT
Standard G&A	18	Plan's response specifies the provision in the contract, evidence of coverage, or member handbook	3 (17%)	15 (83%)
Expedited Appeals	4	Plan's response specifies the provision in the contract, evidence of coverage, or member handbook	1 (25%)	3 (75%)

Conclusion: The DHCS-Partnership HealthPlan of California Contract, Exhibit A, Attachment 14, Provision 1 requires the Plan to implement and maintain a Member Grievance system in accordance with Rule 1300.68. Rule 1300.68(d)(5) requires the Plan's responses to grievances involving a determination that the requested service is not a covered benefit to specify the

provision in the contract, evidence of coverage, or member handbook that excluded the service. The Department's review of files for both standard grievances and appeals, and expedited appeals, revealed that the Plan's responses did not consistently specify the provision in the contract, evidence of coverage, or member handbook that excludes the service. For standard grievances and appeals, the rates of non-compliance were 100%, 19%, and 83% for SPDs in the core counties, SPDs in the rural expansion counties, and non-SPDs in the rural expansion counties, respectively. For expedited appeals, rates of non-compliance were 50%, 100%, and 75% for SPDs in the core counties, SPDs in the rural expansion counties, and non-SPDs in the rural expansion counties, respectively. Therefore, the Department finds the Plan in violation of these contractual and regulatory requirements.

Potential Deficiency #3: The Plan does not consistently document that a reasonable effort was made to provide oral notice of resolution for expedited appeals.

Contractual/Statutory/Regulatory Reference(s): DHCS-Partnership HealthPlan of California Contract, Exhibit A, Attachment 14 – Member Grievance System, Provision 2(A) – Grievance System Oversight and Provision 6(E) – Responsibilities in Expedited Appeals.

DHCS-Partnership HealthPlan of California Contract, Exhibit A, Attachment 14 – Member Grievance System

2. Grievance System Oversight

Contractor shall implement and maintain procedures as described below 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.

A. Procedure to ensure timely acknowledgement resolution and feedback to complainant.
Provide oral notice of the resolution of an expedited review.

6. Responsibilities in Expedited Appeals

E. Contractor must make a reasonable effort to provide oral notice of expedited Contractor-level appeal decision.

Documents Reviewed:

- Policy CGA-003: Medi-Cal Member Grievance System (03/20/13)
- Expedited Appeals files (10 SPD Core; 5 SPD Rural; 6 Medi-Cal Rural)

Assessment: DHCS-Partnership HealthPlan of California Contract, Exhibit A, Attachment 14, Provisions 2(A) and 6(E) require the Plan to implement and maintain procedures to ensure that reasonable efforts are made to provide oral notice of the Plan's decision for expedited grievances and appeals. The Plan's policy, CGA-003: Medi-Cal Member Grievance System, reinforces this requirement and on page 5 states, "Resolutions on expedited reviews include an oral and written notifications [sic]." The policy further states:

The medical director will render the expedited decision and the grievance staff will notify the member as expeditiously as the medical condition requires, but no

later than 3 calendar days from when expedited review was requested. *PHC will provide oral notification of the decision to the member.* [Emphasis added.]

To assess compliance with this standard, the Department reviewed all expedited appeals¹⁴ identified by the Plan during the review period for the following populations: 1) SPDs in the core counties, 2) SPDs in the rural expansion counties, and 3) non-SPDs in the rural expansion counties. The Department’s findings yielded similar results for all three populations and the Department was unable to substantiate that the Plan consistently provided oral notice of resolution members. While compliant files contained documented notes indicating that the member had been notified, deficient files included no such evidence that a reasonable effort had been made. The deficient files are presented below, as well as in Tables 6, 7, and 8, for each of the respective populations.

1. Core Counties – SPD

The Department reviewed 10 expedited appeals. One¹⁵ of 10 (10%) files failed to include documentation to substantiate that the member was provided with oral notice of the resolution.

2. Rural Expansion – SPD

The Department reviewed five expedited appeals. One¹⁶ of five files (20%) failed to include documentation to substantiate that the member was provided with oral notice of the resolution.

3. Rural Expansion – Non-SPD

The Department reviewed six expedited appeals. Three¹⁷ of six files (50%) failed to include documentation to substantiate that the member was provided with oral notice of the resolution.

