CHAPTER 5: Participant Records and Information

Policy:

Participant information is to be treated confidentially. Site administration must provide orientation and annual training to all staff regarding the responsibilities and the expectations of protecting the confidentiality of participant information. The program guidelines provided regarding participant records and information must be followed by all MSSP sites.

Purpose:

This chapter specifies minimum standards for the handling of participant information and records.

References:

- Information Practices Act of 1977 (Calif. Civil Code, 1798 et seq).
- Health Insurance Portability and Accountability Act (HIPAA) of 1996, Public Law 104-191.
- California Welfare and Institutions Code, Section 10850.
- Home- and Community-Based Services Waiver #0141.R04.00.
- CDA Standard Agreement (Site contract).

5.000 In Practice, MSSP Site Staff:

- Will not use any identifiable information concerning a participant for any purpose other than carrying out care management responsibilities or statutory obligations.
- Will not disclose any information to any party other than CDA, DHCS or CMS without prior written authorization from the participant.
- Will, at the expiration or termination of the program contract with CDA, return all such information to CDA, or maintain or destroy such information according to written procedures established by CDA.

5.100 Health Insurance Portability and Accountability Act (HIPPA) of 1996

The Health Insurance Portability and Accountability Act (HIPAA) of 1996 was enacted to achieve two goals: ensuring portability of health insurance coverage, and administrative simplification of electronic health care transactions. Because MSSP sites submit electronic billing transactions of information that is protected health under HIPAA, the sites are considered to be “covered entities” under HIPAA.

CDA, on the other hand, is considered to be a “health oversight agency” due to its monitoring role in an administrative oversight capacity; CDA is also a

"business associate" of MSSP sites. Sites are urged to seek out information regarding their obligations and responsibilities as covered entities.

5.110 HIPPA Privacy Rule

The HIPAA Privacy Rule is published in the Federal Register, Volume 65, Number 250, December 28, 2000. The purpose of the HIPAA Privacy Rule is two-fold: 1) It gives individuals the right to gain access to their own medical records, and 2) it gives individuals greater control over how their protected health information (PHI) can be shared and used. PHI includes information that relates to the past, present, or future physical or mental health of an individual; the provision of health care to an individual; or the past, present or future payment for the provision of health care to an individual. PHI is individually identifiable. HIPAA also requires that the smallest amount of PHI that is needed to respond to a request for PHI is accessed.

MSSP sites are required to do all of the following under HIPAA:

- Designate a HIPAA Privacy Officer.
- Document privacy policies and procedures.
- Train the site workforce and maintain compliance with annual refresher training.
- Establish safeguards for PHI (whether paper documents, verbal conversations, or electronic transmission and storage).
- Provide a process for filing a complaint.

DHCS distributes a Notice of Privacy Practices to all Medi-Cal recipients explaining individual rights and how PHI will be used and disclosed in Medi-Cal programs. In addition, the sites must also inform participants that as participants in MSSP they have the right to:

- Receive a notice of site privacy practices.
- Privacy of their PHI.
- Inspect or obtain copies of their PHI.
- Request limits on who sees their PHI.
- Take back permission to use or disclose their PHI.
- Know who sees their PHI.
- Request amendments to their PHI.
- File a complaint.
- No retaliation.

5.120 HIPPA Security Rule

Where the Privacy Rule applies to PHI in any form, the Security Rule applies to PHI in electronic form. It is published in the Federal Register, Volume 68, Number 34, February 20, 2003. In general, the Security Rule requires that a covered entity (i.e., MSSP site) shall do all of the following:

- Ensure the confidentiality, integrity, and availability of all electronic PHI the entity creates, receives, maintains, or transmits.
- Protect against any reasonably anticipated threats or hazards to the security or integrity of such information.
- Protect against any reasonably anticipated uses or disclosures of such information.
- Ensure compliance with the Security Rule by the entity's workforce.

The Security Rule also specifies certain administrative, physical and technical safeguards to be implemented; that organizational requirements (e.g., business associate contracts) are met; and that policies and procedures comply with the Rule and are documented.

Under the Security Rule, sites are to develop a contingency plan for responding to system emergencies. The purpose of the contingency plan is to protect the availability, integrity and security of data during unexpected negative events. This plan will include, at a minimum, the following: an application(s) and data criticality analysis, a data backup plan, a disaster recovery plan, an emergency mode operation plan, and testing and revision procedures.

