

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

REPORT ON THE MEDICAL AUDIT OF

Health Plan of San Joaquin

Contract Number: 04-35401

Audit Period: July 1, 2018
Through
June 30, 2019

Report Issued: November 7, 2019

TABLE OF CONTENTS

I. INTRODUCTION1

II. EXECUTIVE SUMMARY2

III. SCOPE/AUDIT PROCEDURES4

I. INTRODUCTION

The Health Plan of San Joaquin (the Plan) is a non-profit corporation headquartered in French Camp, CA and established in 1995. In 1996, the Plan received its Knox-Keene license and contracted with the State of California to provide health care services to Medi-Cal members in San Joaquin County.

On January 12, 1995, the State of California contracted with the San Joaquin County Board of Supervisors to serve as the Local Initiative under the 2-Plan Model, pursuant to the California Welfare and Institutions Code, section 14087.31. On January 1, 2013, the Plan began to serve as the Stanislaus Local Initiative. The San Joaquin County Health Commission governs the Plan through an 11-member commission consisting of local government members, clinical, and non-clinical community representatives. In June 2018 the Plan was awarded the National Committee for Quality Assurance accreditation renewal.

Health care services are provided through contracts with independent medical groups and individual physicians (352 primary care physicians). Health care services not provided directly by primary care physicians are arranged through contracts with other medical groups/physicians, allied health service suppliers, and 17 hospitals. The Plan has a network of over 827 specialists and 649 ancillary providers. As of June 30, 2019, the Plan had 341,885 Medi-Cal members. The Plan's market share is about 91.3 percent in San Joaquin County and 67 percent in Stanislaus County.

II. EXECUTIVE SUMMARY

This report presents the audit findings of the Department of Health Care Services (DHCS) medical audit for the period of July 1, 2018 through June 30, 2019. The on-site review was conducted from August 12, 2019 through August 16, 2019. The audit consisted of document reviews, verification studies, and interviews with Plan personnel.

An Exit Conference was held on October 3, 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. 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 to Care, Member Rights, Quality Management (QI), and Administrative and Organizational Capacity. There were no material findings for the audit period. This was a reduced scope audit.

The prior DHCS medical audit issued November 8, 2018 (for the audit period of July 1, 2017 through June 30, 2018) identified deficiencies, which were addressed in a Corrective Action Plan (CAP). The CAP closeout letter dated April 11, 2019, noted that DHCS closed all previous findings.

The Plan's initiatives in resolving last year's findings.

Category 4 – Member's Rights

In the prior year's audit, the Plan did not report 24 hour notifications and/or Privacy Incident Reports (PIR) for Health Insurance Portability and Accountability Act (HIPAA) incidents to DHCS within the timeframes required by the Contract. The Plan's HIPAA reporting system was unable to ensure that all HIPAA incidents were reported timely because the Compliance Department which handles the reporting of incidents had difficulty with employee turnover and hiring new staff.

The Plan implemented training for all compliance staff to ensure timely responses and submission are done for all notifications for PIR and HIPAA incidents. Training included communication to the Privacy Officer and DHCS within the required timeframes. In addition all staff meetings were held to emphasize timely reporting. The Plan added five new staff to the Department and continues to recruit staff for open positions to support meeting timelines. The Plan approved funding during the audit period to improve the tools used by compliance staff to track incidents and hired a new Compliance Director.

The Compliance Department uses a Dashboard to monitor incidents that come into the system and helps remind staff to report them to DHCS on time. The staff also uses an excel spreadsheet to track and input data about each incident. The information from this spreadsheet feeds into the Dashboard.

Annual employee training emphasizing the importance of timely HIPAA incident reporting is given to all employees. There is also training for new employees.

Due to these system improvements the Plan was able to submit all incidents timely after the CAP close out date of April 11, 2019.

Category 6 – Administrative and Organizational Capacity

The finding from the previous audit period concerned the Plan’s fraud, waste, and abuse reporting system inability to ensure that all fraud incidents were reported appropriately to DHCS in a timely manner. The Compliance Department which handles the intake and reporting of fraud incidents had employee turnover and difficulty hiring new staff. The Plan made efforts to cross-train compliance staff to take on these duties. However, DHCS found fraud incidents that were reported late.

The Plan has implemented training for all compliance staff to ensure timely responses and submissions are done for all notifications for fraud, waste, and abuse incidents. In addition all staff meetings were held to emphasize timely reporting. The Plan hired a new Compliance Director and added five new staff to the Department and continues to recruit staff for open positions to support meeting timelines.

The Plan implemented improvement tools for compliance staff to track incidents. The Compliance Department uses a Dashboard to monitor incidents that come into the system and helps remind staff to report them to DHCS on time. The staff also uses an excel spreadsheet to track and input data about each incident. The information from this spreadsheet feeds into the Dashboard.

To ensure all staff know about the importance of reporting fraud issues, the plan holds mandatory training for all new staff. It also presents fraud, waste, and abuse information at certain staff meetings.

Due to these system improvements the Plan was able to submit all incidents timely.

III. SCOPE/AUDIT PROCEDURES

SCOPE

This audit was conducted by DHCS, Medical Review Branch 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.

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.

PROCEDURE

The on-site review was conducted from August 12, 2019 through August 16, 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: 30 prior authorization files (15 medical and 15 pharmacy) were reviewed for timeliness, consistent application of criteria, and appropriate review.

Appeal procedures: 15 prior authorization appeals were reviewed for appropriate and timely adjudication.

Category 2 – Case Management and Coordination of Care

Non-Emergency Medical Transportation (NEMT) and Non-Medical Transportation (NMT): 29 claims (14 NEMT and 15 NMT) were reviewed for timeliness and appropriate adjudication.

Category 3 – Access and Availability of Care

Appointment Availability: 10 contracted providers from the Provider's Directory were reviewed for appointment availability, accuracy, and completeness.

Claims: 42 claims (17 emergency services, 15 family planning, and 10 state supported services) were reviewed for appropriate and timely adjudication.

Category 4 – Member’s Rights

Grievance Procedures: 30 grievances (15 quality of care and 15 quality of service) and five inquiries were reviewed for timely resolution, response to complainant, and submission to the appropriate level for review.

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

Category 6 – Administrative and Organizational Capacity

Fraud and Abuse: 10 cases were reviewed for appropriate reporting and processing within the required timeframes.

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

REPORT ON THE MEDICAL AUDIT OF

Health Plan of San Joaquin

Contract Number: 03-75801
State Supported Services

Audit Period: July 1, 2018
Through
June 30, 2019

Report Issued: November 7, 2019

TABLE OF CONTENTS

I. INTRODUCTION1

II. COMPLIANCE AUDIT FINDINGS2

I. INTRODUCTION

This report presents the audit findings of The Health Plan of San Joaquin (the Plan) State Supported Services Contract No. 03-75801. The State Supported Services contract covers contracted abortion services with the Plan.

The onsite audit was conducted from August 12, 2019 through August 16, 2019. The audit period is July 1, 2018 through June 30, 2019 and consisted of document review of materials supplied by the Plan and interviews conducted onsite.

❖ **COMPLIANCE AUDIT FINDINGS (CAF)** ❖

PLAN: Health Plan of San Joaquin

AUDIT PERIOD: July 1, 2018 - June 30, 2019

DATE OF AUDIT: August 12, 2019 - August 16, 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 FINDING(S):

No deficiencies were noted during this review.

RECOMMENDATION(S):

None