



Edmund G. Brown Jr., Governor
State of California
Health and Human Services Agency
DEPARTMENT OF MANAGED HEALTH CARE
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January 25, 2017

Via USPS Delivery and eFile

Greg Diederich, Chairman of the Board of Directors
San Joaquin County Health Commission dba Health Plan of San Joaquin
7751 South Manthey Road
French Camp, CA 95231

FINAL REPORT OF ROUTINE EXAMINATION OF SAN JOAQUIN COUNTY HEALTH COMMISSION

Dear Mr. Diederich:

Enclosed is the Final Report of a routine examination of the fiscal and administrative affairs of San Joaquin County Health Commission dba Health Plan of San Joaquin (Plan), conducted by the Department of Managed Health Care (Department), pursuant to Section 1382(a) of the Knox-Keene Health Care Service Plan Act of 1975.¹ The Department issued a Preliminary Report to the Plan on November 10, 2016. The Department accepted the Plan's electronically filed response on December 21, 2016.

This Final Report includes a description of the compliance efforts included in the Plan's December 21, 2016 response, in accordance with Section 1382(c).

Section 1382(d) states, "If requested in writing by the plan, the director shall append the plan's response to the final report issued pursuant to subdivision (c). The plan may modify its response or statement at any time and provide modified copies to the department for public distribution not later than 10 days from the date of notification from the department that the final report will be made available to the public. The addendum to the response or statement shall also be made available to the public."

Please indicate within ten (10) days from the date of the Plan's receipt of this letter whether the Plan requests the Department to append its response to the Final Report. If so, please indicate which portions of the Plan's response shall be appended, and electronically file copies of those portions of the Plan's response excluding information

¹ References throughout this report to "Section" are to sections of the Knox-Keene Health Care Service Plan Act of 1975, as codified in the California Health and Safety Code, Section 1340, et seq. References to "Rule" are to the regulations promulgated pursuant to the Knox-Keene Health Care Service Plan Act, found at Chapter 2 of Division 1, Title 28, of the California Code of Regulations, beginning with Section 1300.43.

held confidential pursuant to Section 1382(c). If the Plan requests the Department to append a brief statement summarizing the Plan's response to the Report or wishes to modify any information provided to the Department in its December 21, 2016 response, please provide the electronically filed documentation no later than ten (10) days from the date of the Plan's receipt of this letter through the eFiling web portal. Please file this addendum electronically via the Corrective Action Plan system (CAP system) within the Online Forms Section of the Department's eFiling web portal <https://wpsso.dmhc.ca.gov/secure/login/>, as follows:

- From the main menu, select "eFiling".
- From the eFiling (Home) menu, select "Online Forms".
- From the Existing Online Forms menu click on the "Details" for the DFO Corrective Action Plan S16-R-338.
- Go to the "Messages" tab
 - Select "Addendum to Final Report" (note this option will only be available for 10 days after the Final Report has been issued)
 - Select the deficiency(ies) that are applicable
 - Create a message for the Department
 - Attach and Upload all documents with the name "Addendum to Final Report"
 - Select "Send Message"

The Department finds the Plan's compliance efforts are responsive to the deficiencies cited and the corrective actions required. Therefore, no further response is required.

The Plan is hereby advised that any violations listed in this report may be referred to the Office of Enforcement for appropriate administrative action upon the issuance of this Report.

Questions or problems related to the electronic transmission of the response should be directed to Vijon Morales at (916) 255-2447 or email at Vijon.Morales@dmhc.ca.gov. You may also email inquiries to wpsso@dmhc.ca.gov.

The Department will make the attached Final Report available to the public in ten (10) days from the Plan's receipt of this letter through the eFiling system. The Report will be located at the Department's web site at [View Financial Examination Reports](#).

If there are any questions regarding this Report, please contact me at 916-255-2441 or email: Bill.Chang@dmhc.ca.gov.

