DHCS AUDITS AND INVESTIGATIONS

CONTRACT AND ENROLLMENT REVIEW DIVISION

SAN DIEGO SECTION

REPORT ON THE MEDICAL AUDIT OF SANTA BARBARA SAN LUIS OBISPO REGIONAL HEALTH AUTHORITY DBA CENCAL HEALTH FISCAL YEAR 2024 - 25

Contract Number: 23-30239

Audit Period: November 1, 2023 — October 31, 2024

Dates of Audit: November 12, 2024 — November 22, 2024

Report Issued: March 26, 2025

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I. INTRODUCTION

The Santa Barbara San Luis Obispo Regional Health Authority dba CenCal Health (Plan) was established in September 1983, as the first State Contracted County Organized Health System. Originally known as the Santa Barbara Health Initiative, the Plan began serving San Luis Obispo County in 2009. Since then, the Plan's service area covered two counties, Santa Barbara and San Luis Obispo.

The Plan is a public entity governed by a 13-member Board of Directors appointed by the Santa Barbara and San Luis Obispo County Board of Supervisors. The Board is composed of local government representatives, physicians, hospital representatives, member representatives, other health care provider representatives, and business representatives.

As of December 2024, the Plan's total Medi-Cal enrollment was 241,571 members. Member enrollment is comprised of 174,304 in Santa Barbara County and 67,267 in San Luis Obispo County.

II. EXECUTIVE SUMMARY

This report presents the audit findings of the Department of Health Care Services (DHCS) medical audit for the period of November 1, 2023, through October 31, 2024. The audit was conducted from November 12, 2024, through November 22, 2024. The audit consisted of documentation review, verification studies, and interviews with the Plan's representatives.

An Exit Conference with the Plan was held on February 26, 2025. The Plan was allowed 15 calendar days from the date of the Exit Conference to provide supplemental information addressing the draft audit findings. On March 13, 2025, the Plan submitted a response after the Exit Conference. The evaluation results of the Plan's response are reflected in this report.

The audit evaluated four categories of performance: Population Health Management and Coordination of Care, Network and Access to Care, Member's Rights, and Quality Management.

The prior DHCS medical audit yielded no findings for the period of October 1, 2022, through September 30, 2023, and was issued December 14, 2023. Therefore, no Corrective Action Plan was examined in this audit.

The summary of the findings by category follows:

Category 2 – Population Health Management and Coordination of Care

The Plan must provide, as part of the preventive visit, all age-specific assessments required by the American Academy of Pediatrics (AAP) Bright Futures, including lead risk assessments for members less than 21 years of age. The Plan did not ensure the provision of lead risk assessments to all members less than 21 years of age.

Category 3 – Network and Access to Care

There were no findings noted for this category during the audit period.

Category 4 – Member's Rights

There were no findings noted for this category during the audit period.

Category 5 – Quality Management

There were no findings noted for this category during the audit period.

III. SCOPE/AUDIT PROCEDURES

SCOPE

The DHCS, Contract and Enrollment Review Division conducted the audit to ascertain that medical services provided to Plan members comply with federal and state laws, Medi-Cal regulations and guidelines, and the State Contract.

PROCEDURE

DHCS conducted an audit of the Plan from November 12, 2024, through November 22, 2024, for the audit period of November 1, 2023, through October 31, 2024. The audit included a review of the Plan's Contract with DHCS, policies and procedures for providing services, procedures used to implement the policies, and verification studies of the implementation and effectiveness of the policies. Documents were reviewed and interviews were conducted with Plan administrators and staff.

The following verification studies were conducted:

Category 2 – Population Health Management and Coordination of Care

Initial Health Appointment (IHA): Fifteen medical records were reviewed for provision, completeness, and timeliness of IHAs.

Complex Case Management: Ten members were reviewed for evidence of care coordination between the Plan and providers.

Enhanced Care Management: Five medical records were reviewed for compliance with enhanced care management requirements.

Category 3 – Network and Access to Care

Emergency Services and Family Planning Claims: A total of 46 (23 emergency and 23 family planning) claims were reviewed for appropriate and timely adjudication.

Category 4 – Member's Rights

Grievance Procedures: Ten quality of service standard grievances, five exempt grievances, and five call inquiries were reviewed. All grievances were reviewed for timely resolution, appropriate classification, response to the complainant, submission to the appropriate level for review, and translation into the member's preferred language (if applicable).

Category 5 – Quality Management

There was no verification studies conducted for the audit review.

