

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

REPORT ON THE MEDICAL AUDIT OF

**SANTA BARBARA SAN LUIS OBISPO
REGIONAL HEALTH AUTHORITY
DBA CENCAL HEALTH**

2021

Contract Number: 08-85212

Audit Period: November 1, 2019
Through
September 30, 2021

Dates of Audit: October 25, 2021
Through
November 5, 2021

Report Issued: June 1, 2022

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I. INTRODUCTION

The Santa Barbara San Luis Obispo Regional Health Authority dba CenCal Health (Plan) was established in 1983 originally as the Santa Barbara Health Initiative. The Plan's service area covers two counties, Santa Barbara and San Luis Obispo. The Plan began serving San Luis Obispo County in 2009.

The Plan is a public entity governed by a 13 member Board of Directors appointed by the Santa Barbara and San Luis Obispo County Boards of Supervisors. The Plan provides managed care health services to members under the County Organized Health System model.

The Plan offers behavioral health, substance abuse, California Children's Services (CCS) via the Whole Child Model program, and managed health care services.

As of July 2021, the Plan's enrollment totals for its Medi-Cal line of business was 204,328 members. Membership is comprised of 143,540 members in Santa Barbara County and 60,788 members 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, 2019, through September 30, 2021. The review was conducted from October 25, 2021 through November 5, 2021. The audit consisted of document review, verification studies, and interviews with Plan representatives.

An Exit Conference with the Plan was held on April 26, 2022. The Plan was allowed 15 calendar days from the date of the Exit Conference to provide supplemental information addressing the draft audit report findings. On May 11, 2022 the Plan submitted a response. The results of our evaluation of the Plan's response are reflected in this report.

The audit evaluated six categories of performance: Utilization Management (UM), Case Management and Coordination of Care, Access and Availability of Care, Member's Rights, Quality Management, and Administrative and Organizational Capacity.

The Plan participates in the CCS Whole Child Model program. An evaluation of the Plan's compliance with requirements specified in All Plan Letter (APL) 18-023, CCS Whole Child Model program, was also included in the audit scope.

The prior DHCS medical audit, for the period November 1, 2018, through October 31, 2019, was issued on March 13, 2020. This audit examined the Plan's compliance with its DHCS Contract and assessed implementation of its closed prior year's Corrective Action Plan (CAP).

The summary of the findings by category follows:

Category 1 – Utilization Management

No findings were noted for the audit period.

Category 2 – Case Management and Coordination of Care

The Plan is required to cover and ensure the provision of an Initial Health Assessment (IHA). An IHA consists of a comprehensive history, physical and mental status examination, an Individual Health Education Behavioral Assessment (IHEBA), identified diagnoses, and plan of care. The Plan did not ensure that all required components of an IHA were performed and documented.

Plan is required to ensure that all cited deficiencies in a CAP are completed and verified, as established in the guidelines. The Plan did not ensure that some critical deficiencies identified in a CAP were addressed within the required timeframe.

The Plan is required to inform members, or their families and primary caregivers, about Early and Periodic Screening, Diagnostic and Treatment (EPSDT), and Behavioral Health Treatment (BHT) services and how to obtain these services. The Plan did not inform members on how to obtain ESPDT or BHT services.

The Plan is required to ensure their BHT plans meet the 11-point standardized criteria, including the identification of measurable long, intermediate, and short-term goals. BHT plans did not contain some of the required criteria including identification of measurable long, intermediate, and short-term goals.

The Plan is required to notify members 30 calendar days before the end of the Continuity of Care (COC) period. The Plan did not notify members 30 calendar days before the end of the COC period.

Category 3 – Access and Availability of Care

The Plan is required to ensure its Non-Medical Transportation (NMT) and Non-Emergency Medical Transportation (NEMT) providers are enrolled in the Med-Cal program. The Plan did not ensure that its NEMT and NMT subcontractors or vendors were enrolled in the Medi-Cal program.

Category 4 – Member’s Rights

The Plan is required to follow grievance and appeal requirements. The Plan incorrectly classified call inquiries as exempt grievances.