Sincerely,

Bill Chang, CPA
Supervising Examiner
Office of Financial Review

cc: Amy Shin, CEO, San Joaquin County Health Commission
Pritika Dutt, Deputy Director, Office of Financial Review
Sang Le, Oversight Examiner, Division of Financial Oversight
Getachew Tareke, Examiner, Division of Financial Oversight
Ashika Chiu, Examiner, Division of Financial Oversight
Cassidy Draeger, Attorney, Office of Plan Licensing
Laura Dooley-Beile, Chief, Division of Plan Surveys
Paula Hood, Staff Services Manager I, Help Center

**STATE OF CALIFORNIA
DEPARTMENT OF MANAGED HEALTH CARE
DIVISION OF FINANCIAL OVERSIGHT
FINAL REPORT OF ROUTINE EXAMINATION
OF**

SAN JOAQUIN COUNTY HEALTH COMMISSION

FILE NO. 933-0338

DATE OF FINAL REPORT: JANUARY 25, 2017

SUPERVISING EXAMINER: BILL CHANG

OVERSIGHT EXAMINER: SANG LE

EXAMINER-IN-CHARGE: GETACHEW TAREKE

**FINANCIAL EXAMINERS:
TOM CHAN
JOHN YIN
SULLY WONG-GUERRERO
LINDSAY GONZALES**

BACKGROUND INFORMATION FOR SAN JOAQUIN COUNTY HEALTH COMMISSION

Date Plan Licensed:	January 30, 1996
Organizational Structure:	San Joaquin County Health Commission (Plan) is a public agency created by the County Board of Supervisors (Board) under the two-plan model pursuant to the California Welfare and Institutions code Section 14087.31. The Board appoints the Health Commissioners of the Plan to oversee the management of the Plan. Hence, the Plan is a component unit in the general purpose financial statements of the County. The Plan and Health Plan of San Joaquin Joint Powers Authority, a licensed health maintenance organization that operates in the County, have a mutual guarantee agreement insuring mutual solvency for the two organizations.
Type of Plan:	A full service health care plan providing a full range of medical and hospital services to Medi-Cal beneficiaries through a contract with the Department of Health Care Services.
Provider Network:	The Plan contracts with various health care providers whereby capitation payments and fee-for-service payments are made in return for contracted health care services for its members.
Plan Enrollment:	As of June 30, 2016, the Plan had 338,541 enrollees.
Service Area:	The counties of San Joaquin and Stanislaus.
Date of prior Final Routine Examination Report:	September 15, 2014.

FINAL REPORT OF A ROUTINE EXAMINATION OF SAN JOAQUIN COUNTY HEALTH COMMISSION

This is the Final Report of a routine examination of the fiscal and administrative affairs of San Joaquin County Health Commission (Plan), conducted by the Department of Managed Health Care (Department) pursuant to Section 1382(a) of the Knox-Keene Health Care Service Plan Act of 1975.¹ The Department issued a Preliminary Report to the Plan on November 10, 2016. The Department accepted the Plan's electronically filed response on December 21, 2016.

This Final Report includes a description of the compliance efforts included in the Plan's December 21, 2016 response to the Preliminary Report, in accordance with Section 1382(c). The Plan's response is noted in *italics*.

The Plan is hereby advised that any violations listed in this report may be referred to the Office of Enforcement for appropriate administrative action upon the issuance of this report.

The Department examined the Plan's financial report filed with the Department for the quarter ended June 30, 2016, as well as other selected accounting records and controls related to the Plan's various fiscal and administrative transactions. The Department's findings are presented in this Report as follows:

Section I.	Financial Statements
Section II.	Calculation of Tangible Net Equity
Section III.	Compliance Issues
Section IV.	Internal Control
Section V.	Non-Routine Examination

The Department finds the Plan's compliance efforts are responsive to the deficiencies cited and the corrective actions required. Therefore, no further response is required.

