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

REPORT ON THE MEDICAL AUDIT OF

Partnership HealthPlan of California

Contract Number: 08-85215

Audit Period: January 1, 2018
Through
December 31, 2018

Report Issued: May 8, 2019

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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 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 25% 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, eight more counties were added: Del Norte, Humboldt, Lake, Lassen, Modoc, Shasta, Trinity, and Siskiyou.

As of January 1, 2019, the Plan had 547,217 Medi-Cal members. Medi-Cal members are distributed as follows: Del Norte 11,188, Humboldt 51,667, Lake 29,957, Lassen 7,042, Marin 36,735, Mendocino 38,197, Modoc 3,140, Napa 27,139, Shasta 58,845, Siskiyou 17,330, Solano 105,808, Sonoma 104,204, Trinity 4,267, and Yolo 51,698.

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, 2018 through December 31, 2018. The onsite review was conducted from February 4, 2019 through February 8, 2019. The audit consisted of document review, verification studies, and interviews with Plan personnel.

An exit conference was held on April 11, 2019 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 submitted supplemental information after the exit conference which is reflected in this report.

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

The prior DHCS medical audit (for the period of January 1, 2017 through December 31, 2017) was issued on August 10, 2018. The corrective action plan (CAP) closeout letter was issued on October 1, 2018.

The summary of the findings by category follows:

Category 1 – Utilization Management

No findings.

Category 2 – Case Management and Coordination of Care

No findings.

Category 3 – Access and Availability of Care

No findings.

Category 4 – Member's Rights

The finding from the previous audit period concerned the Plan's Health Insurance Portability and Accountability Act (HIPAA) system's inability to process a high volume of HIPAA incidents. This led to delays in the notification of HIPAA incidents and submission of Privacy Incident Reports (PIR) to DHCS within the time requirements of the contract.

The Plan updated its system as a result of the prior audit findings, however, the Plan's HIPAA training program did not ensure that all Plan employees followed through with the requirement of immediate and accurate reporting of potential HIPAA incidents to the Plan's compliance department. This resulted in HIPAA incidents not being reported timely to

DHCS.

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 February 4, 2019 through February 8, 2019. 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.

The following verification studies were conducted:

Category 1 – Utilization Management

Prior authorization requests: 20 medical prior authorization requests were reviewed for timeliness, consistent application of criteria, and appropriate review.

Appeal procedures: 20 Medical prior authorizations appeals were reviewed for appropriate and timely adjudication.

Category 2 – Case Management and Coordination of Care

Non-Emergency Medical Transportation: 15 claims were reviewed for to confirm compliance with the Non-Emergency Medical Transportation requirements.

Non-Medical Transportation: 20 claims were reviewed to confirm compliance with the Non-Medical Transportation requirements.

Category 3 – Access and Availability of Care

Appointment availability verification: 10 in-network providers of routine, urgent, specialty, and prenatal care were reviewed. The third next available appointment was used to measure access to care.

Claims: 20 emergency services claims were reviewed for appropriate and timely adjudication.

Category 4 – Member's Rights

Grievance Procedures: 52 grievances (sample includes 27 quality of care and 25 quality of service) were reviewed for timely resolution, response to complainant, and submission to the appropriate level for review.

HIPAA: 5 HIPAA cases were reviewed for appropriate reporting and processing.

Category 5 – Quality Management

None.

Category 6 – Administrative and Organizational Capacity

Fraud and Abuse: 10 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 (CAF) ❖

PLAN: Partnership HealthPlan of California

AUDIT PERIOD: January 1, 2018 – December 31, 2018
DATE OF AUDIT: February 4, 2019 – February 8, 2019

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 FINDING(S):

4.3.1 **Timely Reporting of Health Insurance Portability and Accountability Act (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 made multiple changes to the HIPAA intake and reporting system during the audit period, however, the Plan did not send notifications and PIRs for HIPAA incidents to DHCS within the time requirements in the contract.

During the audit period, 30 suspected HIPAA incidents were not reported within the DHCS time requirements. Data collected from the verification study sample of five HIPAA incidents showed that three of five were not reported to DHCS within 24 hours, three initial PIRs were not sent within 72 hours, and one complete PIR was not sent within 10 working days.

During the audit period, there were delays between the time Plan employees discovered HIPAA incidents and the time they reported them to the Plan's compliance department. This was noted in the compliance committee minutes, which identified instances of late internal reports and errors. The Plan's HIPAA training program did not ensure that all Plan employees follow through with the requirement of immediate and accurate reporting of potential HIPAA incidents. This resulted in HIPAA incidents not being reported timely to DHCS.

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 appropriate action against protected information breaches.

This is a repeat finding.

RECOMMENDATION(S):

4.3.1 Develop and implement procedures and corrective actions to ensure compliance with HIPAA reporting requirements.

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, 2018
Through
December 31, 2018

Report Issued: May 8, 2019

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INTRODUCTION

This report was created for informational purposes. Department of Health Care Services (DHCS) did not conduct a review of the Partnership HealthPlan of California (PHC) state supported services contract number 08-85222. The State Supported Services contract covers contracted abortion services with PHC. There were no prior year findings for State Supported Services.

❖ COMPLIANCE AUDIT FINDINGS (CAF) ❖	
PLAN: Partnership HealthPlan of California	
AUDIT PERIOD: January 1, 2018 - December 31, 2018	DATE OF AUDIT: February 4, 2019 - February 8, 2019

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:

DHCS did not conduct a review of the Partnership HealthPlan of California State Supported Services contract number 08-85222.

RECOMMENDATIONS:

N\A