During onsite interviews, when asked whether a reasonable effort had been made to provide the member with oral notice of the resolution in each of the deficient files identified, Plan staff indicated that members are routinely notified of resolution as delineated in the Plan’s policy. The Plan clarified that it was a failure to document the phone call rather than a failure to notify the member.

TABLE 6
Expedited Appeals – Core Counties (SPD)

FILE TYPE	NUMBER OF FILES	ELEMENT	COMPLIANT	DEFICIENT
Expedited Appeals	10	Oral notice of resolution provided to the member	9 (90%)	1 (10%)

TABLE 7
Expedited Appeals – Rural Expansion Counties (SPD)

¹⁴ All expedited *grievances* identified by the Plan during the review period were *appeals*.

¹⁵ File: 1.

¹⁶ File: 4.

¹⁷ Files: 2; 3; 4.

FILE TYPE	NUMBER OF FILES	ELEMENT	COMPLIANT	DEFICIENT
Expedited Appeals	5	Oral notice of resolution provided to the member	4 (80%)	1 (20%)

TABLE 8
Expedited Appeals – Rural Expansion Counties (Non-SPD)

FILE TYPE	NUMBER OF FILES	ELEMENT	COMPLIANT	DEFICIENT
Expedited Appeals	6	Oral notice of resolution provided to the member	3 (50%)	3 (50%)

Conclusion: DHCS-Partnership HealthPlan of California Contract, Exhibit A, Attachment 14, Provision 2(A) requires the Plan to implement and maintain procedures to provide oral notice of resolution for expedited grievances. DHCS-Partnership HealthPlan of California Contract, Exhibit A, Attachment 14, Provision 6(E) requires the Plan to make a reasonable effort to provide oral notice of resolution for expedited appeals. The Department’s review of expedited appeals revealed a lack of documentation to substantiate that the Plan had consistently made a reasonable effort to provide oral notice of resolution to members. Rates of non-compliance were 10%, 20%, and 50% for SPDs in the core counties, SPDs in the rural expansion counties, and non-SPDs in the rural expansion counties, respectively. Therefore, the Department finds the Plan in violation of these contractual requirements.

Potential Deficiency #4: The Plan’s grievance acknowledgment letters do not consistently advise members of the grievance receipt date.

Contractual/Statutory/Regulatory Reference(s): DHCS-Partnership HealthPlan of California Contract, Exhibit A, Attachment 14 – Member Grievance System, Provision 1 – Member Grievance System and Provision 6(C) – Responsibility in Expedited Appeals; Rule 1300.68(d)(1); Rule 1300.68.01(a)(2).

DHCS-Partnership HealthPlan of California Contract, Exhibit A, Attachment 14 – Member Grievance System

1. Member Grievance System

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).

DHCS-Partnership HealthPlan of California Contract, Exhibit A, Attachment 14 – Member Grievance System

6. Responsibilities in Expedited Appeals

C. Contractor must provide a Member notice, as quickly as the Member's health condition requires, within three (3) working days from the day Contractor receives the Contractor-level appeal.

Rule 1300.68(d)(1)

(d) The plan shall respond to grievances as follows:

(1) A grievance system shall provide for a written acknowledgment within five (5) calendar days of receipt, except as noted in subsection (d)(8). The acknowledgment will advise the complainant that the grievance has been received, the *date of receipt*, and provide the name of the plan representative, telephone number and address of the plan representative who may be contacted about the grievance. [Emphasis added.]

Rule 1300.68(a)(2)

(a) Every plan shall include in its grievance system, procedures for the expedited review of grievances involving an imminent and serious threat to the health of the enrollee, including, but not limited to, severe pain, potential loss of life, limb or major bodily function ("urgent grievances"). At a minimum, plan procedures for urgent grievances shall include:

(2) A written statement to the Department and the complainant on the disposition or pending status of the urgent grievance within three (3) calendar days of receipt of the grievance by the Plan.

