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

REPORT ON THE MEDICAL AUDIT OF

Partnership Health Plan of California

2023

Contract Number:	08-85215
Audit Period:	July 1, 2022 through June 30, 2023
Dates of Audit:	December 4, 2023 through December 15, 2023
Report Issued:	March 22, 2024

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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 (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 2023, the Plan had approximately 698,404 Medi-Cal members. Medi-Cal members are distributed as follow: Del Norte 13,065, Humboldt 62,667, Lassen 9,228, Lake 36,038, Marin 52,603, Mendocino 42,681, Modoc 4,287, Napa 36,117, Shasta 73,712, Siskiyou 19,836, Sonoma 135,705, Solano 142,226, Trinity 5,900, and Yolo 64,339.

II. EXECUTIVE SUMMARY

This report presents the audit findings of the Department of Health Care Services (DHCS) medical audit for the period July 1, 2022, through June 30, 2023. The audit was conducted from December 4, 2023, through December 15, 2023. The audit consisted of document reviews, verification studies, and interviews with Plan representatives.

An Exit Conference was held on March 1, 2024. 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 13, 2024, 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, 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 April 5, 2023.

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

Review of the Plan's Case Management and Coordination of Care yielded no findings.

Category 3 – Access and Availability of Care

Review of the Plan's Access and Availability of Care yielded no findings.

Category 4 – Member's Rights

If the Plan has multiple levels of grievance resolution or appeal, all levels must be completed within 30 days of receiving the grievance. The Plan did not complete all levels of grievance resolution or appeal within 30 days of receipt.

Category 5 – Quality Management

The Plan is responsible for taking effective action to improve the Quality of Care (QOC) delivered by providers where deficiencies are identified. The Plan did not take effective

action to improve deficient QOC issues to ensure professionally recognized standards of practice are delivered to members.

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 that the 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, 2022, through June 30, 2023. The audit was conducted from December 4, 2023, through December 15, 2023. 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.

The following verification studies were conducted:

Category 1 – Utilization Management

PA Requests: 26 PA requests were reviewed for timeliness, consistent application of criteria, appropriateness of review, and communication of results to members and providers.

Appeal Process: 15 PA appeals were reviewed for appropriate and timely adjudication.

Category 2 – Case Management and Coordination of Care

Initial Health Assessment (IHA): 13 medical records were reviewed to confirm completion of IHAs and 20 were reviewed for completion of Blood Lead Screening tests.

Behavioral Health Treatment: 20 medical records were reviewed for compliance with behavioral health treatment requirements.

Category 3 – Access and Availability of Care

Non-Emergency Medical Transportation (NEMT): 23 records were reviewed to confirm compliance with NEMT requirements.

Non-Medical Transportation (NMT): 22 records were reviewed to confirm compliance with NMT requirements.

Category 4 – Member's Rights

Grievance Procedures: 20 quality of service and 15 QOC grievance cases were reviewed for timely resolution, appropriate response to complainant, and submission to the appropriate level for review. Ten exempt grievances were reviewed for proper classification and routing to the appropriate level for review.

Category 5 – Quality Management

Quality Improvement System: 21 Potential Quality Issue (PQI) cases were reviewed for timely evaluation and effective action taken to address improvements.

Category 6 – Administrative and Organizational Capacity

Fraud, Waste, and Abuse: 14 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 ❖
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CATEGORY 4 – MEMBER'S RIGHTS

4.1	GRIEVANCE SYSTEM

4.1.1 Grievance Resolution Timeframe

The Plan shall have a system in accordance with California Code of Regulations (CCR), Title 28, section 1300.68 and 1300.68.01; CCR, Title 22, section 53858; and Code of Federal Regulations, Title 42, section 438.402-424. The Plan shall follow grievance and appeal requirements. *(Contract, Exhibit A, Attachment 14(1))*

The Plan shall provide a resolution notice to the member within 30 days from the date the Plan receives the grievance. *(Contract, Exhibit A, Attachment 14(1)(B))*

If the Plan has multiple levels of grievance resolution or appeal, all levels must be completed within 30-days of the Plan receiving the grievance. *(CCR, Title 28, section 1300.68(a)(4)(A))*

Even though federal regulations allow for a 14-calendar day extension for standard and expedited appeals, this allowance does not apply to grievances. *(All Plan Letter (APL) 21-011, Grievance and Appeal Requirements, Notice and "Your Rights" Templates)*

The Plan's policy, *CGA024, Medi-Cal Member Grievance System (reviewed 9/14/22)*, states that standard grievances are resolved within 30 days of the member's grievance request. In the event a resolution cannot be completed within 30 days of the member's request, the case may be eligible for a 14-day extension. A second level grievance is an appeal of a denied grievance and has a resolution timeframe of 30 days. This 30-day period is in addition to the 30-day timeframe for the initial grievance.

