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

Health Plan of San Joaquin

Contract Number: 04-35401

Audit Period: July 1, 2017
Through
June 30, 2018

Report Issued: November 8, 2018

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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 started 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.

Health care services are provided through contracts with independent medical groups and individual physicians (337 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 18 hospitals. The Plan has a network of over 799 specialists and 1235 ancillary providers. As of July 1, 2018, the Plan had 345,087 Medi-Cal members. The Plan's market share is about 91% in San Joaquin County and 64% in Stanislaus County.

In the past three years the Plan reported specialist numbers were overstated by defining ancillary provider's non-medical practitioners as specialists. Once the error was identified the report was generated from the new database which accurately counts all contracted network physicians.

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, 2017 through June 30, 2018. The on-site review was conducted from August 13, 2018 through August 23, 2018. The audit consisted of document reviews, verification studies, and interviews with Plan personnel.

An exit conference was held on October 18, 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 to Care, Member Rights, Quality Management (QI), and Administrative and Organizational Capacity.

The prior DHCS medical audit issued June 8, 2018 (for the audit period of July 1, 2016 through June 30, 2017) identified a deficiency, which was addressed in a corrective action plan (CAP). The CAP closeout letter dated July 18, 2018, noted that DHCS closed all previous findings.

The summary of findings by category are as follows:

Category 2 – Case Management and Coordination of Care

There are no systemic findings in Behavioral Health Treatment (BHT) section. The previous audit finding regarding the lack of required elements in BHT treatment plans was corrected. The Plan also updated its policies to require oversight to include quarterly audits with results presented to the Quarterly Joint Operations and Delegation Oversight Committee.

Category 4 – Member's Rights

The Plan did not send 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.

Category 6 – Administrative and Organizational Capacity

The Plan's fraud, waste and abuse reporting system was unable 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.

III. SCOPE/AUDIT PROCEDURES

SCOPE

This audit was conducted by the Department of Health Care Services (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 of Management and Administrative and Organizational Capacity. In addition, the Plan's Senior, Persons with Disabilities (SPD) population was included in this review period.

PROCEDURE

The on-site review was conducted from August 13, 2018 through August 23, 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.

The following verification studies were conducted:

Category 1 – Utilization Management

Prior authorization requests: 15 medical (sample includes five SPD) and 15 pharmacy (sample includes five SPD) prior authorization requests were reviewed for timeliness, consistent application of criteria, and appropriate review.

Appeal procedures: 15 (sample includes five SPD) prior authorizations appeals were reviewed for appropriate and timely adjudication.

Category 2 – Case Management and Coordination of Care

California Children's Services: Three medical records were reviewed for evidence of coordination of care between the Plan and CCS Providers.

Complex Case Management: Six (sample includes three SPD) medical records were reviewed for evidence of continuous tracking, monitoring, and coordination of resources to members who received complex case management services.

Behavioral Health Treatment: Ten (sample includes eight SPD) files were reviewed for completeness.

Category 3 – Access and Availability of Care

Appointment Availability: 15 contracted providers from the Provider's Directory were reviewed to determine if appointments were accurate, complete, and available. The third next available appointment was used to measure access to care.

Claims: 15 family planning claims were reviewed for appropriate and timely adjudication.

Category 4 – Member's Rights

Grievance Procedures: 32 grievances (19 quality of care and 13 quality of service that included 15 SPD) were reviewed for timely resolution, response to complainant, and submission to the appropriate level for review.

Confidentiality Rights: Ten cases were reviewed for proper reporting of all suspected and actual breaches to the appropriate entities within the required time frame.

Category 6 – Administrative and Organizational Capacity

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

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

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CATEGORY 4 – MEMBER'S RIGHTS

4.3	CONFIDENTIALITY RIGHTS

Members' Right to Confidentiality
Contractor shall implement and maintain policies and procedures to ensure the Members' right to confidentiality of medical information.

1) Contractor shall ensure that Facilities implement and maintain procedures that guard against disclosure of confidential information to unauthorized persons inside and outside the network.
2) Contractor shall counsel Members on their right to confidentiality and Contractor shall obtain Member's consent prior to release of confidential information, unless such consent is not required pursuant to Title 22 CCR Section 51009.

2-Plan Contract A.13.1.B

Health Insurance Portability and Accountability Act (HIPAA) Responsibilities:
Business Associate agrees:

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, below. Business Associate will provide DHCS with its current and updated policies.

2-Plan Contract G.III.C.2.

