MEDICAL REVIEW - NORTHERN SECTION II
AUDITS AND INVESTIGATIONS
DEPARTMENT OF HEALTH CARE SERVICES

Partnership HealthPlan of California

Contract Number: 08-85215

Audit Period: January 1, 2017
Through
December 31, 2017

Report Issued: August 10, 2018

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I. INTRODUCTION

Partnership HealthPlan of California (PHC or the Plan) is a non-profit community based health care organization. The Plan is a County Organized Health System (COHS) established in 1994 in Solano County. The Plan is governed by a Board of Commissioners. The Board is comprised of locally elected officials, provider representatives, and patient advocates.

The Plan provides managed health care services to Medi-Cal members under the provision of Welfare and Institutions Code, Section 14087.54. A federal waiver granted under Social Security Act Section 1115(a) permits mandatory enrollment of Medi-Cal only Seniors and Persons with Disabilities (SPD) into Medi-Cal managed care. The waiver allows the Department of Health Care Services to achieve care coordination, better manage chronic conditions, and improve health outcomes.

The Plan provides services to 14 Northern California counties: Del Norte, Humboldt, Lake, Lassen, Marin, Mendocino, Modoc, Napa, Shasta, Siskiyou, Solano, Sonoma, Trinity, and Yolo. Plan members account for 26% of all residents in the 14 county service area.

The Plan began operations in 1994 serving only Solano County. Between 1998 and 2011, Yolo, Sonoma, Marin, and Mendocino counties were added. On September 1, 2013, as part of the Rural Expansion (RE), eight more counties were added: Del Norte, Humboldt, Lake, Lassen, Modoc, Shasta, Trinity, and Siskiyou.

As of January 1, 2018, the Plan had 562,512 Medi-Cal members which include 33,580 SPD members. Medi-Cal members are distributed as follows:

Del Norte	11,402
Humboldt	52,297
Lake	31,052
Lassen	7,365
Marin	39,075
Mendocino	38,640
Modoc	3,134
Napa	28,310
Shasta	58,680
Siskiyou	17,532
Solano	108,475
Sonoma	109,298
Trinity	4,327
Yolo	52,925

II. EXECUTIVE SUMMARY

This report presents the audit findings of the Department of Health Care Services (DHCS) medical audit for the period of January 1, 2017 through December 31, 2017. The onsite review was conducted from January 29, 2018 through February 8, 2018. The audit consisted of document review, verification studies, and interviews with Plan personnel.

An exit conference was held on July 17, 2018 with the Plan. The Plan was allowed 15 calendar days from the date following the Exit Conference to provide supplemental information addressing the preliminary audit report findings. The Plan did not submit supplemental information after the exit conference.

The audit evaluated six categories of performance: Utilization Management (UM), Case Management and Coordination of Care, Access and Availability of Care, Member Rights, Quality Improvement (QI), and Administrative and Organizational Capacity.

The prior DHCS medical audit (for the period of January 1, 2016 through December 31, 2016, with onsite review conducted from January 30, 2017 through February 3, 2017) was issued on June 15, 2017. The corrective action plan (CAP) closeout letter was issued on August 17, 2017.

To ensure parity in services, this medical audit reviewed coverage for the Plan's Medi-Cal SPD and non-SPD population. The audit identified no significant variance in coverage for either population.

The summary of the findings by category follows:

Category 1 – Utilization Management

There are no systemic findings in this section for this audit period. The finding from the previous audit period concerning acknowledgement letters not being sent or not being sent in a timely fashion has been addressed by the Plan. Policy # MCUP3037 was updated to reflect appropriate written communication to both the member and provider within five calendar days upon receipt of an appeal by a provider on behalf of a member. An appeal letter was created to be sent to providers and members. Policy #MCUP3037 was approved by DHCS within the Grievance and Appeals deliverable. In addition, the Plan trained staff on sending acknowledgment letters to providers when providers file an appeal on behalf of a member. The Department closed the prior Corrective Action Plan (CAP) on August 14, 2017.

Category 2 – Case Management and Coordination of Care

There are no systemic findings in Behavioral Health Treatment section this audit period.