Finding: The Plan did not complete all levels of grievance resolution or appeal within 30 days of receiving the grievance.

Plan policy, *CGA024* states that a grievance may be eligible for a 14-day extension if a resolution cannot be completed within 30 days. The policy also states that a second level grievance is an appeal of a denied grievance and has a resolution timeframe of 30 days, which is in addition to the 30-day timeframe for the initial grievance. However, these provisions of the policy are contractually inaccurate. According to APL 21-011, the federal 14 calendar day extension for standard appeals does not apply to grievances. Additionally, CCR, Title 28, section 1300.68, states if the Plan has multiple levels of grievance resolution or appeal, all levels must be completed within 30 days of receipt of the grievance.

The verification study revealed that two QOC grievances were not resolved within 30 days of receipt. The following are examples of the deficiencies:

- A member filed a grievance on 11/18/22, stating the neurologist was neglecting her and that she had an allergic reaction to a prescribed medication. The grievance resolution letter was sent 12/30/22, 42 days after receipt of the grievance. The second level grievance was filed 12/30/22. The grievance resolution letter for the second level grievance was sent 1/27/23. In total, 70 days elapsed after receipt of the initial grievance.
- A member filed a grievance on 5/25/22, stating he was not able to arrange a timely follow-up with his provider and received an injection from an unqualified staff. The grievance resolution letter was sent 7/6/22, 42 days after receipt of the grievance. The second level grievance was filed 7/14/22. The grievance resolution letter for the second level grievance was sent 8/15/22. In total, 82 days elapsed after receipt of the initial grievance.

In both verification study cases, the grievances were resolved based on the Plan's policy provisions that did not adhere to regulatory requirements. Furthermore, the description of the second level grievance was carried over from the initial grievance. This demonstrates the second level grievances were a continuation of the initial grievances, not separate and distinct reviews after the initial grievances were resolved. Therefore, both grievances were not resolved within 30 days of receipt.

During the interview, the Plan acknowledged their second level grievance process was introduced in May 2019, to align with the national accreditation standards. Nevertheless, the Plan was unable to confirm the process was thoroughly evaluated and vetted relative to the Medi-Cal Managed Care Contract prior to its implementation. Therefore, due to a lack of oversight, deficient policies and procedures were fully integrated into the grievance processing system.

Adopting a grievance process that does not contractually conform to the standard 30 day timeframe can delay member's informed healthcare decisions.

Recommendation: Revise and implement policies and procedures to ensure the grievance process with multiple levels of resolution or appeal are resolved within the required timeframe.

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CATEGORY 5 – QUALITY MANAGEMENT

5.1	QUALITY IMPROVEMENT SYSTEM

5.1.1 Quality Improvement System Oversight

The Plan shall monitor, evaluate, and take effective action to address any needed improvements in the QOC delivered by all providers rendering services on its behalf, in any setting. *(Contract Exhibit A, Attachment 4(1))*

The Plan's quality assurance program must be directed by providers and must document that the QOC provided is being reviewed and that problems are being identified. The Plan is also responsible to take effective action to improve care where deficiencies are identified, and that follow-up is planned where indicated. *(CCR, Title 28, section 1300.70 (a)(1))*

The Plan must continuously review the QOC provided to ensure that a level of care which meets professionally recognized standards of practice is being delivered to all members; and QOC problems are identified and corrected for all provider entities. *(CCR, Title 28, section 1300.70 (b)(1)(A) and (B))*

The Plan's policy, *MPQP1053, Peer Review Committee (PRC) (review date 6/14/23),* states that the PRC will evaluate the quality concern related to the clinical care and determine whether there is sufficient evidence that the involved practitioner failed to provide care within generally accepted standards.

