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

CenCal Health Plan

Contract Number: 08-85212

Audit Period: August 1, 2013
Through
July 31, 2014

Report Issued: April 2, 2015

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I. INTRODUCTION

CenCal Health, formerly known as Santa Barbara Regional Health Authority, was established in 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 Systems (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 is a full-service health plan contracted in Santa Barbara County and San Luis Obispo County as a COHS. For CenCal Health's Medi-Cal product, CenCal Health is exempt from the provisions of the Knox-Keene Health Care Service Plan Act of 1975. CenCal Health provides healthcare coverage for Medi-Cal, Healthy Kids – Santa Barbara, Access for Infants and Mothers and In-Home Supportive Service Programs.

As of October 1, 2014, CenCal Health's enrollment for Medi-Cal and Healthy Kids Santa Barbara (SB) was approximately 145,049 Members in Santa Barbara and San Luis Obispo Counties. Enrollment by product line was as follows:

- Medi-Cal Members: 144,246
- Healthy Kids Santa Barbara: 803

II. EXECUTIVE SUMMARY

This report presents the audit findings of the Department of Health Care Services (DHCS) medical audit for the period of August 1, 2013 through July 31, 2014. The on-site review was conducted from October 14, 2014 through October 24, 2014. The audit consisted of document review, verification studies, and interviews with Plan personnel.

An exit conference was held on January 23, 2015 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 (UM), Continuity of Care, Access and Availability of Care, Members' Rights, Quality Management (QI), and Administrative and Organizational Capacity.

Category 1 – Utilization Management

The Plan did not comply with Contract requirements for timely processing of pharmacy Prior Authorizations. In a verification study, the Plan did not meet the 24-hour timeframe for one authorization of pharmaceuticals, as specified in the Contract. The Plan's Policy failed to include specific language on timeframes for authorizations as stated in the Contract.

Category 2 – Case Management and Coordination of Care

The Plan is required to ensure the provision of Comprehensive Medical Case Management Services to each Member. These services are provided through either Basic or Complex Case Management activities, based on the medical needs of the Member. The Plan's Policy failed to include Contract language to describe the delivery of services both within and outside the Plan's Provider network.

The requirement for ensuring the provision of an Initial Health Assessment (IHA) within required timelines for each new Member was not met. The Plan lacked documentation for the completion of the IHA in the medical records, and in some instances, IHAs were completed outside of required timeframes.

Category 3 – Access and Availability of Care

The Plan did not monitor waiting times to obtain the initial prenatal care appointment. Wait times in Provider offices were also not monitored.

The Plan's Emergency Services Policy does not include the timeframe for claims reimbursement as required by Contract.

The Plan's Policy was inconsistent with current practice with regards to monitoring drugs prescribed in emergency circumstances.

Category 4 – Member's Rights

As mandated by the Contract, the Plan failed to notify the Department of Health Care Services (DHCS) Medi-Cal Managed Care Division (MMCD) Contract Manager and the DHCS Privacy Officer and Information Security Officer of suspected Health Insurance Portability and Accountability Act (HIPAA) breaches. The Plan did not include language in its Policy regarding notification to DHCS of the elements of a breach within five (5) working days of the discovery of a breach.

Category 5 – Quality Management

The verification studies of medical records from the Plan's Provider locations indicate that the network Providers failed to maintain complete and accurate medical records for all Members.

The Plan failed to have Policies and Procedures in place regarding the Informed Consent process and the documentation requirements, including instructions for the completion of the sterilization form.

Category 6 – Administrative and Organizational Capacity

The Plan did not ensure that all potential fraud, waste, and abuse cases were reported to DHCS within the timeframes required by the Contract.

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 audit of CenCal Health was conducted from October 14, 2014 through October 24, 2014. The audit included a review of the Plan's Contract with DHCS, its 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 Request: 22 medical and 23 pharmacy prior authorizations were reviewed for timeliness, consistent application of criteria, appropriateness review, and communication of results to Members and Providers.

Appeals Process: 22 appeals requests were reviewed for appropriate and timely adjudication.

