

REPORT ON THE MEDICAL AUDIT OF PARTNERSHIP HEALTH PLAN OF CALIFORNIA YEAR 2025

**DHCS Audits and Investigations
Contract and Enrollment Review Division
Sacramento Section**

Contract Number: 23-30236

Audit Period: July 1, 2024 — December 31, 2025

Dates of Audit: April 20, 2026 — May 1, 2026

Report Issued: October 20, 2026

TABLE OF CONTENTS

I.	INTRODUCTION	3
II.	EXECUTIVE SUMMARY	4
III.	SCOPE/AUDIT PROCEDURES	7
IV.	COMPLIANCE AUDIT FINDINGS	
	Category 2 – Population Health Management and Coordination of Care	9
	Category 4 – Grievances, Appeals, and Member Rights	13
	Category 5 – Quality Improvement and Health Equity Transformation Program.....	18
	Category 6 – Plan Administration and Organization	21

I. INTRODUCTION

Partnership Health Plan of California (Plan) is a non-profit, community-based health care organization. The Plan is governed by a Board of Commissioners comprised of locally elected officials, provider representatives, and patient advocates. The Plan is a County Organized Health System managed care model endorsed by the County Board of Supervisors.

The Plan began operations in 1994, serving Solano County and has expanded to 24 northern California counties: Butte, Colusa, Del Norte, Glenn, Humboldt, Lake, Lassen, Marin, Mendocino, Modoc, Napa, Nevada, Placer, Plumas, Shasta, Sierra, Siskiyou, Solano, Sonoma, Sutter, Tehama, Trinity, Yolo, and Yuba.

As of April 2026, the Plan had approximately 863,119 Medi-Cal members. Medi-Cal members are distributed as follows: Butte 83,188, Colusa 9,759, Del Norte 11,901, Glenn 12,961, Humboldt 54,487, Lake 32,479, Lassen 8,173, Marin 42,785, Mendocino 38,775, Modoc 3,654, Napa 26,137, Nevada 28,202, Placer 59,972, Plumas 5,271, Shasta 63,665, Sierra 816, Siskiyou 17,397, Solano 95,487, Sonoma 103,280, Sutter 43,495, Tehama 28,427, Trinity 4,921, Yolo 52,048, and Yuba 35,839.

II. EXECUTIVE SUMMARY

This report presents the audit findings of the Department of Health Care Services (DHCS) medical audit for the period of July 1, 2024, through December 31, 2025. The audit was conducted from April 20, 2026, through May 1, 2026. The audit consisted of documentation review, verification studies, and interviews with the Plan's representatives.

An Exit Conference with the Plan was held on October 6, 2026. The Plan was allowed 15 calendar days from the date of the Exit Conference to provide supplemental information addressing the draft audit findings. On October 19, 2026, the Plan submitted a response after the Exit Conference. The evaluation results of the Plan's response are reflected in this report.

The audit evaluated six categories of performance: Utilization Management Program, Population Health Management and Coordination of Care, Network and Access to Care, Grievances, Appeals, and Member Rights, Quality Improvement and Health Equity Transformation Program, and Plan Administration and Organization.

The prior DHCS medical audit for the period of July 1, 2023, through June 30, 2024, was issued on April 9, 2025. This audit examined the Plan's compliance with the DHCS Contract and assessed the implementation and effectiveness of the Plan's prior year 2024, Corrective Action Plan (CAP).

The summary of the findings by category is as follows:

Category 1 – Utilization Management Program

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

Category 2 – Population Health Management and Coordination of Care

The Plan is required to ensure eligible members in all applicable Enhanced Care Management (ECM) Populations of Focus receive all seven ECM core service components. The core ECM services include Comprehensive Assessment and Care Management Plan, Enhanced Coordination of Care, Health Promotion, Comprehensive Transitional Care, Member and Family Supports, Outreach and Engagement and Coordination, and Referral to Community and Social Support Services. Finding 2.25.1:

The Plan did not ensure that ECM providers delivered all ECM core service components, including Comprehensive Assessment and Care Management Plan and Comprehensive Transitional Care.

The Plan is required to perform an Initial Health Appointment (IHA) within 120 calendar days of enrollment. The Plan is also required to make reasonable attempts to contact members to schedule an IHA and is required to document all attempts made. Finding 2.29.1: The Plan did not ensure timely completion of IHAs and did not maintain documentation of reasonable outreach attempts to contact members.