¹ References throughout this report to "Section" are to sections of the Knox-Keene Health Care Service Plan Act of 1975, as codified in the California Health and Safety Code, Section 1340, et seq. References to "Rule" are to the regulations promulgated pursuant to the Knox-Keene Health Care Service Plan Act, found at Chapter 2 of Division 1, Title 28, of the California Code of Regulations, beginning with Section 1300.43.

SECTION I. FINANCIAL REPORT

The Department's examination did not result in any adjustments or reclassifications to the Plan's financial statements for the quarter ended June 30, 2016, as filed with the Department. A copy of the Plan's financial statements can be viewed at the Department's website by typing the link <http://wpsso.dmhca.gov/fe/search/#top> and selecting San Joaquin County Health Commission on the second drop down menu.

No response was required to this Section.

SECTION II. CALCULATION OF TANGIBLE NET EQUITY (TNE)

Net Worth as reported by the Plan as of Quarter Ended June 30, 2016	\$ 139,538,172
Required TNE	<u>37,821,828</u>
TNE Excess per Examination	<u>\$ 101,716,344</u>

The Plan is in compliance with the TNE requirement of Section 1376 and Rule 1300.76 as of June 30, 2016.

No response was required to this Section.

SECTION III. COMPLIANCE ISSUES

A. PROVIDER DISPUTE RESOLUTION MECHANISM

Rule 1300.71.38 requires all health care service plans and their capitated providers that pay claims to establish a fast, fair and cost-effective dispute resolution mechanism to process and resolve contracted and non-contracted provider disputes.

Rule 1300.71.38(m)(2) states that the failure of a plan to comply with the requirements of a fast, fair and cost-effective dispute resolution mechanism shall be a basis for disciplinary action against the plan.

The Department's examination found that the Plan failed to comply with the requirements of a fast, fair and cost-effective resolution mechanism for the three month period ended June 30, 2016, as summarized below:

1. UNTIMELY PAYMENT ON PROVIDER DISPUTES – *Repeat Deficiency*

Rule 1300.71.38(g) states that if a provider dispute or amended provider dispute involves a claim and is determined in whole or in part in favor of the provider, the plan shall pay any outstanding monies determined to be due, and all interest and penalties required under Sections 1371 and 1371.35 and Rule 1300.71, within five (5) working days of the issuance of the written determination.

The Department's examination disclosed that the Plan failed to pay additional amounts due to providers within five (5) working days from the determination letter date in 18 out of 50 provider disputes reviewed (a compliance rate of 64 percent). This deficiency was noted in provider dispute samples: PDR-4, PDR-5, PDR-6, PDR-8, PDR-14, PDR-22, PDR-23, PDR-27, PDR-31, PDR-37, PDR-43, PDR-44, PDR-45, PDR-46, PDR-47, PDR-48, PDR-49, and PDR-50.

The Plan's failure to timely pay additional amounts due to providers resulting from provider disputes is a repeat deficiency, as this issue was previously noted in the Department's Final Report of examination dated September 15, 2014, for the three months period ended January 31, 2014. This examination disclosed that the Plan's compliance efforts in response to the prior examination report have not achieved the necessary levels of compliance with the Regulation cited.

The Plan was required to explain why the corrective actions implemented by the Plan to resolve the deficiency found in the Department's prior examination were not effective for ensuring ongoing compliance.

In addition, the Plan was required to submit a Corrective Action Plan (CAP) to bring the Plan into compliance with the above Rule, and to include the following:

- a. Training procedures to ensure that claim processors are properly trained on the requirement that additional payments resulted from a provider dispute are issued within five (5) working days of the determination letter.
- b. Audit procedures to ensure that payments on provider disputes determined in favor of the provider are issued timely, in compliance with Rule 1300.71.38(g).
- c. The date of training and implementation of the audit procedures, and the management position(s) responsible for ensuring ongoing compliance.

PLAN'S RESPONSE

The Plan indicated that the previous corrective action implemented by the plan stood on the date of the Remittance Advice (RA), not the date of the check, resulting in Dispute Resolution Letters sent outside of the five day turn-

around time of the corresponding payment. All Dispute Resolution letters are placed in an auto-queue, released and dated each Tuesday to ensure they are mailed out within five days of the corresponding payment made on Friday.