Category 2 – Case Management and Coordination of Care

California Children's Services (CCS): 10 medical records were reviewed for evidence of coordination of care between the Plan and CCS providers.

Early Intervention and Developmental Disabilities: 6 medical records were reviewed for evidence of coordination of care between the Plan and Regional Center.

Individual Health Assessment: 34 medical records were reviewed for completeness and timeliness.

Category 3 – Access and Availability of Care

Emergency Service Claims: 20 emergency service claims were reviewed for appropriate and timely adjudication.

Family Planning Claims: 20 family planning claims were reviewed for appropriate and timely adjudication.

Category 4 – Member's Rights

Grievance Procedures: 38 grievances were reviewed. Twenty (20) Quality of Care grievances and eighteen (18) Quality of Services grievances files were reviewed for timely resolution, response to complaint, and submission to the appropriate level of review.

Category 5 – Quality Management

Medical Records: 34 medical records were reviewed for completeness.

Informed Consent: 30 informed consent records were reviewed for completeness of the Informed Consent form number PM 330.

Category 6 – Administrative and Organizational Capacity

New Provider Training: 10 new provider training records were reviewed for timely Medi-Cal Managed Care program training.

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

❖ COMPLIANCE AUDIT FINDINGS ❖	
PLAN: CenCal Health Plan	
AUDIT PERIOD: August 1, 2013 through July 31, 2014	**DATE OF ONSITE AUDIT:** October 14, 2014 through October 24, 2014

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... (as required by Contract)
COHS Contract A.5.2

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.F

Notification of Prior Authorization Denial, Deferral, or Modification:
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:

The Plan has policies and procedures for prior authorization requests for medical and pharmacy services. Review criteria are applied using nationally recognized clinical criteria. Inter-rater reliability (IRR) studies are used to ensure consistent application of the Utilization Management guidelines; all Utilization Management (UM) staff completed and passed the IRR review. The Work Plan Evaluations for 2013 and 2014 describes the consistent processing of prior authorizations in a timely fashion. Plan staff receives ongoing training to use InterQual interactive software to assist with consistency and timeliness of UM decision-making.

The Plan has qualified staff to review the requested services for medical necessity. The Chief Medical Director and Medical Director are accountable for oversight of all review processes and have direct responsibility for all denied decisions. The Plan has an extensive prior authorization process in place with appropriate Physician oversight in all denials. In the case of denials or modifications, the verification studies show the reasons for denials are appropriately documented by the involved Medical Director or Pharmacist.

The Plan notifies Members of a decision to deny, defer or modify requests for prior authorization by providing written notification to Members as required by Contract. The Notice of Action letters are sent in a timely fashion and include preferred language in which the patient can understand, including the right to appeal an unfavorable decision.

Prior authorization requirements are not applied to emergency services, family planning services, preventive services, basic prenatal care, sexually transmitted disease services, HIV testing and other confidential services.

A total of 45 prior authorizations denials, twenty-two (22) medical and twenty-three (23) pharmacy were reviewed for a verification study. All Twenty-two (22) medical prior authorizations were adjudicated appropriately and in a timely manner. Twenty-three (23) pharmacy prior authorizations were reviewed appropriately by a pharmacist. However, one (1) out of 23 pharmacy services did not meet the 24-hour turnaround time frame. The denial was decided in two business days instead of 24 hours or one business day as according to Contract requirements. Additionally, the Plan's Policy failed to include specific language on timeframes for authorizations as stated in the Contract. The Contract stipulates for prior 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 Reference: Exhibit A.5.3.F]

Decisions are clearly documented and criteria utilized for denials are present in the case file. In the Notice of Action letters, details of the decision are clearly documented.

RECOMMENDATIONS:

- Amend Policy to assure that the required Pharmacy approval or denial timeframes as described in the Contract are also included in the applicable Policy and Procedure.
- Adhere to the specified Contract requirement for a 24-hour turnaround time for pharmacy authorizations.

