



State of California—Health and Human Services Agency
Department of Health Care Services



EDMUND G. BROWN, JR.
GOVERNOR

August 19, 2015

Robert Layne
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Partnership HealthPlan of California
4665 Business Center Drive
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PLAN NAME: Partnership HealthPlan of California
CONTRACT NUMBER: 08-85215
CASE NUMBER: C504-2015
AUDIT PERIOD: December 1, 2013 through November 30, 2014

Dear Mr. Layne:

We have completed the medical audit of Partnership HealthPlan of California (Plan) for the audit period December 1, 2013 through November 30, 2014. This audit was conducted in accordance with Welfare and Institutions Code, section 14456. In conducting this medical audit, the audit team evaluated the Plan's compliance with its contract and regulations in the areas of utilization management, case management and coordination of care, availability and accessibility, member's rights, quality management, and administrative and organizational capacity.

In accordance with the California Code of Regulations, Title 22, section 51021, an Exit Conference was held with the Plan on July 8, 2015. Prior to the Exit Conference, the Plan received a report of the preliminary findings. During the Exit Conference, the audit team discussed the findings in the report and gave the Plan the opportunity to submit additional documentation. The findings in the report reflect the evaluation of all relevant information received prior and subsequent to the Exit Conference. Please review the enclosed audit report. Medi-Cal Managed Care Division will be contacting the Plan to address corrective action procedures for audit deficiencies.

Robert Layne
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If you have any questions, please contact Erika Penilla, Section Chief, Medical Review Branch at (213) 620-6560.

Sincerely,

Originally signed by Erika Pinella for

Mark P. Mimnaugh, R.N., CCRN, M.P.A.
Chief, Medical Review Branch
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Enclosure

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MEDICAL REVIEW – SOUTHERN SECTION I
AUDITS AND INVESTIGATIONS
DEPARTMENT OF HEALTH CARE SERVICES

Partnership HealthPlan of California

Contract Number: 08-85215

Audit Period: December 1, 2013
Through
November 30, 2014

Report Issued: August 19, 2015

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I. INTRODUCTION

Partnership HealthPlan of California (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 provides managed healthcare services to Medi-Cal members under the provision of Welfare and Institution Code, section 14087.54. The Plan is governed by a Board of Commissioners. The Board is comprised of locally elected officials, provider representatives, and patient advocates.

The Plan is licensed in accordance with the provisions of the Knox-Keene Health Care Service Plan Act since 2005. The Plan is not a National Committee on Quality Assurance (NCQA) accredited health plan.

Prior to September 2013, the Plan provided healthcare coverage to six northern California counties: Solano, Napa, Yolo, Sonoma, Marin, and Mendocino. On September 1, 2013, the Plan expanded services to additional eight counties: Del Norte, Humboldt, Lake, Lassen, Modoc, Shasta, Trinity, and Siskiyou.

As of June 30, 2014, the Plan's Medi-Cal enrollment was approximately 462,316 members. Enrollment by program was as follows:

- Medi-Cal: 452,942
- Healthy Kids: 1,259
- Partnership *Advantage*: 8,115

II. EXECUTIVE SUMMARY

This report presents the audit findings of the Department of Health Care Services (DHCS) medical review audit for the review period of December 1, 2013 through November 30, 2014. The on-site review was conducted from February 23, 2015 through March 6, 2015. The audit consisted of document review, verification studies, and interview with Plan personnel.

An Exit Conference was held on July 8, 2015 with the Plan. The Plan was allowed 15 calendar days from the date of the Exit Conference to provide supplemental information addressing the draft audit report findings.

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

The summary of the findings by category follows:

Category 1 – Utilization Management

The Plan did not fully address the issue of insufficient information on the initial request for prior authorizations. The Plan did not have a system to identify the causes of the denial. This resulted in unnecessary delays in the delivery of medically necessary services.

The Plan did not have a system to track the specialist referrals to completion. The Plan did not implement a process to effectively track and monitor open or unused referrals which may result in the members not receiving specialty care.

Category 2 – Case Management and Coordination of Care

The Plan did not ensure the completion of Initial Health Assessments (IHA) for newly enrolled members within the required timeframe of 120 days. The Plan needs to ensure components of the IHA requirements in the member's medical records.

Category 3 – Access and Availability of Care

The Plan did not fully monitor the wait time to ensure members receive appointments for routine care within the required timeframes.

The Plan did not fully monitor the wait time to ensure members receive appointments for urgent care within the required timeframe.

The Plan did not adjudicate emergency service claims and family planning claims within the required timeframe of 45 working days.

Category 4 – Member's Rights

The Plan did not fully report any suspected breaches or security incidents within 24 hours timeframe and investigation reports were not provided within 72 hours of discovery. The Plan's policy does not indicate that the initial notification of discovery of breach be submitted within 24 hours to the DHCS Program Contract Manager, the DHCS Privacy Officer, and the DHCS Information Security Officer. In addition, the Plan did not submit such notifications to required DHCS personnel in a timely manner.

Category 6 – Administrative and Organizational Capacity

The Plan did not timely report suspected fraud and abuse cases to DHCS Compliance Unit within the required 10 working days.