The Plan’s written resolution of a standard grievance is required to contain a clear and concise explanation of the Plan’s decision. Furthermore, the Plan is required to ensure adequate consideration of grievances and appeals and rectification when appropriate. If multiple issues are presented by the beneficiary, the Plan must ensure that each issue is addressed and resolved. The Plan’s Quality of Care (QOC) grievance resolution letters did not address all the issues.

The Plan is required to develop and implement policies and procedures for assessing the performance of individuals who provide linguistic services. The Plan’s policy and procedure did not include linguistic proficiency and capability requirements.

Category 5 – Quality Management

The Plan is required to have a health practitioner or a contracting physician available 24-hours a day, 7-days a week to coordinate the transfer of care of a member whose emergency condition is stabilized, to authorize medically necessary post-stabilization services, and for general communication with Emergency Room (ER) personnel. The Plan did not have a health practitioner/contracting physician available 24-hours a day, 7-days a week, to coordinate care of post ER stabilized patients.

Category 6 – Administrative and Organizational Capacity

The Plan is required to have a provision for a method to verify, by sampling or other methods, whether services that have been represented to have been delivered by network providers were received by members, and the application of this verification process on a regular basis. The Plan did not have a method to verify that services that have been delivered by network providers were received by members.

III. SCOPE/AUDIT PROCEDURES

SCOPE

This audit was conducted by the DHCS Medical Review Branch 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 the audit of the Plan from October 25, 2021 through November 5, 2021. 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 the 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: Ten medical and 11 pharmacy prior authorization requests were reviewed for timely decision making, consistent application of criteria, and appropriate review.

Appeals: Seven medical and four pharmacy appeals were reviewed for appropriateness and timely adjudication.

Delegated Prior Authorization Requests: 12 medical prior authorization requests were reviewed for appropriate and timely adjudication.

Category 2 – Case Management and Coordination of Care

CCS: Ten medical records were reviewed for appropriate CCS identification, referral to the CCS program, and coordination of care for non-eligible CCS conditions.

IHA: 30 medical records were reviewed for appropriate documentation, timely completion, and fulfillment of all required IHA components.

Complex Case Management: Ten medical records were reviewed for continuous tracking, monitoring, and coordination of services.

BHT: 20 medical records were reviewed for coordination, completeness, and compliance with BHT provision requirements.

COC: 12 medical records were reviewed to evaluate timeliness and appropriateness of COC request determination.

Category 3 – Access and Availability of Care

Claims: 18 emergency services and 12 family planning claims were reviewed for appropriate and timely adjudication.

NEMT: 21 claims were reviewed for timeliness and compliance with NEMT requirements.

NMT: 20 claims were reviewed for timeliness and compliance with NMT requirements.

Category 4 – Member’s Rights

Grievance Procedures: 52 grievances, including 23 quality of service, ten QOC, and 19 exempt, were reviewed for timely resolution, response to complainant, and appropriate level of review and medical decision-making.

Confidentiality Rights: 20 Health Insurance Portability and Accountability Act cases were reviewed for appropriate reporting and processing.

Category 5 – Quality Management

Provider Training: Ten newly contracted providers were reviewed for timely Medi-Cal Managed Care program training.

Potential Quality Issues: 19 cases were reviewed for timely evaluation and effective action was taken to address improvements.

Category 6 – Administrative and Organizational Capacity

Fraud and Abuse: 12 fraud and abuse cases were reviewed for processing and appropriate reporting.

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

❖ COMPLIANCE AUDIT FINDINGS (CAF) ❖

**PLAN: Santa Barbara San Luis Obispo Regional Health Authority
dba CenCal Health**

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CATEGORY 2 – CASE MANAGEMENT AND COORDINATION OF CARE

2.1	INITIAL HEALTH ASSESSMENT
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2.1.1 Initial Health Assessment Components

The Plan is required to cover and ensure the provision of an IHA to each new member within 120 days of enrollment. An IHA consists of a comprehensive history, physical and mental status examination, an IHEBA, identified diagnoses, and plan of care. (*Contract, Exhibit A, Attachment 10(3)*)

Plan IHA Protocols identified the components of an IHA. As a comprehensive assessment, an IHA must include all of the following components: a comprehensive physical exam, a physical and mental health history, identification of high-risk behaviors, assessment of need for preventive screenings or services and health education, diagnosis and plan for treatment of any diseases, and Staying Healthy Assessment (SHA) form.