CATEGORY 2 – CASE MANAGEMENT AND COORDINATION OF CARE

2.1	CASE MANAGEMENT AND COORDINATION OF CARE: WITHIN AND OUT-OF-PLAN

Case Management and Coordination of Services:
Contractor shall ensure contracted providers provide basic comprehensive Medical Case Management to each Member.

Contractor shall maintain procedures for monitoring the coordination of care provided to Members, including but not limited to all Medically Necessary services delivered both within and outside the Contractor's provider network.
COHS Contract A.11.1

Out-of-Plan Case Management and Coordination of Services:
Contractor shall implement procedures to identify individuals who may need or who are receiving services from out-of-plan providers and/or programs in order to ensure coordinated service delivery and efficient and effective joint case management for services…
COHS Contract A.11.4

SUMMARY OF FINDINGS:

The Plan has policies and procedures to ensure the provision of Comprehensive Medical Case Management to each Member. The Plan has maintained procedures for monitoring the coordination of care provided to Members, including but not limited to all medically necessary services delivered both within and outside the Plan's Provider network. These services are provided through either basic or complex case management activities based on the medical needs of the Member. In addition, the Plan has implemented procedures to identify individuals who may need or who are receiving services from out-of-network Providers in order to ensure coordination and effective joint case management services.

The Plan has provided, in accordance with the contractual requirements, comprehensive case management and coordination of care to Members from their assigned Primary Care Physician (PCP), to promote the coordination of medically necessary health care services, the provision of preventive services in accordance with established standards and periodicity schedules and the continuity of care. Services are provided by the PCP or by a PCP-supervised Physician Assistant (PA), Nurse Practitioner (NP), or Certified Nurse Midwife (CNM). Coordination of carved out and linked services are considered basic case management services.

Case Management records for five (5) eligible Members were reviewed to evaluate the effectiveness of the Plan's case management function. The records reflected care coordination between the Plan, the counties of Santa Barbara and San Luis Obispo California Children's Services (CCS) programs and Regional Centers.

Interviews with both Santa Barbara and San Luis Obispo CCS centers revealed comprehensive case management and coordination of care is being provided to each CenCal Health Member.

Case Management Services are delivered within and outside of the Plan's network. However, the Plan Policy fails to include this information. According to the Contract, the Plan is required to include this language in its Policies and Procedures. [COHS Contract Reference: Exhibit A.11.4]

RECOMMENDATION:

Amend Policy to ensure the required Case Management covered services as described in the Contract are also included in the applicable Policy and Procedure.

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)...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 is responsible to cover and 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.10.4.A1-2
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.10.5

SUMMARY OF FINDINGS:

The Plan has policies and procedures to address the completion of the Initial Health Assessment (IHA) for Members under the age of 18 months and for Members over the age of 18 months to include completion within appropriate timeframes and office visit criteria.

Pursuant to the Plan's Policy, *New Member Enrollment Process*, (300-3000-D), the Plan will cover and ensure the provision of an Individual Health Assessment, which includes the Individual Health Education Behavioral Assessment (IHEBA), within 120 days of enrollment. The Plan will make and document at least three repeated attempts to schedule the IHA to include at least one telephone call and one mail notification.

In a verification study, thirty-four (34) medical records were reviewed to ascertain IHA completion. Out of 34 medical records, four (4) medical records exceeded the time frame to perform the IHA and 2 (two) medical records did not have a comprehensive assessment required of an IHA.

The requirement for ensuring the provision of an Initial Health Assessment within required timelines for each new Member was not consistently met.

In the Plan's response to this audit finding, the different methods utilized to inform Members of the availability of an IHA were discussed. While the Plan takes an active role to promote the scheduling of an IHA, the recommendation is specific to the Member's completion of an IHA. On the basis of our sample results, we found the provision of an IHA was not consistently met; thus, enhancing quality controls ensures a complete IHA for all new Members.

RECOMMENDATION:

Enhance quality controls to ensure that Providers complete the Individual Health Assessment for all new Members within the timelines stipulated in the Contract.