III. SCOPE/AUDIT PROCEDURES

SCOPE

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

PROCEDURE

DHCS conducted an on-site audit of the Plan from February 23, 2015 through March 6, 2015. The audit included a review of the Plan's Contract with DHCS, its policy 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 the Plan administrators and staff.

The following verification studies were conducted:

Category 1 – Utilization Management

Prior Authorization Request: 32 medical and 25 pharmacy prior authorizations were reviewed for timeliness, consistent application of criteria, appropriateness of review, and communication of results to members and providers.

Prior Authorization Appeal Process: 40 appeals were reviewed for appropriateness and decision making in a timely manner.

Category 2 – Case Management and Coordination of Care

Case Management and Coordination (Complex Case Management): 3 medical records were reviewed for coordination of care between the Plan, Primary Care Providers (PCP) and members.

California Children's Services (CCS): 3 medical records were reviewed for evidence of coordination of care between the Plan and Regional Centers.

Initial Health Assessments: 24 medical records were reviewed for completeness and timely completion.

Category 3 – Access and Availability of Care

Emergency Service Claims: 20 emergency service claims were reviewed for appropriate and timely adjudication.

Family Planning Claims: 20 family planning claims were reviewed for appropriate and timely adjudication.

Category 4 – Member’s Rights

Grievance Procedures: 49 grievances were reviewed: 18 Quality of Care and 31 Quality of Services were reviewed for timely resolution, response to complaint, and submission to the appropriate level of review.

Confidentiality Rights: 10 cases were reviewed for proper reporting of all breaches to appropriate entities within the required timeframe.

Category 6 – Administrative and Organizational Capacity

Provider Training: 13 new provider training records were reviewed for timely provision of Medi-Cal Managed Care program training.

Fraud and Abuse Reporting: 12 cases were reviewed for proper reporting of all suspected fraud and/or abuse to the appropriate entities within the required timeframe.

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

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CATEGORY 1 - UTILIZATION MANAGEMENT

1.2

PRIOR AUTHORIZATION REVIEW REQUIREMENTS

Prior Authorization and Review Procedures:

Contractor shall ensure that its pre-authorization, concurrent review and retrospective review procedures meet the following minimum requirements:

- A. Qualified health care professionals supervise review decisions, including service reductions, and a qualified Physician will review all denials that are made, whole or in part, on the basis of medical necessity. For purposes of this provision, a qualified Physician or Contractor's Pharmacist may approve, defer, modify, or deny prior authorizations for pharmaceutical services, provided that such determinations are made under the auspices of and pursuant to criteria established by the Plan medical director, in collaboration with the Plan Pharmacy and Therapeutics Committee (PTC) or its equivalent.
- B. There is a set of written criteria or guidelines for Utilization Review that is based on sound medical evidence, is consistently applied, regularly reviewed, and updated.
- C. Reasons for decisions are clearly documented.
- G. Decisions and appeals are made in a timely manner and are not unduly delayed for medical conditions requiring time sensitive services.
- H. Records, including any Notice of Action, shall meet the retention requirements described in Exhibit E, Attachment 2, Provision 17.B. Records Retention.
- I. Contractor must notify the requesting provider or Member of any decision to deny, approve, modify, or delay a service authorization request, or to authorize a service in an amount, duration, or scope that is less than requested. The notice to the provider may be orally or in writing.

COHS Contract A.5.2.A, B, C, F, H, I

Exceptions to Prior Authorization:

Prior Authorization requirements are not applied to Emergency Services, Minor Consent Services, family planning services, preventive services, basic prenatal care, sexually transmitted disease services, and HIV testing.

COHS Contract A.5.2.G

Timeframes for Medical Authorization

Pharmaceuticals: 24 hours or one (1) business day on all drugs that requires prior authorization in accordance with Welfare and Institutions Code Section 14185(a)(1).

COHS Contract A.5.F

Routine authorizations: five (5) working days from receipt of the information reasonably necessary to render a decision (these are requests for specialty service, cost control purposes, out-of-network not otherwise exempt from prior authorization) in accordance with Health and Safety Code Section 1367.01(h)(1), or any future amendments thereto, but, no longer than 14 calendar days from the receipt of the request. The decision may be deferred and the time limit extended an additional 14 calendar days only where the Member or the Member's provider requests an extension, or the Contractor can provide justification upon request by the State for the need for additional information and how it is in the Member's interest. Any decision delayed beyond the time limits is considered a denial and must be immediately processed as such.

COHS Contract A.5.H

Denial, Deferral, or Modification of Prior Authorization Requests:

Contractor shall notify Members of a decision to deny, defer, or modify requests for Prior Authorization by providing written notification to Members and/or their authorized representative, regarding any denial, deferral or modification of a request for approval to provide a health care service. This notification must be provided as

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1.2

PRIOR AUTHORIZATION REVIEW REQUIREMENTS

specified in Title 22 CCR Sections 51014.1, 51014.2, 53894, and Health and Safety Code Section 1367.01. COHS Contract A.13.8.A

References Cited:

Title 22, CCR § 51014.1, Fair Hearing Related to Denial, Termination or Reduction in Medical Services

Title 22, CCR § 51014.2, Medical Assistance Pending Fair Hearing Decision

Title 22, CCR § 53894, Notice to Members of Plan Action to Deny, Defer or Modify a Request for Medical Services

Health and Safety Code Section 1367.01, Written Policies and Procedures on Plan's Process of Prior Authorization Denial, Deferral, or Modification

SUMMARY OF FINDINGS:

The Contract requires the Plan to ensure decisions regarding prior authorizations are made in a timely manner and are not unduly delayed for medical conditions requiring time sensitive services. The Plan shall notify the requesting provider or member of the decision by written notifications within the timeframe.