Plan Policy and Procedure, *PS-CR08, Individual Health Education Behavioral Assessment: the Staying Healthy Assessment (revised 04/22/2019)*, indicated that IHEBA are to be administered to all Plan members at the initial and at subsequent periodic health assessments as required. In addition, the Plan promotes the use of the SHA, developed by the California DHCS for the documentation of the IHEBA. The Plan monitors the provision of the SHA through ongoing monitoring of preventive care visits and Healthcare Effectiveness Data and Information Set measures through its Quality Assessment and Improvement Program as well as through Medical Record Audit process.

Finding: The Plan did not ensure that all required components of IHA were performed and documented.

In a verification study, 17 of 30 records reviewed revealed medical records lacked documentation of an initial examination, completion of an IHEBA/SHA and various health screenings such as tuberculosis, colorectal, and blood lead level screenings.

During the interviews, the Plan could not explain why the assessments were missing required components.

When the Plan does not ensure completion of all IHA components, members may not get proper treatment for existing conditions that are not identified.

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Recommendation: Implement policy, procedure, and protocol to ensure completion of all components of IHA.

2.1.2 Facility Site Reviews

The Plan is required to conduct facility site and medical record reviews on all primary provider sites in accordance with the Site Review *Policy Letter (PL) 14-004*, and Title 22, CCR, Section 53856. The Plan shall ensure that a CAP is developed to correct cited deficiencies and that corrections are completed and verified within established guidelines as specified in *PL 14-004. (Contract, Exhibit A, Attachment 4(10)(A)(D))*

The Plan is required to identify nine critical elements of the site review, which defined the potential for adverse effect on patient health or safety. The Primary Care Provider (PCP) site must correct any critical element deficiency identified during a site review, focused survey, or monitoring visit within ten business days of the survey date and the Plan must verify the corrective actions within 30 calendar days of the survey date. The Plan must ensure that sites that are found deficient in any critical element during a site review correct 100 percent of the survey deficiencies, regardless of the site's survey score. (*PL 14-004, Site Reviews: Facility Site Reviews (FSR) and Medical Record Review (05/22/2014)*)

Plan Policy and Procedure, *PS-CR02, Medi-Cal Facility Site & Medical Record Quality Improvement Program (revised 05/15/2019)*, stated that at the time of the survey, the site reviewer will notify providers of non-passing survey scores, critical and non-critical element deficiencies, and other deficiencies determined by the reviewer or Plan to require immediate corrective action, and the CAP requirements for these deficiencies. Within ten business days of the survey date, providers must submit the completed critical element CAP with verification for all critical elements and/or other survey deficiencies requiring immediate correction. Within 30 days of the survey date, the site reviewer re-evaluates and verifies correction of critical elements and all other survey deficiencies requiring immediate correction. In all circumstances, CAPs must be closed within 120 days of the written CAP request.

Finding: The Plan did not ensure that a contracted provider addressed some of the critical deficiencies identified in a CAP within the required timeframe.

A FSR verification study revealed that one of eight FSR reports contained uncorrected deficiencies related to six critical elements. The Plan did not complete the CAP that required the provider to undergo trainings for the critical deficiencies. The trainings were not completed within the established timeframe.

❖ COMPLIANCE AUDIT FINDINGS (CAF) ❖

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The Plan did not follow its policy and procedures to verify the CAP, related to critical elements, were corrected within 30 calendar days of the survey date. The Plan accepted the provider's initial CAP without ensuring the required training was completed. The Plan had one staff member conducting the FSRs, which caused several items to be missed including critical elements.

Failure to address all CAP items related to the identified critical elements in a timely manner may result in potential adverse effects on members' health and safety.

Recommendation: Implement a process to ensure that critical elements and all survey deficiencies are corrected within the required timeframe.