The Plan's policy, *MPQP1016, Potential Quality Issue Investigation and Resolution (review date 06/14/23)*, states that the Plan will level and score the severity of the PQI and may refer the PQI to the PRC. The PRC may recommend/implement a Corrective Action Plan (CAP), which is a plan approved by the PRC to help ensure that a related quality issue does not occur in the future.

The Plan's Quality Improvement Program Evaluation (July 2022, through June 2023), states that the Quality and Performance Improvement (QI/PI) program provides a systematic process to monitor and evaluate the quality of clinical care and health care service delivery to all Plan members. This includes an organized framework to implement strong interventions when opportunities for improvement are identified.

Finding: The Plan did not take effective action to improve deficient QOC issues to ensure professionally recognized standards of practice are delivered to members.

The Plan's QI/PI program provides systematic processes to monitor and evaluate the quality of clinical care and health care service delivery to Plan members, which includes a framework to implement strong interventions when opportunities for improvement are identified. The Plan's PRC is responsible for reviewing PQIs referred to the committee and for recommending CAPs to remediate deficient QOC provided to members. However, despite having identified providers who delivered deficient QOC, the Plan confirmed there were no CAPs issued; only letters of concern were sent with no follow-up required prior to closure of the case.

The verification study revealed that the Plan did not take effective action to appropriately address 14 out of 21 PQIs related to deficient QOC provided to members. For example:

- A mother complained about the misdiagnosis and delay in treatment of her child with new-onset diabetes. The treating provider misdiagnosed type 1 diabetes mellitus as type 2 diabetes mellitus and therefore, the child was sent home with the incorrect course of treatment plan. The child returned to the clinic and saw a different provider with continued clinical signs of untreated type 1 diabetes. The provider's medical team again failed to properly manage the type 1 diabetes within accepted standards of care. These errors resulted in the child's hospitalization for Diabetic Ketoacidosis (DKA) related to untreated type 1 diabetes. The Plan's PRC reviewed the case and sent the clinics administration a letter of concern for failure to properly identify and differentiate between type 1 and type 2 diabetes, and for failure to appropriately manage a pediatric patient presenting in DKA from untreated type 1 diabetes; no remedial education and/or the issuance of a CAP was sent to the clinics administration to remediate any future occurrences.
- A newborn infant's delivery was complicated by meconium and shoulder dystocia. Following a neonatologist's consultation and instruction to initiate intubation, the following physicians failed to properly manage the airway of the newborn: a pediatrician, an emergency room physician, and an anesthesiologist. The Plan's subject matter expert noted that a laryngeal mask airway was not used or available at the warmer bedside, which would have been the standard of care if unable to intubate the baby. The PRC only recommended to send a letter of concern to the hospital administration; no remedial education was sent to the treating providers to ensure that a similar incident of inadequate care would not happen again.

During the interview, the Plan confirmed their PRC has the responsibility for recommending and implementing CAPs on providers who deliver deficient QOC. The Plan acknowledged that only templated letters of concern directed by the PRC were sent to providers outlining the QOC lapses. The Plan stated that these letters have not been updated for many years and agreed that more definitive language could have been included to address the providers

knowledge gaps and to remediate their QOC concerns. Furthermore, the Plan's PRC minutes noted that no follow-up action was required in these cases.

When the Plan does not recommend strong interventions to improve deficient QOC related issues, the Plan's members are at risk to repeated incidences of poor QOC in the future.

Recommendation: Implement Plan policies and procedures to ensure strong corrective actions are enacted to improve QOC delivered to Plan members.

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REPORT ON THE MEDICAL AUDIT OF

Partnership Health Plan of California

2023

Contract Number:	08-85222 State Supported Services
Audit Period:	July 1, 2022 through June 30, 2023
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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 Number 08-85222 with the State of California. The Contract covers abortion services for the Plan.

The audit covered the audit period from July 1, 2022, through June 30, 2023. The audit was conducted from December 4, 2023, through December 15, 2023. 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 1, 2024. There were no deficiencies identified for the audit of the Plan's State Supported Services.

❖ COMPLIANCE AUDIT FINDINGS ❖

PLAN: Partnership Health Plan of California

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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, (4))*

The Plan's policy, *MCCL-02 Family Planning Services (review date 03/01/2023)*, states 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.