

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

CenCal Health

Contract Number: 08-85212

Audit Period: October 1, 2014
Through
September 30, 2015

Report Issued: April 25, 2016

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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 is funded with both private and public funds. 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.

As of October 1, 2015, CenCal Health's enrollment for Medi-Cal, Healthy Kids, and AIM was approximately 169,512 members in Santa Barbara and San Luis Obispo counties. Enrollment by product line was as follows:

- Medi-Cal Members: 168,718
- Healthy Kids: 773
- AIM: 21

II. EXECUTIVE SUMMARY

This report presents the audit findings of the Department of Health Care Services (DHCS) medical audit for the period of October 1, 2014 through September 30, 2015. The on-site review was conducted from October 20, 2015 through October 30, 2015. The audit consisted of document review, verification studies, and interviews with Plan personnel.

An exit conference was held on March 17, 2016 with the Plan. The Plan was allowed fifteen (15) calendar days from the date of the exit conference to provide supplemental information addressing the draft audit report findings. The Plan submitted supplemental information after the exit conference which is reflected in this report.

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 prior DHCS medical audit (for the period of August 1, 2013 through July 31, 2014, with the on-site review conducted from October 14 through 24, 2014) was issued April 2, 2015. The corrective action plan (CAP) closeout letter dated December 28, 2015 noted that all previous findings were closed. Overall, the Plan revised its policies and procedures and implemented much of the CAP as of this audit. There were findings identified from the prior audit that were not fully addressed in the Plan's CAP which appear in the body of the report.

The summary of the findings by category follows:

Category 1 – Utilization Management

Prior authorization notice of action letters did not always identify the reviewing pharmacist. In a few instances, notices were not sent.

Appeal decisions did not always indicate whether a different reviewer involved in the original decision was involved in the final decision.

Category 2 – Case Management and Coordination of Care

The Plan's methodology to monitor compliance with the Initial Health Assessment (IHA) requirement is inadequate.

Medical record documentation for a complete IHA lacked a comprehensive office visit.

Category 3 – Access and Availability of Care

The Plan's policy lacks the contractual time frame for the initial prenatal appointment of

10 business days upon request.

The Plan insufficiently monitors emergency pharmaceutical services.

Category 4 – Member’s Rights

The Plan was compliant with the requirements in this Category.

Category 5 – Quality Management

The Plan was compliant with the requirements in this Category.

Category 6 – Administrative and Organizational Capacity

The Plan did not establish language for notification requirements of suspended providers in its Anti-Fraud and Abuse Program as contractually required.

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's County Organized Health System Contract.

PROCEDURE

The on-site review was conducted from October 20, 2015 through October 30, 2015. 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

California Children's Services (CCS): 4 medical records were reviewed for evidence of coordination of care between the Plan and CCS providers.

Initial Health Assessment: 30 medical records were reviewed for completeness and timeliness.

Complex Case Management: 4 medical records were reviewed for evidence of coordination of care between the Plan and providers.

Category 3 – Access and Availability of Care

Emergency Services and Family Planning Claims: 20 emergency service claims and 15 family planning claims were reviewed for appropriate and timely adjudication.

Category 4 – Member’s Rights

Grievance Procedures: 40 grievances were reviewed for timely resolution, response to complainant, and submission to the appropriate level of review.

Category 5 – Quality Management

New Provider Training: 8 new provider training records were reviewed for timely Medical Managed Care program training.

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

❖ COMPLIANCE AUDIT FINDINGS ❖

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CATEGORY 1 - UTILIZATION MANAGEMENT

1.2

PRIOR AUTHORIZATION REVIEW REQUIREMENTS

Prior Authorization and Review Procedures:

Contractor shall ensure that its pre-authorization, concurrent review and retrospective review procedures meet the following minimum requirements...

A. Qualified health care professionals supervise review decisions, including service reductions, and a qualified Physician will review all denials that are made, whole or in part, on the basis of medical necessity. For purposes of this provision, a qualified Physician or Contractor's Pharmacist may approve, defer, modify, or deny prior authorizations for pharmaceutical services, provided that such determinations are made under the auspices of and pursuant to criteria established by the Plan medical director ...(as required by Contract).
COHS Contract A.5.2.A, B, C, F, H, I

Exceptions to Prior Authorization:

Prior Authorization requirements are not applied to Emergency Services, Minor Consent Services, family planning services, preventive services, basic prenatal care, sexually transmitted disease services, and HIV testing.

COHS Contract A.5.2.G

Timeframes for Medical Authorization

Pharmaceuticals: 24 hours or one (1) business day on all drugs that require prior authorization in accordance with Welfare and Institutions Code Section 14185(a)(1).