Policy Number MCUP 3041: *TAR Review Process* outlines the TAR review process. Certain procedures, services and medications require prior authorization from the Plan before reimbursement. A decision is made within five (5) business days of receipt of all required documentation but no more than 14 calendar days from the receipt of the request. Expedited services are processed within three (3) business days after receipt of request for services. TARs are not required for services related to emergency services, minor consent, family planning and preventive services, basic prenatal care, sexually transmitted disease services and HIV testing. Providers will be notified of the decision to approve, modify, defer, or deny the TAR in writing within one working day. Members will be notified in writing of denials, deferrals, and modifications within two working days of the determination.

According to the Plan, the administrative denials are 18,251 or 9.19 percent of the Prior Authorization requests and the denials for medical necessity are 721 or .36 percent. The CMO or Physician Designee reviews the initial Prior Authorization requests and determines if additional documentation is needed. The Health Services staff will fax the request to the involved providers for additional information. If the additional information were not received within 14 days of request, then an administrative denial is issued. The Plan does not attempt to contact the providers with a final verbal request for the information needed prior to issuing the administrative denials. The providers cannot appeal the administrative denials; however, they do have the right to submit a new prior authorization request with the requested information.

The Plan reported 3.1 percent or one-third of the administrative denials are reversed after the providers submit a new prior authorization request with the requested information. The Plan did not address the issue of insufficient information on the initial prior authorization request. In addition, the Plan did not perform any review to identify the causes of the denials for reducing the administrative denial rate. The Plan does not have a systematic review of the aggregate data in order to find ways to improve the prior authorization process. This resulted in unnecessary delays in the delivery of medically necessary services.

During the onsite interview, Plan personnel stated they have instituted a process to contact providers with a final verbal request for the requested information prior to issuing a denial at the end of the 14 days extension period. A review of the Q/UAC minutes revealed no discussion of UM data.

For the verification study, 32 medical and 25 pharmacy prior authorizations were reviewed for timeliness, consistent application of criteria, appropriateness of review, and communication of results to members and providers. The Plan

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complied with the Contract requirements.

RECOMMENDATIONS:

1. Develop a system to review the denials and modifications in order to improve the Prior Authorization process.
2. Ensure that providers are aware of the Plan's documentation and timeframe requirements for submitting Prior Authorization requests.

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1.3

REFERRAL TRACKING SYSTEM

Referral Tracking System:

Contractor is responsible to ensure that the UM program includes: ... An established system to track and monitor services requiring prior authorization through the Contractor. The system shall include authorized, denied, deferred, or modified prior authorizations, and the timeliness of the determination.

COHS Contract A.5.1.F

SUMMARY OF FINDINGS:

The Contract requires the Plan to ensure the UM program has an established system to track and monitor services requiring prior authorization through the Contractor. The system shall include authorized, denied, deferred or modified prior authorization, and timeliness.

The Plan uses the Referral Authorization Form (RAF) to assess the number of referrals to specialists on an annual basis. Services beyond a year require a new RAF. The Plan does not use the RAFs to track unused referrals. The Plan does not have any formal on-going mechanisms to track unused referrals.

The Plan leaves the responsibility to the providers to track the referral. The Plan does not provide oversight of this delegated function. When a Primary Care Provider (PCP) determines a member needs specialty services, the PCP submits a RAF to the Plan. Review of the Specialty Access Work Group minutes from July 2014 shows the Plan has two concerns regarding PCPs' tracking referrals: developing a referral review process and having a system in place for tracking the referrals to ensure members receive the specialty care. Although the Plan has identified the concerns, the Plan has not developed and implemented a referral tracking program to actively monitor the unused referrals. This may result in the members not receiving specialty care.

The Plan expects the PCPs to track the referrals; however, the Plan does not have a process to monitor PCP responsibility for tracking referrals. Although Policy MPQP1012: *Monitoring Continuity and Coordination of Care* describes the monitoring of coordination of care between PCPs and specialists via the facility site review and medical record review process, there is no explicit reference to the tracking of authorized, open and or unused referrals.

During the onsite interview, Plan personnel stated that the responsibility for referral tracking lies with the PCPs. Plan personnel also stated that the Plan does not have an oversight process to monitor PCP responsibility for tracking referrals.

RECOMMENDATIONS:

1. Develop a system to track all specialist referrals to completion.
2. Develop and implement a process to effectively track and monitor open or unused referrals.
3. Ensure there is an oversight process if the referral tracking is delegated to the PCPs.