Documents Reviewed:

- Policy CGA-003: Medi-Cal Member Grievance System (03/20/13)
- Form #MLMN001: Member Complaint, Appeal and Hearing Information (effective April 2013)
- Standard Grievances & Appeals files (36 SPD Core; 24 SPD Rural; 20 Medi-Cal Rural)
- Expedited Appeals files (10 SPD Core; 5 SPD Rural; 6 Medi-Cal Rural)

Assessment: Rule 1300.68(d)(1) requires grievance acknowledgment letters to advise members that the grievance has been received, the date of receipt, and the name, telephone number, and address of the plan representative who may be contacted about the grievance. For standard grievances, plans must send this written acknowledgment within five calendar days of receipt of the grievance. The requirements are almost identical for expedited grievances, except under DHCS-HealthPlan of California Contract, Exhibit A, Attachment 14, Provision 6(C) and Rule 1300.68(a)(2), the written acknowledgment must be sent within three calendar days of receipt of the grievance. The Plan's document, Member Complaint, Appeal and Hearing Information, provides members with an overview of the grievance process. The information presented is consistent with the contractual and regulatory provisions and on page 3 states:

As a member of the Partnership HealthPlan of California (PHC), you have the following rights in filing a grievance with PHC:

1. You will receive written acknowledgement of your grievance request within five (5) calendar days from the date your grievance was received. *The acknowledgement letter will let you know the day that PHC received your grievance request* and the name, address and phone number of the PHC grievance staff that will be handling your grievance.

2. You will receive a written response/resolution to your grievance within thirty (30) calendar days of the date it was received by PHC.

...

7. You may request an expedited review of your grievance.... In the case of expedited review of grievances, PHC makes a decision and notifies you as expeditiously as the medical condition requires, but no later than three (3) calendar days from the date the expedited review was requested.

To assess compliance with these standards, the Department reviewed a random sample of standard grievances and appeals files, as well as expedited appeals files, for the following populations: 1) SPDs in the core counties, 2) SPDs in the rural expansion counties, and 3) non-SPDs in the rural expansion counties. The Department's findings yielded similar results for all three populations, indicating that for all files reviewed, the Plan consistently resolved both standard grievances and appeals, and expedited appeals, within the required 30- and three-calendar day timeframes, respectively. In many cases, the Plan resolved standard grievances well within the 30-day timeframe, taking only five calendar days to resolve the grievance. Therefore, in cases where the Plan was able to achieve resolution with five calendar days for standard grievances and appeals, or three calendar days for expedited appeals, the Plan issued a "combination" letter that was meant to satisfy both the acknowledgment letter and resolution letter requirements. However, in all files where a combination letter was issued, the Plan failed to include the grievance receipt date, as required by Rule 1300.68(d)(1). The deficient files are presented below, as well as in Tables 9, 10, and 11, for each of the respective populations.

1. Core Counties – SPD

- *Standard Grievances and Appeals:*
The Department reviewed 36 standard grievances and appeals. 24 of 36 files (67%) included acknowledgment letters that contained the grievance receipt date, as required. In the remaining 12¹⁸ files (33%), the Plan was able to resolve the grievance within five calendar days and sent out a combination acknowledgement and resolution letter. However, the letter failed to advise the member of the grievance receipt date.
- *Expedited Grievances and Appeals:*
The Department reviewed all 10 expedited appeals identified by the Plan during the review period. In all 10¹⁹ files (100%), the Plan was able to resolve the grievance within three calendar days and sent out a combination acknowledgement and resolution letter. However, the letter failed to advise the member of the grievance receipt date.

2. Rural Expansion – SPD

- *Standard Grievances and Appeals:*
The Department reviewed 24 standard grievances and appeals. 19 of 24 files (79%) included acknowledgment letters that contained the grievance receipt date, as required.

¹⁸ Files: 1; 3; 11; 20; 21; 25; 26; 27; 28; 33; 34; 35.

¹⁹ Files: 1; 2; 3; 4; 5; 6; 7; 8; 9; 10.

In the remaining five²⁰ files (21%), the Plan was able to resolve the grievance within five calendar days and sent out a combination acknowledgement and resolution letter. However, the letter failed to advise the member of the grievance receipt date.

- *Expedited Grievances and Appeals:*
 The Department reviewed all five expedited appeals. In all five²¹ files (100%), the Plan was able to resolve the grievance within three calendar days and sent out a combination acknowledgement and resolution letter. However, the letter failed to advise the member of the grievance receipt date.