COHS Contract A.5.F

Routine authorizations: five (5) working days from receipt of the information reasonably necessary to render a decision (these are requests for specialty service, cost control purposes, out-of-network not otherwise exempt from prior authorization) in accordance with Health and Safety Code Section 1367.01(h)(1), or any future amendments thereto, but, no longer than 14 calendar days from the receipt of the request. The decision may be deferred and the time limit extended an additional 14 calendar days only where the Member or the Member's provider requests an extension, or the Contractor can provide justification upon request by the State for the need for additional information and how it is in the Member's interest. Any decision delayed beyond the time limits is considered a denial and must be immediately processed as such.

COHS Contract A.5.H

Denial, Deferral, or Modification of Prior Authorization Requests:

Contractor shall notify Members of a decision to deny, defer, or modify requests for Prior Authorization by providing written notification to Members and/or their authorized representative...This notification must be provided as specified in Title 22 CCR Sections 51014.1, 51014.2, 53894, and Health and Safety Code Section 1367.01.

COHS Contract A.13.8.A

SUMMARY OF FINDINGS:

1.2.1 Prior Authorization Review Requirements

The Plan shall ensure that a qualified physician or pharmacist reviews all denials that are made, whole or in part, on the basis of medical necessity. [Contract, Exhibit A, Attachment 5 (2)(A)]

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The Plan did not ensure that Notice of Action (NOA) letters identified a qualified physician or pharmacist who made the decision to deny pharmacy prior authorizations (PAs). The DHCS medical audit included a verification study of 20 pharmacy prior authorizations. Eleven (11) of the NOA letters reviewed did not have an electronic signature of the pharmacist who made the decision to deny the medication. While nine (9) of the NOA letters had electronic signatures, when compared to the Plan's prior authorization log the person identified as the decision maker on the log did not match the signature on the NOA letter. As a result of this missing or inconsistent information the identity of the person making the decision to deny pharmacy prior authorizations could not be confirmed.

The Plan maintained that all denied pharmacy PAs were reviewed by pharmacists. In all 11 instances, the same pharmacist's electronic signature was omitted from the NOA.

During the audit period, the Plan was under contract with MedImpact who is the Pharmacy Benefits Manager (PBM), to process prior authorization requests. The Plan is aware of the issue of unsigned NOA letters and is working to correct the problem with the PBM.

The Plan was not in compliance with 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.

1.2.2 **Notice of Action Letters were not always sent**

The Plan shall notify members of a decision to deny, defer, or modify requests for PA by providing written notification to members and/or their authorized representative. [*Contract, Exhibit A, Attachment 13 (8)(A)*]

The Plan's Policy, *Pre-Service Review (400-1007-D)*, states notification to members regarding service requests denied, deferred or modified are made as specified contractually and that the Plan notifies the requesting provider of any decision to deny, approve, modify, or delay a service authorization request, or to authorize a service in an amount, duration, or scope that is less than requested.

The DHCS medical audit included a verification study of 20 pharmacy prior authorizations. Two (2) of 20 NOA letters reviewed in the pharmacy PA verification study sample were not sent to the member.

The Plan did not follow its policies requiring notification of the decision.

RECOMMENDATIONS:

- 1.2.1 Ensure to identify the reviewing pharmacist on all prior authorizations.
- 1.2.2 Adhere to the Plan's Policy to notify members of a decision.

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1.4

PRIOR AUTHORIZATION APPEAL PROCESS

Appeal Procedures:

There shall be a well-publicized appeals procedure for both providers and Members.
COHS Contract A.5.2.E

Grievance System Oversight:

Plan shall implement and maintain procedures as described below to monitor the Member's Grievance system and the expedited review of grievances required under Title 28 CCR Sections 1300.68 and 1300.68.01 and Title 22 CCR Section 53858.

Procedure to ensure that the person making the final decision for the proposed resolution of a grievance has not participated in any prior decisions related to the grievance,...

COHS Contract A.14.2.G

SUMMARY OF FINDINGS:

1.4.1 Appeal Procedures

The Plan is required to implement and maintain a procedure to ensure that the person making the final decision for the proposed resolution of a grievance has not participated in any prior decisions related to the grievance. [*Contract, Exhibit A, Attachment 14 (2)(G)*]

In the Plan's Policy, *Member Grievance System (Complaints/Appeals)* 300-1000-M, it describes the clinical appeals review process, where a physician reviewer must be different than the physician who reviewed the initial request; however, the appeal files reviewed were inconclusive.

