CONTRACT AND ENROLLMENT REVIEW DIVISION – SOUTH SAN DIEGO
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

2022

Contract Number:	08-85212
Audit Period:	October 1, 2021 Through September 30, 2022
Dates of Audit:	October 17, 2022 Through October 28, 2022
Report Issued:	May 23, 2023

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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 March 2008. 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 Boards of Supervisors. The Board of Directors is composed of local government, physician, hospital, member, other health care provider, and business representatives.

As of October 2022, the Plan's enrollment total for its Medi-Cal line of business was 225,354 members. Membership is comprised of 158,458 members in Santa Barbara County and 66,896 members in San Luis Obispo County.

II. EXECUTIVE SUMMARY

This report presents the results of the medical audit for the period of October 1, 2021 through September 30, 2022. DHCS conducted an audit of the Plan from October 17, 2022 through October 28, 2022. The audit consisted of document reviews, verification studies, and interviews with Plan representatives.

An Exit Conference with the Plan was held on April 20, 2023. The Plan was allowed 15 calendar days from the date of the Exit Conference to provide supplemental information to address the preliminary audit findings. The findings in this report reflect the evaluation of relevant information received prior and subsequent to the Exit Conference.

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 (QM), and Administrative and Organizational Capacity.

The prior DHCS medical audit issued on June 1, 2022, for the audit period of November 1, 2019 through September 30, 2021, identified deficiencies, which were addressed in a Corrective Action Plan (CAP). As of December 12, 2022, the CAP is closed.

Findings denoted as repeat findings are uncorrected deficiencies substantially similar to those identified in the previous audit.

The summary of the findings by category follows:

Category 1 – Utilization Management

Category 1 covers requirements and procedures for the UM program, including prior authorization (PA) review, medical director and medical decisions, the delegation of UM, and the appeal process.

The Plan is required to notify members of a decision to deny, defer, or modify requests for PA. The written communication shall include the name and telephone number of the health care professional responsible for the denial, delay, or modification. The Plan did not provide a direct telephone number for the decision-maker or the specific unit of the UM Department responsible for adverse benefit determinations in the Notice of Action (NOA) letters.

The Plan is required to ensure that members, or a provider or authorized representative acting on behalf of a member and with the member's written consent, may request an appeal. The Plan did not obtain written consent from a member when a provider filed an appeal on the member's behalf.

Category 2 – Case Management and Coordination of Care

Category 2 includes requirements for Initial Health Assessment (IHA), Behavioral Health Treatment (BHT), and Continuity of Care (COC).

The Plan is required upon approval of a COC request to notify the member within seven calendar days. The notice shall include information regarding the request approval, the duration of the COC arrangement, the process that will occur to transition the member's care at the end of the COC period, and the member's right to choose a different provider from the Plan's provider network. The Plan did not notify members of the approved COC request.

Category 3 – Access and Availability of Care

Category 3 includes the requirements regarding members' access to care, and the provision of Non-Emergency Medical Transportation (NEMT) and Non-Medical Transportation (NMT) services for medically necessary services.

The Plan and its transportation brokers are required to use a DHCS-approved Physician Certification Statement (PCS) form to determine the appropriate level of service for members. The Plan must also ensure that it or its transportation broker provides the appropriate modality prescribed by the member's provider in the PCS form. The Plan did not ensure that PCS forms were complete and included the transportation modality to determine the appropriate level of service for members.

The Plan must conduct monitoring activities of transportation brokers no less than quarterly, which may include verification of the no show rates for NEMT and NMT providers. The Plan did not monitor no show rates of NEMT and NMT providers.

Category 4 – Member's Rights

Category 4 includes the requirements and procedures to establish and maintain a grievance system, and to protect members' rights by properly reporting suspected or actual breaches or security incidents.

Grievances are exempt from the requirement to send a written acknowledgment and response when they are received over the telephone and are not coverage disputes, disputed health care services involving medical necessity or experimental or investigational treatment, and resolved by the close of the next business day. The Plan did not resolve exempt grievances by the next business day.

The Plan is required to ensure that written resolution letters must contain a clear and concise explanation of the Plan's decision. The Plan's quality of care (QOC) grievance resolution letters did not contain a clear and concise explanation of the Plan's decision.