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.
2-Plan Contract G.III.J

SUMMARY OF FINDINGS:

4.3.1 **Timely Reporting of HIPAA Incidents**

Pursuant to the contract, on discovery of breaches the Plan must "notify DHCS immediately by telephone call plus e-mail or fax upon the discovery of breach of security of PHI in computerized form if the PHI was, or is reasonably believed to have been, acquired by an unauthorized person; or within 24 hours by e-mail or fax of any suspected security incident, intrusion or unauthorized use or disclosure of PHI in violation of this Contract, or potential loss of confidential data affecting this Contract."
Contract, Amendment 10, Exhibit G, (3)(H)(1)

Pursuant to the contract, on discovery of breaches the Plan must "immediately investigate such security incident, breach, or unauthorized use or disclosure of PHI or confidential data. Within 72 hours of the discovery, to notify the DHCS MMCD Contracting Officer, the DHCS Privacy Officer, and the DHCS Information Security Officer. "
Contract, Amendment 10, Exhibit G, (3)(H)(2)

The contractor shall maintain the organization and staffing for implementing and operating the Contract in accordance with Title 28, CCR, Section 1300.67.3 and Title 22 CCR Sections 53800, 53851 and 53857. Contract, Amendment 10, Exhibit A, Attachment 1(4)

The Plan did not send 24 hour notifications and/or Privacy Incident Reports (PIR) for HIPAA incidents to DHCS within the timeframes required by the contract. Data collected in the verification study sample of ten HIPAA incidents showed that five of ten were not reported or were not documented that they were reported to DHCS within 24 hours. Four of those five did not include initial PIRs that were sent within 72 hours. One of these incidents was not reported by Plan staff to the Plan's own compliance department for nine days.

The Plan's HIPAA reporting system was unable to ensure that all HIPAA incidents were reported appropriately to DHCS in a timely manner. The compliance department which handles the intake and reporting of fraud incidents had difficulty with employee turnover and hiring new staff, despite the utilization of temporary agencies. Two key compliance staff left the plan during the audit period which affected the plan's ability to report timely.

In addition to staffing issues, during the first three months of the audit period there was only one staff member with expertise in writing and submitting Privacy Incident Reports to DHCS, as well as only one staff who had access to the plan's HIPAA intake mailbox ("Privacy Officer Mailbox"). This led to slowdowns in reporting and a discontinuity of duties when that staff left the plan, which happened during the audit period. As of October 2017, the Plan has made efforts to expand their succession planning efforts by cross-training compliance staff to take on these duties and utilizing temporary agencies. However, DHCS found HIPAA incidents that were reported late even after these initiatives were implemented.

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

RECOMMENDATIONS:

4.3.1 Improve HIPAA system by ensuring the Plan maintains adequate compliance staff and continues to cross-train employees. Continue to monitor that all HIPAA incidents are reported to DHCS in a timely manner.

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CATEGORY 6 – ADMINISTRATIVE AND ORGANIZATIONAL CAPACITY

6.3	FRAUD AND ABUSE

Fraud and Abuse Reporting
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….

1) Contractor shall establish an Anti-Fraud and Abuse Program in which there will be a compliance officer and a compliance committee for all fraud and/or abuse issues, and who shall be accountable to senior management. This program 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, and provide for the development of corrective action initiatives relating to the contract.
2) Contractor shall provide effective training and education for the compliance officer and all employees.
3) Contractor shall make provision for internal monitoring and auditing including establishing effective lines of communication between the compliance officer and employees and enforcement of standards through well-publicized disciplinary guidelines.
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 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 42 CFR 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….

2-Plan Contract E.2.26.B

SUMMARY OF FINDINGS:

6.3.1 **Timely Reporting of fraud, waste and abuse Incidents**

The contractor shall establish an Anti-Fraud and Abuse Program in which there will be a compliance officer and a compliance committee for all fraud and/or abuse issues, and who shall be accountable to senior management. This program 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, and provide for the development of corrective action initiatives relating to the contract. Contract, Amendment 10, Attachment 2, (26)(B)(1)

The 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 10 working days of the date Contractor first becomes aware of, or is on notice of, such activity. Contract, Amendment 10, Attachment 2, (26)(B)(2)

The contractor shall maintain the organization and staffing for implementing and operating the Contract in accordance with Title 28, CCR, Section 1300.67.3 and Title 22 CCR Sections 53800, 53851 and 53857. Contract, Amendment 10, Exhibit A, Attachment 1(4)

The Plan's fraud, waste and abuse reporting system was unable 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 difficulty with employee turnover and hiring new staff, despite the utilization of temporary agencies. Two key compliance staff left the plan during the audit period which affected the plan's ability to report timely.

In addition to staffing issues, during the first three months of the audit period there was only one staff member with expertise in writing and submitting MC609 reports to DHCS, as well as only one staff who had access to the plan's fraud intake mailbox. This led to slowdowns in reporting and a discontinuity of duties when that staff left the plan during the audit period. As of October 2017, the Plan made efforts to expand their succession planning efforts by cross-training compliance staff to take on these duties and utilizing temporary agencies. However, DHCS found HIPAA incidents that were reported late after these initiatives were implemented.

The purpose of the timely reporting requirements is to help ensure patient safety and program integrity. Fraud incidents that are not reported in a timely fashion to DHCS could cause a lapse in preventive action against potential patient harm.

RECOMMENDATIONS:

6.3.1 Improve fraud, waste and abuse system by ensuring the Plan maintains adequate compliance staff and continues to cross-train employees. Continue to monitor that all fraud incidents are reported to DHCS in a timely manner.

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

Health Plan of San Joaquin

Contract Number:	03-75801 State Supported Services
Audit Period:	July 1, 2017 Through June 30, 2018
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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 13, 2018 through August 23, 2018. The audit period is July 1, 2017 through June 30, 2018 and consisted of document review of materials supplied by the Plan and interviews conducted onsite.

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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:

No deficiencies were noted during this review.

RECOMMENDATIONS:

None