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2.3 BEHAVIORAL HEALTH TREATMENT

2.3.1 Informing Members on Obtaining Services

The Plan is required to comply with all existing final Policy Letters and APLs issued by DHCS. All Policy Letters and APLs issued by DHCS subsequent to the effective date and during the term of the Contract shall provide clarification of the Plan's obligations pursuant to the Contract, and may include instructions regarding implementation of mandated obligations pursuant to changes in state or federal statutes, regulations, or pursuant to judicial interpretation. (*Contract, Exhibit E, Attachment 2(1)(D)*)

The Plan is required to inform members, or their families/primary caregivers, about EPSDT, BHT, services and how to obtain these services and the necessary scheduling assistance available. (*APL 19-010, Requirements for Coverage of Early and Periodic Screening, Diagnostic, and Treatment Services for Medi-Cal Members Under the Age of 21 (08/14/2019)*)

Plan Policy and Procedure, *HS-QI 403, Early and Periodic Screening, Diagnostic and Treatment Services (revised 11/24/2020)*, stated that the Plan will ensure annual notification of EPSDT benefits and services in addition to the provision of the explanation of care whether or not EPSDT services have been accessed.

Plan Policy and Procedure *HS-BH300, Behavioral Health Treatment (BHT) (revised 04/07/2020)*, described the Plan's responsibility for providing BHT services pursuant to Section 1905(a)(4)(B) of the Social Securities Act for EPSDT services and the procedure by which this service may be provided to members.

Finding: The Plan did not inform members on how to obtain BHT services as a part of EPSDT.

The Plan's documents, such as Policy and Procedures *HS-300, Behavioral Health Treatment (BHT) (revised 04/07/2020)*, and other written documentation did not include information on how to obtain BHT services.

The Plan's policy and procedures did not specify how members were informed on how to access BHT benefits. The procedures were not updated to include the APL requirements.

By not informing members on how to access BHT services, members may not be aware of how to access needed services.

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Recommendation: Develop procedures to inform members about BHT, as part of EPSDT services and how to obtain them.

2.3.2 Behavioral Health Treatment Plan

The Plan is required to comply with all existing final Policy Letters and APLs issued by DHCS. All Policy Letters and APLs issued by DHCS subsequent to the effective date and during the term of the Contract shall provide clarification of the Plan's obligations pursuant to the Contract, and may include instructions regarding implementation of mandated obligations pursuant to changes in state or federal statutes, regulations, or pursuant to judicial interpretation. (*Contract, Exhibit E, Attachment 2(1)(D)*)

The Plan is required to ensure BHT treatment plans meet medical necessity and meet the 11-point standardized criteria, including identification of measurable long, intermediate, and short-term goals. (*APL 19-014, Responsibilities for Behavioral Health Treatment Coverage for Members under the Age of 21 (11/12/2019)*)

Plan Policy and Procedure, *HS-QI403, Early and Periodic Screening, Diagnostic and Treatment Services (revised 11/24/2020)*, stated that the Plan ensures medical necessity for BHT treatment.

Plan Policy and Procedure, *HS-BH300, Behavioral Health Treatment (revised 04/07/2020)*, stated that the behavioral treatment plan must meet criteria that identifies measurable long, intermediate, and short-term goals and objectives that are specific, behaviorally defined, developmentally, appropriate, socially significant and based upon clinical observation.

Finding: BHT files did not contain some of the required criteria including identification of measurable long, intermediate, and short-term goals.

In a verification study, 12 out of 14 files did not clearly identify measurable long, intermediate, and short-term goals.

The Plan's delegate completes a form to check off standardized criteria for BHT services; however, the Plan did not verify that all items checked off were included in the files. The Plan's annual review of delegates resulted in no findings for BHT services.

Without clearly defined goals, members' progression and care will not be traceable.

Recommendation: Develop and implement a process to ensure BHT plans meet criteria and contain all required elements.

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2.4 CONTINUITY OF CARE

2.4.1 Notification to Members Before the End of Continuity of Care

The Plan is required to notify the member 30 calendar days before the end of the COC period about the process that will occur to transition the member's care to an in-network provider at the end of the COC period. This process includes engaging with the member and provider before the end of the COC period to ensure continuity of services through the transition to a new provider. (*APL 18-008, Continuity of Care for Medi-Cal Members who Transition into Medi-Cal Managed Care (07/10/2018)*)

Plan Policy and Procedure, *MM-UM08, Continuity of Care (revised 10/26/2020)*, stated that the Plan notifies the member 30 calendar days before the end of the COC period about the process that will occur to transition his or her care at the end of the COC period. This process includes engaging with the member and provider before the end of the COC period to ensure continuity of services through the transition to a new provider.

