DHCS
CALIFORNIA DEPARTMENT OF
HEALTH CARE SERVICES
Michelle Baass | Director

October 23, 2023

Danielle Ogren,
Associate Director of Compliance & Program Strategy
Partnership HealthPlan of California
4665 Business Center Drive.
Fairfield, CA 94534

RE: Department of Health Care Services Medical Audit

Dear Ms. Ogren:

The Department of Health Care Services (DHCS), Audits and Investigations Division conducted an on-site Medical Audit of Partnership Health Plan of California, a Managed Care Plan (MCP), from December 5, 2022 through December 16, 2022. The audit covered the period of July 1, 2021 through June 30, 2022.

The items were evaluated and DHCS accepts the MCP's submitted Corrective Action Plan (CAP). The CAP is hereby closed. The enclosed documents will serve as DHCS' final response to the MCP's CAP. Closure of this CAP does not halt any other processes in place between DHCS and the MCP regarding the deficiencies in the audit report or elsewhere, nor does it preclude the DHCS from taking additional actions it deems necessary regarding these deficiencies.

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

If you have any questions, please reach out to CAP Compliance personnel.

Sincerely,

[Signature on file]

Lyubov Poonka, Chief
Audit Monitoring Unit
Managed Care Quality and Monitoring Division
Department of Health Care Services Department of Health Care Services

Enclosures: Attachment A (CAP Response Form)

cc: Stacy Nguyen, Chief
Managed Care Monitoring Branch
Managed Care Quality and Monitoring Division
Department of Health Care Services

Maria Angel, Lead Analyst
Audit Monitoring Unit
Managed Care Quality and Monitoring Division
Department of Health Care Services

Jalen Yip, Contract Manager
Medi-Cal Managed Care Division
Department of Health Care Services

**ATTACHMENT A**
**Corrective Action Plan Response Form**

**Plan: Partnership Health Plan of California (Partnership)**

**Review Period:** 07/01/2021 - 06/30/2022

**Audit Type:** Medical Audit

**On-site Review:** 12/05/2022 – 12/16/2022

MCPs are required to provide a CAP and respond to all documented deficiencies included in the medical audit report within 30 calendar days, unless an alternative timeframe is indicated in the CAP Request letter. MCPs are required to submit the CAP in Word format that will reduce turnaround time for DHCS to complete its review. According to ADA requirement, the document should be at least 12 pt.

The CAP submission must include a written statement identifying the deficiency and describing the plan of action taken to correct the deficiency, and the operational results of that action. The MCP shall directly address each deficiency component by completing the following columns provided for MCP response: 2. Action Taken, 3. Implementation Documentation, and 4. Completion/Expected Completion Date. The MCP will be required to include project timeline with milestones in a separate document for each finding. Supporting documentation should accompany each Action Taken. If supporting documentation is missing, the MCP submission will not be accepted. For policies and other documentation that have been revised, please highlight the new relevant text, and include additional detail such as title of the document, page number, revision date, etc. in the column "Supporting Documentation" to assist DHCS in identifying any updates that were made by the plan. For deficiencies that require short-term corrective action, implementation should be completed within 30 calendar days. For deficiencies that may be reasonably determined to require long-term corrective action for a period longer than 30 days to completely remedy or operationalize, the MCP is to indicate that it has initiated remedial action and is on the way towards achieving an acceptable level of compliance. In those instances, the MCP will be required in addition to the above steps, to include the date when full compliance will be achieved. Policies and procedures submitted during the CAP process must still be sent to the MCP's Contract Manager for review and approval, as applicable in accordance with existing requirements.

**Please note, DHCS expects the plan to take swift action to implement improvement interventions as proposed in the CAP, therefore DHCS encourages all remediation efforts to be in place no later than month 6 of the CAP, unless prior approval for an extended implementation effort is granted by DHCS.**

