DHCS AUDITS AND INVESTIGATIONS

CONTRACT AND ENROLLMENT REVIEW DIVISION

SACRAMENTO SECTION

REPORT ON THE MEDICAL AUDIT OF PARTNERSHIP HEALTH PLAN OF CALIFORNIA FISCAL YEAR 2024-25

Contract Numbers: 08-85215 and 23-30236

Audit Period: July 1, 2023 — June 30, 2024

Dates of Audit: December 9, 2024 — December 20, 2024

Report Issued: April 9, 2025

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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. Plan members account for 31 percent of all residents in the 24 county service area.

As of June 2024, the Plan had approximately 902,738 Medi-Cal members. Medi-Cal members are distributed as follows: Butte 84,536, Colusa 10,221, Del Norte 12,317, Glenn 13,567, Humboldt 58,599, Lake 34,487, Lassen 8,691, Marin 46,522, Mendocino 41,348, Modoc 3,936, Napa 26,965, Nevada 28,353, Placer 59,620, Plumas 5,893, Shasta 68,015, Sierra 838, Siskiyou 18,067, Solano 102,086, Sonoma 110,264, Sutter 43,533, Tehama 30,147, Trinity 5,544, Yolo 53,590, and Yuba 35,599.

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, 2023, through June 30, 2024. The audit was conducted from December 9, 2024, through December 20, 2024. The audit consisted of documentation review, verification studies, and interviews with the Plan's representatives.

An Exit Conference with the Plan was held on March 20, 2025. The Plan was allowed 15 calendar days from the date of the Exit Conference to provide supplemental information addressing the draft audit findings. On April 4, 2025, 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 four categories of performance: Utilization Management, Network and Access to Care, Member's Rights, and Quality Improvement and Health Equity Transformation.

The prior DHCS medical audit for the period of July 1, 2022, through June 30, 2023, was issued on March 22, 2024. This audit examined the Plan's compliance with the DHCS Contracts and assessed the implementation of the prior year 2023, Corrective Action Plan.

The summary of the findings by category follows:

Category 1 – Utilization Management

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

Category 3 – Network and Access to Care

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

Category 4 – Member's Rights

The Plan is required to implement and maintain a member grievance system that shall receive, review, and resolve grievances within 30 calendar days of receipt. The Plan did not resolve Quality of Care (QOC) grievances within 30 calendar days of receipt.

Category 5 – Quality Improvement and Health Equity Transformation

The Plan is required to include the qualifications (education, experience, and training) of staff responsible for Quality Improvement (QI) activities in the QI Program written description and Quality Improvement and Health Equity Transformation Program (QIHETP) policies and procedures. The Plan did not include the qualifications of staff in the QI Program written description and QIHETP policies and procedures.

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 December 9, 2024, through December 20, 2024, for the audit period of July 1, 2023, through June 30, 2024. The audit included a review of the Plan's Contracts 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

Prior Authorization (PA) Requests: Thirty PA requests were reviewed for timeliness, consistent application of criteria, appropriateness of review, and communication of results to members and providers.

Appeal Process: Twenty-six PA appeals were reviewed for appropriate and timely adjudication.

Category 3 – Network and Access to Care

Non-Emergency Medical Transportation: Sixteen records were reviewed to confirm compliance with Non-Emergency Medical Transportation requirements.

Non-Medical Transportation: Sixteen records were reviewed to confirm compliance with Non-Medical Transportation requirements.

Category 4 – Member's Rights

Grievance Procedures: Sixteen quality of service and 24 QOC grievance cases were reviewed for timely resolution, appropriate response to the complainant, and submission to the appropriate level for review.

Category 5 – Quality Improvement and Health Equity Transformation

QI System: Fifteen Potential Quality Issue (PQI) cases were reviewed for timely evaluation and effective action taken to address improvements.

COMPLIANCE AUDIT FINDINGS

Category 4 – Member's Rights

4.1 GRIEVANCE SYSTEM

4.1.1 Timely Resolution of Grievances

The Plan is required to implement and maintain a member grievance system in accordance with Title 28, California Code of Regulations (CCR), Section 1300.68. *(Contract 08-85215, Exhibit A, Attachment 14(1))*

The Plan is required to have in place a member grievance system that complies with *Title 28, CCR, Section 1300.68. (Contract 23-30236 A02, Exhibit A, Attachment III, 4.6.1)*

The Plan's grievance system shall receive, review, and resolve grievances within 30 calendar days of receipt. "Resolved" means the grievance has reached a final conclusion with respect to the member's submitted grievance. Grievances not resolved within 30 calendar days shall be reported as pending. *(CCR, Title 28, section 1300.68(a)(4))*