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CATEGORY 2 – CASE MANAGEMENT AND COORDINATION OF CARE

2.4

INITIAL HEALTH ASSESSMENT

Provision of Initial Health Assessment:

Contractor shall cover and ensure the provision of an IHA (complete history and physical examination) in conformance with Title 22 CCR Section 53851 (b)(1) and Section 53910.5(a)(1) to each new Member within 120 days of enrollment.

COHS Contract A.10.3.A

Reference Cited:

Title 22 CCR Section 53851 (b)(1) – Scope of Services

Title 22 CCR Section 53910.5(a)(1) – Scope of Services

Contractor shall make repeated attempts, if necessary, to contact a Member and schedule an IHA.

- 1) Contractor shall make at least three (3) documented attempts that demonstrate Contractor's unsuccessful efforts to contact a Member and schedule an IHA. Contact methods must include at least one (1) telephone and one (1) mail notification.
- 2) Contractor must document all attempts to perform an IHA at subsequent office visit(s) until all components of the IHA are completed.

COHS Contract A.10.3.E

Provision of IHAs for Members under Age 21:

- 1) For Members under the age of 18 months, Contractor shall ensure the provision of an IHA within 120 calendar days following the date of enrollment or within the most recent periodicity timelines established by the American Academy of Pediatrics (AAP) for ages two (2) and younger, whichever is less.
- 2) For Members 18 months of age and older upon enrollment, Contractor is responsible to ensure an IHA is performed within 120 calendar days of enrollment.

COHS Contract A.10.5

Services for Adults Twenty-One (21) Years of Age and Older:

Contractor shall cover and ensure that an IHA for adult Members is performed within 120 calendar days of enrollment.

COHS Contract A.10.6

Individual Health Education Behavioral Assessment (IHEBA):

Contractor shall ensure that the IHA includes the IHEBA as described in Exhibit A, Attachment 10, Provision 8, Paragraph A using an age appropriate DHCS approved assessment tool.

COHS Contract A.10.3.B

Contractor shall ensure that all new Members complete the IHEBA within 120 calendar days of enrollment as part of the initial health assessment and that all existing Members complete the IHEBA at their next non-acute care visit, but no later than their next scheduled health screening exam.

COHS Contract A.10.8.A.9

SUMMARY OF FINDINGS:

The Contract requires the Plan to cover and ensure the provision of an Initial Health Assessment (IHA) to each new member within 120 days of enrollment. The IHA shall include a history of the member's medical or dental health, an

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identification of risks, an assessment of needed preventive screens or services and health education, and the diagnosis and treatment plan of any diseases. The Plan shall document attempts for members who missed their scheduled IHA. The Contract also requires the Plan to ensure that all new members complete the Individual Health Education Behavioral Assessment (IHEBA) within 120 calendar days of enrollment as part of the IHA.

Policy Number MCPQP1021: *Initial Health Assessment and Behavioral Risk Assessment* defines an IHA as a member's visit to his or her Primary Care Provider (PCP) or other provider of primary care services, within stipulated timelines for an evaluation that consists of a history and physical examination sufficient to assess and manage the acute, chronic and preventive health needs of the member. The IHA must be documented in the member's medical record. Each contracting PCP is required to schedule and perform an IHA within 120 calendar days of notice of enrollment with the Plan.

The Initial Health Assessment Compliance Report identified 48.45 percent of the Plan's members had an IHA completed within 120 days after enrollment during the period of September 2013 through March 2014.

During the onsite interview, Plan personnel stated that a list of new members is sent monthly to providers with a letter emphasizing the importance of conducting an IHA within 120 days of member's enrollment. Providers can access the Plan's web based online e-eligibility system that gives the original effective date with the Plan in order to determine the date by which the IHA must be completed.

The Plan utilizes two methods to monitor or track the provision of IHA and IHEBA. First, the Plan conducts a full scope Facility Site Review (FSR) at each provider location every three years. During the FSR, the Plan's nurses review medical record to determine if the provider's documentation meets IHA/IHEBA requirements and if it was completed within 120 days from enrollment. The Plan uses claims and encounter data (service codes) submitted by their contracted providers as the second method to monitor and report the Plan IHA Compliance Rate. The Plan uses a list of "IHA & IHEBA Applicable Visit Codes" which include Current Procedural Terminology (CPT) codes and International Classification of Disease (ICD-9) services codes to determine if an IHA has been completed.

Based on the verification study, twenty four (24) medical records (12 adults and 12 pediatric) were reviewed for completeness and timely completion. In nine (9) medical records, the IHA were not performed within 120 days of enrollment. In twelve (12) medical records, a comprehensive history and physical exam as well as age appropriate screening were not included in the IHA. In seventeen (17) medical records, the IHEBAs were not documented in the IHA. This is an ongoing finding.

RECOMMENDATIONS:

1. Ensure the provision of an IHA for each new member is completed within 120 days of enrollment.
2. Ensure components of the IHA as required by regulation are documented in the members' medical records.