Category 3 – Network and Access to Care

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

Category 4 – Grievances, Appeals, and Member Rights

The Plan is required to ensure adequate consideration of grievances and that each issue presented by the member is addressed and resolved. The Plan is also required to ensure that network providers comply with all applicable contract requirements and all requirements set forth in their network provider agreements. Finding 4.2.1: The Plan did not ensure grievances were fully investigated and therefore did not ensure to resolve each issue presented in Quality of Care (QOC) grievances prior to closure.

The Plan is required to ensure Grievance Resolution letters provide a clear and concise rationale for its decision and comprehensively address and resolve each concern raised by the member. Finding 4.2.2: Grievance Resolution letters did not contain clear and concise explanations of the Plan's decision.

Category 5 – Quality Improvement and Health Equity Transformation Program

The Plan is required to document that the quality of care provided is reviewed and ensure effective action is taken to improve care where deficiencies are identified. Finding 5.6.1: The Plan did not take effective action to ensure the correction of identified quality of care deficiencies.

Category 6 – Plan Administration and Organization

The Plan is required to regularly review exclusionary databases. If a network provider is found to be excluded or suspended from the Medi-Cal program, the Plan is required to notify DHCS immediately or provide written notice of the termination within 10 calendar

days. Finding 6.15.1: The Plan did not have a process in place to ensure notification to DHCS within 10 calendar days of discovering a network provider's exclusionary status.

The Plan is required to ensure payment is not made to an excluded provider. Finding 6.15.2: The Plan did not have a process in place to ensure suspension of payments to excluded and ineligible providers.

III. SCOPE/AUDIT PROCEDURES

SCOPE

The DHCS, Contract and Enrollment Review Division conducted the audit to ascertain that medical services provided to Plan members comply with federal and state laws, Medi-Cal regulations and guidelines, and the State Contract.

PROCEDURE

DHCS conducted an audit of the Plan from April 20, 2026, through May 1, 2026, for the audit period of July 1, 2024, through December 31, 2025. The audit included a review of the Plan's Contract with DHCS, policies and procedures for providing services, 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 the Plan's administrators and staff.

The following verification studies were conducted:

Category 1 – Utilization Management Program

Prior Authorization Requests: Thirty-five prior authorization requests were reviewed for timeliness, consistent application of criteria, appropriateness of review, and communication of results to members and providers.

Category 2 – Population Health Management and Coordination of Care

ECM: Fourteen medical records were reviewed to confirm coordination of care and fulfillment of ECM requirements.

IHA: Sixteen cases were reviewed to confirm the performance and completeness of the IHA.

Category 3 – Network and Access to Care

Claims: Twenty-nine emergency services and 19 family planning claims were reviewed for appropriate and timely adjudication.

Category 4 – Grievances, Appeals, and Member Rights

Grievance Procedures: Fifteen quality of service and 30 QOC grievances were reviewed for timely resolution, response to the complainant, and submission to the appropriate level for review.

Appeal Process: Thirty prior authorization appeals were reviewed for appropriate and timely adjudication.

Category 5 – Quality Improvement and Health Equity Transformation Program

Quality Improvement System: Fifteen potential quality issue cases were reviewed for timely evaluation and effective action taken to address improvements.

Category 6 – Plan Administration and Organization

Fraud, Waste, and Abuse: Fifteen fraud, waste, and abuse cases were reviewed to ensure timely reporting to DHCS.

Suspended, Excluded, and Ineligible Providers: Twenty-three excluded providers were reviewed to confirm compliance with contractual and regulatory requirements.

COMPLIANCE AUDIT FINDINGS

Category 2 – Population Health Management and Coordination of Care

2.25 Enhanced Care Management

2.25.1 Enhanced Care Management Core Service Components

The Plan is required to ensure members receive all seven ECM core service components: Outreach and Engagement, Comprehensive Assessment and Care Management Plan, Enhanced Coordination of Care, Health Promotion, Comprehensive Transitional Care, Member and Family Supports, and Coordination of and Referral to Community and Social Support Services. (*Contract, Exhibit A, Attachment III, 4.4.11*)

The Plan must administer ECM and provide the seven core ECM services to eligible members in applicable ECM Populations of Focus. The requirements under the core service components are described below, which must include, but is not limited to:

Comprehensive Assessment and Care Management Plan

- Identifying necessary clinical and non-clinical resources that may be needed to appropriately assess member health status and gaps in care and may be needed to inform the development of an individualized Care Management Plan
 - Incorporating into the Member's Care Management Plan identified needs and strategies to address those needs, including, but not limited to physical and developmental health, mental health, dementia, substance use disorders, Long Term Services and Supports (LTSS), oral health, palliative care, necessary community-based and social services, and housing
- Ensuring the Care Management Plan is reviewed, maintained, and updated under appropriate clinical oversight

