CONTRACT AND ENROLLMENT REVIEW
RANCHO CUCAMONGA
AUDITS AND INVESTIGATIONS
DEPARTMENT OF HEALTH CARE SERVICES

REPORT ON THE MEDICAL AUDIT OF

PARTNERSHIP HEALTH PLAN OF CALIFORNIA

2022

Contract Number:	08-85215
Audit Period:	July 1, 2021 Through June 30, 2022
Dates of Audit:	December 5, 2022 Through December 16, 2022
Report Issued:	April 5, 2023

TABLE OF CONTENTS

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 (COHS) managed care model endorsed by the County Boards of Supervisors.

The Plan began operations in 1994 serving Solano County and has expanded to 14 Northern California counties: Del Norte, Humboldt, Lassen, Lake, Marin, Mendocino, Modoc, Napa, Shasta, Siskiyou, Sonoma, Solano, Trinity, and Yolo. Plan members account for 31 percent of all residents in the 14 county service area.

As of June 2022, the Plan had approximately 653,686 Medi-Cal members. Medi-Cal members are distributed as follow: Del Norte 12,412, Humboldt 59,760, Lassen 8,635, Lake 34,274, Marin 48,167, Mendocino 40,485, Modoc 3,967, Napa 34,000, Shasta 69,256, Siskiyou 19,159, Sonoma 125,862, Solano 132,167, Trinity 5,519, and Yolo 60,023.

II. EXECUTIVE SUMMARY

This report presents the audit findings of the Department of Health Care Services (DHCS) medical audit for the period July 1, 2021 through June 30, 2022. The audit was conducted from December 5, 2022 through December 16, 2022. The audit consisted of document reviews, verification studies, and interviews with Plan representatives and a delegate entity.

An Exit Conference was held on March 14, 2023. The Plan was allowed 15 calendar days from the date of the Exit Conference to provide supplemental information to address the preliminary audit findings. On March 27, 2023, the Plan submitted a response to address the audit findings. The results of the DHCS evaluation of the Plan's response are reflected in this report.

The audit evaluated six categories of performance: Utilization Management (UM), case management and coordination of care, access and availability of care, member's rights, quality management, and administrative and organizational capacity.

The prior DHCS medical audit report was issued on February 17, 2022.

The summary of findings follows:

Category 1 – Utilization Management

Review of Prior Authorization (PA) and appeal requests for appropriate and timely adjudication yielded no findings.

Category 2 – Case Management and Coordination of Care

The Plan is required to complete an Initial Health Assessment (IHA) for new members within 120 calendar days of enrollment. The Plan did not complete an IHA for new members within 120 days of enrollment.

The Plan is required to ensure the provision of a Blood Lead Screening (BLS) test to members at ages one and two. The Plan did not ensure the provision of BLS tests to age appropriate members or did not document the reason for not performing a BLS test in the child's medical record.

Category 3 – Access and Availability of Care

The Plan is required to terminate a network provider agreement upon notification that the provider cannot be enrolled in the Medi-Cal program. The Plan did not terminate its transportation providers from its network upon receiving notification the providers cannot be enrolled in the Medi-Cal program.

Category 4 – Member's Rights

Review of the Plan's member's rights system yielded no findings.

Category 5 – Quality Management

Review of the Plan's quality improvement system yielded no findings.

Category 6 – Administrative and Organizational Capacity

Review of the Plan's organizational capacity to guard against fraud and abuse yielded no findings.

III. SCOPE/AUDIT PROCEDURES

SCOPE

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

PROCEDURE

The audit period was July 1, 2021 through June 30, 2022. The audit was conducted from December 5, 2022 through December 16, 2022. The audit included a review of the Plan's policies for providing services, the procedures used to implement the policies, and verification studies to determine that policies were implemented and effective. Documents were reviewed and interviews were conducted with Plan representatives and a delegated network provider.

The following verification studies were conducted:

Category 1 – Utilization Management

PA Requests: Ten medical, five Seniors and Persons with Disabilities, and 15 pharmacy PA requests were reviewed for timeliness, consistent application of criteria, appropriateness of review, and communication of results to members and providers.