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CATEGORY 3 – ACCESS AND AVAILABILITY OF CARE

3.1

APPOINTMENT PROCEDURES AND WAITING TIMES

Appointment Procedures:

Contractor shall implement and maintain procedures for Members to obtain appointments for routine care, Urgent Care, routine specialty referral appointments, prenatal care, children's preventive periodic health assessments, and adult initial health assessments. Contractor shall also include procedures for follow-up on missed appointments.

COHS Contract A.9.3.A

Members must be offered appointments within the following timeframes:

- c) Non-urgent primary care appointments – within ten (10) business days of request;
- d) Appointment with a specialist – within 15 business days of request;

COHS Contract A.9.3.A.2

Prenatal Care:

Contractor shall ensure that the first prenatal visit for a pregnant Member will be available within 10 business days upon request.

COHS Contract A.9.3.B

Monitoring of Waiting Times:

Contractor shall develop, implement, and maintain a procedure to monitor waiting times in the providers' offices, telephone calls (to answer and return), and time to obtain various types of appointments indicated in Subprovision A, Appointments, above.

COHS Contract A.9.3.C; See Appointment Procedures above, Contract A.9.3.A

SUMMARY OF FINDINGS:

The Contract requires the Plan to implement and maintain procedures for members in appointments for routine care, urgent care, routine specialty referral appointments, prenatal care, children's preventive periodic health assessments, and adult initial health assessments. Non-urgent primary care appointments should be available within 10 business days of request. Appointment with a specialist and non-urgent appointment for ancillary services should be given within 15 business days of request. Plan shall also monitor wait times in the providers' offices, telephone calls, and in obtaining appointments. Based on available survey, the Plan did not comply with the required timeframe for members to receive appointments for routine care.

Policy Number MPQP 1023: *Access Standards* states members are offered appointments for covered health care services within a standard time frame appropriate for their condition. The policy outlines the timeframes that members must be offered appointments for newborn, routine care, prenatal care, urgent care, emergency care, specialty care, non-urgent non-physician mental health care, preventive dental care, non-urgent dental care, and urgent dental care.

The Plan informs its members on appointment procedures and wait times through the Member Handbook, its website, and member newsletters.

The 2014 PCP and Specialty Access Survey revealed members did not obtain appointments within the required timeframes. The Survey shows the result of the Plan's access standards on appointment availability as follows:

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- Adult new patient appointment within 14 days (10 business days) compliance rate was 71%.
- Adult established patient appointment within 14 days (10 business days) compliance rate was 87.9%.
- Pediatric new patient appointment within 14 days (10 business days) compliance rate was 83.6%.
- Pediatric established patient appointment within 14 days (10 business days) compliance rate was 92.9%.

The Plan is aggressively exploring various avenues to address challenges posed by the scarcity of medical providers in the rural areas of the counties covered by the Plan. The Plan has initiated programs such as telemedicine, econsults, and access to OBGYN services through Sutter in Solano County. Contracted PCPs are also given the opportunity to improve appointment access, decrease no-show rates, reduce cycle times, and use team-based care and operational data to achieve true transformation through the PHC-Sponsored Coleman Dramatic Performance Improvement Collaborative.

RECOMMENDATION:

1. Monitor the effectiveness of actions taken to comply with the required timeframes for routine care appointments.

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3.2

URGENT CARE / EMERGENCY CARE

Urgent Care:

Members must be offered appointments within the following timeframes:

- a) Urgent care appointment for services that do not require prior authorization – within 48 hours of a request
- b) Urgent appointment for services that do require prior authorization – within 96 hours of a request

COHS Contract A.9.3.A.2

Emergency Care:

Contractor shall ensure that a Member with an Emergency Condition will be seen on an emergency basis and that Emergency Services will be available and accessible within the Service Area 24-hours a day, 7-days a week.
COHS Contract A.9.6

Contractor shall have as a minimum a designated emergency service facility within the Service Area, providing care on a 24 hours a day, 7 days a week basis. This designated emergency service facility will have one or more Physicians and one (1) Nurse on duty in the facility at all times.
COHS Contract A.6.4

SUMMARY OF FINDINGS:

The Contract requires the Plan to offer members urgent care appointments for services that do not require prior authorization within 48 hours of request. Urgent care requiring prior authorization should be offered appointment within 96 hours of a request. The Plan shall ensure that a member with emergency condition will be seen on an emergency basis and that emergency services will be available and accessible within the Service Area 24-hours a day, 7-days a week.

Policy Number MPQP 1023: *Access Standards* states that emergency treatment must be available immediately to all members 24 hours a day. During hours when PCP offices are closed, members should be directed to after hours or emergency care location depending on the nature of the problem. Urgent care should be provided within 48 hours of the request.

The 2014 PCP and Specialty Access Survey measure appointment availability for members. The Plan uses 48 hours as the access standard for urgent care appointments. The 2014 PCP and Specialty Access Survey result showed the urgent care appointment compliance rate was 93.7 percent. The survey result indicated Plan members did not obtain urgent care appointment within required timeframe of 48 hours.

The Plan monitors the accessibility of urgent and emergency services through member complaints, member focus group, PHC QI activities, and provider focus group. When issues are identified, the Provider Relations Department takes immediate action with the practice site and implements corrective action to ensure compliance.

The Plan complied with contract requirements for Emergency Care.