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
Prenatal Care:
Contractor shall ensure that the first prenatal visit for a pregnant Member will be available within two (2) weeks 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:

The Plan's Policy, *Access to Care* (500-3002-E) describes the accessibility standards for preventive care, urgent and non-urgent, specialty, and emergency care appointments and services. It also contains monitoring procedures to assess compliance with the accessibility standards. These standards are communicated to network Providers to ensure health services are available and accessible to Members within a reasonable period of time.

The Plan informs Members on appointment procedures and waiting times through the Member Handbook, its website, and Member newsletters.

The Plan informs Providers on its policies and procedures regarding appointment procedures and waiting times through the Provider Manual, its website, and Provider newsletters.

The Plan monitors access requirements by conducting an annual survey of waiting times reporting in the Timely Access Report. The survey measures waiting times in the Providers' offices and the length of time for Provider responses to phone calls.

Through the Consumer Assessment of Health Care Providers and Systems (CAHPS) Member Satisfaction Survey, the Plan monitors standards for timely appointments.

The Plan did not monitor waiting times to obtain the initial prenatal care appointment. Through Healthcare Effectiveness Data Information Set (HEDIS), the Plan measured the percentage of women with live birth who had at least one prenatal care visit in their first trimester or within 42 days of enrollment with the health Plan but excluded whether the first prenatal visit for pregnant Members was available within two weeks upon request.

The Plan monitored waiting times for Providers to answer and/or return telephone calls at Provider offices. The Plan did not monitor waiting times in Providers' offices during the audit period. The Plan stated they monitored waiting times in Providers' offices through the Plan's 2009 appointment availability survey with questions relating to the average wait time in the office for scheduled appointments.
The Plan's response to this audit finding indicated that during and prior to the audit period, the Plan monitored first

prenatal visit wait times through the routine analysis of access complaints/appeals received through the Plan's Member grievance system. In addition, the Plan presented information regarding its use of Televox, an automated message system, to promote interaction with the Plan's Member Services Representatives to schedule prenatal appointments as an effort to promote compliance with health recommendations and guidelines.

The Contract specifically requires that the "Plan shall develop, implement, and maintain a procedure to monitor waiting times... to obtain various types of appointments..." Sole reliance by the Plan on Members to report a waiting time issue for an appointment through the grievance process does not by itself constitute an effective monitoring procedure. The Plan must establish a more active method to ensure that the first prenatal visit meets timely access standards.

RECOMMENDATIONS:

- Develop and implement monitoring procedures to ensure that prenatal care visits meet access standards as required by the Contract.
- Develop and implement a procedure to monitor waiting time in Provider offices.

3.5	EMERGENCY SERVICE PROVIDERS (CLAIMS)

Emergency Service Providers: (Claims)
Contractor is responsible for coverage and payment of emergency services and post stabilization care services and must cover and pay for emergency services regardless of whether the provider that furnishes the services has a contract with the Plan.
COHS Contract A.8.12.A

Contractor shall pay for Emergency Services received by a Member from non-contracting Providers.
COHS Contract A.8.12.C

At a minimum, Contractor must reimburse the non-contracting emergency department and, if applicable, its affiliated providers for Physician services at the lowest level of emergency department evaluation and management CPT (Physician's Current Procedural Terminology) codes, unless a higher level is clearly supported by documentation, and for the facility fee and diagnostic services such as laboratory and radiology.
COHS Contract A.8.12.D

For all non-contracting providers, reimbursement by Contractor or by a subcontractor who is at risk for out-of-plan Emergency Services, for properly documented claims for services rendered on or after January 1, 2007 by a non-contracting provider pursuant to this provision shall be made in accordance with provision 4, Claims Processing, above, and 42 USC Section 1396u-2(b)(2)(D).
COHS Contract A.8.12.E

Claims Processing—Contractor shall pay all claims submitted by contracting providers in accordance with this provision....Contractor shall comply with 42 USC Section 1396a(a)(37) and Health and Safety Code Sections 1371 through 1371.39.
COHS Contract A.8.4

Contractor shall cover emergency medical services without prior authorization pursuant to Title 28 CCR Section 1300.67(g)(1).
COHS Contract A.9.6.A