Appeal Process: 15 medical and 15 pharmacy PA appeal requests were reviewed for appropriate and timely adjudication.

Delegation of UM: Five PA requests from a delegate entity were reviewed for appropriate and timely adjudication.

Category 2 – Case Management and Coordination of Care

Whole Child Model: Ten medical records were reviewed for comprehensive treatment including appropriate care coordination for eligible and non-eligible California Children's Services conditions.

IHA: 18 medical records were reviewed to confirm completion of IHAs and 19 were reviewed for completion of BLS tests.

Continuity of Care: Ten medical records were reviewed to evaluate timeliness and appropriate determination of the Continuity of Care request.

Behavioral Health Treatment: 15 medical records were reviewed for compliance with behavioral health treatment requirements.

Category 3 – Access and Availability of Care

Emergency Service and Family Planning Claims: 15 emergency service claims and 10 family planning claims were reviewed for appropriate and timely adjudication.

Non-Emergency Medical Transportation (NEMT): 30 records were reviewed to confirm compliance with NEMT requirements.

Non-Medical Transportation (NMT): 15 records were reviewed to confirm compliance with NMT requirements.

Category 4 – Member's Rights

Grievance Procedures: 15 quality of service and ten quality of care grievance cases were reviewed for timely resolution, appropriate response to complainant, and submission to the appropriate level for review. Ten exempt grievances and five inquiry calls were reviewed for proper classification and routing to the appropriate level for review.

Confidentiality Rights: 15 cases were reviewed for reporting of privacy incidents to DHCS Program Contract Manager, DHCS Privacy Officer, and DHCS Information Security Officer within the required timeframes.

Category 5 – Quality Management

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

Provider Training: 15 newly contracted provider records were reviewed to determine if providers received Medi-Cal Managed Care program training within the required timeframe.

Category 6 – Administrative and Organizational Capacity

Fraud, Waste, and Abuse: 15 fraud and abuse cases were reviewed for proper reporting of suspected fraud, waste, or abuse to DHCS within the required timeframe.

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

❖ COMPLIANCE AUDIT FINDINGS (CAF) ❖

PLAN: Partnership Health Plan of California

AUDIT PERIOD: July 1, 2021 through June 30, 2022
DATES OF AUDIT: December 5, 2022 through December 16, 2022

CATEGORY 2 – CASE MANAGEMENT AND COORDINATION OF CARE

2.1	INITIAL HEALTH ASSESSMENT

2.1.1 Initial Health Assessment

The Plan is required to cover and ensure the provision of an IHA (comprehensive history and physical examination) in conformance with Title 22 CCR Section 53851 (b)(1) and 53910.5(a)(1) to each new member within 120 days of enrollment. *(Contract, Exhibit A, Attachment 10 (3)(A))*

All new Plan members must have a complete IHA within 120 calendar days of enrollment. The Plan must have written procedures for requiring healthcare providers to document all components of the IHA, or any applicable IHA exemption, in the Member's Medical Record (MMR) in a timely manner. Furthermore, the Plan must have written procedures for monitoring IHA completion within the required timeframes. *(Medi-Cal Managed Care Division Policy Letter No. 08-003)*

Plan policy MCQP1021, *IHA and Behavioral Risk Assessment (revised 03-09-2022),* stated that each contracting Primary Care Provider (PCP) is required to schedule and perform an IHA within 120 days of a member's enrollment to the Plan. The Plan conducts a Facility Site Review (FSR)/Medical Record Reviews (MRR) to monitor PCP compliance with IHA requirements, including timeliness of IHA completion. Furthermore, the Plan annually reviews PCP claims data and encounters with specific billing codes to identify the percentage of new members who had an IHA within 120 days.

Finding: The Plan did not ensure completion of an IHA for new members within 120 days of enrollment.

Plan policy MCQP1021 stated that contracting PCPs are required to perform an IHA within 120 days of enrollment. In addition, the Plan will monitor for compliance during FSRs and through review of claims data and billing codes specific to IHA encounters. However, the DHCS audit found that the Plan did not ensure completion of an IHA for new members within the required timeframe.

The verification study showed that 12 medical records did not have complete IHAs within 120 days of enrollment for new members.