RECOMMENDATIONS:

1. Monitor the wait time to ensure members receive urgent care appointments within the required timeframe of 48 hours.

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3.5

EMERGENCY SERVICE PROVIDERS (CLAIMS)

Emergency Service Providers (Claims)

Contractor is responsible for coverage and payment of emergency services and post stabilization care services and must cover and pay for emergency services regardless of whether the provider that furnishes the services has a contract with the plan.

COHS Contract A.8.12.A

Contractor shall pay for Emergency Services received by a Member from non-contracting providers. Payments to non-contracting providers shall be for the treatment of the Emergency Medical Condition, including Medically Necessary inpatient services rendered to a Member until the Member's condition has stabilized sufficiently to permit referral and transfer in accordance with instructions from Contractor, or the Member is stabilized sufficiently to permit discharge. The attending emergency physician, or the provider treating the Member is responsible for determining when the Member is sufficiently stabilized for transfer or discharge and that determination is binding on the Contractor. Emergency services shall not be subject to Prior Authorization by Contractor.

COHS Contract A.8.12.C

At a minimum, Contractor must reimburse the non-contracting emergency department and, if applicable, its affiliated providers for Physician services at the lowest level of emergency department evaluation and management CPT (Physician's Current Procedural Terminology) codes, unless a higher level is clearly supported by documentation, and for the facility fee and diagnostic services such as laboratory and radiology.

COHS Contract A.8.12.D

For all non-contracting providers, reimbursement by Contractor or by a subcontractor who is at risk for out-of-plan Emergency Services, for properly documented claims for services rendered on or after January 1, 2007 by a non-contracting provider pursuant to this provision shall be made in accordance with provision 4, Claims Processing, above, and 42 USC Section 1396u-2(b)(2)(D).

COHS Contract A.8.12.E

Claims Contractor shall cover emergency medical services without prior authorization pursuant to Title 28 CCR Section 1300.67(g)(1).

COHS Contract A.9.6.A

Time for Reimbursement. A plan and a plan's capitated provider shall reimburse each complete claim, or portion thereof, whether in state or out of state, as soon as practical, but no later than thirty (30) working days after the date of receipt of the complete claim by the plan or the plan's capitated provider, or if the plan is a health maintenance organization, 45 working days after the date of receipt of the complete claim by the plan or the Plan's capitated provider, unless the complete claim or portion thereof is contested or denied, as provided in subdivision (h).

CCR, Title 28, Section 1300.71(g)

References Cited:

42 USC Section 1396u-2(b)(2)(D) – Emergency services furnished by non-contract providers

42 USC Section 1396a(a)(37) – Claims Payment Procedures

Health and Safety Code Sections 1371 through 1371.39 – Health Care Service Plan Claim Reimbursement

Title 28 CCR Section 1300.67(g)(1) – Scope of Basic Health Care Services

SUMMARY OF FINDINGS:

The Contract requires the Plan to pay emergency service claims within 45 working days from the date of receipt of the complete claim. The Plan's policies and procedures require that all claims are processed and paid for

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emergency or urgent care services pursuant to statutory and contractual requirements.

Policy Number MCU3014: *Emergency Services* defines the circumstances under which emergency services are covered which include acute symptoms of sufficient severity, including severe pain, such that the absence of immediate medical attention could result in placing the health of the individual in serious injury, serious impairment to bodily function, and serious dysfunction of any body organ or part. Plan covers emergency services without prior authorization for evaluation and treatment of an emergency medical condition.

Policy Number CL #2L: *Claims Processing Standards for PHC* outlines the claims processing standards specifically the time frames for receiving, processing, and paying or denying claims. Ninety-five (95%) of claims submitted for which no further documentation or substantiation is required should be paid or denied within 45 working days after receipt.

During the onsite interview, Plan personnel stated that claims are processed electronically through Plan's Amisys claims processing system. The Plan processed and paid about 7,000 claims per week. Plan personnel also stated that there is a delay in payment because of the Plan's expansion to different counties causing a drastic increase in claims received and understaffed in the Claims Department.

In the verification study, twenty (20) emergency service claims were reviewed for appropriate and timely adjudication. Eleven (11) emergency service claims were not paid within the required 45 working days from the date of receipt.

RECOMMENDATIONS:

1. Ensure emergency claims are paid within 45 working days as required by the Contract and regulations.

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3.6

FAMILY PLANNING (PAYMENTS)

Claims Family Planning (Claims)

Contractor shall reimburse non-contracting family planning providers at no less than the appropriate Medi-Cal FFS rate....

COHS Contract A.8.8

Claims Processing—Contractor shall pay all claims submitted by contracting providers in accordance with this provision, unless the contracting provider and Contractor have agreed in writing to an alternate payment schedule.