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

| Finding Number and Summary | Action Taken | Supporting Documentation | Implementation Date* (*Short-Term, Long-Term) | DHCS Comments |
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| **2. Case Management and Coordination of Care** | | | | |
| **2.1.1 Initial Health Assessment**<br><br>The Plan did not ensure completion of an IHA for new members within 120 days of enrollment. | Several factors contributed to Partnership's poor performance on IHA completion rates. Providers cite significant staffing shortages and the suspension of the IHA requirement from December 2019 – September 2021 as contributing to de-prioritization of this improvement activity. The lack of a clear path to identifying IHA elements thru coding sets for retrieval from electronic health records and claims also impedes the ability to accurately report IHA completion. The overarching effect of the COVID-19 pandemic on the healthcare system, including decreased access to care and avoidance of medical care (patients unwilling to come into a doctor's office), must be considered when evaluating IHA rates during the measurement year (MY). Numerous published, peer reviewed analyses document the very significant declines in preventive health care and primary care quality measures experienced nationally in the first year of the pandemic. While studies looking at the second two years of the pandemic are pending, preliminary reviews of visit numbers reflect a persistent drop off in office based medical visits compared to pre-pandemic rates. Clearly, any quality measure looking at non-urgent, non-treatment oriented medical care, like the IHA measure, was and continues to be negatively impacted by the COVID-19 pandemic. | Various based on planned intervention – includes but is not limited to, provider and member education, industry best practices, meeting minutes, updated webpages | Long term Interventions implemented between 04/12/23 – 10/01/2023 with oversight/adjustments on-going | The following documentation supports the MCP's efforts to correct this finding:<br><br>**MONITORING AND OVERSIGHT**<br><br>• Monthly outreach includes:<br>o Sample Newsletter Article on updated IHA requirements. (File #1_Sample Newsletter Article) Provider Online Portal Instructions to access monthly list of new members in need of an IHA (2.1.1 #1 Provider Porter Login instructions attached to Outreach Email)<br><br>o A sample tracker, "How to Complete the 3 Attempt Tracker" include directions on documenting attempts to schedule and IHA. (2.1.1 #1 3 Attempt Tracker attached to Outreach Email)<br><br>o Updated IHA billing codes/guide for Adult and Pediatric members. (3_PHC Billing Guide_Adult – Peds – OB)<br><br>o Monthly list of newly enrolled members includes mailing labels, sample member letters to use to welcome new members which outlines IHA requirements.<br><br>• Internal auditing – IHA focused audits for each county of operation. Cases are randomly |

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| | Partnership is responding to the failure of providers to complete and document Initial Health Appointments (IHA) in several ways.<br>1. Provider's will be reminded of the requirement at multiple opportunities including clinical site review, newsletters, face to face Clinical Operations meetings with providers and Partnership staff, and at Medical Director forums and leadership meetings. The importance of completing the IHA are on the Partnership Provider website. Providers will also receive monthly updated lists of members eligible for IHA completion with the expectation they will use the lists to reach out to get members scheduled.<br>2. Members will receive many notifications and reminders of the importance of scheduling and completing the IHA. These reminders will include mailed letters, flyers available at provider's offices, flyers included in packets of materials for new parents, and verbal reminders during phone calls with new members. Information about the IHA is also available on the Member Website. Partnership will attend community events attended by Partnership members and provide written materials and verbal reminders about the availability and importance of the IHA.<br>3. Partnership will talk with other Medi-Cal | | | selected, and CAPs are required for providers found not meeting APL 22-030 requirements. Plan submitted sample audit, staff/provider training, CAP cover letter and CAP as evidence of implementation. (2.1.1 #5 IHA Example Audit)<br>• QI Department will partner with individual provider offices who are on a FSR CAP or are interested in improving IHA performance.<br>• Member Outreach – Updated new member outreach letter encourages members to schedule a checkup with PCP within 90 days of enrollment. (6_ New Member Letter First Mailing)<br>• Revised call scripts for member services that encourages members to contact their assigned PCP and schedule an initial health appointment. (7_Member Services Script)<br>• Plan contracts with a call vendor to conduct outreach to members to schedule visits and complete required assessments.<br>• Healthy Child Preventive Services Calls to reinforce the importance of establishing care with a PCP. Incentives are provided to obtain preventive services.<br>• New member outreach flyer and schedule of |

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| | health plans in California whose providers have done better than Partnership with IHA completion and apply any best practices believed to likely improve Partnership's rates.<br>4. Augment notifications to providers and members about the IHA requirement and benefit thru written, verbal and online communications.<br>5. Finally, Partnership will randomly audit providers across its network to see that IHA visits are being done and will enforce Corrective Action Plans for providers not meeting expected levels of IHAs. | | | community outreach events<br><br>**TRAINING**<br><br>• PowerPoint, "IHA Redwood Rural" demonstrates MCP's effort to provide continuing education. The training will be individualized for each provider site. (14_IHA Redwood Rural_4.20.23)<br><br>• The Site Review Team offers 1:1 educational training about IHA requirements at every site review exit interview. This educational piece is also posted on the PHC Website. (PHC Billing Guide)<br><br>**The corrective action plan for finding 2.1.1 is accepted.** |
| **2.1.2 Blood Lead Screening Tests**<br><br>The Plan did not ensure the provision of BLS tests to child members at ages one and two or did not document the reason for not performing a BLS test in the child's | Several factors contributed to Partnership's poor performance on the childhood Blood Lead Screening (BLS). These include: the lingering effects of the COVID-19 pandemic on parent/ guardian willingness to take a child to a medical office for a non-treatment, non-urgent problem (like "check-ups" where BLS is done); limited access to BLS testing services in rural and medically under-served communities; a "recall" of the only available "point of care" lead testing devices approved in the USA; Public Health Lab resource limitations, and parent/ guardian and | Various based on planned intervention – includes but is not limited to, provider and member education, industry best practices, meeting minutes, updated webpages | Long term Interventions implemented between 03/30/2023 – 10/01/2023 with oversight/adjustments on-going | The following documentation supports the MCP's efforts to correct this finding:<br><br>**POLICY AND PROCEDURES**<br><br>• Updated P&P, "MCQG1015: Pediatric Preventive Health Guidelines" (03/08/23) to state that the MCP will confirm the provision of BLS tests to child members at ages one and two, and to document the reason for not performing a BLS test in the child's medical record. (PPMCQG1015). |