Time for Reimbursement. A plan and a plan's capitated Provider shall reimburse each complete claim, or portion thereof, whether in state or out of state, as soon as practical, but no later than thirty (30) working days after the date of receipt of the complete claim by the plan or the plan's capitated Provider, or if the plan is a health maintenance organization, 45 working days after the date of receipt of the complete claim by the plan or the plan's capitated provider, unless the complete claim or portion thereof is contested or denied, as provided in subdivision (h).
CCR, Title 28, Section 1300.71(g)

SUMMARY OF FINDINGS:

The Plan processes and pays all clean claims for professional and facility services related to emergency and urgent care within the statutory guidelines. The Plan processes clean claims for emergency or urgent care services within the statutory and contractual requirements. This applies to both contracted and non-contracted Providers. These services are not subject to prior authorization requirements.

Although the Plan has developed and implemented policies and procedures for emergency services claims, the Policy *Payment of Emergency and Urgent Services* (800-2000-C), only cites the regulation as reference to the

statutory and contractual requirements for payment of emergency services claims within 30 days from the date of receipt. The Plan must ensure timely processing and appropriate payment of emergency services claims and therefore, specific language related to processing and paying claims in a timely manner for services rendered should be included in the existing Policy to comply with California Code of Regulations, Title 28, section 1300.71(g).

Through the Member Handbook, the Plan informs Members of Emergency Care services, available 24 hours, both in and outside of Santa Barbara and San Luis Obispo Counties. Prior authorization is not required.

In the Provider Manual, the Plan informs Providers that prior authorization is not required for emergency medical conditions. Contracted Provider claims are reimbursed at the appropriate contract rates. Non-contracted providers are reimbursed at no less than the Medi-Cal Fee-For-Service rate.

In a verification study, twenty (20) emergency services claims were reviewed. The claims were processed appropriately and within the required timeframe.

RECOMMENDATION:

Update Policy, *Payment of Emergency and Urgent Services,* (800-2000-C) to include a stipulation that complete claims be reimbursed within thirty (30) working days after the date of receipt.

3.7	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). COHS Contract A.10.7.F.1

SUMMARY OF FINDINGS:

The Plan's Policy, *Prescribed Drugs Under Emergency Circumstances* (500-5004-D) requires the Plan to provide Members needing prescription drugs under emergency circumstances either a 72-hour supply of the drug or an initial dose of medication and a prescription for additional medication, which together cover the Member for the 72-hour period. The policy states that the Plan:

- Will review the network hospitals' protocols to ensure that they are consistent with this requirement.
- Will monitor the pharmacy network semi-annually to ensure they provide 7 days per week access throughout the service area.
- May opt to perform random reviews of dispensing logs or emergency room medical records of the involved network hospital to monitor compliance with this requirement on an as-needed basis, when prompted by changes in protocols, Member or Provider complaints, or other potentially adverse information.

The Plan utilizes a Pharmacy Benefits Manager, *MedImpact Healthcare Systems, Inc.*, for a comprehensive scope of contract services including the provision of pharmacy services and prescribed drugs.

The Pharmacy & Therapeutics Committee serves as the advisory committee to the Plan for the development and implementation of a Plan-wide medication management program.

The Member Handbook informs Members of their pharmacy benefits for medications they need as part of their medical care. It includes a list of the drugs and medications that are covered by the Plan. It informs Members of the procedures to follow should the medication they need require prior authorization.

During the audit period, the Plan did not monitor any emergency providers to ensure Members were provided an emergency provision of prescribed drugs. The Plan's monitoring is optional and triggered only by certain factors.

The Plan is contracted with all three 24-hour pharmacies within its service area. However, the Plan did not survey Members to determine and ensure whether existing 24-hour pharmacies in its network were accessible and met Members' after-hours pharmacy needs. [COHS Contract Reference: Exhibit A.10.7.F.1]

RECOMMENDATION:

Develop policies and procedures for monitoring to ensure the provision of prescribed drugs in emergency circumstances.