Finding: The Plan did not notify members 30 calendar days before the end of COC period.

A verification study identified three cases in which the Plan did not have evidence of notification to members before the end of COC.

The Plan did not follow its policy and procedures for notifying members. The Provider Services Department is responsible for sending notifications to members within 60 calendar days prior to a PCP's effective termination date.

Without notifying members before the end of COC, members may be not be aware of their status and upcoming transition of care.

Recommendation: Implement policy and procedure to notify members before the end of COC period.

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CATEGORY 3 – ACCESS AND AVAILABILITY OF CARE

3.8	NON-EMERGENCY MEDICAL TRANSPORTATION NON-MEDICAL TRANSPORTATION
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3.8.1 Medi-Cal Enrollment of NEMT and NMT Providers

The Plan is required to develop and implement a managed care provider screening and enrollment process that meets the requirements of the APL, or they may direct their network providers to enroll through the DHCS or another state department with a recognized enrollment pathway. Plans may direct their network providers to enroll through a state-level enrollment pathway. (*APL 19-004, Provider Credentialing/Re-credentialing and Screening/Enrollment (06/12/2019)*)

The Plan is required to ensure that their subcontractors and delegated entities comply with all applicable state and federal laws and regulations; Contract requirements; reporting requirements; and other DHCS guidance including, but not limited to APLs. The Plan must have in place policies and procedures to communicate these requirements to all subcontractor and delegated entities. (*APL 17-004, Subcontractual Relationships and Delegation (04/18/2017)*)

Plan Policy and Procedure *PS-CR01, Provider Enrollment and Screening Policy (revised 11/1/2019)*, stated that the Plan shall ensure that all providers are enrolled as Medi-Cal providers as part of the onboarding process for providers applying to participate in the plan's managed care network.

Finding: The Plan did not ensure that its NEMT and NMT subcontractors or vendors were enrolled in the Medi-Cal program.

A verification study found two transportation vendors were not enrolled in the Medi-Cal program provided NEMT and NMT services to members.

The Plan's transportation broker, who also provides transportation services, is enrolled in the Medi-Cal program; however, the broker contracted two vendors that were not enrolled. The Plan did not provide documentation demonstrating that the two vendors were enrolled using any of the enrollment pathways.

Medi-Cal members may be subject to inadequate and unsafe transportation conditions, if unscreened transportation providers do not meet the Medi-Cal program requirements.

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Recommendation: Implement the screening and enrollment policy and procedure to ensure all providers of NEMT and NMT services are enrolled in the Medi-Cal program.

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CATEGORY 4 – MEMBER’S RIGHTS

4.1	GRIEVANCE SYSTEM
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4.1.1 Exempt Grievance

The Plan is required to have in place a system in accordance with CCR, Title 28, section 1300.68 and 1300.68.01, CCR, Title 22, section 53858, Exhibit A, Attachment 13, Provision 4, paragraph E.13, and 42 CFR 438.420.402-424, the Plan shall follow grievance and appeal requirements, and use all notice templates included in APL 17-006. (*Contract, Exhibit A, Attachment 14(1)*)

Exempt Grievances received over the telephone that are not coverage disputes; disputed health care services involving medical necessity; or experimental or investigational treatment; that are resolved by the close of the next business day are exempt from the requirement to send a written acknowledgment and response. (*APL 17-006, Grievance and Appeal Requirements and Revised Notice Templates and “Your Rights” Attachments (05/09/2017)*)

Plan Policy and Procedure *MS-20, Member Grievance and Appeals System (Revised 10/02/2020)*, stated that exempt grievances received through the Plan’s call center that are not coverage disputes, disputed health care services involving medical necessity, or experimental or investigational treatment and that are resolved by the close of the next business day are exempt from the requirement to send a written acknowledgment and response. These grievances are tracked with the same information that is captured in a standard grievance on the on-line Grievance and Appeal Tracking System and are incorporated and reported quarterly to the DHCS.

Finding: The Plan incorrectly classified call inquiries as exempt grievances.

A verification study of five exempt grievances involving billing issues found that in all cases the billing issue was not resolved by the next business day. The Plan stated that it takes more than 30 days to resolve billing issues. In order to meet grievance timeframe requirements, the Plan would capture the member’s dissatisfaction as an exempt grievance and then instruct members to submit the billing issue separately. These grievances should have been identified as standard grievances and members given written acknowledgement.