The Plan provided the following response for each of the cited deficiencies:

- a. The Plan submitted a Claim Training Procedures with its response to the Preliminary report. Processors were aware that the Dispute Resolution Letter is to be sent within five days of the corresponding payment; however, they were making the determination based on the RA date and not the check date.*
- b. The Plan submitted a Claim Auditing Process Policy with its response to the Preliminary Report. The queue is auto-released every Tuesday. The Plan receives two weekly reports with the letter print date for verification. The first report would be used by auditing to verify that all overturned claims produced a letter and the second report is used by the Plan's Analyst II Supervisor to verify that all letters and checks were sent within five days.*
- c. The Plan also indicated that this process was tested and implemented on October 18, 2016. Audit verification began weekly starting October 25, 2016. The Plan also stated that management positions responsible for ensuring ongoing compliance are the Claims II Supervisor, and the Claims Director.*

The Department finds that the Plan's compliance effort is responsive to the corrective action required. Therefore, no further response is required.

B. OTHER COMPLIANCE ISSUES

1. MANAGEMENT CHANGES

Section 1352(c) and Rule 1300.52.2 set forth the requirements that a plan shall, within five (5) days, give written notice to the director in the form as by rule may be prescribed, of a change in the officers, directors, partners, controlling shareholders, principal creditors, or persons occupying similar positions or performing similar functions, of the plan and of a management company of the plan, and of a parent company of the plan or management company. The Director may by rule define the positions, duties, and relationships which are referred to in this subdivision.

The Department's examination found that the Plan did not notify the Department of the following changes in key personnel within the five (5) day requirement:

Name-Title	Action	Effective Date	Date of Filing	Days Late
Gentry Vu-Commissioner	Resigned	01/16/2016	04/18/2016	58
Moses Zapien-Commissioner	Appointed	02/09/2016	02/19/2016	2
Mohsen Saadat-Commissioner	Resigned	02/09/2016	02/19/2016	2
Carlos Vilapudua-Commissioner	Appointed	02/09/2016	02/19/2016	2
Michelle D. Tetreault-CFO	Appointed	06/01/2015	07/01/2015	17
Jennifer Dinwoodie-COO	Appointed	06/01/2015	07/01/2015	17
Steve Bestolarides-Commissioner	Resigned	08/26/2015	07/01/2015	34
John Zeiter-Commissioner	Appointed	04/07/2016	04/28/2016	10
Kathy Miller - Commissioner	Appointed	02/25/2015	03/10/2015	4
Christopher Rose - Commissioner	Resigned	09/01/2015	09/11/2015	2
Rod Kawano-Commissioner	Appointed	09/01/2015	09/11/2015	2

The Plan was required to state the policies and procedures implemented to ensure that any changes in personnel are filed within five (5) working days as required by Section 1352(c). The Plan is also required to state the date of implementation, and the management position(s) responsible for ensuring continued compliance with the Section stated above.

PLAN'S RESPONSE

The Plan submitted a policy and procedure for Board of Directors/Executive Management Changes that was implemented in August 2015 and amended in May 2016 with its responses to the Preliminary Report. The Plan stated that the Compliance Officer is responsible for ensuring continued compliance with the Section stated above.

The Department finds that the Plan's compliance effort is responsive to the corrective action required. Therefore, no further response is required.

2. AMENDMENT/MATERIAL MODIFICATIONS

Section 1352(a) and Rule 1300.52 require all plans to file an amendment with the director within thirty (30) days after any changes in the information contained in its application, other than financial or statistical information. Section 1352(b) and Rule 1300.52.1 requires all plans to file material changes to the plan's operations as a Notice of Material Modification to be filed twenty (20) days prior to any changes being implemented. Rule 1300.52.4 sets forth standards for amendment and notices of material modification filings.