The appeal files do not routinely contain the signature of the pharmacist who initially reviewed the prior authorization; thus, there is no mechanism to determine whether the same physician or pharmacist who reviewed the subsequent appeal also reviewed the original prior authorization request. As explained in 1.2.1 *Prior Authorization Review Requirements*, the Plan is working with the PBM to correct the problem.

Seven (7) of 20 initial Notice of Action (NOA) letters in the appeals verification study sample were unsigned; therefore, the identity of the initial prior authorization reviewer could not be verified. Confirmation could not be made that the appeal process was handled by a different reviewer as required by Contract.

According to the Plan, a separate pharmacist at the Plan's contracted PBM reviewed the initial request. Following the exit conference, the Plan provided documented evidence from their PBM that identifies the person who reviewed the initial requests; which shows a different reviewer than that of the appeal. The Plan has a process in place to ensure that the person making the final decision has not participated in any prior decision. However, the sampled NOA letters do not routinely contain the signature of the initial reviewer.

RECOMMENDATION:

1.4.1 Ensure the identity of the person who reviewed the initial prior authorization is documented in all appeals.

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CATEGORY 2 – CASE MANAGEMENT AND COORDINATION OF CARE

2.4

INITIAL HEALTH ASSESSMENT

Provision of Initial Health Assessment:

Contractor shall cover and ensure the provision of an IHA (complete history and physical examination) in conformance with Title 22 CCR Section 53851 (b)(1) and Section 53910.5(a)(1) to each new Member within 120 days of enrollment.

COHS Contract A.10.3.A

Contractor shall make repeated attempts, if necessary, to contact a Member and schedule an IHA.....(as required by Contract)

COHS Contract A.10.3.E

Provision of IHAs for Members under Age 21:

- 1) For Members under the age of 18 months, Contractor shall ensure the provision of an IHA within 120 calendar days following the date of enrollment or within the most recent periodicity timelines established by the American Academy of Pediatrics (AAP) for ages two (2) and younger, whichever is less.
- 2) For Members 18 months of age and older upon enrollment, Contractor is responsible to ensure an IHA is performed within 120 calendar days of enrollment.

COHS Contract A.10.5

Services for Adults Twenty-One (21) Years of Age and Older:

Contractor shall cover and ensure that an IHA for adult Members is performed within 120 calendar days of enrollment.

COHS Contract A.10.6

SUMMARY OF FINDINGS:

2.4.1 The Plan's methodology is inadequate to ensure that *Initial Health Assessments (IHAs)* for new members are completed within 120 calendar days of enrollment

The Plan is required to ensure the provision of an IHA in conformance with CCR, Title 22, section 53910.5 (a) (1) to each new member within 120 calendar days following the date of enrollment [*Contract, Exhibit A, Attachment 10 (3) (A)*] and to have procedures for monitoring IHA completion (MMCD Policy Letter No. 08-003 Initial Comprehensive Health Assessment).

The Plan's methods for monitoring IHA completion were inadequate. Two methods were used: Facility Site Reviews (FSRs) and an IHA completion rate calculation based on claims data; specifically, Current Procedural Terminology (CPT) codes.

The Plan conducts a FSR every three years to monitor and ensure comprehensive medical assessment and follow-up care is rendered. Retrospective review of IHA completion every three years during the FSRs does not constitute effective monitoring of IHA completion. The other method utilized by the Plan includes review of claims data to determine a compliance rate. The compliance rate is calculated with new member claims data submitted by Primary Care Physicians (PCPs). The rate is determined when a PCP bills a comprehensive preventive medical visit within 120 calendar days of new member enrollment. The Plan maintains a list of CPT codes used to represent an IHA, but there was no testing to ensure claim validity.

The Plan does not conduct a review to validate claims data with the medical record documentation to verify

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if the PCPs are meeting the documentation requirements for a comprehensive preventative assessment.

Without an effective monitoring system the Plan can not verify if the provider completed a comprehensive IHA.

2.4.2 Initial Health Assessment Documentation

The Plan shall cover and ensure the provision of an IHA (complete history and physical examination) in conformance with California Code of Regulations, Title 22 sections 53851 (b)(1) and 53910.5(a)(1) to each new Member within 120 calendar days of enrollment. *[Contract, Exhibit A, Attachment 10 (3) (A)]*

The medical records reviewed did not have sufficient documentation of a complete history and physical examination to reflect a comprehensive office visit. This issue was previously identified as a finding in the prior audit but was not addressed in the plan's corrective action plan (CAP).