5.200 Security

In addition to security of electronic PHI data covered by HIPAA (see above), each MSSP site is responsible for the security and confidentiality of all information collected on each of its participants. This includes hard copy and any other medium of storage or recording participant information. All participant records are to be maintained in secured files. Participant-specific data transmitted electronically between sites and CDA will be transmitted **only** through the Secure File Transfer (SFT) site.

Sites will establish and implement policies and procedures to ensure resto-ration/recovery of any loss of client files and/or electronic data in the event of fire, vandalism, natural disaster, or system failure. Specifically, sites will develop a contingency plan for all client information, regardless of format, to protect the availability, integrity and security of participant information during disasters and other unexpected negative events.

5.300 Maintenance and Storage

All information, records, data elements, and print-outs collected and maintained for the operation of MSSP and pertaining to participants must be protected from unauthorized disclosure in accordance with the following:

- CDA site contract.
- California Welfare and Institutions Code, Section 10850.
- California Information Practices Act of 1977.

- Health Insurance Portability and Accountability Act (HIPAA).

Participant records must be accurately written, promptly completed, properly filed and retained, and accessible. Participant records are to be kept as long as the case is open and active. Following termination, participant records will be maintained for a period of seven years. A longer period of retention may be established by individual sites.

To facilitate storage, vendor records may be stored electronically. In addition, terminated participant records may be stored electronically following two years of termination. The site bears the responsibility to produce the records in paper format upon request.

5.400 Access to Minimum Necessary Information

Site staff must assure that only information needed by MSSP staff and those agencies directly serving participants is shared, and that unrelated oral or written information remains confidential. Individuals/agencies most likely to need information about participants include informal support persons, physicians, service providers, and consultants working with MSSP care management staff.

CDA staff, DHCS staff, fiscal or audit staff, and MIS contractor staff shall be permitted access to care management information for program development, monitoring and auditing purposes.

Participants (or their authorized representatives) shall be permitted access to their own case records. While site staff is not obligated to provide free copies of any and all information about participants, it is suggested that information be made accessible to the maximum extent possible. Any fees charged by a site for copying these documents shall be based on prevailing rates, as determined by a survey of local businesses providing this service. Exceptions include information received from third party sources (psychological reports, physical examination reports, etc.) that should not be released without the knowledge and permission of the originating source.

Site Director approval is required for all requests for release of participant information coming from outside agencies or individuals not directly involved in serving the participants (courts, family members), to ensure that the requested data are adequately defined and that the intended use meets requirements for release. The participant's name and other identifying or personal information must be deleted from documents made available to the public.

5.500 Authority to Inspect Medi-Cal Provider Records

MSSP is delegated the authority to examine books and records pertaining to services rendered to Medi-Cal beneficiaries. Welfare and Institutions Code Article 3, Administration, Section 14124.2 originally grants this authority to the Department of Health Care Services. The delegation of this authority is conditional on the understanding that in exercising it, MSSP will comply with the limitations on disclosure of such information and that this authority will be executed in the following situations:

1. Examination of medical records of Medi-Cal beneficiaries who are MSSP participants residing in nursing facilities who have executed the MSSP Application form and the MSSP Authorization for Use and Disclosure of Protected Health Information form (Appendix 14).

2. Examination of records and charts of Medi-Cal beneficiaries who are patients in acute care hospitals and are not yet MSSP participants, for purposes of determining eligibility for MSSP and the patient's need for MSSP services

3. Examination of records of Medi-Cal beneficiaries, not yet MSSP participants, who are patients in an acute care hospital and who have been authorized placement in a nursing facility but are still on a waiting list, for purposes of determining eligibility and needs for MSSP services.

5.600 Case Recording Practices

The participant case record consists of essential documents accessed by all care management staff. These records enable the care management staff to meet the changing needs of participants.

The documentation in the case record verifies the following:

- applicant's choice to participate in MSSP;
- the level of care certification confirming medical eligibility for placement in a nursing facility;
- the necessity and appropriateness of MSSP services, including the need for care management;
- the care plan;
- monitoring and follow up of services and the effectiveness of the interventions. The record must detail all MSSP interventions from the point of the application process to the participant's termination.

Entries in a language other than English must be translated into English. Translation is not required for standardized casework forms (Application forms, State Hearing Notice, Request for a State Hearing Form, Client Rights in MSSP, and Authorization for Use/Disclosure of Information). Other forms

(Care Plan, Notices of Action, and Negotiated Risk Agreement) that contain individualized information written in another language must be translated into English. Correspondence written in a language other than English must be addressed in the record. It may be either: 1) translated in its entirety, or 2) summarized in the progress notes.