CATEGORY 4 – MEMBER'S RIGHTS

4.3	CONFIDENTIALITY RIGHTS

Health Insurance Portability and Accountability Act (HIPAA) Responsibilities:
Contractor agrees:

B. Safeguards—To implement administrative, physical, and technical safeguards that reasonably and appropriately protect the confidentiality, integrity, and availability of the PHI, including electronic PHI, that it creates, receives, maintains or transmits on behalf of DHCS; and to prevent use or disclosure of PHI other than as provided for by this Contract.

H. Notification of Breach During the term of this Contract:
   1. Discovery of Breach. To notify DHCS immediately by telephone call plus e-mail or fax upon the discovery of breach of security of PHI in computerized form if the PHI was, or is reasonably believed to have been, acquired by an unauthorized person; or within 24 hours by e-mail or fax of any suspected security incident, intrusion or unauthorized use or disclosure of PHI in violation of this Contract, or potential loss of confidential data affecting this Contract. ...
   2. Investigation of Breach. To immediately investigate such security incident, breach, or unauthorized use or disclosure of PHI or confidential data. Within five (5) working days of the discovery, ...

I. Notice of Privacy Practices. To produce a Notice of Privacy Practices (NPP) in accordance with standards and requirements of HIPAA, the HIPAA regulations, applicable State and Federal laws and regulations, and Section 2.A. of this Exhibit. ...

COHS Contract G.3.B.H and I

SUMMARY OF FINDINGS:

The Plan's Health Insurance Portability and Accountability Act (HIPAA) Privacy and Security Policies state that the Plan implements administrative, physical, and technical safeguards that reasonably and appropriately protect the confidentiality, integrity, and availability of Protected Health Information (PHI). The Plan's HIPAA Privacy Program stipulates should the Plan discover a breach of the security of electronic PHI, or if the PHI was, or is reasonably believed to have been, acquired by an unauthorized person, a telephone call notification to the Department of Health Care Services (DHCS) is required, in addition to an e-mail or fax notifying of the breach within 24 hours. Notification shall be provided to the DHCS Medi-Cal Managed Care Division Contracting Officer, the DHCS Privacy Officer, and Information Security Officer.

Members are informed of their right to privacy and confidentiality through the Member Handbook, the Plan's website, and Member newsletters. The Plan provides its Notice of Privacy Practices (NPP) to all Members at enrollment, upon request, and no less frequently than every three years or within 60 days after a material change.

Providers are informed that Members have the right to have the privacy and confidentiality of their records protected through the Provider Manual and the Plan's website. The manual provides the Plan's NPP document.

The Plan provides HIPAA compliance training for new hires and refresher courses to all Plan staff annually. However, since 2011 and during the audit period, staff did not receive a refresher course as the Plan is currently reviewing online HIPAA annual training programs with attestation.

The Plan's Privacy Officer is responsible for overseeing the reporting and investigation of the privacy breaches.

The Plan reported no privacy breach during the audit period or in the year prior to the audit period. The Plan provided the HIPAA Privacy Incident Log for the audit period with two incidents listed. The Incident Summary Reports revealed that the Plan does not report "suspected" or "potential" breaches to DHCS as the Contract requires. [COHS Contract Reference: Exhibit G.3.H.1]

The Contract also requires the Plan to notify DHCS of the elements of the breach within five (5) working days of the discovery. However, the Plan's Policy does not include this statement. [COHS Contract Reference: Exhibit G.3.H.2]

RECOMMENDATIONS:

- Update Policy to include language regarding notifying DHCS of the elements of the breach within five (5) working days of the discovery of the breach.
- Enhance quality controls to ensure notification to DHCS of actual and suspected security incident, intrusion or unauthorized use or disclosure of protected health information or potential loss of confidential data within the required timeframe as stipulated in Plan's policies and the DHCS Contract and to all required DHCS personnel.

CATEGORY 5 – QUALITY MANAGEMENT

5.5	MEDICAL RECORDS

Medical Records

A. General Requirement
Contractor shall ensure that appropriate Medical Records for Members, pursuant to Title 28, CCR, Section 1300.80(b)(4), Title 42 USC Section 1396a(w), shall be available to health care providers at each Encounter in accordance with Title 28, CCR Section 1300.67.1(c).