During the interview, the Plan stated that they monitored the completion of IHAs through MRRs, FSRs, and PCPs claims and encounter data. Plan nurses were assigned to review PCPs records for quality improvement and a corrective action plan was issued in areas of non-compliance. The Plan acknowledged that their process did not provide an accurate indication of a completed IHA due to the various ways PCPs submitted billing codes for IHA encounters. Therefore, the Plan could not ensure IHAs were completed within the required timeframe.

If IHAs are not provided in a timely manner, members' health needs may not be appropriately identified increasing risk for injury or disease.

Recommendation: Revise and implement procedures to ensure completion of IHAs for new members within the required timeframe.

2.1.2 Blood Lead Screening Tests

The Plan shall cover and ensure the provision of a BLS test to members at ages one and two. The Plan shall also document and appropriately follow up on BLS test results, make reasonable attempts to ensure the BLS test is provided, and shall document attempts to provide the test in the MMR. Documentation shall also be entered in to the MMR to indicate the receipt of BLS testing and test results, or of voluntary refusal of these services. *(Contract, Exhibit A, Attachment 10 (5)(D))*

The Plan must ensure that network providers order or perform BLS tests on all child members at 12 and 24 months of age or when the network provider performing a PHA becomes aware that a child member 12 months to 24 months of age or members 24 to 72 months of age has no documented evidence of a BLS test taken. The Plan must also ensure that the network provider documents the reason(s) for not performing the BLS test in the child member's medical record. *(All Plan Letter (APL) 20-016, BLS of Young Children)*

Plan policy MCQG1015, *Pediatric Preventive Health Guidelines (revised 2-09-2022)* stated, all child members should be tested and as applicable, treated for elevated Blood Lead Levels (BLL) at ages 12 and 24 months. If the parents or legal guardians refuse BLL screening, a refusal form must be signed by the parent or guardian and documented on the medical record. If the parent/guardian refuses to sign the refusal form, the provider must note this refusal and reason in the medical record.

Finding: 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 medical record.

Plan policy *MCQG1015* stated child members should be tested and treated for elevated BLL at ages 12 and 24 months. In addition, if the BLL screening is refused, the provider must document the refusal and reason in the medical record. However, the Plan did not ensure BLS tests were performed or document the refusal in the MMR.

The verification study revealed 17 medical records did not show evidence of a BLS test or the documented refusal of the service.

During the interview, the Plan stated that providers were monitored for compliance in meeting the requirements of BLS as part of their FSR medical record review. Furthermore, on a monthly basis, the Plan provided a list of members who did not show evidence of receiving a BLS test to their network providers. Although the Plan had a system to monitor through their FSR, there was a lack of follow-up that lead to BLS tests not being performed or documented in the MMR by providers.

If BLS tests are not provided and reasons for refusal are not documented in the MMR of age-appropriate members, at risk children may not be identified and treated, which may cause adverse learning and behavioral problems due to missed lead poisoning screening.

Recommendation: Implement procedures to ensure providers perform BLS tests, or document the refusal of these services, in the MMR.

❖ COMPLIANCE AUDIT FINDINGS (CAF) ❖
PLAN: Partnership Health Plan of California
AUDIT PERIOD: July 1, 2021 through June 30, 2022 **DATES OF AUDIT:** December 5, 2022 through December 16, 2022

CATEGORY 3 – ACCESS AND AVAILABILITY OF CARE

3.8	NON-EMERGENCY MEDICAL TRANSPORTATION AND NON-MEDICAL TRANSPORTATION

3.8.1 Medi-Cal Enrollment of Transportation Providers

The Plan is required to comply with all applicable requirements specified in federal and state laws and regulations. *(Contract, Exhibit E, Attachment 2 (7))*

Managed Care Organizations may execute network provider agreements pending the outcome of the enrollment process up to 120 days, but must terminate a network provider immediately upon notification from the state that the network provider cannot be enrolled, or the expiration of one 120 day period without enrollment of the provider, and notify affected enrollees. *(Code of Federal Regulations, Title 42, section 438.602 (b)(2))*