The decision to translate or summarize is made by the care management staff. The intent is to provide any reader of the record access to its contents, ranging from staff responding to client needs in the absence of the assigned care manager to supervisory and administrative review activities.

All entries must be legible and complete, and must be authenticated and dated promptly by the person (identified by name and professional initials or title) who created the entry. The case record and its contents constitute a formal legal document, subject to subpoena and judicial review. It should be documented in the record when/if it has been photo-copied.

5.610 Electronic Record Keeping

Sites have the option of maintaining electronic records to supplement the hard copy system; however, electronic files do not supplant or take the place of hard copy documents at this time. Sites that employ electronic record keeping must be able to provide hard copy participant files upon request.

Electronic versions of case documents and recording must be regularly and securely backed-up, and printed out as required for care management at the site level or at the request of CDA. Processes and procedures that ensure the ability to generate accurate and complete copies of records in both printed and electronic form must be in place.

Sites that use an electronic system for casework and record keeping must ensure the safety and integrity of those records. The system must ensure that once a record is input, it is unalterable.
Sites must also develop and implement policies and procedures to include safeguards for confidentiality and unauthorized access, authentication by electronic signature keys, and system maintenance.

Specifically, for electronic signatures, the system must:

1. Identify the signatory individual, including the date when the signature was executed, and the meaning associated with the signature (review, approval, responsibility, authorship, and authentication).

2. Assure the integrity of a document's content, including any actions taken to create, modify, or strike out an electronic entry.

3. Provide for non-repudiation (strong and substantial evidence that will make it difficult for the signer to claim that the electronic representation is not valid).

Each of these features must be readable/viewable as part of the electronic record or printed form of the electronic record.

MSSP providers interested in a partial or full conversion to electronic records, **must** submit a written proposal to CDA MSSP Branch. The proposal must address how the partial/full conversion to electronic records will ensure that all program and waiver requirements are met. The proposal should be submitted to the MSSP Service mail box at: MSSPService@aging.ca.gov.

The written proposal must identify if the MSSP Provider is seeking a partial or full conversion to electronic records and include the following:

- A description of how a printable version of the electronic record is accessed, if necessary.
- An explanation of how electronic signatures align with current MSSP requirements as defined in this section.
- A description of the MSSP Provider's security and back-up system for electronic records and how the back-up system ensures the safety, integrity, and security of the electronic record as defined in this section.
- An explanation of how the care management software ensures that document alteration or corruption does not occur, while allowing for appropriate corrections.
- A description of how the care management security system maintains the desired document integrity and allows "permissions" by user groups for document access.

For MSSP sites seeking a partial conversion, the proposal must also identify which of the following required forms will be converted to an electronic format:

- Application for MSSP
- Level of Care certification (LOC)
- Initial Health Assessment
- Initial Psychosocial Assessment
- Reassessment

- Authorization for Use and Disclosure of Protected Health Information (AUDPHI)
- Care Plan
- Progress Notes
- Service Planning and Utilization Summary (SPUS)

5.700 Corrections

The participant record is required to be complete, timely, accurate, and legible. Clean corrections preserve the accuracy of the participant's record and protect staff. In order to avoid legal problems, the following methods for changing information in a participant's record should be employed:

a. Draw one line through any incorrect information, without obscuring it. Initial and date.

b. If you have used the wrong record, draw a line through the entry and write "wrong record" and initial.

c. If you have written the wrong information, add the correct information. If all your comments are legible, you do not have to write the reason for your change.

d. If you have misspelled a word, spell it correctly. You do not need to add the date and your initials if you discover the misspelling right away.

e. If you omitted information, record it when you remember it. Mark the addition "late entry." Never try to squeeze additional information into the original entry.

f. Do not change another person's error.

g. Do not compound your error by correcting an error improperly. When you correct it, make sure that both the incorrect and correct information are readable and that the reason for the change is obvious.

If a participant has filed a fair hearing appeal or an appeal is pending, do not make a correction in the participant's record. You may, however, make your own record of what the correct changes should be in the event you are questioned about the error. Do not be pressured into changing the error.

5.800 Case Documents

The participant case record must include, (but not be limited to), the following, listed in the order of completion:

1. Screening Form.

2. Application Form.*

3. MSSP Authorization for Use and Disclosure of Protected Health Information.*

4. Client Enrollment/Termination Information Form.*

5. Level of Care Certification/Recertification Form (LOC).*

6. Initial Health Assessment* and Initial Psychosocial Assessment*, and Reassessments.*

7. Care Plan* and Service Planning and Utilization Summary (SPUS).* The SPUS may be kept in the case record or centrally filed.