B. Medical Records
Contractor shall develop, implement and maintain written procedures pertaining to any form of medical records:
1) Initial Health Assessment within 120 days of enrollment.
2) For storage and filing of medical records including: collection, processing, maintenance, storage, retrieval identification, and distribution.
3) To ensure that medical records are protected and confidential in accordance with all Federal and State law.
4) For the release of information and obtaining consent for treatment.
5) To ensure maintenance of medical records in a legible, current, detailed, organized and comprehensive manner (records may be electronic or paper copy).

C. On-Site Medical Records
Contractor shall ensure that an individual is delegated the responsibility of securing and maintaining medical records at each site.

D. Member Medical Record
Contractor shall ensure that a complete medical record is maintained for each Member that reflects all aspects of patient care, including ancillary services, and at a minimum includes:
1) Member identification on each page; personal/biographical data in the record.
2) Initial Health Assessment within 120 days of enrollment in accordance with MMCD Policy Letter 08-003.
3) Member's preferred language (if other than English) prominently noted in the record, as well as the request or refusal of language/interpretation services.
4) All entries dated and author identified; for Member visits, the entries shall include at a minimum, the subjective complaints, the objective findings, and the plan for diagnosis and treatment.
5) The record shall contain a problem list, a complete record of immunizations and health maintenance or preventive services rendered.
6) Allergies and adverse reactions are prominently noted in the record.
7) All informed consent documentation, including the human sterilization consent procedures required by Title 22 CCR Sections 51305.1 through 51305.6, if applicable.
8) Reports of emergency care provided (directly by the contracted provider or through an emergency room) and the hospital discharge summaries for all hospital admissions.
9) Consultations, referrals, specialists', pathology, and laboratory reports. Any abnormal results shall have an explicit notation in the record.
10) For medical records of adults, documentation of whether the individual has been informed and has executed an advanced directive such as a Durable Power of Attorney for Health Care.
11) Health education behavioral assessment and referrals to health education services.

COHS Contract A.4.13.A, B, C, D

❖ COMPLIANCE AUDIT FINDINGS ❖	
PLAN: CenCal Health Plan	
AUDIT PERIOD: August 1, 2013 through July 31, 2014	**DATE OF ONSITE AUDIT:** October 14, 2014 through October 24, 2014

SUMMARY OF FINDINGS:

The Plan's *Physician Services Provider Agreement* communicates the procedures for medical record documentation and confidentiality standards, including storage and access. The agreement communicates standards for the administration and maintenance of medical records by individual practitioners to facilitate communication, coordination and continuity of care, and to promote efficient and effective care.

Facilities visited had properly secured medical records and had a designated person responsible for securing and maintaining medical records.

Facility Site Reviews provided by the Plan showed 80 percent or greater compliance rate. There were no corrective action plans mandated to these contracted Providers.

In a verification study, thirty-four (34) medical records were received according to the Contract requirements, including documentation review of medical services and coordination of care. Twenty-five (25) of 34 medical records reviewed were missing elements of a complete medical record. In some instances, there was no documentation of a complete record of immunizations, health maintenance, or preventative services rendered. [COHS Contract Reference: Exhibit A.4.13.D]

RECOMMENDATIONS:

- Enhance quality controls to ensure that a complete medical record is maintained for each Member.
- Continue to monitor Provider compliance with Facility Site Reviews including medical record reviews.

5.6	INFORMED CONSENT

Informed Consent
Contractor shall ensure that a complete medical record is maintained for each Member that reflects all aspects of patient care, including ancillary services, and at a minimum includes: ...All informed consent documentation, including the human sterilization consent procedures required by Title 22 CCR Sections 51305.1 through 51305.6, if applicable.
COHS Contract A.4.13.D.7

Contractor shall ensure that informed consent is obtained from Medi-Cal enrollees for all contraceptive methods, including sterilization, consistent with requirements of Title 22 CCR Sections 51305.1 and 51305.3.
COHS Contract A.9.8.A.1

SUMMARY OF FINDINGS:

