MEDICAL REVIEW – SOUTHERN SECTION III
AUDITS AND INVESTIGATIONS
DEPARTMENT OF HEALTH CARE SERVICES

CenCal Health

Contract Number: 08-85212

Audit Period: October 1, 2015 through September 30, 2016

Report Issued: March 6, 2017

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I. INTRODUCTION

CenCal Health, formerly known as Santa Barbara Regional Health Authority, was established on September 1, 1983 and assumed responsibility for the Medi-Cal program in Santa Barbara County (known as the Santa Barbara Health Initiative or SBHI) as the first state-contracted County Organized Health System (COHS). In March 2008, San Luis Obispo County became part of CenCal's service area of the managed care Medi-Cal program, (San Luis Obispo Health Initiative or SLOHI).

CenCal Health provides managed care health services to Medi-Cal beneficiaries under the provision of Welfare and Institutions Code, Section 14499.5. CenCal Health is a public entity that is governed by a 13-member Board of Directors appointed by the Santa Barbara and San Luis Obispo County Board of Supervisors. Its Board of Directors is composed of local government, physicians, hospital, member, and other health care provider and business representatives.

CenCal Health's program, Healthy Kids Santa Barbara began in 2005 and was funded with both private and public funds. The Santa Barbara Healthy Kids program ended on June 30, 2016. In the Access for Infants and Mothers (AIM) program, mothers are eligible during their pregnancy and 60 days after delivery. Newborns are covered by the Medi-Cal Program. The AIM program ended September 30, 2016. Current members will be terminated after their postpartum period has ended. Effective July 2017, CenCal Health will no longer have any AIM members enrolled.

As of October 1, 2016, CenCal Health's enrollment for Medi-Cal and AIM was approximately 179,666 members in Santa Barbara and San Luis Obispo counties. Enrollment by product line was as follows:

- Medi-Cal Members: 179,616
- AIM: 50

II. EXECUTIVE SUMMARY

This report presents the results of the Department of Health Care Services (DHCS) medical audit for the period of October 1, 2015 through September 30, 2016. The on-site review was conducted from October 18, 2016 through October 20, 2016. The audit consisted of document review, verification studies, and interviews with Plan personnel.

An exit conference was offered to the Plan on March 3, 2017. The Plan declined to hold an exit conference since there were no areas of noncompliance found in this review.

The prior DHCS medical audit issued April 25, 2016 (for the audit period of October 1, 2014 through September 30, 2015) identified deficiencies, which were addressed in a *corrective action plan* (CAP). The CAP closeout letter dated August 19, 2016 noted that all previous findings were closed.

The audit confirmed that the Plan revised its policies and procedures and implemented the CAP recommendations. As a result, there were no deficiencies noted in any of the categories reviewed.

The following section presents categories that had deficiencies in the previous audit and what the Plan has implemented to resolve those deficiencies.

Category 1 – Utilization Management

The Plan complies with prior authorization review requirements to ensure that a qualified physician or pharmacist reviews all denials that are made, whole or in part, on the basis of medical necessity. In addition, the Plan's policies and procedures establish an appeal process to ensure that the person making the final decision has not participated in any prior decision.

In the prior year medical review, Notice of Action (NOA) letters did not have an electronic signature of the pharmacist who made the decision to deny the medication and NOA letters were not always sent. Appeal files did not routinely contain the signature of the pharmacist who initially reviewed the prior authorization. According to the Plan, they were aware of the issue and were in the process of issuing a corrective action to the Pharmacy Benefits Manager (PBM), MedImpact.

The Plan implemented a weekly NOA letter review to confirm the presence of clinical level signatures and compliance with member notification requirements. Furthermore, the Plan issued a corrective action to the Plan's PBM, to ensure information about the individuals making decisions is consistently documented.

A verification study of prior authorization files shows evidence the Plan clearly and consistently documents the pharmacist reviewer's name and credentials in compliance with contract requirements. Notice of Action Letters were sent to the member and provider and properly identified the pharmacist reviewer. Appeals documentation confirms they are handled by a different reviewer as required by Contract.

Category 2 – Case Management and Coordination of Care

The prior audit found that the Plan monitored Initial Health Assessment (IHA) timeliness through encounter claims data. However, the Plan did not conduct a medical record review to validate whether the claims data correlated with documentation requirements of a comprehensive IHA. The Plan also failed to ensure IHA documentation met requirements.

In order to bring the deficiencies into compliance, the Plan enhanced its methodology to track and monitor IHAs. Along with encounter claims data, the Plan utilized a newly developed *IHA Assessment Review Tool* to validate whether encounter claims data correlate with documentation requirements of a comprehensive IHA. IHA compliance monitoring and reporting frequency was increased from bi-annual to quarterly. Reports generated were given to providers for their review and for quality improvement. The Plan provided ongoing education for all providers and additional training for those with low performance scores in IHA compliance. A provider incentive program was launched by the Plan and the "Members Due for IHA" reports are sent monthly to providers to improve IHA timeliness and member appointment scheduling.