Comprehensive Transitional Care

- Providing the member services to reduce avoidable admissions and readmissions by evaluating the member's medical care needs, developing a treatment plan, and coordinating any support services to facilitate safe and appropriate transitions to, from, and among treatment facilities, including admissions and discharges

- Supporting members by tracking admissions and discharges to or from an Emergency Department, hospital inpatient facility, skilled nursing facility, or other treatment center, and communicating with the appropriate care team members to include coordinating medication review and reconciliation
- Providing adherence support and referral to the appropriate services

(All Plan Letter (APL) 23-032, Enhanced Care Management Requirements)

The Plan must perform oversight of ECM providers, holding them accountable to all ECM requirements contained in the Contract, DHCS policies and guidance, APLs, and the Plan's Model of Care. *(Contract, Exhibit A, Attachment III, 4.4.13)*

The Plan is responsible for knowing when all members are admitted, discharged, or transferred and must assign a Care Manager to ensure all transitional care services are completed for all high-risk members. The Plan is responsible for ensuring that ECM providers have access to or are provided Admission, Discharge and Transfer (ADT) feed data information for enrolled members to allow them to manage transitions as part of ECM. *(CalAIM Enhanced Care Management Policy Guide, updated August 2024)*

Plan policy, *MCAP7002 CalAIM Enhanced Care Management* (reviewed 09/10/2025), states that the Plan will ensure all ECM enrolled members receive the core service components from their assigned ECM provider. The Plan will perform quarterly audits, or more frequently as needed, to evaluate the ECM provider performance and compliance to ensure state, federal, and contractual requirements are met, and at a minimum, a review of ECM files including delivery of the core service components of ECM.

Finding: The Plan did not ensure that ECM providers delivered all ECM core service components, including Comprehensive Assessment and Care Management Plan and Comprehensive Transitional Care.

A verification review of 14 ECM medical records identified 13 samples where the Plan did not ensure the provision of all ECM core service components:

- In three cases, the standardized LTSS referral questions used to identify and refer to members who may have LTSS needs were not included in the comprehensive assessment, preventing determination of whether the members required LTSS services
- In four cases, there was no evidence of clinical oversight of the Care Management Plan for members' clinical needs
- In 12 cases, the ADT data indicated that members had been hospitalized; however, there was no documented evidence of post discharge tracking or member follow up as a part of Comprehensive Transitional Care

- In 1 of the 12 cases, the ADT data showed that a member experienced 11 separate admissions and discharges, yet the record contained no documentation demonstrating that the Lead Care Manager completed the required transitional care activities

Plan policy MCAP7002 states the Plan will ensure that core service components are provided for all members receiving ECM. However, the Plan did not have adequate oversight to ensure full compliance with these requirements by ECM providers.

During an interview, the Plan acknowledged the gap in its oversight audit process of ECM providers. The Plan's audit process did not include sufficient criteria or documentation standards to verify delivery of all ECM core service components. Audit tools lacked depth, ECM provider documentation was not consistently required or reviewed, and the Plan did not enforce oversight mechanisms needed to ensure provider compliance with ECM requirements.

When the Plan does not ensure that providers deliver all required ECM core service components to members with complex medical health needs, it may result in gaps in care and increase the risk of adverse health outcomes.

Recommendation: Implement policies and procedures to ensure ECM providers consistently deliver all ECM core service components as required and maintain compliance with these requirements.

2.29 Initial Health Appointment

2.29.1 Initial Health Appointment Timely Completion and Outreach

The Plan is required to ensure an IHA is performed within 120 calendar days of enrollment. (*Contract, Exhibit A, Attachment III, 5.3.4 (A)(1)(2)*)

The Plan is required to make reasonable attempts to contact a member to schedule an IHA. The Plan is required to document all attempts to contact a member. Documented attempts that demonstrate the Plan's efforts to unsuccessfully contact a member and schedule an IHA will be considered evidence in meeting this requirement. (*Contract, Exhibit A, Attachment III, 5.3.3 (C)*)

Plan policy, *MCQP1021 Initial Health Appointments for Children and Adults* (reviewed 01/08/2025), states that the Plan's documentation must include at least two outreach attempts to the member. Primary care physicians or other providers of primary care services must document the performance of an IHA in the member's medical record or state that equivalent information is part of the medical record. On an annual basis, the

Plan pulls claims and encounters with specific visit codes for primary care providers to identify the potential percentage of their newly assigned members who had a visit within 120 days of being newly assigned. Due to limitations and the lack of a singular IHA billing code, the report is only able to show potential IHA's completed.