- A. Contractor shall comply with 42 USC Section 1396a(a)(37) and Health and Safety Code Sections 1371 through 1371.39.
- B. Contractor shall pay 90 percent of all clean claims from practitioners who are in individual or group practices or who practice in shared health facilities, within 30 days of the date of receipt and 99 percent of all clean claims within 90 days. The date of receipt shall be the date Contractor receives the claim, as indicated by its date stamp on the claim. The date of payment shall be the date of the check or other form of payment.
- C. Contractor shall maintain procedures for prepayment and post payment claims review, including review of data related to provider, Member and Covered Services for which payment is claimed.
- D. Contractor shall maintain sufficient claims processing/tracking/payment systems capability to: comply with applicable State and Federal law, regulations and Contract requirements, determine the status of received claims, and calculate the estimate for incurred and unreported claims.
- E. Contractor shall submit claims payment summary reports to DHCS on a quarterly basis as specified in Exhibit A, Attachment 2, Provision 2. Financial Audit Reports Paragraph B. 2.

COHS Contract A.8.4

Time for Reimbursement. A plan and a plan's capitated provider shall reimburse each complete claim, or portion thereof, whether in state or out of state, as soon as practical, but no later than thirty (30) working days after the date of receipt of the complete claim by the plan or the plan's capitated provider, or if the plan is a health maintenance organization, 45 working days after the date of receipt of the complete claim by the plan or the Plan's capitated provider, unless the complete claim or portion thereof is contested or denied, as provided in subdivision (h).

CCR, Title 28, Section 1300.71(g)

References Cited:

42 USC Section 1396u-2(b)(2)(D) – Emergency services furnished by non-contract providers

42 USC Section 1396a(a)(37) – Claims Payment Procedures

Health and Safety Code Sections 1371 through 1371.39 – Health Care Service Plan Claim Reimbursement

Title 28 CCR Section 1300.67(g)(1) – Scope of Basic Health Care Services

SUMMARY OF FINDINGS:

The Contract requires the Plan to pay family planning claims within 45 working days after the date of receipt of the complete claim. The Plan's policies and procedures require that all claims are processed and paid for family planning services pursuant to statutory and contractual requirements.

Policy Number MCU3015: *Family Planning By-Pass Services* provides members with direct access to the full range of family planning services and providers, without prior authorization. These family planning services are applied to both contracting and non-contracting providers.

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Policy Number CL #2L: *Claims Processing Standards for PHC* outlines the claims processing standards for the Plan, specifically the timeframes for receiving, processing, and paying or denying claims. Ninety-five (95%) of claims submitted, for no further documentation nor substantiation is required, should be paid or denied within 45 working days after receipt.

During the onsite interview, Plan personnel stated that claims are processed electronically through Plan's Amisys claims processing system. The Plan processed and paid about 7,000 claims per week. Plan personnel also stated that there is a delay in payment because of the Plan's expansion to different counties causing a drastic increase in claims received and understaffed in the Claims Department.

For verification study, twenty (20) family planning claims were reviewed for appropriate and timely adjudication. Three (3) family planning claims were not paid within the required 45 working day timeframe from the date of receipt.

RECOMMENDATIONS:

1. Ensure family planning claims are paid within 45 working days as required by the Contract and regulations.

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CATEGORY 4 – MEMBER'S RIGHTS

4.3

CONFIDENTIALITY RIGHTS

Health Insurance Portability and Accountability Act (HIPAA) Responsibilities:

C. 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. Business Associate shall develop and maintain a written information privacy and security program that includes administrative, technical and physical safeguards appropriate to the size and complexity of the Business Associate's operations and the nature and scope of its activities, and which incorporates the requirements of section 3, Security...
- I. **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

References Cited:

45 CFR Section 164.308 – Administrative Safeguards

45 CFR Section 164.310 – Physical Safeguards

45 CFR Section 164.312 – Technical Requirements

45 CFR Section 164.316 – Policies and Procedures and Documentation Requirements

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SUMMARY OF FINDINGS:

The Contract requires the Plan to implement and maintain policies and procedures to ensure the members' right to confidentiality of Protected Health Information (PHI). The Plan shall implement safeguards to protect the confidentiality, integrity, and availability of PHI and submit notifications and investigative reports of breaches to the DHCS Program Contract Manager, DHCS Privacy Officer, and DHCS Information Security Officer. Notification of a breach should be reported within 24 hours upon the discovery of a breach. The investigation should be conducted and the investigation report should be submitted within 72 hours of the discovery. The complete report of investigation should be reported within ten (10) working days of the discovery.

Policy Number CMP-13: *Minimum Necessary Use or Disclosure of Member Information* establishes the Plan's policy on limiting the use and disclosure of members' health information to only the amount of information necessary to accomplish the Plan's objectives. The Plan shall maintain appropriate physical, technical, and administrative safeguards to control access to members' health information stored in paper files or stored electronically in the Plan's information systems.

Policy Number CD-03: *Privacy Incident Investigating and Reporting* stipulates the Plan Privacy Officer maintains and is responsible for the Privacy Program and its performance. All suspected privacy breaches shall be reported by the Plan Compliance Staff to the applicable health oversight agency, according to the reporting requirements of that agency and federal and state law. Privacy referrals will be investigated and resolved no later than 60 calendar days after the issue was discovered. When the Plan suspects a breach has occurred, a report is filed using the Privacy Incident Reporting form.