The Plan must comply with the State's timeframe of 30 calendar days for grievance resolution. "Resolved" means the grievance has reached a final conclusion with respect to the member's submitted grievance. The Plan must ensure adequate consideration of grievances and that each issue is addressed and resolved if multiple issues are presented. The Plan must maintain a system for grievances that are pending and unresolved for 30 calendar days or more. *(All Plan Letter 21-011, Grievance and Appeal Requirements, Notice and "Your Rights" Templates)*

Plan policy, *CGA024 Medi-Cal Member Grievance System* (approved 10/11/2023), stated that standard member grievances are resolved within 30 calendar days. In the event that the resolution of a standard grievance is not reached within 30 calendar days, the Plan will notify the member in writing of the status of the grievance and the estimated date of resolution.

Plan policy, *MPQP1016 Potential Quality Issue Investigation and Resolution* (approved 06/14/2023), stated that all PQI cases will be processed and closed with a final severity level within 120 days from the date the case is received by the QI Department.

Finding: The Plan did not resolve QOC grievances within 30 calendar days of receipt.

The verification study revealed that seven QOC grievances were not resolved within the required timeframe. The grievances were closed, and resolution letters were mailed within 30 days. However, the grievances met the definition of "pending" grievances, not "resolved" grievances, as a final conclusion had not been reached with respect to the members' submitted concerns. The Plan did not obtain and evaluate all relevant information for the grievance investigations and therefore did not ensure adequate consideration of the grievances and that each issue was addressed and resolved. Instead, the grievances were referred to the QI Department for further investigation as PQI cases. It was at the PQI level that the Plan conducted the full investigation and reached a final conclusion.

In an interview, the Plan stated that it utilizes a 120-day resolution timeframe for PQI cases after receipt by the QI Department. For the seven unresolved grievances that were closed and referred to PQI, the PQI investigations were finished 63 to 146 days after the grievances were received by the Plan, which is contractually noncompliant with the required 30-day timeframe for grievance resolution. Examples of grievances resolved at the PQI level:

- A member filed a grievance because a broken bone was not seen on the initial x-rays. The physician who reviewed the grievance requested that the case be sent to PQI for additional investigation as adequate information was not obtained. The PQI investigation was closed 63 days after the grievance was received by the Plan.
- A member filed a grievance because the nurse did not remove an IV prior to discharge and was rude to them. The nursing notes and a provider response were requested for the grievance investigation. The nursing notes were not obtained, and the provider response did not specifically address the member's concerns. The case was referred to PQI for investigation of the member's claim regarding the IV. Also, a summary stated that the member's concerns were referred to PQI for further investigation as no specific responses were given by the provider. Some nursing documentation was obtained during the PQI investigation, which was closed 108 days after the grievance was received by the Plan.
- A member filed a grievance against a provider because she was prescribed a medication that worsened her kidney function, resulting in hospitalization. As part of the grievance investigation a provider response was requested but not obtained. During the PQI investigation the provider response was obtained, and the investigation was closed 104 days after the grievance was received by the Plan.

In an interview, the Plan outlined their process for a standard grievance and stated that the Grievance Nurse Specialist reviews the documents received by the Plan and prepares a summary. The Medical Director then reviews the available information. If sufficient to determine the grievance is a QOC issue, the grievance is closed, and the case is referred to PQI for further investigation. However, prior to closing the grievance, the Plan does not ensure that the available information is sufficient to reach a final conclusion with respect to the member's submitted grievance, and thus "resolve" the grievance. The Plan stated that documents requested for grievance investigations, but not obtained, may still be needed. This process is deficient as the Plan's standard for closing a grievance is whether the Plan can make a QOC determination, not that the grievance has been adequately considered, brought to a final conclusion with respect to the member's submitted grievance, and resolved as contractually required.

The Plan's policy, *CGA024* stated that standard member grievances are resolved within 30 calendar days. However, the policy does not define "resolved" and does not state that the Plan will reach a final conclusion with respect to the member's submitted grievance within this timeframe. Thus, the Plan's policy did not provide sufficient guidance to ensure grievances were resolved within the required timeframe.

Not resolving grievances in a timely manner limits members' ability to make informed healthcare decisions. This may cause delays in obtaining necessary care and adversely affect clinical outcomes.

Recommendation: Revise and implement policies and procedures to ensure QOC grievances are resolved within the required timeframe.