The finding from the previous audit period concerning not meeting all of the required elements that the treatment plan must have as specified in All Plan Letters (APL) 15-025 have been rectified and corrected. Providers have also been educated on the changes. The Department closed the prior Corrective Action Plan (CAP) on August 14, 2017.

Category 3 – Access and Availability of Care

There are no systemic findings in Network Adequacy Requirements this audit period. The finding from the previous audit period was not meeting network adequacy requirements in all of its geographic service areas. The Plan has implemented several initiatives to increase provider access across the network and especially in the rural counties. Several of the access measures that did not meet geographic access standards and the Plan's 3rd next available appointment standards in 2016 met standards in 2017. The Department closed the prior Corrective Action Plan (CAP) on August 14, 2017.

There are no systemic findings in Emergency Services and Family Planning section this audit period. The finding from the previous audit period was for carved-out services claims and claim denial reasons in remittance advice or denial letters have been addressed by the Plan. The Plan updated P&P CL#26pp, Medi-Cal Emergent/ Urgent Care Claims on 04/01/17 to indicate that claims received on or after 06/21/17 will no longer be checked for possible California Children's Services (CCS) financial responsibility on emergent/urgent care claims. Claims are no longer pended for review and are paid immediately. The Plan updated its claims system to include all denial codes in its remittance advices to providers. The Department closed the prior Corrective Action Plan (CAP) on August 14, 2017.

Category 4 – Member's Rights

There were no systemic findings in the Grievance section. The finding from the previous audit period concerning the Medical Director not being involved in medical grievances documenting and processing expressions of dissatisfaction have been addressed by the Plan. The Plan updated P&P, "CGA-024, Medi-Cal Member Grievance System" (06/21/17) which describes the Plan's new process as of 07/03/17 of funneling quality of care grievances (QOC) to the Medical Director through the Grievance Clinical Lead (GLC) who logs all cases. In addition, the Plan has a process to validate whether the GCL consistently categorizes QOC grievances and 10 cases are reviewed per quarter by the Chief Medical Officer. Member services implemented an intake form that captures all instances of expressed dissatisfaction both standard and exempt grievances and will be captured in Grievance and Appeal case management system (Everest). The Department closed the prior Corrective Action Plan (CAP) on August 14, 2017.

The Plan's HIPAA system was unable to handle unexpectedly high volume of Health Insurance Portability and Accountability Act (HIPAA) incidents. This lead to HIPAA incident delays in notifying DHCS within 24 hours and submitting Privacy Incident Reports (PIR) to DHCS within the time requirements per the contract. The Plan's process for in-taking HIPAA complaints lead to the creation of HIPAA cases that did not involve the disclosure or breach of protected health information. The additional volume of non HIPAA incident cases processed caused delays in reporting to DHCS. The Plan has recognized this issue and is planning to modify the incident reporting process.

Category 5 – Quality Management

No findings.

Category 6 – Administrative and Organizational Capacity

No findings.

III. SCOPE/AUDIT PROCEDURES

SCOPE

This audit was conducted by the Department of Health Care Services (DHCS) Medical Review Branch (MRB) to ascertain that the medical services provided to Plan members comply with federal and state laws, Medi-Cal regulations and guidelines, and the state contract.

PROCEDURE

The onsite review was conducted from January 29, 2018 through February 8, 2018. The audit included a review of the Plan's policies for providing services, the 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 Plan administrators and staff. To ensure parity in services, the verification studies included both SPD and non-SPD members in the samples.

The following verification studies were conducted:

Category 1 – Utilization Management

Prior authorization requests: 22 medical (sample includes 11 SPD and 11 RE) and 14 pharmacy (sample includes 5 SPD and 8 RE) prior authorization requests were reviewed for timeliness, consistent application of criteria, and appropriate review.

Appeal procedures: 20 Medical (sample includes 9 SPD and 14 RE; not mutually exclusive) and 5 Pharmacy (sample includes 3 SPD and 2 RE) prior authorizations appeals were reviewed for appropriate and timely adjudication.

Category 2 – Case Management and Coordination of Care

Behavioral Health Treatment (BHT): 16 (sample includes 8 RE) files were reviewed for completeness.

Initial Health Assessment (IHA): 9 (sample includes 4 SPD and 4 RE) medical records were reviewed for required elements, completeness, and timely completion.