The prior audit found that four (4) medical records exceeded the time frame to perform an IHA and two (2) medical records did not establish a comprehensive assessment. As part of its CAP, the Plan was to re-inform its primary care providers of the requirement to complete IHA within 120 days of receipt of Medi-Cal eligibility. In addition, the Plan will offer members and providers incentives to complete the IHA timely. The Plan submitted its outreach communication to its contracted providers reinforcing the requirements of an IHA; the item was closed. At the time of this medical audit, the Plan was in the process of implementing the incentive program.

The current DHCS medical audit included a verification study of 30 medical records. Three (3) medical records reviewed did not meet the requirements for IHA completion. The medical records showed the PCP failed to document the key elements necessary to support a comprehensive history, pertinent review of systems and a physical examination sufficient to assess and diagnose acute and chronic conditions and provide a plan of care to include follow up activities.

The Plan's current system to monitor a complete IHA fails to determine whether the provider's documentation meets the elements of a comprehensive office visit. Comparative analysis of the submitted claims data with the contents of the actual medical record would confirm if components of a completed IHA are supported.

In response to the prior year findings, the Plan has also developed an *Interim Facility Site Review* form to expand the oversight of the FSR process. The form is a self-assessment interim review to address the required time frame and new member contact. Components of a complete IHA or review of the medical record for IHA completion are not addressed in this self-assessment form.

Although the Plan has methods to inform its provider network of the Plan's policies, due dates of the IHA for newly enrolled members, and offers incentives to providers to complete the IHA timely; the Plan has not provided guidance about the required components of a complete IHA examination in the medical records.

RECOMMENDATIONS:

- 2.4.1 Ensure procedures for monitoring IHA compliance are based on validated methodologies.
- 2.4.2 Ensure members' medical records contain all elements of a complete IHA.

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CATEGORY 3 – ACCESS AND AVAILABILITY OF CARE

3.1

APPOINTMENT PROCEDURES AND WAITING TIMES

Appointment Procedures:

Contractor shall implement and maintain procedures for Members to obtain appointments for routine care, urgent care, routine specialty referral appointments, prenatal care, children’s preventive periodic health assessments, and adult initial health assessments. Contractor shall also include procedures for follow-up on missed appointments.

COHS Contract A.9.3.A

Members must be offered appointments within the following timeframes:

c) Non-urgent primary care appointments – within ten (10) business days of request;

d) Appointment with a specialist – within 15 business days of request;

COHS Contract A.9.3.A.2

Prenatal Care:

Contractor shall ensure that the first prenatal visit for a pregnant Member will be available within 10 business days upon request.

COHS Contract A.9.3.B

Waiting Times:

Contractor shall develop, implement, and maintain a procedure to monitor waiting times in the providers’ offices, telephone calls (to answer and return), and time to obtain various types of appointments indicated in Subprovision A, Appointments, above.

COHS Contract A.9.3.C

SUMMARY OF FINDINGS:

3.1.1 Initial Prenatal Appointment Availability Standards

The Plan shall implement, and maintain procedures for members to obtain appointments for routine care, urgent care, routine specialty referral appointments, prenatal care, children’s preventive periodic health assessments, and adult initial health assessments. The Plan shall ensure that the initial prenatal visit for a pregnant member will be available within 10 business days upon request. *[Contract, Exhibit A, Attachment 9 (3)(B)]*

The Plan informs members and providers of the initial prenatal visit time frame through the member handbook, provider manual, and website.

However, the Plan’s Policy, *Access to Care* (500-3002-H), does not contain the contractual time frame for the initial prenatal appointment of 10 business days upon request.

RECOMMENDATION:

3.1.1 Update Plan’s policy to include the initial prenatal appointment time frame standard of 10 working days.

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3.6

ACCESS TO PHARMACEUTICAL SERVICES

Pharmaceutical Services and Prescribed Drugs:

Contractor shall cover and ensure the provision of all prescribed drugs and Medically Necessary pharmaceutical services. Contractor shall provide pharmaceutical services and prescription drugs in accordance with all Federal and State laws and regulations...

Contractor shall arrange for pharmaceutical services to be available, at a minimum, during regular business hours. Contractor shall develop and implement effective drug utilization reviews and treatment outcomes systems to optimize the quality of pharmacy services.

Contractor shall ensure access to at least a 72-hour supply of a covered outpatient drug in an emergency situation. Contractor shall meet this requirement by doing all of the following: ... (as required by Contract).

Having written policies and procedures, including, if applicable, written policies and procedures of Contractor's network hospitals' policies and procedures related to emergency medication dispensing, which describe the method(s) that are used to ensure that the emergency medication dispensing requirements are met, including, if applicable, specific language in network hospital subcontracts.