3. Rural Expansion – Non-SPD

- *Standard Grievances and Appeals:*
 The Department reviewed 20 standard grievances and appeals. 15 of 20 files (75%) included acknowledgment letters that contained the grievance receipt date, as required. However, in the remaining five²² files (25%), the Plan was able to resolve the grievance within five calendar days and sent out a combination acknowledgement and resolution letter. However, the letter failed to advise the member of the grievance receipt date.
- *Expedited Grievances and Appeals:*
 The Department reviewed all six expedited appeals identified by the Plan during the review period. In all six²³ files (100%), the Plan was able to resolve the grievance within three calendar days and sent out a combination acknowledgement and resolution letter. However, the letter failed to advise the member of the grievance receipt date.

TABLE 9
Grievance Acknowledgment – Core Counties (SPD)

FILE TYPE	NUMBER OF FILES REVIEWED	ELEMENT	COMPLIANT	DEFICIENT
Standard G&A	36	Written acknowledgment includes the grievance receipt date	24 (67%)	12 (33%)
Expedited Appeals	10	Written acknowledgment includes the grievance receipt date	0 (0%)	10 (100%)

TABLE 10
Grievance Acknowledgment – Rural Expansion Counties (SPD)

FILE TYPE	NUMBER OF FILES REVIEWED	ELEMENT	COMPLIANT	DEFICIENT
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²⁰ Files: 3; 5; 6; 12; 18.

²¹ Files: 1; 2; 3; 4; 5.

²² Files: 2; 13; 15; 16; 18.

²³ Files: 1; 2; 3; 4; 5; 6.

Standard G&A	24	Written acknowledgment includes the grievance receipt date	19 (79%)	5 (21%)
Expedited Appeals	5	Written acknowledgment includes the grievance receipt date	0 (0%)	5 (100%)

TABLE 11
Grievance Acknowledgment – Rural Expansion Counties (Non-SPD)

FILE TYPE	NUMBER OF FILES REVIEWED	ELEMENT	COMPLIANT	DEFICIENT
Standard G&A	20	Written acknowledgment includes the grievance receipt date	15 (75%)	5 (25%)
Expedited Appeals	6	Written acknowledgment includes the grievance receipt date	0 (0%)	6 (100%)

Conclusion: DHCS-Partnership HealthPlan of California Contract, Exhibit A, Attachment 14, Provision 1 requires the Plan to implement and maintain a Member Grievance system in accordance with Rules 1300.68 and 1300.68.01. Rule 1300.68(d)(1) requires the Plan’s written acknowledgment of grievances to advise the members of the date of receipt of the grievance. In addition, the Plan’s acknowledgment letters for standard grievance and appeals must be sent within five calendar days after the Plan receives the grievance. DHCS-Partnership HealthPlan of California Contract, Exhibit A, Attachment 14, Provision 6(C) and Rule 1300.68.01(a)(2) require the Plan’s acknowledgment letters for expedited grievances and appeals be sent within three calendar days after the Plan receives the grievance.

The Department’s review of files for both standard grievances and appeals, and expedited appeals, revealed that the Plan’s acknowledgment letters did not consistently contain the grievance receipt date. Specifically, in cases where the Plan was able to achieve resolution with five calendar days for standard grievances and appeals, or three calendar days for expedited appeals, the Plan issued a “combination” letter that was meant to satisfy both the acknowledgment letter and resolution letter requirements. However, in all files where a combination letter was issued, the Plan failed to include the grievance receipt date. For standard grievances and appeals, the rates of non-compliance were 33%, 21%, and 5% for SPDs in the core counties, SPDs in the rural expansion counties, and non-SPDs in the rural expansion counties, respectively. For expedited appeals, rates of non-compliance were all 100% for SPDs in the core counties, SPDs in the rural expansion counties, and non-SPDs in the rural expansion counties. Therefore, the Department finds the Plan in violation of these contractual and regulatory requirements.