Finding: The Plan did not ensure timely completion of IHAs and did not maintain documentation of reasonable outreach attempts to contact members.

A verification review of 16 medical records revealed 7 instances in which the Plan did not ensure completion of IHAs within the required timeframe and lacked documentation of reasonable outreach efforts indicating unsuccessful attempts to contact members and arrange an IHA.

Although Plan policy MCQP1021 states that the Plan's documentation must include at least two attempts to outreach the member, the Plan did not have an adequate process to ensure documentation of outreach attempts made to schedule an IHA.

During an interview, the Plan explained that monitoring of IHA completion is conducted through facility site reviews, medical record reviews, provider attestations, and reviews of primary care physician claims and encounter data. The Plan also stated that IHA outreach tracker forms were utilized but noted difficulties in obtaining these forms due to security restrictions, and therefore, did not maintain documentation of member outreach attempts.

Despite the Plan's monitoring efforts, the Plan did not have a functional process to track and store outreach attempts, and its monitoring mechanisms (facility site reviews, medical record reviews, claims and encounter reviews) do not verify outreach documentation. Outreach tracker forms were not accessible due to system restrictions, and the Plan lacked oversight processes to ensure IHA outreach was documented.

When the Plan does not ensure timely IHAs and ensure documentation of reasonable outreach attempts to contact members, this can compromise timely identification and management of members' medical and preventative care needs.

Recommendation: Implement policies and procedures to ensure timely completion and documentation of IHA member outreach attempts.

COMPLIANCE AUDIT FINDINGS

Category 4 – Grievances, Appeals, and Member Rights

4.2 Grievance Process

4.2.1 Quality of Care Grievance Resolution

The Plan is required to follow grievance requirements set forth in *APL 21-011, Grievance and Appeal Requirements, Notice and "Your Rights" Templates*. (Contract, Exhibit A, Attachment III, 4.6.1)

The Plan is required to comply with all DHCS guidance, including APLs. APLs existing on the effective date of the Contract will be considered part of the Contract. (Contract, Exhibit E, 1.1.2(A)(1))

The Plan is required to ensure adequate consideration of grievances and that each issue presented by the member is addressed and resolved. "Resolved" means the grievance has reached a final conclusion with respect to the member's submitted grievance. (APL 21-011, Grievance and Appeal Requirements, Notice and "Your Rights" Templates)

The Plan is required to maintain policies and procedures to ensure network providers fully comply with all applicable terms and conditions of the Contract. The Plan must oversee and remain responsible for any functions undertaken by a network provider and meet all applicable requirements set forth in state and federal law, regulations, APLs, DHCS guidance, and the Contract. (Contract, Exhibit A, Attachment III, 3.1.4)

The Plan is required to develop and maintain effective systems for prompt and thorough correction of compliance issues to reduce the potential for recurrence. (Contract, Exhibit A, Attachment III, 1.3.1(L))

The Plan is required to ensure network providers comply with all applicable Contract requirements and all requirements set forth in their network provider agreements. (Contract, Exhibit A, Attachment III, 3.1.1(C))

Plan policy, *CGA024 Medi-Cal Member Grievance System* (reviewed 02/14/2024), states that the Plan strives to reach a fair resolution for grievances after thorough evaluation of each issue. The Grievance Resolution letter summarizes the grievance and describes the resolution.

Plan policy, *CMP38 Escalation and Corrective Action* (reviewed 08/15/2024), states that upon identification of noncompliance, subject matter experts, including departments with authority and responsibility for monitoring a specific area, and/or the Regulatory Affairs and Compliance Department may rectify the deficiency through escalation or a CAP.

Finding: The Plan did not ensure to resolve each issue presented in QOC grievances prior to closure.

A verification review of 25 routine QOC grievances found 3 cases in which the Plan did not resolve each issue presented before closure and sent Grievance Resolution letters that did not provide a clear explanation of outcomes for all issues. The three cases were filed against Sutter Health (Plan network provider), where the requested responses from the provider were not supplied to the Plan:

- A member's mother filed a grievance against a rehabilitation facility due to issues with scheduling appointments. The Grievance Resolution letter stated that the Plan was unable to obtain a response from the provider, and the medical records were not sufficient to fully investigate the grievance. The Grievance Resolution letter added that the grievance was shared with the quality improvement team, and the grievance process was completed.
- A member filed a grievance against a provider regarding the plan of care for a kidney stone. The Grievance Resolution letter stated that the provider did not supply a detailed response to the Plan's request for information. The grievance was shared with the Regulatory Affairs and Compliance Department and the quality improvement team. This completed the grievance process. The Grievance Resolution letter did not contain resolutions for all issues presented within the grievance.
- A member filed a grievance against a hospital regarding treatment for a viral infection. The Grievance Resolution letter stated that the Medical Director reviewed the grievance and identified a potential QOC concern, the grievance was shared with the quality improvement team, and the grievance process was completed.