8. Client progress notes and other participant-related information (correspondence, medical/psychological/social records).

9. Denial or Termination Letters.* In preparing the Denial or Termination Letter, the care manager should select only the appropriate reason for the action and should delete the remaining options.

*CDA-mandated forms are identified with an asterisk (*) and may be reproduced on the site's letterhead. The information contained in these forms may not be altered without CDA approval.

5.810 Staff Signatures and Signature Requirements

All required documents contained in the case record must be complete, including name and signature of the person responsible for the completion of the form.

Whenever there is a signature required in the case record it must be written (not printed) in ink and include the following:

- The individual's full name or first initial and full last name.
- The person's professional initials: RN (Registered Nurse), or the MSSP job classification title: SWCM for social work care manager or

NCM for nurse care manager. Other agency staff must also use their appropriate agency job title.
- The date the document was signed.

The documents listed below require staff signatures. Some forms also require participant signature and/or supervisory sign-off.

Screen/Intake Form - MSSP staff person.

Application - MSSP staff person and participant. If the participant is unable to sign for themselves, the following individuals may sign for them:

1. Conservator. This is a person appointed by a court.

2. Agent. This is a person named as the participant's power of attorney for health care and/or other legal documents.

3. Personal representative. This is an adult designated by the participant, either in writing or orally, in the presence of an MSSP care manager. This permission must be documented in the case record on the Application, in the re/assessment, or in the Progress Notes

Level of Care Certification/Recertification Form – Nurse care manager.

Health Assessment – Nurse care manager.

Health Assessment Summary – Nurse care manager.

Psychosocial Assessment - Social work care manager.

Psychosocial Assessment Summary - Social work care manager.

Reassessment – Nurse or social work care manager.

Reassessment Summary – Nurse or social work care manager.

Care Plan - Primary care manager (SWCM or NCM), supervising care manager (SCM), and the participant. If the participant is unable to sign for themselves, the following individuals may sign for them:

1. Conservator. This is a person appointed by a court.

2. Agent. This is a person named as the participant's power of attorney for health care and/or other legal documents.

3. Personal representative. This is an adult designated by the participant, either in writing or orally, in the presence of an MSSP care manager. This permission must be documented in the case record on the Care Plan, re/assessment, or in the Progress Notes.

SPUS – Primary care manager signs the final SPUS each month. If the client's tracked costs are more than 95% but less than 120% of the site's benchmark, the SCM must also sign; if costs exceed 120%, the Site Director must sign as well.

Progress Note(s) - Each entry must be signed by the responsible MSSP staff person. Entries by a student intern must be cosigned by the SCM.

Termination/Denial Letter (Notice of Action) - Site Director, SCM or designee. The information contained in the termination and denial letters may be reproduced on the site's letterhead. Of the choices given for denial or termination, the care manager should select only the appropriate reason and delete the remaining options.

5.820 Timing Intervals Required For Case Recording

Several elements of case recording and documentation must occur at prescribed intervals. The following are the minimum requirements for case recording elements:

- Enrollment: completed within 30 days of the application for MSSP.

- Enrollment occurs after the client has completed and signed the Application, and the Nurse Care Manager has completed the initial Level of Care certification.

- Level of Care Certification: completed prior to or upon enrollment to MSSP confirming program eligibility.

- Level of Care Recertification: completed, at a minimum, every twelfth month using the date of the last LOC as the due by date. **In no instance may an LOC exceed 365 days from the previous LOC.**

- Initial Assessments (health and psychosocial): either of the assessments must be completed within two weeks of enrollment, with the second assessment occurring within the next two weeks. They may be completed concurrently.

- Reassessment: completed annually, based on the month of enrollment (one month grace period either way). If the LOC is part of the reassessment process, the reassessment date must comply with the LOC timelines cited above.

- Care Plan: completed within two weeks of the re/assessment.

- Quarterly Face-to-Face Home Visit: completed quarterly at three month intervals.

- Monthly Contact: completed monthly.

- Alternate Discipline Visits: completed annually not to exceed 12 month intervals. If however, it is the site's practice to complete the alternate discipline visit concurrently with the Reassessment, the 13 month grace period is allowed.

The above represents the minimum amount of care management activities required for program compliance. A MSSP site may have internal practices that exceed the above.

If these minimum time frames cannot be met, the reason for any delay must be documented in the progress notes. Shortage of staff is not an acceptable reason for delay.