The Plan has established guidelines for processing claims, which clearly state CenCal Health's requirements on the handling of sterilization claims. However, the Plan does not have policies and procedures for the criteria and eligibility of sterilization procedures. The Plan also lacks policies and procedures regarding Provider requirements in obtaining sterilization consent forms for designated procedures prior to performing sterilization procedures. Additionally, there are no policies and procedures giving specific instructions for the completion of the sterilization consent form (PM 330). Furthermore, there are no policies in place to educate Members of the full access to Family Planning Services and the right to choose and access a qualified Family Planning Provider without prior authorization. [COHS Contract Reference: Exhibit A.4.13.D.7 and A.9.8.A.1]

The Member Handbook informs Members about birth control options available. Services are available to Members without a referral from their Primary Care Physician.

Through the Provider Manual, Providers are informed about the guidelines and regulations to follow for each Member seeking family planning and sterilization services.

Samples of thirty (30) sterilization claims were reviewed: twenty (20) paid claims and ten (10) denied claims. Claims were reviewed for compliance standards. All sterilization claims reviewed, included a complete Informed Consent form (PM 330).

RECOMMENDATION:

Develop Policies and Procedures regarding the Informed Consent process and the documentation requirements with specific instructions for the completion of the sterilization form.

CATEGORY 6 – ADMINISTRATIVE AND ORGANIZATIONAL CAPACITY

6.5	FRAUD AND ABUSE

Fraud and Abuse Reporting
B. Contractor shall meet the requirements set forth in 42 CFR 438.608 by establishing an Anti-Fraud and Abuse Program in which there will be a central point of contact for all fraud and/or abuse issues. This program will establish policies and procedures for identifying, investigating and taking appropriate action against fraud and/or abuse in the provision of health care services under the Medi-Cal Program...

Fraud and Abuse Reporting
1) 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.
2) Plan shall monitor and prohibit from employment or from contracting with Physicians or other health care providers that are excluded, suspended or terminated from participation in the Medicare or Medi-Cal/Medicaid programs in accordance with 42 CFR 438.610.
COHS Contract E.2.24.B.1-2

SUMMARY OF FINDINGS:

Pursuant to the Plan's Policy, *Fraud Waste and Abuse Identification Reporting and Investigation* (100-2300-A), the Plan shall report results from suspected fraud, waste or abuse investigations to the Department of Health Care Services (DHCS) within ten (10) working days after the conclusion of such investigation. The Plan has also formalized an organizational process for detecting, investigating, documenting and reporting suspected fraud, waste or abuse of any Plan Member, Provider, employee, or any other person.

The Plan's newly hired employees receive a "Welcome letter" describing policies and procedures and rules relating to compliance, privacy and fraud, waste and abuse as part of the employee education program.

Members are informed through the Member Handbook, Member newsletter, and the Plan's website, to report any wrongdoing or fraud to the Plan by email, mail, or by calling the Compliance Hotline.

Through the Provider Manual and bulletins the Plan has systems in place to identify fraud and/or abuse and to take proper action to report suspect fraud, waste, and abuse to the Compliance Department by mail, email, or phone.

Monitoring sources and periodicity for tracking suspended providers is indicated in the Plan's Policy, *Provider Credentialing Policy,* (500-2010-I). The Plan must check suspended Providers lists to ensure its Providers are in good standing with Medicare and Medi-Cal programs. As part of the credentialing or re-credentialing process, all providers are cross-referenced to both lists, the Office of Inspector General (OIG) List of Excluded Individuals/Entities and the Medi-Cal Suspended and Ineligible Provider List.

The Contract stipulates that all cases of suspected fraud and/or abuse should be reported within ten (10) working days. Nine (9) Fraud and Abuse cases were reviewed. The Plan reported five (5) fraud and abuse cases to the DHCS within the timeframe of ten (10) working days to comply with contractual requirements; however, four (4) suspected fraud and abuse cases were not reported at all. [COHS Contract Reference: Exhibit E.2.24.B.1]

RECOMMENDATION:

Enhance quality controls to ensure that all cases of suspected fraud and abuse are reported to the Department of Health Care Services within the required timeframe of ten (10) working days.