In the cases reviewed, the Plan did not ensure Sutter Health complied with the Contract and APL requirements regarding grievance resolution. During an interview, the Plan stated that Sutter Health did not consistently provide responses during grievance investigations. When Sutter Health did not respond, a standard letter was sent to the Plan stating that Sutter Health performs its own internal investigations when notified of

a grievance involving one of its providers. However, the Plan lacked oversight and did not ensure Sutter Health provided the results of its investigation to the Plan. The Plan was unable to verify whether Sutter Health conducted a proper investigation, what the outcomes were, or if any corrective actions were implemented.

The Plan was responsible for making sure the grievance process was followed and did not assign this responsibility to Sutter Health. However, the Plan did not take appropriate steps to ensure Sutter Health fully participated in the grievance resolution process. The Plan explained during an interview that the Grievance Department did not properly identify the network provider response problem as a compliance issue due to lack of clearly defined criteria within Plan policy CMP38 for identification and escalation of compliance issues. As a result, the Plan did not implement corrective action to ensure Sutter Health's cooperation with grievance investigations. Consequently, the Plan did not ensure grievances were fully investigated prior to closure, member concerns were left unresolved and Grievance Resolution letters issued were not compliant with contractual obligations.

When QOC grievances are not fully resolved prior to closure and Grievance Resolution letters are sent, members may be deprived of information necessary to make informed healthcare decisions, which could adversely affect QOC.

Recommendation: Revise policies and implement procedures to ensure each issue presented in QOC grievances is resolved before closing and sending Grievance Resolution letters to members.

4.2.2 Grievance Resolution Letters

The Plan must have a Member Grievance and Appeal System that complies with federal and state regulations for covered services. The Plan must follow all grievance and appeal requirements in *APL 21-011, Grievance and Appeal Requirements, Notice and "Your Rights" Templates* and use the required notice templates. (*Contract 23-30221, Exhibit A, Attachment III, 4.6.1*)

The Plan's grievance resolution and written response is required to contain a clear and concise explanation of the Plan's decision. The regulation does not require the Plan to disclose information to the member that is otherwise confidential or privileged by law. (*California Code of Regulations (Cal. Code Regs.), title 28, section 1300.68(d)(3)*)

The Plan's written resolution must contain a clear and concise explanation of the Plan's decision. "Resolved" means that the grievance has reached a final conclusion with

respect to the member's submitted grievance as delineated in state regulations. (*APL 21-011, Grievance and Appeal Requirements, Notice and "Your Rights" Templates*)

The Plan policy, *CGA024 Grievance System Policy* (revised 02/12/2025), states that "Resolved" is when the Plan has reviewed all relevant documentation, conducted any necessary investigation, and reached a final determination with respect to each issue raised by the member.

The Plan procedure, *GA-INC C00001 Standard Grievance Desktop* (revised 07/19/2023), states that the Grievance Resolution letter must provide the resolution in a clear and concise manner, and describe all additional concerns brought up by the member during investigation.

The Plan procedure, *GA-AUD-A00001 Internal Auditing Desktop* (revised 10/30/2024), states that supervisors are required to review findings and provide guidance to case analysts if internal audits identify any deficiencies in the grievance resolution.

Finding: Grievance Resolution letters did not contain clear and concise explanations of the Plan's decisions.

A review of 15 quality of service grievances found that 4 Grievance Resolution letters lacked clear and concise explanations of the Plan's decisions:

- A grievance involving time-sensitive dialysis transportation showed that the Plan's written resolution did not provide a clear or concise explanation of how the Plan evaluated the member's report of repeated delays. Instead, the letter offered a general apology without briefly stating the Plan's assessment or the basis for its determination.
- A grievance regarding delays in establishing care with a primary care physician showed that the Plan's Grievance Resolution letter did not clearly describe the Plan's determination. The letter relied on vague and unverified provider statements without offering a direct explanation of how the Plan reached its conclusion.
- A grievance involving accessibility and communication barriers for durable medical equipment delivery showed that the Plan's Grievance Resolution letter lacked a clear and concise description of the Plan's determination. Although the letter included general instructions on requesting delivery photos, it did not present a direct explanation of the Plan's decision.
- A transportation grievance involving service delays and suspected driver intoxication showed that the Plan's written resolution did not state its

determination in a clear and concise manner. The Grievance Resolution letter explained that the Plan could not verify the reported behavior but did not provide a clear explanation of how the Plan reached its conclusion.