COMPLIANCE AUDIT FINDINGS

Category 2 – Population Health Management and Coordination of Care

2.1 Blood Lead Screening

2.1.1 Preventive Services for Members Under Age 21

The Plan must provide preventive health visits for all members less than 21 years of age at times specified by the most recent AAP Bright Futures Periodicity Schedule and anticipatory guidance as outlined in the AAP Bright Futures Periodicity Schedule. The Plan must provide, as part of the preventive visit, all age-specific assessments and services required by AAP Bright Futures. (*Contract, Exhibit A, Attachment III, 5.3.4 (B)(1)*)

The Plan must provide Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) services to eligible members under the age of 21. EPSDT services shall at a minimum include laboratory tests (including lead blood level assessment appropriate for age and risk factors). (*All Plan Letter 23-005, Requirements for Coverage of Early and Periodic Screening, Diagnostic, and Treatment Services (EPSDT) for Medi-Cal Members Under the Age of 21)*.

The Plan's policy, *QU-07, Ensuring EPSDT Screening, AAP Bright Futures Preventive Services, and Medically Necessary Diagnostic and Treatment Services, for Members Under Age 21* (revised October 2023), states that for all members less than 21 years of age, the Plan's Primary Care Physicians (PCP) are required to provide preventive health visits and anticipatory guidance at times specified and as outlined in the most recent AAP Bright Futures Periodicity Schedule. The Plan's PCPs provide, as part of the periodic preventive visit, all age-specific assessments and services required by AAP Bright Futures. If the services are refused, documentation is entered in the member's medical record which indicates the services were advised, and the member's (if an emancipated minor), or the parent(s) or guardian of the member's voluntary refusal of the services.

Finding: The Plan did not ensure the provision of lead risk assessments to all members less than 21 years of age.

A verification study determined two of six members (aged six months and four years old) did not receive a lead risk assessment. There was no documentation about the history of lead screening or refusal of a lead test from the member's representative.

Review of the Plan's 2023 Quality Improvement (QI) and Health Equity Transformation Program Evaluation identified preventative and risk screenings and services as

opportunities for improvement, including the intervention or education to aid in improvement of lead risk assessments. However, the Plan's 2024 QI and Health Equity Committee Work Plan did not indicate any QI initiatives related to lead risk assessments.

Additionally, review of the Plan's Medical Record Review criteria shows that the Plan reviews for completion of blood lead testing but the Plan does not review for documentation of lead risk assessments.

If the Plan does not provide age-specific assessments at preventive health visits, there may be missed opportunities to identify health issues, such as lead exposure, which may delay early intervention and treatment.

Recommendation: Implement policies and procedures to ensure the provision of age-specific assessments and services are completed for all members less than 21 years of age as required by AAP Bright Futures.

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SAN DIEGO SECTION

REPORT ON THE MEDICAL AUDIT OF SANTA BARBARA SAN LUIS OBISPO REGIONAL HEALTH AUTHORITY DBA CENCAL HEALTH FISCAL YEAR 2024 - 25

Contract Number: 23-30271

Contract Type: State Supported Services

Audit Period: November 1, 2023 — October 31, 2024

Dates of Audit: November 12, 2024 — November 22, 2024

Report Issued: March 26, 2025

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I. INTRODUCTION

This report presents the results of the audit of Santa Barbara San Luis Obispo Regional Health Authority dba CenCal Health (Plan) compliance and implementation of the State Supported Services contract number 23-30271 with the State of California. The State Supported Services Contracts cover abortion services with the Plan.

The audit covered the period of November 1, 2023, through October 31, 2024. The audit was conducted from November 12, 2024, through November 22, 2024, which consisted of a document review and verification study with the Plan administration and staff.

An Exit Conference with the Plan was held on February 26, 2025. No deficiencies were noted during the review of the State Supported Services Contract.

COMPLIANCE AUDIT FINDINGS

State Supported Services

The Plan is required to provide, or arrange to provide, to eligible members State Supported Services, which include abortion and abortion-related services.

The Plan's policy, *CLM-09 Claims and Payment for Pregnancy Termination Abortio*n (revised June 2024), states that members can access abortion services in and out of network without prior authorization. The Plan defines abortion services as a "sensitive service" and assures members' confidentiality and accessibility. Non-emergency inpatient hospitalization for the performance of an abortion requires prior authorization under the same criteria as other medical procedures.

The Plan's Member Handbook informs members that some providers may have a moral objection to abortion and have a right not to offer this service. However, members can contact the Plan for assistance. Members are also informed that referrals are not needed from primary care physicians for abortion and abortion-related services.

The Plan's Provider Manual informs providers of the members' freedom of choice in obtaining sensitive services, such as abortion services, without prior authorization.

Finding: No deficiencies were identified in the audit.

Recommendation: None.