During the interview, the Plan personnel indicated that suspected or actual breaches were reported to the Compliance Unit. An initial Privacy Incident Report is submitted to DHCS within 72 hours of notification. The timeframe for investigating suspected or actual breaches and submitting updated Privacy Incident Report to DHCS is 90 days.

Ten HIPAA cases were reviewed for proper reporting to the appropriate entities within the required timeframe for the verification study.

- Notifications for six (6) cases were not sent to the DHCS Information Security Officer.
- Notification for one (1) case was not sent to the DHCS Program Contract Manager and the DHCS Information Security Officer.
- DHCS was not notified within 24 hours and investigation reports were not provided within 72 hours of discovery for six (6) cases.
- Complete investigation reports for five (5) cases were not submitted to DHCS within ten (10) working days of discovery.

RECOMMENDATIONS:

1. Update the language in Policy Number CD-03: *Privacy Incident Investigating and Reporting* to include the initial notification of discovery of breach will be submitted within 24 hours by telephone, e-mail, or fax to the Department of Health Care Services (DHCS) Program Contract Manager, DHCS Privacy Officer, and DHCS Information Security Officer.
2. Ensure that initial notification of Protected Health Information breach is submitted to the required DHCS personnel within the required 24 hour time frame.
3. Ensure complete report of investigation is submitted to DHCS Program Contract Manager, DHCS Privacy Officer, and DHCS Information Security Officer within ten working days.
4. Ensure notifications and investigative reports of breaches are submitted to the DHCS Program Contract Manager, DHCS Privacy Officer, and DHCS Information Security Officer.

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CATEGORY 6 – ADMINISTRATIVE AND ORGANIZATIONAL CAPACITY

6.5

FRAUD AND ABUSE

Fraud and Abuse Reporting

B. Contractor shall meet the requirements set forth in 42 CFR 438.608 by establishing administrative and management arrangements or procedures, as well as a mandatory compliance plan, which are designed to guard against fraud and abuse. These requirements shall be met through the following:

4. Fraud and Abuse Reporting

Contractor shall report to DHCS all cases of suspected fraud and/or abuse where there is reason to believe that an incident of fraud and/or abuse has occurred by subcontractors, members, providers, or employees. Contractor shall conduct, complete, and report to DHCS, the results of a preliminary investigation of the suspected fraud and/or abuse within ten (10) working days of the date Contractor first becomes aware of, or is on notice of, such activity....

5. Tracking Suspended Providers

Contractor shall comply with Title 42 CFR Section 438.610. Additionally, Contractor is prohibited from employing, contracting or maintaining a contract with Physicians or other health care providers that are excluded, suspended or terminated from participation in the Medicare or Medi-Cal/Medicaid programs. A list of suspended and ineligible providers is maintained in the Medi-Cal Provider Manual, which is updated monthly and available on line and in print at the DHCS Medi-Cal website (www.medi-cal.ca.gov) and by the Department of Health and Human Services, Office of Inspector General, List of Excluded Individuals and Entities (<http://oig/hhs.gov>). Contractor is deemed to have knowledge of any providers on these lists. Contractor must notify the Medi-Cal Managed Care Program/Program Integrity Unit within ten (10) State working days of removing a suspended, excluded, or terminated provider from its provider network and confirm that the provider is no longer receiving payments in connection with the Medicaid program.

COHS Contract E.2.27.B

References Cited:

42 CFR 438.608 – Program Integrity Requirements

42 CFR 438.610 – Prohibited Affiliations with Individuals Debarred by Federal

SUMMARY OF FINDINGS:

The Contract requires the Plan to have an Anti-Fraud and Abuse Program that will establish policies and procedures for identifying, investigating and providing a prompt response against fraud and/or abuse in the provision of health care services under the Medi-Cal Program. The Plan shall conduct, complete, and report to DHCS Compliance Unit the results of a preliminary investigation of the suspected fraud and/or abuse within ten (10) working days of the date the Plan first becomes aware of such activity.

Policy Number CD-01: *FWA Processing* provides the Plan's Compliance Unit Staff with the necessary instructions to receive and process Fraud, Waste, and Abuse (FWA) complaints. The Plan's employees are required to report suspected FWA to the Compliance Unit. Suspected or identified FWA must be reported immediately. Medi-Cal FWA cases must be reported to Compliance Unit using form MC609. Reports are to be made no later than 10 working days when the Plan is first aware or is noticed of the FWA activity.

During the onsite interview, Plan personnel stated that once the Plan becomes aware of suspected fraud and abuse, an email is sent to DHCS by the Plan's Compliance Coordinator. A MC609 form is sent to DHCS Compliance Unit. The Plan was not aware of how many days it takes for the Plan to report to DHCS. After the cases have been

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reported to DHCS, follow ups are conducted as needed.

Based on the verification study, twelve (12) cases were reviewed. Three (3) cases were not reported to the DHCS Compliance Unit within ten (10) working days of Plan's acknowledgement. Three (3) cases did not have documentation to support if the cases were reported to DHCS Compliance Unit within ten (10) working days of Plan's acknowledgement.

RECOMMENDATIONS:

1. Ensure that all suspected fraud and/or abuse cases are reported to the Department of Health Care Services Compliance Unit within the required 10 working days.