COMPLIANCE AUDIT FINDINGS

Category 5 – Quality Improvement and Health Equity Transformation

5.1 QUALITY IMPROVEMENT SYSTEM

5.1.1 Qualifications of Quality Improvement Staff

The Plan is required to implement and maintain a written description of the QI Program, including the qualifications (education, experience, and training) of staff responsible for QI studies and activities. *(Contract 08-85215, Exhibit A, Attachment 4(7)(C))*

The Plan is required to develop, implement, and periodically update its Quality Improvement and Health Equity Transformation Program (QIHETP) policies and procedures that include the qualifications and identification of staff responsible for QI and health equity activities. *(Contract 23-30236 A02, Exhibit A, Attachment III, 2.2.6(C))*

The Plan is required to ensure the Contract is a high priority and that it is committed to supplying any necessary resources to assure full performance of the Contract. The Plan shall attest to the compliance and fulfillment of the Contract terms, conditions, provisions, and responsibilities. *(Contract 08-85215, Exhibit A, Attachment 1(4)(B,C))*

The Plan must ensure Contract compliance is a high priority and that it is committed to supplying any necessary resources to assure full performance of the Contract. *(Contract 23-30236 A02, Exhibit A, Attachment III, 1.1.4(B))*

Plan policy, *MPQD1001 Quality and Performance Improvement Program Description* (9/23), stated that member safety activities are largely governed by the Department of Health Care Services (DHCS). The Plan maintains a system to monitor and implement regulatory guidance, including All Plan Letters and Contract amendments that inform the QI program.

Plan policy, *MCED6001 Quality Improvement and Health Equity Transformation Program (QIHETP) Program Description* (11/23), stated that the scope of the QIHETP includes the quality of clinical care and services for all members receiving Medi-Cal services from the Plan.

Finding: The Plan did not include the qualifications (education, experience, and training) of staff responsible for QI activities in the QI Program written description and QIHETP policies and procedures.

A review of Plan policies MCED6001 and MPQD1001 revealed the roles and responsibilities of the officers and directors responsible for QI activities. However, the qualifications of these staff were not included. Thus, the Plan was contractually noncompliant with the requirements of the QI Program written description and QIHETP policies and procedures.

At the interview, the Plan confirmed that the qualifications of staff responsible for QI activities are not included in the QI Program written description. The Plan does not have a policy that outlines the information to be included in the description; instead, the Contract is used as the informing document. The Plan was also asked for a narrative clarifying why the required information was not included in the description. The Plan acknowledged that while the Contract states the Plan shall identify the qualifications of QIHETP staff, DHCS' implementation tools for the 2024 Contract deliverables did not include the requirement to provide staff qualifications in the program description. Nevertheless, the Plan is responsible for assuring full performance of the Contract. The Plan lacked an effective process to ensure required information was integrated into the QI Program Description and QIHETP policies and procedures.

If the qualifications of staff responsible for QI activities are not included in the QI Program written description and QIHETP policies and procedures, individuals reviewing these programs cannot determine if the staff are qualified to ensure quality healthcare services are provided to members.

Recommendation: Develop and implement policies and procedures to ensure the qualifications of staff responsible for QI activities are included in the QI Program written description and QIHETP policies and procedures.

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SACRAMENTO SECTION

REPORT ON THE MEDICAL AUDIT OF PARTNERSHIP HEALTH PLAN OF CALIFORNIA FISCAL YEAR 2024-25

Contract Numbers: 22-20497 and 23-30268

Contract Type: State Supported Services

Audit Period: July 1, 2023 — June 30, 2024

Dates of Audit: December 9, 2024 — December 20, 2024

Report Issued: April 9, 2025

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I. INTRODUCTION

This report presents the results of the audit of Partnership Health Plan of California's (Plan) compliance and implementation of the State Supported Services contract numbers 22-20497 and 23-30268 with the State of California. The State Supported Services Contracts cover abortion services with the Plan.

The audit covered the period of July 1, 2023, through June 30, 2024. The audit was conducted from December 9, 2024, through December 20, 2024, which consisted of a document review and verification study with the Plan's administration and staff.

An Exit Conference with the Plan was held on March 20, 2025. No deficiencies were noted during the review of the State Supported Services Contracts.

COMPLIANCE AUDIT FINDINGS

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, 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))*

Plan policy, *MCCL-02 Family Planning Services* (approved 03/17/2023), stated that family planning services include abortion services and the supplies that are incidental or preliminary to the abortion. Without parental consent, the Plan allows abortion services for minors and will help any member find a provider if a hospital, clinic, or other provider refuses to provide the service. Additionally, the Plan is responsible for paying all family planning services except for members assigned to Kaiser Permanente.

The verification study revealed that the Plan appropriately processed, paid, or denied abortion service claims within the required timeframes.

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

Recommendation: None.