Although Plan procedure GA-INC C00001 is in compliance with contractual requirements and states that Grievance Resolution letters must be written in a clear and concise manner, the Plan acknowledged during an interview that grievance coordinators responsible for resolving these quality-of-service grievances did not consistently follow the established policies and procedures to ensure Grievance Resolution letters contained clear and concise explanation of the Plan's decision.

In addition, Plan procedure GA-AUD-A00001 states that supervisors are required to review findings and provide guidance to Grievance Case Analysts if deficiencies in the grievance resolution were identified; however, the Plan did not enforce oversight procedures designed to ensure grievance resolution quality. Grievance Case Analysts did not consistently follow policy requirements for addressing all member concerns, and supervisors did not complete required corrective actions when internal audits identified deficiencies. The absence of peer review and inconsistent supervisory follow-through contributed directly to unclear and incomplete Grievance Resolution letters.

When Grievance Resolution letters do not provide a clear and concise explanation, members may not receive the information necessary to make informed health care decisions.

Recommendation: Implement policies and procedures to ensure Grievance Resolution letters contain clear and concise explanations of the Plan's decisions.

COMPLIANCE AUDIT FINDINGS

Category 5 – Quality Improvement and Health Equity Transformation Program

5.6 Quality Improvement and Health Equity Transformation Program Policies and Procedures

5.6.1 Effective Action to Improve Quality of Care

The Plan must implement a Quality Improvement and Health Equity Transformation Program that includes the standards set forth in Cal. Code Regs., tit. 28, section 1300.70. The Plan must monitor, evaluate, and take timely action to address necessary improvements in the quality of care delivered by all its providers in any setting. The Plan is responsible for the quality of all covered services. (*Contract, Exhibit A, Attachment III, 2.2*)

The Plan's Quality Assurance Program must document that the quality of care provided is reviewed, problems are identified, and effective action is taken to improve care where deficiencies are identified. The program must ensure that quality of care problems are identified and corrected for all provider entities. (*Cal. Code Regs., tit. 28, section 1300.70(a)(1) and 1300.70 (b)(1)(B)*)

The Plan must maintain policies and procedures to ensure network providers fully comply with all applicable terms and conditions of the Contract. The Plan must oversee and remain responsible for any functions undertaken by a network provider and meet all applicable requirements set forth in state and federal law, regulations, APLs, DHCS guidance, and the Contract. (*Contract, Exhibit A, Attachment III, 3.1.4*)

The Plan must develop and maintain effective systems for prompt and thorough correction of compliance issues to reduce the potential for recurrence. (*Contract, Exhibit A, Attachment III, 1.3.1(L)*)

Plan policy, *MPQP1016 Potential Quality Issue (PQI) Investigation and Resolution* (reviewed 06/12/2024), defines a CAP for QOC issues as a plan approved by the Peer Review Committee to help ensure that a related quality issue does not occur in the future. CAPs are issued to the provider. CAPs clearly state goals and timeframes for completion. When the Peer Review Committee recommends a CAP, the provider must

respond within 30 calendar days. CAPs may include required completion of continuing education programs.

Plan policy, *CMP38 Escalation and Corrective Action* (reviewed 08/15/2024), defines a CAP for compliance issues as a written plan to correct deficiencies identified through oversight activities. A CAP is required for contracted delegates, subcontractors, or network providers with demonstrated noncompliance. Subject matter experts, including departments with authority and responsibility for monitoring a specific area, and/or the Regulatory Affairs and Compliance Department may rectify the deficiency through escalation or a CAP. The Plan reserves the right to bypass the escalation process and require corrective action.

Finding: The Plan did not take effective action to ensure the correction of identified quality of care deficiencies.

A verification review found that 6 out of 15 potential quality issue cases presented significant and confirmed quality of care concerns; these cases were submitted for peer review, and CAPs were implemented for the providers. However, in the following 2 of the 6 cases with CAPs, the Plan did not ensure corrective actions were completed to address and resolve the identified deficiencies:

- A member had a procedure without appropriate testing and suffered a bleeding complication that required a nine-day hospitalization. The Plan issued a CAP requiring the physician and Clinical Effectiveness Consultant to provide attestations that they reviewed protocols, policies, and procedures related to pre-procedural evaluations and implemented appropriate interventions.
- The provider did not diagnose and treat a member with a skin infection. The member was later admitted to the hospital for 11 days. The Plan issued a CAP requiring the provider to supply either an attestation or copy of a continuing medical education certificate after completing two hours of continuing medical education.