The Plan also developed an IHA Focused Medical Record Review to address IHA documentation requirements. The review was performed in July 2016 and a sample of 90 medical records from eight primary care providers were examined. The Plan reviewed whether the four major components (Comprehensive History, Physical Exam, Preventive Services, Screening Assessments) of a comprehensive IHA were present in the medical records.

The Plan's overall efforts to meet IHA contract requirements is determined to be adequate at this time and will be examined in future audits to evaluate the Plan's operational systems.

Category 3 – Access and Availability of Care

There were no deficiencies noted in the review of this category.

Category 4 – Member's Rights

There were no deficiencies noted in the review of this category.

Category 5 – Quality Management

There were no deficiencies noted in the review of this category.

Category 6 – Administrative and Organizational Capacity

There were no deficiencies noted in the review of this category.

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 Management, and Administrative and Organizational Capacity.

The Medical Review Branch performed an audit of the Plan to determine whether the health plan provides quality health care services, the effectiveness of peer review, utilization control mechanisms, and the overall performance of the health plan in providing health care benefits to its enrollees.

These audits assist the department with its overall monitoring effort and identify areas of deficiency which form the basis for corrective actions.

PROCEDURE

The on-site review was conducted from October 18, 2015 through October 20, 2016. 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 those 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 and 20 pharmacy prior authorization requests were reviewed for timeliness, consistent application of criteria, appropriate review, and communication of results to members and providers.

Appeal Procedures: 20 prior authorization appeals were reviewed for appropriate and timely adjudication.

Category 2 – Case Management and Coordination of Care

Complex Case Management: 5 medical records were reviewed for evidence of coordination of care between the Plan and providers.

California Children's Services (CCS): 5 medical records were reviewed for evidence of coordination of care between the Plan and CCS providers.

Initial Health Assessment: 18 medical records were reviewed for completeness and timeliness.

Category 3 – Access and Availability of Care

Appointment Availability: 13 providers from the Plan's Provider Network were reviewed. The third next available appointment was used to measure access to care.

Emergency Services and Family Planning Claims: 5 emergency service claims and 5 family planning claims were reviewed for appropriate and timely adjudication.

Category 4 – Member's Rights

Grievance Procedures: 25 grievances were reviewed for timely resolution, response to complainant, and submission to the appropriate level of review.

MEDICAL REVIEW – SOUTHERN SECTION III
AUDITS AND INVESTIGATIONS
DEPARTMENT OF HEALTH CARE SERVICES

CenCal Health

Contract Number: 08-85219
State Supported Services

Audit Period: October 1, 2015 through September 30, 2016

Report Issued: March 6, 2017

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I. INTRODUCTION

This report presents the audit findings of CenCal Health State Supported Services Contract No. 08-85219. The State Supported Services contract covers contracted abortion services with CenCal Health.

The on-site audit was conducted from October 18, 2016 through October 20, 2016. The audit period is October 1, 2015 through September 30, 2016 and consisted of document review of materials supplied by the Plan and interviews conducted on-site.

❖ COMPLIANCE AUDIT FINDINGS (CAF) ❖

PLAN: CenCal Health

AUDIT PERIOD: October 1, 2015 through Sept. 31, 2016

DATE OF AUDIT: October 18 through October 20, 2016

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:

The Plan's Policy 800-2006-A, *State Supported Services/Pregnancy Termination/Abortion*, states that members of Santa Barbara Health Initiative and San Luis Obispo Health Initiative (CenCal Health) may obtain abortion services from contracted and non-contracted providers without medical justification or prior authorization.

Abortion services are classified as sensitive services, in which minors under the age of 18 may access these services without parental consent. Inpatient hospitalization for the performance of an abortion requires prior authorization in accordance to *California Code of Regulations* [CCR], Title 22, Section 51327.

The Plan covers both surgical abortions Current Procedural Terminology CPT-4 codes 59840 through 59857; Healthcare Common Procedure Coding (HCPCS) codes A4649-U1(X1516) and A4649-U2 (X1518); and medical abortions HCPCS codes S0199 (Z0336), S0190 Mifepristone 200 mg RU-486 (X7724) and S0191 Misoprostol 200 mcg (X7726).

Providers are informed about abortion services on the Plan's website. The Plan informs members about their rights to access "sensitive services" through the Member Handbook which includes abortion (ending pregnancy) services and counseling. Members can access this information on the website or call the Plan's Member Services Department for further assistance.

The Plan's claims payment system contains all of the required pregnancy termination billing codes and the claims are automatically adjudicated in the Plan's system without prior authorization.

The Plan is in compliance with contractual requirements.