When a grievance is incorrectly classified, a member may not receive written acknowledgement and response to the grievance.

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Recommendation: Implement policies and procedures to ensure that grievances are classified as a standard grievance if not resolved by the next business day.

4.1.2 Quality of Care Resolution Letters

The Plan is required to have in place a system in accordance with CCR, Title 28, section 1300.68 and 1300.68.01, CCR, Title 22, section 53858, Exhibit A, Attachment 13, Provision 4, paragraph E.13, and 42 CFR 438.420.402-424, the Plan shall follow grievance and appeal requirements, and use all notice templates included in APL 17-006. (*Contract, Exhibit A, Attachment 14(1)*)

The Plan's written resolution of standard grievances is required to contain a clear and concise explanation of the Plan's decision. Furthermore, the Plan is required to ensure adequate consideration of grievances and appeals and rectification when appropriate. If multiple issues are presented by the beneficiary, the Plan must ensure that each issue is addressed and resolved. (*APL 17-006, Grievance and Appeal Requirements and Revised Notice Templates and "Your Rights" Attachments (05/09/2017)*)

Finding: The Plan's QOC Grievance Resolution Letters did not address all grievance issues. The Plan's Policy and Procedure *MS-20, Member Grievance and Appeals System (revised 10/02/2020)*, did not include a procedure to address grievances with multiple issues.

The verification study revealed that eight QOC Grievance Resolution Letters did not consistently contain an explanation of the Plan's resolution addressing all issues that would not be covered by quality of care confidentiality issues.

The Plan's letters provided a standard response that stated, "due to peer review related to medical treatment, the information cannot be shared." However, issues not specifically related to QOC concerns were not being addressed by the Plan.

Failure to ensure complete resolution and notification of all issues can potentially delay members' care and appeal rights.

Recommendation: Develop and implement policies and procedures to ensure all issues within a grievance are addressed and resolved in the Grievance Resolution Letters.

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4.2 CULTURAL AND LINGUISTIC SERVICES

4.2.1 Linguistic Services

The Plan is required to develop and implement policies and procedures for assessing the performance of individuals who provide linguistic services as well as for overall monitoring and evaluation of the Cultural and Linguistic Services Program. (*Contract, Exhibit A, Attachment 9(12)(E)*)

Plan Policy and Procedure *MS-31, Cultural and Language Access to Services Program (revised 11/20/2019)*, stated that the Plan evaluates the proficiency of bilingual staff. The Plan developed a formal evaluation process and tool to test and evaluate the capacity of the bilingual staff. The evaluation consists of assessing oral fluency and expression, listening, comprehension, and health care vocabulary of the bilingual staff member by an independent outside evaluator.

Finding: The Plan's policy and procedure did not include linguistic proficiency and capability passing requirement.

During the interview, the Plan stated that they contract with an independent certified evaluator to assess the proficiency of their bilingual staff. Staff undergo an evaluation of verbal and written proficiency in the threshold language, Spanish. Staff must receive a passing score of 80 percent or higher on the Translation Evaluation Report to be certified and provide linguistic services.

The Plan's policy and procedure did not detail the required qualification, and or passing score that staff must meet to provide linguistic services to members, for overall assessing and monitoring.

By not assessing and monitoring the proficiency of staff providing linguistic services, the Plan cannot ensure the communication of medical services are adequate and accurately conveyed to its members.

Recommendation: Revise policy and procedures to include clear requirements and standards of bilingual staff to ensure proficiency and linguistic capabilities.

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CATEGORY 5 – QUALITY MANAGEMENT

5.1	QUALITY IMPROVEMENT SYSTEM
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5.1.1 Physician for Post-Stabilized Care

The Plan is required to have a health practitioner or contracting physician available 24-hours a day, 7-days a week to coordinate the transfer of care of a member whose emergency condition is stabilized, to authorize medically necessary post-stabilization services, and for general communication with ER personnel. (*Contract, Exhibit A, Attachment 6 (8)*)

The Plan is required to ensure adequate follow-up care for those members who have been screened in the ER and require non-emergency care. (*Contract, Exhibit A, Attachment 9 (6)(B)*)

UM Program Description 2021 stated that the Plan used pre-established decision criteria for service approval and allowed for automatic authorization of services during non-working hours.