The Plan issued CAPs for two confirmed QOC cases involving Sutter Health providers. However, the Plan did not receive required documentation verifying CAP completion. Sutter Health communicated that it conducts internal investigations but did not share results or evidence of any corrective action taken. As a result, the Plan could not verify that providers completed corrective actions regarding quality of care issues, nor confirm that the identified deficiencies were resolved.

The Plan is required to monitor, evaluate, and undertake timely and effective measures to address necessary improvements in the quality of care provided by all its network providers. However, the Plan lacked robust escalation procedures and comprehensive policy guidance for managing noncompliant providers. The Plan's network provider, Sutter Health, did not cooperate with requests for quality improvement or with investigations, thus inhibiting the Plan's ability to ensure completion of corrective actions.

During an interview, the Plan acknowledged that failure to complete CAPs may jeopardize the fulfillment of Contract requirements regarding effective and timely remediation of quality of care issues. Furthermore, Plan policy CMP38 did not articulate clear criteria for escalation or CAP enforcement, and staff members did not employ enforcement mechanisms to address Sutter Health's non-compliance. Consequently, quality of care issues remained uncorrected.

Not taking effective action to address necessary improvements and correct quality of care issues could result in continued substandard care and adversely affect clinical outcomes.

Recommendation: Revise policies and implement procedures to ensure the Plan has an effective system for prompt and thorough correction of compliance issues and that effective action is taken to correct identified quality of care deficiencies.

COMPLIANCE AUDIT FINDINGS

Category 6 – Plan Administration and Organization

6.15 Obligations Regarding Suspended, Excluded, and Ineligible Providers

6.15.1 Department of Health Care Services Notification of Network Provider Termination

The Plan is required to notify DHCS within 10 calendar days of the termination of network providers upon discovery of a Network Provider's exclusionary status, as described in *APL 21-003, Medi-Cal Network Provider and Subcontractor Terminations*. (*Contract, Exhibit A, Attachment III, 1.3.4*)

The Plan is required to review exclusionary databases on a regular basis, at least monthly, and take appropriate action. Upon discovery that a network provider has been excluded or suspended from the Medi-Cal program, the Plan must immediately, or within 10 calendar days of learning of a network provider's exclusionary status, provide DHCS with written notice of the termination. (*APL 21-003, Medi-Cal Network Provider and Subcontractor Terminations*)

Plan policy, *MPPR209 Provider Network/Subcontractor Contract Terminations and Facility De-certifications and Suspensions* (reviewed 04/09/2025), states that the Plan shall review state and federal exclusionary databases, no less frequently than monthly, to determine network provider status. The Plan shall take appropriate action if a network provider is determined to be excluded. Immediately, or within 10 calendar days of learning of a network provider's exclusionary status, provide DHCS with written notice of the termination as described in APL 21-003.

Plan policy, *MPCR500 Ongoing Monitoring and Interventions* (reviewed 02/14/2024), states that the credentialing staff collects and reviews information on a monthly basis to ensure all network providers remain free of Medi-Cal and Medicare sanctions and maintain a valid and unrestricted license in the states he or she provides services to Plan members.

Finding: The Plan did not have a process in place to ensure notification to DHCS within 10 calendar days of discovering a network provider's exclusionary status.

A verification review of 23 suspended, excluded, and ineligible providers revealed that the Plan did not have a process in place to ensure appropriate notification to DHCS regarding the exclusionary status and termination of individual network providers.

During an interview, the Plan stated to have misinterpreted APL 21-003 to apply to contracts with provider groups and not individual providers and confirmed that Plan policy MPPR209 was applied to group contract terminations and not for individual provider exclusions. The Plan further confirmed that they do not have a functional policy or process to ensure DHCS notification of individual provider exclusions or terminations.

Although Plan policy MPPR209 stated the Plan shall take appropriate action if a network provider is determined to be excluded and provide DHCS with written notice of the termination, the Plan did not apply this policy to that of individual network providers.

In addition, Plan policies MPPR209 and MPCR500 lacked procedures for individual provider exclusions. The Network Services Department and Compliance Department had no defined hand-off to trigger notification, and no controls to ensure DHCS notification requirements were met.

Without timely DHCS notification, DHCS cannot assess member access impacts, ensure continuity of care, or take program-integrity actions. This increases the risk of continued payments to ineligible providers and compromises statewide oversight.