The Department's examination disclosed that the Plan did not comply with the above Sections and Rules. There were a number of contracts between the Plan and Administrative, Claims, and other services vendors that were not filed with the Department. The Plan has previously informed and provided the Department with a list of contracts that have not yet been filed and the Plan is working with the Department's Office of Plan Licensing (OPL) to gradually file these contracts.

The Plan was required to submit a matrix showing the timeline of the proposed filings of the Plan's Administrative, Claims, and other services contracts with vendors in its response to the Preliminary Report.

The Plan was also required to state the policies and procedures implemented to ensure that amendments to the Plan's application are timely filed with the Department, the date of implementation, and the management position(s) responsible for ensuring continued compliance with the Sections and Rules stated above.

PLAN'S RESPONSE

The Plan indicated that its Compliance Officer worked with the Office of Plan Licensing at the Department to create a matrix showing the timeline of the proposed filings of the Plan's Administrative, Claims, and other services contracts with vendors. The Plan submitted policy CMP22 Compliance with Applicable Laws and Regulations in its response to the Preliminary Report. This policy was implemented in April 01, 2016 to ensure timely filings with the Department. The Plan's Compliance Officer is responsible for ensuring compliance with these policies.

The Department finds that the Plan's compliance effort is responsive to the corrective action required. Therefore, no further response is required.

SECTION IV. INTERNAL CONTROL

Sections 1384, 1345(s), and Rule 1300.45(q) include requirements for filing financial statements in accordance with generally accepted accounting principles (GAAP) and other authoritative pronouncements for the accounting profession.

Statement on Auditing Standards (SAS) No. 78 states, "Internal control is a process---effected by an entity's board of directors, management, and other personnel---designed to provide reasonable assurance regarding the achievement of objectives in the following categories: (a) reliability of financial reporting, (b) effectiveness and efficiency of operations, and (c) compliance with applicable laws and regulations."

SAS 115 requires an auditor to communicate reportable conditions noted during the examination to appropriate personnel. Reportable conditions involve matters coming to the auditor's attention relating to significant deficiencies in the design or operation of the internal control structure, which could adversely affect the organization's ability to record, process, summarize, and report financial data consistent with the assertions of management in the financial statements.

Rule 1300.67.3(a)(3) requires a licensed health care service plan to have written procedures for the conduct of the business of the plan so as to provide effective controls.

The Department's examination disclosed the following weaknesses in internal controls:

STALE DATED CHECKS

The Plan's "Outlawed Warrants Policy and Procedures" stated that pursuant to "Government Code Section 29802, any warrant issued is void if not presented for payment within six months after its date. After six months, the warrant/check is no longer valid for payment by a bank. It is stale-dated and "outlawed." The Department's examination disclosed that the Plan did not follow its policy and procedures for stale-dated checks as follows:

- a. There were 244 checks in the HPSJ account that were more than 180 days old totaling \$277,180.28.
- b. There were 60 checks in the SJTPA account that were more than 180 days old totaling \$15,068.90.
- c. There were also two checks in LIPH account that were more than 180 days old totaling \$241.50.

The Plan should have voided these checks and created a specific liability account for them.

The Plan was required to state the policies and procedures implemented to resolve the above deficiency, the date of implementation, the management position(s) responsible for compliance, and the controls implemented for monitoring continued compliance.

PLAN'S RESPONSE

The Plan submitted a Desk Procedure of Stale Dated Checks with its response to the Preliminary Report. The Plan stated that the policy and procedure have been

created for finance staff to follow for voiding stale-dated checks. The policy and procedure are effective on November 10, 2016 and the Plan's Controller is to ensure future compliance.

The Department finds that the Plan's compliance effort is responsive to the corrective action required. Therefore, no further response is required.

SECTION V. NON-ROUTINE EXAMINATION

The Plan is advised that the Department may conduct a non-routine examination, in accordance with Rule 1300.82.1, to verify representations made to the Department by the Plan in response to this Report. The cost of such examination will be charged to the Plan in accordance with Section 1382 (b).

No response was required to this Section.