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| medical record. | even medical provider faulty beliefs that they are living and working in areas of low risk for lead, so no testing is indicated.<br>Partnership is responding to the lack of blood lead screening (BLS) tests of child members in several ways.<br>1. Remind providers of the BLS requirement at multiple opportunities including clinical site reviews, in newsletters, at face to face Clinical Operations meetings with providers and Partnership staff, and at Medical Director forums and other leadership meetings. The importance of BLS testing and trainings are posted on the Partnership Provider website. Providers will also regularly receive updated lists of members eligible for BLS testing with the expectation they will use the lists to increase testing. Some providers may be offered medical equipment to perform testing in their offices so patients do not have to go to a lab.<br>2. Members will receive many notifications and reminders of the importance of scheduling and completing BLS testing. These reminders will include mailed letters, flyers available at provider's offices, flyers included in packets of materials for new parents, and verbal reminders during phone calls with parents and guardians of children eligible for | | | • Meeting Agenda, "Partnership Healthplan of California Physician Advisory Committee Meeting" (10/06/23) as evidence that the MCP has added a BLS measure to the MCP's Quality Improvement Program Primary Care Providers measure set for family medicine and pediatrics practices. This will provide an added incentive to improve BLS performance in practices caring for children. The measure addition was approved by the Physicians Advisory Committee on 10/11/23 for inclusion in the PCP QIP (family medicine and pediatric) measure set for 2024. (Pages from October 11 PAC meeting).<br><br>• Meeting Minutes, "Lead Screening Sub-Committee Monthly Meeting" (June 2023) as evidence that a Lead Sub-Committee was formed and meets monthly. The Lead Sub-Committee reviews the DHCS CAP with a focus on the BLS. Also, the QMSI Pediatrics workgroup meets monthly. (Lead Screening Sub-Committee Meeting Minutes).<br><br>**TRAINING**<br><br>• "Pediatric Lead Testing Requirements" and "Pediatric Blood Lead Testing Frequently Asked Questions" as evidence that the MCP's Site Review Team will provide these flyers and educate all pediatric care providers on |

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| | testing. Information about BLS is also available on the Member Website. Partnership will attend community events attended by Partnership members and provide written materials and verbal reminders about the importance of BLS testing.<br>3. Partnership will talk with participating providers who have done better than others with BLS testing to learn how they are able to get more children tested and then share lessons learned with other providers who are not doing as well.<br>4. Similarly, Partnership will talk with other Medi-Cal health plans in California whose providers have done better than Partnership with BLS testing to learn how they are able to get more children BLS tested and apply any best practices believed to likely improve BLS testing.<br>5. Partnership will possibly add (pending appropriate committee approvals) a BLS measure to the family medicine and pediatrics PCP quality improvement programs to further incentivize providers to increase BLS testing. | | | childhood Blood Lead Screening during their exit interview process of the Site Review. (Pediatric Lead Testing Requirements Flyer, Pediatric Blood Lead Testing FAQ).<br>• "Parents' Guide to Taking Care of Baby" as evidence that the MCP will conduct outreach to pregnant and newly delivered moms with 4 calls and 2 incentives that reinforce the importance of early well-baby care including vaccinations and blood lead testing. (Parents' Guide Baby Info).<br>• "Healthy Toddlers Preventative Services Postcard" as evidence that the MCP will conduct outreach to members by mail which reinforces the importance of periodic visits including vaccinations and blood lead testing. (Healthy Child Preventative Services Postcard).<br>• "Healthy Kids GTP Screening," "Healthy Kids GTP Mailer Booklet," and "Healthy Kids Flyer," as evidence that the MCP will conduct outreach to members by mail and telephone reinforcing the importance of annual visits including vaccinations and catch-up blood lead testing from ages 12-35 months with 4 outbound calls with an incentive. (GTP Healthy Kids Initial Call, Healthy Kids GTP Mailer Booklet, Healthy Kids Flyer). |