Category 3 – Access and Availability of Care

Claims: 26 (sample includes 5 SPD) emergency services claims were reviewed for appropriate and timely adjudication.

Category 4 – Member's Rights

Grievance Procedures: 59 grievances (sample includes 21 quality of care and 38 quality of service that include 25 SPD and 24 RE) were reviewed for timely resolution, response to complainant, and submission to the appropriate level for review.

HIPAA: 10 HIPAA cases were reviewed for appropriate reporting and processing.

Category 5 – Quality Management

None.

Category 6 – Administrative and Organizational Capacity

Fraud and Abuse: 20 cases were reviewed for appropriate reporting and processing within the required timeframes.

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

❖ COMPLIANCE AUDIT FINDINGS ❖	
PLAN: Partnership HealthPlan of California	
AUDIT PERIOD: January 1, 2017 – December 21, 2017	DATE OF ONSITE AUDIT: January 29, 2018 – February 8, 2018

CATEGORY 4 – MEMBER'S RIGHTS

4.3	CONFIDENTIALITY RIGHTS

Health Insurance Portability and Accountability Act (HIPAA) Responsibilities:

A. Responsibilities of Business Associate.

2. Safeguards. To implement administrative, physical, and technical safeguards that reasonably and appropriately protect the confidentiality, integrity, and availability of the PHI, including electronic PHI, that it creates, receives, maintains, uses or transmits on behalf of DHCS, in compliance with 45 CFR sections 164.308, 164.310 and 164.312, and to prevent use or disclosure of PHI other than as provided for by this Agreement. Business Associate shall implement reasonable and appropriate policies and procedures to comply with the standards, implementation specifications and other requirements of 45 CFR section 164, subpart C, in compliance with 45 CFR section 164.316….(as required by Contract)

J. **Breaches and Security Incidents.** During the term of this Agreement, Business Associate agrees to implement reasonable systems for the discovery and prompt reporting of any breach or security incident, and to take the following steps:

1. **Notice to DHCS.** (1) To notify DHCS immediately by telephone call plus email or fax upon the discovery of a breach of unsecured PHI or PI in electronic media or in any other media if the PHI or PI was, or is reasonably believed to have been, accessed or acquired by an unauthorized person, or upon the discovery of a suspected security incident that involves data provided to DHCS by the Social Security Administration. (2) To notify DHCS within 24 hours by email or fax of the discovery of any suspected security incident, intrusion or unauthorized access, use or disclosure of PHI or PI in violation of this Agreement and this Addendum, or potential loss of confidential data affecting this Agreement. A breach shall be treated as discovered by Business Associate as of the first day on which the breach is known, or by exercising reasonable diligence would have been known, to any person (other than the person committing the breach) who is an employee, officer or other agent of Business Associate….

2. **Investigation and Investigation Report.** To immediately investigate such security incident, breach, or unauthorized access, use or disclosure of PHI or PI. Within 72 hours of the discovery, Business Associate shall submit an updated "DHCS Privacy Incident Report" containing the information marked with an asterisk and all other applicable information listed on the form, to the extent known at that time, to the DHCS Program Contract Manager, the DHCS Privacy Officer, and the DHCS Information Security Officer:

3. **Complete Report.** To provide a complete report of the investigation to the DHCS Program Contract Manager, the DHCS Privacy Officer, and the DHCS Information Security Officer within ten (10) working days of the discovery of the breach or unauthorized use or disclosure….

COHS Contract G.III.C, J

SUMMARY OF FINDINGS:

4.3.1 Timely Reporting of HIPAA Incidents

Contract states "notify Department of Health Care Services (DHCS) immediately upon the discovery of a breach of unsecured PHI… is reasonably believed to have been, accessed or acquired by an unauthorized person... (2) To notify DHCS within 24 hours by email or fax of the discovery of any suspected security incident, intrusion or unauthorized access, use or disclosure of PHI or PI in violation of this Agreement…A breach shall be treated as discovered by Business Associate as of the first day on which the breach is known, or by exercising reasonable diligence would have been known, to any person (other than the person committing the breach) who is an employee, officer or other agent of Business Associate".
Contract A19, Exhibit G (III) (J) (1)