Finding: The Plan did not have a health practitioner/contracting physician available 24-hours a day, 7-days a week, to coordinate care of post ER stabilized patients.

During the interview, the Plan stated that they did not have UM personnel, on-call physicians, and/or healthcare professionals available during the weekend, as the department operated only during regular working hours. The Plan relied on the decisions of bedside providers.

When a physician is not available 24-hours a day, 7-days a week, members may not receive coordinated and specialized care timely.

Recommendation: Develop and implement policy and procedures to ensure the Plan has a designated health practitioner, or contracting physician, available 24-hours a day, 7-days a week.

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CATEGORY 6 – ADMINISTRATIVE AND ORGANIZATIONAL CAPACITY

6.2	FRAUD AND ABUSE
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6.2.1 Delivery of Services

The Plan is required to 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. The requirements shall be met through written policies and procedures that articulate a commitment to comply with all applicable requirements and standards under this Contract, and all applicable federal and state requirements. Additionally, provision for a method to verify, by sampling or other methods, whether services that have been represented to have been delivered by network providers were received by members, and the application of this verification processes on a regular basis. (*Contract, Exhibit E, Attachment 2 (27)(B)(1-5)*)

Finding: The Plan did not have policies and procedures to verify that services that have been represented to have been delivered by network providers were received by members.

The Plan was unable to provide an explanation on why they did not have a policy and procedures for this requirement.

Without policy and procedures in place to verify services were received by members, the Plan cannot detect and prevent potential fraud, waste, or abuse.

Recommendation: Develop and implement policies and procedures for the verification that services represented to have been delivered by network providers were received by members.

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

REPORT ON THE MEDICAL AUDIT OF

**SANTA BARBARA SAN LUIS OBISPO
REGIONAL HEALTH AUTHORITY
DBA CENCAL HEALTH**

2021

Contract Number: 08-85219
State Supported Services

Audit Period: November 1, 2019
Through
September 30, 2021

Dates of Audit: October 25, 2021
Through
November 5, 2021

Report Issued: June 1, 2022

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I. INTRODUCTION

This report presents the review of the Santa Barbara San Luis Obispo Regional Health Authority dba CenCal Health (Plan) compliance and implementation of the State Supported Services Contract with the State of California. The State Supported Services Contract covers abortion services for the Plan.

The audit was conducted from October 25, 2021 through November 5, 2021. The audit covered the period from November 1, 2019 through September 30, 2021 and consisted of the review of documents and interviews with the Plan's staff.

An Exit Conference with the Plan was held on April 26, 2022. There were no deficiencies found for the review period for the Plan's State Supported Services.

❖ COMPLIANCE AUDIT FINDINGS (CAF) ❖

**PLAN: Santa Barbara San Luis Obispo Regional Health Authority
dba CenCal Health**

**AUDIT PERIOD: November 1, 2019 through September 30, 2021
DATE OF AUDIT: October 25, 2021 through November 5, 2021**

STATE SUPPORTED SERVICES

The Plan is required to provide, or arrange to provide, to eligible members the following State Supported Services: Current Procedural Terminology Codes 59840 through 59857 and the Centers for Medicare and Medicaid Services Common Procedure Coding System Codes: X1516, X1518, X7724, X7726, Z0336. These codes are subject to change upon the Department of Health Care Services implementation of the Health Insurance Portability and Accountability Act of 1996 electronic transaction and code sets provisions. (*State Supported Services Contract, Exhibit A, (4)*)

Plan Policy and Procedure, *CLM-09, State Supported Services/Pregnancy Termination/Abortion (revised 09/22/2020)*, stated the Plan's policy for the review and payment of pregnancy termination procedures, supplies, and drugs. The policy implemented procedures to ensure members can access State Supported Services without prior authorization. This applied to both contracted and non-contracted providers. Furthermore, medical justification and authorization for pregnancy termination/abortion were not required.

The verification study revealed that the Plan appropriately processed abortion claims for payment and did not demonstrate any deficiencies related to State Supported Services.

Based on the review of the Plan's documents, there were no deficiencies noted for the review period.

Recommendation: None.