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| | | | | • Updated Member and Provider Resources, “Blood Lead Screening Resources, Pediatric Blood Lead Testing FAQ's, Pediatric Blood Lead Testing Flyer, Pediatric Lead Testing Requirements” as evidence that the MCP has updated information on blood lead screening for providers and members. (Webpage Screenshots).<br><br>**MONITORING AND OVERSIGHT**<br><br>• “Blood Lead Screening CAP” as evidence that the MCP will impose corrective actions on non-compliant providers who do not document the refusal of these services. The CAP includes the Recommended Corrective Action, Correction Date, and Practitioners Comments. (Copy of BLS CAP Test).<br><br>• Webinar, “Point of Care Lead Testing in Primary Care Clinics” (09/07/23) and application, “PHC Program Application: LeadCare II Point of Care Testing” as evidence that the MCP is implementing a new program aimed at improving lead testing for age-appropriate pediatric patients in primary care clinics. The MCP will distribute "point of care" blood lead testing devices to selected practices. Practices would be monitored for use of the devices on a monthly basis, comparing lists of BLS eligible members to members seen to confirm efforts are made to perform testing at every |

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| | | | | opportunity. (Point of Care Testing in Primary Care Clinics, LeadCare II Program Application).<br><br>• Email Template and Survey, "PHC Lead Screening Follow Up Survey" which the MCP will utilize to follow up with providers to encourage compliance and to identify barriers to blood lead screening. The survey asks the provider what actions were taken for blood lead screening, outreach efforts, and barriers. In addition, the MCP will also conduct a spot audit of eligible members on 10 PCP sites to evaluate compliance to verify if the PCP has contacted members and members have been tested and received anticipatory guidance. The spot audit will begin in January 2024. (PHC Lead Screening Follow Up Survey).<br><br>• The MCP has processes in place to prevent future noncompliance.<br><br>**The corrective action plan for finding 2.1.2 is accepted.** |
| **3. Access and Availability of Care** | | | | |

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| **3.8.1 Medi-Cal Enrollment of Transportation Providers**<br><br>The Plan did not terminate its transportation providers upon receiving notification from DHCS that the providers cannot be enrolled in the Medi-Cal program. | MPCR20 "Medi-Cal Managed Care Plan Provider Screening and Enrollment Policy" revised to reflect applicable language.<br><br>Staff training conducted to remind staff to use the Immediate Termination Form when a network provider is denied enrollment. | 1. Redlined version of MPCR20 Medi-Cal Managed Care Plan Provider Screening and Enrollment Policy.<br>2. Immediate Termination Form.<br>3. Meeting minutes from staff policy training<br>4. Email to MCOD | May 1, 2023 | The following documentation supports the MCP's efforts to correct this finding:<br><br>**POLICIES AND PROCEDURES**<br><br>• MPCR20 Medi-Cal Managed Care Plan Provider Screening & Enrollment<br>o The Plan will immediately terminate network providers who have been denied enrollment into the Medi-Cal program. Provider Relations will complete & process an "Immediate Termination Form". [VI. POLICY/PROCEDURE, page 2]<br>o Within 120 days of receipt of a provider's screening application, the Plan must complete the enrollment process & provide the applicant with a written determination. [G. Procedure, 7. d. 1., page 6]<br><br>**MONITORING AND OVERSIGHT**<br><br>• Partnership Roster 2023<br>o The Plan's transportation provider roster has been reviewed & verified, confirming that providers are either enrolled or have been terminated. The roster was approved by the MCQMD Transportation SME on 07/18/2023.<br><br>• MPCR20 Medi-Cal Managed Care Plan Provider Screening & Enrollment<br>o On a monthly basis, the Plan will cross |

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| | | | | check various databases to confirm that network providers maintain good standing in the Medi-Cal Program.<br>○ Any provider terminated from the Medi-Cal program may not participate in the Plan's provider network. [G. Procedure, 7. b. 1-3., page 6]<br><br>**The corrective action plan for finding 3.8.1 is accepted.** |

**Submitted by: Robert Moore** **Date: May 9, 2023**

**MD MPH MBA, Partnership HealthPlan of California**
**Title: Chief Medical Officer**

**Submitted by: Amy Turnipseed** **Date: May 9, 2023**

**Partnership HealthPlan of California**
**Title: Compliance Officer**