COHS Contract A.10.8.F.1

SUMMARY OF FINDINGS:

3.6.1 Emergency Pharmaceutical Services Monitoring

The Plan is required to have written policies and procedures to describe how it and/or its network hospitals will monitor compliance with ensuring member access to at least a 72-hour supply of a covered outpatient drugs in an emergency situation. [Contract, Exhibit A, Attachment 10 (8)(F)(1)(b)]

The Plan did not effectively monitor compliance to ensure member access to at least a 72-hour drug supply in an emergency situation. This issue was previously identified as a finding in the prior audit but was not fully addressed in the plan's corrective action plan (CAP).

The prior audit found that the Plan did not monitor any emergency providers to ensure members were provided an emergency provision of prescribed drugs as required by the Contract. As part of its CAP, the Plan submitted revisions to its policy, Credentialing of Organizational Providers (500-2007-D). The policy revision included a requirement that emergency providers submit emergency department (ED) protocols concerning dispensing of outpatient medications, as part of the annual credentialing process; the item was closed.

In the Plan's Policy *Prescribed Drugs in Emergency Circumstances* (500-2004-D), it states the Plan monitors emergency pharmaceutical services on an **as-needed basis**, when prompted by changes in hospital protocols, member or provider complaints, or other potentially adverse information, the Plan may opt to perform random reviews of dispensing logs or emergency room medical records of the involved network hospital to monitor compliance with the 72 hour supply requirement.

Although the Plan maintains policies and procedures to monitor adequate supply of drugs in an emergency, neither of the policies represent an effective system to monitor its network hospitals' compliance with the 72-hour requirement. Sole reliance on members to report emergency pharmaceutical issues through the grievance process does not by itself constitute an effective monitoring procedure.

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RECOMMENDATION:

- 3.6.1 Implement an effective system to monitor network hospitals' compliance with ensuring member access to a 72-hour drug supply in an emergency situation.

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CATEGORY 6 – ADMINISTRATIVE AND ORGANIZATIONAL CAPACITY

6.3

FRAUD AND ABUSE

B. 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. These requirements shall be met through the following:

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 ten (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 Title 42 CFR Section 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. A list of suspended and ineligible providers is maintained in the Medi-Cal Provider Manual, which is updated monthly and available on line and in print at the DHCS Medi-Cal website (www.medi-cal.ca.gov) and by the Department of Health and Human Services, Office of Inspector General, List of Excluded Individuals and Entities (<http://oig/hhs.gov>). Contractor is deemed to have knowledge of any providers on these lists. Contractor must notify the Medi-Cal Managed Care Program/Program Integrity Unit within ten (10) State working days of removing a suspended, excluded, or terminated provider from its provider network and confirm that the provider is no longer receiving payments in connection with the Medicaid program.

COHS Contract E.2.27.B

SUMMARY OF FINDINGS:

6.3.1 Fraud and Abuse Policy

The Plan must notify the Medi-Cal Managed Care Program/Program Integrity Unit within ten (10) State working days of removing a suspended, excluded, or terminated provider from its provider network and confirm that the provider is no longer receiving payments in connection with the Medicaid program. *[Contract, Exhibit E, Attachment 2 (27)(B)(5)]*

The Plan is required to establish an Anti-Fraud and Abuse Program that 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.

In the Plan's *Provider Credentialing Policy* (500-2010-1), it fails to establish Contract language to report the termination of suspended, excluded, or terminated providers within 10 state working days to the Medi-Cal Managed Care Program/Program Integrity Unit and for the Plan to confirm that the provider is no longer receiving payments in connection with the Medicaid program.

During interviews, the Plan stated it's aware of the Contract requirement to report suspended network providers timely and to confirm that the providers are no longer receiving payments. The Plan further

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explained the reason the process is not included in the Policy, is because it seldom happens.

Although the Plan's policy lacks the required Contract language, there were no providers removed from its network due to suspension, exclusion, or termination from the Medicaid program during the audit period.

RECOMMENDATION:

- 6.3.1 Enhance language in the current Policy for the notification requirement and confirmation of ceased payments to suspended providers.

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

CenCal Health

Contract Number: 08-85219
State Supported Services

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September 30, 2015

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II. COMPLIANCE AUDIT FINDINGS2

I. INTRODUCTION

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

The on-site audit was conducted from October 20, 2015 through October 30, 2015. The audit period is October 1, 2014 through September 30, 2015 and consisted of document review of materials supplied by the Plan and interviews conducted on-site.

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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:

The Plan's policy *State Supported Services/Pregnancy Termination/Abortion (800-2006-A)* 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.