The Plan is required to ensure that their subcontractors and delegated entities comply with all applicable state and federal laws and regulations; Contract requirements; reporting requirements; and other DHCS guidance including, but not limited to APLs. *(APL 17-004, Subcontractual Relationships and Delegation, issued 4/18/2017)*

Plan policy MPCR20, *Medi-Cal Managed Care Plan Provider Screening and Enrollment (last review date 4/13/2022)*, stated all Medi-Cal Managed Health Care Plan network providers, including NEMT providers must enroll in the Medi-Cal program. According to this policy, the Plan will check enrollment of contracted and subcontracted providers through the DHCS open data portal on a monthly basis. Additionally, before contracting with a provider, the Plan will verify the provider's enrollment in the Medi-Cal program through the DHCS Provider Application and Validation for Enrollment portal. Furthermore, any provider terminated from the Medi-Cal Program may not participate in the Plan's provider network.

Finding: The Plan did not terminate its transportation providers upon receiving notification from DHCS that the providers cannot be enrolled in the Medi-Cal program.

Although Plan policy *MPCR20* stated the Plan would verify the enrollment status of transportation providers in the Medi-Cal program, the Plan did not terminate providers from their network upon receiving notice of their denied status.

The verification study revealed the Plan utilized two transportation providers that were denied enrollment in the Medi-Cal program. The two providers completed a total of 106,552 trips for

Medi-Cal members. Even though DHCS issued the providers denial letters, the Plan continued to utilize their services throughout the audit period.

During the interview, the Plan acknowledged using non-Medi-Cal enrolled transportation providers to fulfill ride services where no other provider was available. However, the Plan did not adhere to its contractual requirement to terminate non-enrolled providers from their network.

If the Plan does not terminate network providers who have been denied enrollment into the Medi-Cal program, the Plan may be placing Medi-Cal members in care of unqualified drivers and unsafe vehicles.

Recommendation: Implement policies and procedures to ensure transportation providers who are denied enrollment in the Medi-Cal program are terminated from the Plan's provider network.

CONTRACT AND ENROLLMENT REVIEW
RANCHO CUCAMONGA
AUDITS AND INVESTIGATIONS
DEPARTMENT OF HEALTH CARE SERVICES

REPORT ON THE MEDICAL AUDIT OF

PARTNERSHIP HEALTH PLAN OF CALIFORNIA

2022

Contract Number:	08-85222 State Supported Services
Audit Period:	July 1, 2021 Through June 30, 2022
Dates of Audit:	December 5, 2022 Through December 16, 2022
Report Issued:	April 5, 2023

TABLE OF CONTENTS

I. INTRODUCTION

This report presents the audit results of Partnership Health Plan of California's (Plan) compliance and implementation of the State Supported Services Contract No. 08-85222 with the State of California. The Contract covers abortion services for the Plan.

The audit covered the audit period from July 1, 2021 through June 30, 2022. The audit was conducted from December 5, 2022 through December 16, 2022. It consisted of document reviews, a verification study, and interviews with the Plan's staff.

An Exit Conference with the Plan was held on March 14, 2023. There were no deficiencies identified for the audit of the Plan's State Supported Services.

STATE SUPPORTED SERVICES

The Plan is required to provide, or arrange to provide, to eligible members the following State Supported Services: Current Procedural Terminology Codes 59840 through 59857 and the Centers for Medicare and Medicaid Services Common Procedure Coding System Codes: X1516, X1518, X7724, X7726, 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, (4))*

Plan policy *MCUP3050, Medical Abortion (approved 10/13/2021)*, defined the guidelines for appropriate management of medical abortions. The policy stated that the Plan does not require prior authorization or medical justification for abortion services. Medical abortions are considered sensitive services provided through the member's primary care provider and is the Plan's responsibility to reimburse Medi-Cal providers for these services.

The Plan provided information on covered services to new members through their Member Handbook. The information stated that abortion services are available to members without a referral or prior authorization, members have a right to services in a timely manner, and members may self-refer to any certified family planning provider.

The verification study revealed the Plan appropriately processed abortion claims for payment and did not demonstrate any deficiencies related to State Supported Services.

Based on the review of the Plan's documents, there were no deficiencies noted for the audit period.

Recommendation:

None