APPENDIX A. MEDICAL SURVEY TEAM MEMBERS

DEPARTMENT OF MANAGED HEALTH CARE TEAM	
Jeanette Fong	Survey Team Lead
Jennifer Friedrich	Health Program Specialist
Cindy Liu	Attorney
PMPM CONSULTING GROUP OF WEISERMAZARS	
James Hendrickson, MD	Quality Management Surveyor Continuity of Care Surveyor
Alice Morrison	Utilization Management Surveyor
Anthony Browne	Member Rights Surveyor
Gerry Long	Availability and Accessibility Surveyor
Tammy Putnam	File Review Surveyor

APPENDIX B. PLAN STAFF INTERVIEWED

PARTNERSHIP HEALTHPLAN OF CALIFORNIA	
Jack Horn	CEO
Liz Gibboney	Deputy Executive Director/COO
Sonja Bjork	Deputy Chief Operating Officer
Amy Tunipseed	Director of Policy & Program Development
Robb Layne	Compliance Director
Margaret Kisliuk	Northern Region Executive Director
Patti McFarland	CFO
Michelle Rollins	Associate Director of Regulatory Affairs and Counsel
Tammy Fisher	Director Quality and Performance Improvement
Nadine Harris, RN	Manager of Compliance
Jess Thacher	Manager of Performance Improvement
Sonia Spears-Tatney	HEDIS & PI Project Coordinator
Robert Moore, MD	Chief Medical Officer
Peggy Hoover, RN	Senior Director, Health Services
Ogo Nwosu, RN	Associate Director of Care Coordinator
Katherine Barresi, RN	Team Manager/CC
Cristina Lauck, RN	Manager of General Case Management
Betsy Campbell	Senior Health Educator
Carly Fronefield, RN	Associate Director of Health Services
Mary Kerlin	Senior Director of Provider Relations
Heather Brandeburg	Associate Director of Provider Relations
Daniel Santos	Provider Services Supervisor
Debbie Shafer	Senior Director of Member Services
Terri De. Marce	Associate Director of Call Center
Mary Enos	Associate Director of Enrollment
Edna Villasenor	MS Call Center Quality & Training Manager
Paula Frederickson	Senior Claims Director
Jing Sancho	Associate Director of Claims Technical Support
Jessica Friedlander	Grievance System Manager
Jessica Hernandez	Lead Grievance Coordinator
Gary Louie, Pharm D	Pharmacy Services Director
Dina Haynes	Pharmacy Operations Manager

APPENDIX C. LIST OF FILES REVIEWED

Note: The statistical methodology utilized by the Department is based on an 80% confidence level with a 7% margin of error. Each file review criterion is assessed at a 90% compliance rate.

Core Counties – SPD

Type of Case Files Reviewed	Sample Size (Number of Files Reviewed)	Explanation
Standard Grievances and Appeals	45	The Plan identified a universe of 103 files during the review period. Based on the Department’s File Review Methodology, a random sample of 45 files were reviewed.
Expedited Appeals	10	The Plan identified a universe of 10 files during the review period. Based on the Department’s File Review Methodology, all 10 files were reviewed.
Exempt Grievances	62	The Plan identified a universe of 290 files during the review period. Based on the Department’s File Review Methodology, a random sample of 62 files were reviewed.
Potential Quality Issues	35	The Plan identified a universe of 60 files during the review period. Based on the Department’s File Review Methodology, a random sample of 35 files were reviewed.

Rural Expansion Counties (SPD)

Type of Case Files Reviewed	Sample Size (Number of Files Reviewed)	Explanation
Standard Grievances and Appeals	44	The Plan identified a universe of 96 files during the review period. Based on the Department’s File Review Methodology, a random sample of 44 files were reviewed.
Expedited Appeals	5	The Plan identified a universe of 5 files during the review period. Based on the Department’s File Review Methodology, all 5 files were reviewed.
Exempt Grievances	54	The Plan identified a universe of 164 files during the review period. Based on the Department’s File Review Methodology, a random sample of 54 files were reviewed.

Potential Quality Issues	24	The Plan identified a universe of 24 files during the review period. Based on the Department's File Review Methodology, all 24 files were reviewed.
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Rural Expansion Counties (Non-SPD)

Type of Case Files Reviewed	Sample Size (Number of Files Reviewed)	Explanation
Standard Grievances and Appeals	29	The Plan identified a universe of 44 files during the review period. Based on the Department's File Review Methodology, a random sample of 29 files were reviewed.
Expedited Appeals	6	The Plan identified a universe of 6 files during the review period. Based on the Department's File Review Methodology, all 6 files were reviewed.
Exempt Grievances	58	The Plan identified a universe of 218 files during the review period. Based on the Department's File Review Methodology, a random sample of 58 files were reviewed.
Potential Quality Issues	39	The Plan identified a universe of 75 files during the review period. Based on the Department's File Review Methodology, a random sample of 39 files were reviewed.