Recommendation: Develop and implement policies and procedures to ensure notification to the DHCS within 10 calendar days of removing a suspended, excluded, or terminated provider from its provider network.

6.15.2 Ineligible Provider Payment Suspension

The Plan is responsible for knowledge of all ineligible providers on all exclusionary database lists. The Plan is required to confirm that the ineligible providers are no longer receiving payments, either directly or indirectly, in connection with the Medi-Cal program. In addition, the Plan is prohibited from paying providers that are excluded, suspended, or ineligible to participate, either directly or indirectly, in the Medi-Cal program. (*Contract, Exhibit A, Attachment III, 1.3.4*)

The Plan cannot make payments to anyone, or any entity excluded from Medicare, Medicaid, CHIP, suspended or debarred from federal health care programs, or listed on federal or state exclusion lists. (*Code of Federal Regulations, title 42, section 438.610*)

Plan policy, *MPCR500 Ongoing Monitoring and Interventions* (reviewed 02/14/2024), states that the credentialing staff collects and reviews information on a monthly basis to ensure all network providers remain free of Medi-Cal and Medicare sanctions and maintain a valid and unrestricted license in the state where he or she provides services to Plan members.

Finding: The Plan did not have a process in place to ensure suspension of payments to ineligible providers.

A review of 23 suspended, excluded, or ineligible providers found that the Plan had no mechanism to ensure that ineligible providers were removed from the claims payment system.

The Plan lacked documented procedures and internal controls to ensure suspension of payments upon identifying an ineligible provider. The Plan confirmed during an interview and within a written narrative that roles and responsibilities between the Network Services, Compliance, and Claims departments were not defined, and no automated system edits or communication workflows existed to prevent payments.

Because the Network Services Department did not communicate provider removal to the Claims Department, the Claim's Department payment system continued to allow payments after exclusion dates. Additionally, staff were not trained in exclusion-related payment requirements. As a result, the Plan could not demonstrate any process or internal controls to prevent or suspend payments to ineligible providers.

Failure to prevent payments to excluded and ineligible providers undermines program integrity safeguards intended to ensure only eligible providers are reimbursed, which may potentially cause financial penalties for the state and medical networks, and risk exposing members to unethical or substandard care.

Recommendation: Develop and implement policies and procedures to ensure payment suspension of excluded providers for Medi-Cal services delivered after the effective date of the exclusion.

REPORT ON THE MEDICAL AUDIT OF PARTNERSHIP HEALTH PLAN OF CALIFORNIA YEAR 2025

**DHCS Audits and Investigations
Contract and Enrollment Review Division
Sacramento Section**

Contract Number: 23-30268

Contract Type: State Supported Services

Audit Period: July 1, 2024 — December 31, 2025

Dates of Audit: April 20, 2026 — May 1, 2026

Report Issued: October 20, 2026

TABLE OF CONTENTS

I. INTRODUCTION 3

II. COMPLIANCE AUDIT FINDINGS 4

I. INTRODUCTION

This report presents the results of the audit of Partnership Health Plan of California (Plan) compliance and implementation of the State Supported Services contract number 23-30268 with the State of California. The State Supported Services Contract covers abortion services with the Plan.

The audit covered the period of July 1, 2024, through December 31, 2025. The audit was conducted from April 20, 2026, through May 1, 2026, which consisted of a document review and verification study with the Plan administration and staff.

COMPLIANCE AUDIT FINDINGS

State Supported Services

The Plan is required to provide, or arrange to provide, to eligible members enrolled under either this Contract or the Primary Contract, the following private services:

- Current Procedural Terminology codes: 59840 through 59857
- Centers for Medicare & Medicaid Services Common Procedure Coding System codes: X1516, X1518, X7724, X7726, and Z0336

These codes are subject to change upon the Department of Health Care Services implementation of the Health Insurance Portability and Accountability Act of 1996 electronic transaction and code sets provisions. (*State Supported Services Contract, Exhibit A, 1.2.1 and 1.2.2*)

The Plan is required to cover abortion services, as well as the medical services and supplies incidental or preliminary to an abortion, consistent with the requirements in the Medi-Cal Provider Manual. The Plan, network providers, and subcontractors are prohibited from requiring medical justification, imposing any utilization management or utilization review requirements, including prior authorization, for the coverage of outpatient abortion services. (*All Plan Letter 24-003, Abortions and Directly Related Medical Services and Supplies*)

Finding: No deficiencies were identified in the audit.

Recommendation: None.