The contract states "immediately investigate such security incident, breach, or unauthorized access, use or disclosure of PHI or PI. Within 72 hours of the discovery, Business Associate shall submit an updated "DHCS Privacy Incident Report" containing the information marked with an asterisk and all other applicable information listed on the form, to the extent known at that time…"
Contract A19, Exhibit G (III) (J) (2)

The contract states "provide a complete report of the investigation to the DHCS Program Contract Manager, the DHCS Privacy Officer, and the DHCS Information Security Officer within ten (10) working days of the discovery of the breach or unauthorized use or disclosure".
Contract A19, Exhibit G (III) (J) (3)

The Plan did not send notifications and Privacy Incident Reports (PIR) for HIPAA incidents to DHCS within the time requirements in the contract. Data collected from the verification study sample of 10 HIPAA incidents showed that 10 of 10 were not reported to DHCS within 24 hours, seven initial PIR were not sent within 72 hours, and seven final PIRs were not sent within 10 working days. Four of 10 HIPAA cases not reported within 24 hours to DHCS were submitted late to the Plan's compliance department.

The Plan's HIPAA system was unable to handle unexpectedly high volume of HIPAA incidents and report them in a timely manner. Currently, the process for in-taking HIPAA complaints leads

to the creation of HIPAA cases that do not involve the disclosure or breach of PHI. These types of cases do not need to be reported to DHCS but are still processed by Plan staff. This leads to delays in the processing of cases that require reporting to DHCS. The Plan has recognized this issue and is planning to modify the incident reporting process to ask a set of questions to the person reporting the incident, and before a case is created for the incident. This new process aims to eliminate unnecessary cases from being generated, reducing the HIPAA case load for compliance staff, which totaled 672 incidents during the audit period.

The purpose of the timely reporting requirements is to help ensure patient safety and privacy. If HIPAA incidents are not reported in a timely fashion to DHCS, it could cause a lapse in preventative action against information breaches.

RECOMMENDATIONS:

4.3.1 Improve HIPAA incident intake process to prevent unnecessary HIPAA incident reports from being generated and follow up on its effectiveness, and continue to monitor caseload of compliance department staff to ensure HIPAA incidents are reported to DHCS in a timely manner.

MEDICAL REVIEW - NORTHERN SECTION II
AUDITS AND INVESTIGATIONS
DEPARTMENT OF HEALTH CARE SERVICES

Partnership HealthPlan of California

Contract Number: 08-85222
State Supported Services

Audit Period: January 1, 2017
Through
December 31, 2017

Report Issued: August 10, 2018

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INTRODUCTION

This report presents the audit findings of Partnership HealthPlan of California (the Plan) State Supported Services contract No. 08-85222. The State Supported Services contract covers contracted abortion services.

The onsite audit was conducted from January 29, 2018 through February 8, 2018. The audit period was January 1, 2017 through December 31, 2017 and consisted of document review and interviews with Plan personnel.

An Exit Conference was held on July 17, 2018 with the Plan.

❖ COMPLIANCE AUDIT FINDINGS (CAF) ❖	
PLAN: Partnership HealthPlan of California	
AUDIT PERIOD: January 1, 2017 - December 31, 2017	DATE OF AUDIT: January 29, 2018 - February 8, 2018

STATE SUPPORTED SERVICES CONTRACT REQUIREMENTS
Abortion *Contractor agrees to provide, or arrange to provide, to eligible Members the following State Supported Services:* *Current Procedural Coding System Codes*: 59840 through 59857* *HCFA Common Procedure Coding System Codes*: X1516, X1518, X7724, X7726, Z0336* **These codes are subject to change upon the Department of Health Services' (DHS') implementation of the Health Insurance Portability and Accountability Act of 1996 (HIPAA) electronic transaction and code sets provisions. Such changes shall not require an amendment to this Contract.* *State Supported Services Contract Exhibit A.1*

SUMMARY OF FINDINGS:

The Plan's policies include all abortion codes identified in the Contract. The Plan's Explanation of Coverage and the Member Handbook document services are covered, do not have age restrictions, do not require parental consent and do not require prior authorization. The Plan is in compliance with the terms of the State Supported Services Contract.

RECOMMENDATIONS:

None.