The Plan is required to ensure that written resolution letters must contain a clear and concise explanation of the Plan's decision. The Plan's quality of service (QOS) grievance resolution letters did not contain a clear and concise explanation of the Plan's decision.

Category 6 – Administrative and Organizational Capacity

Category 6 includes requirements to conduct, complete, and report fraud and abuse cases to DHCS.

The Plan is required to notify DHCS when the Plan receives information about changes in member's circumstances that may affect the member's eligibility, such as changes in the member's residence, changes in the member's income, and the death of a member. The Plan did not ensure notification of DHCS regarding changes in a member's circumstances that may affect member eligibility.

III. SCOPE/AUDIT PROCEDURES

SCOPE

This audit was conducted by DHCS Contract and Enrollment Review Division (formerly Medical Review Branch) to ascertain that the medical services provided to Plan members comply with federal and state laws, Medi-Cal regulations and guidelines, and the state Contract.

PROCEDURE

The review was conducted from October 17, 2022 through October 28, 2022. The audit included a review of the Plan's policies for providing services, the procedures used to implement the policies, and verification studies of the implementation and effectiveness of those policies. Documents were reviewed and interviews were conducted with Plan administrators and staff.

The following verification studies were conducted:

Category 1 – Utilization Management

PA Requests: 30 medical PA requests (28 denied and 2 modified) and 25 delegated entity PA requests (20 denied and 5 approved) were reviewed for timeliness, consistent application of criteria, and appropriate review.

Appeal Procedures: 26 appeals of denied medical PAs (12 upheld and 14 overturned) were reviewed for appropriate and timely adjudication.

Category 2 – Case Management and Coordination of Care

IHA: 25 medical records were reviewed for appropriate documentation, timely completion, and fulfillment of all required IHA components.

BHT: 20 medical records were reviewed to confirm care coordination and fulfillment of behavioral health requirements.

COC: 18 medical records were reviewed to evaluate the timeliness and appropriateness of COC request determination.

Category 3 – Access and Availability of Care

NEMT and NMT: 19 records (14 NEMT and 5 NMT) were reviewed to confirm compliance with transportation requirements for timeliness and appropriate adjudication.

Category 4 – Member's Rights

Grievance Procedures: 55 standard grievances (28 QOC and 27 QOS), 30 exempt grievances, and 25 call inquiries were reviewed for classification, timely resolution, response to the complainant, submission to the appropriate level for review, and translation in member's preferred language (if applicable).

Confidentiality Rights: 12 cases were reviewed for processing and reporting requirements.

Category 5 – Quality Management

Potential Quality Issues: Seven files were reviewed for evaluation and effective action taken to address needed improvement.

Category 6 – Administrative and Organizational Capacity

Fraud and Abuse: 19 fraud and abuse cases were reviewed for processing and reporting requirements.

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

CATEGORY 1 – UTILIZATION MANAGEMENT

1.2	PRIOR AUTHORIZATION REVIEW REQUIREMENTS

1.2.1 Contents of Notice of Action

The Plan shall comply with all existing final Policy Letters and All Plan Letters (APLs) issued by DHCS. *(Contract, Exhibit E, Attachment 2(1)(D))*

For decisions based in whole or in part on medical necessity, the written NOA must contain among other criteria: the name and direct telephone number or extension of the decision maker. If the Plan can substantiate through documentation that effective processes are in place to allow the provider to easily contact the decision-maker through means other than a direct phone number (e.g., telephone number to the specific unit of the UM Department that handles provider appeals directly), a direct telephone number or extension is not required. *(APL 21-011, Grievance and Appeals Requirements, Notice and Your Rights Templates)*

The Plan's policy HS-UM07, *Pre-Service Review* (revised April 27, 2022), states that the Plan notifies both the provider and member of decisions to deny, delay, terminate, modify, or carve-out service requests by issuing a written notification known as a NOA. The NOA to the member and provider shall include: (1) a statement of the action, (2) a clear and concise explanation of the reason/rationale for the decision, (3) a description of the criteria or guidelines used, and (4) the clinical reasons for the decisions regarding medical necessity. For provider notifications, the name and contact number of the decision maker is provided.

Finding: The Plan did not provide a direct telephone number for the decision-maker or the specific unit of the UM Department responsible for adverse benefit determinations in the NOA letters.

A verification study found that all 30 sampled PA denials contained an NOA letter that presented only a general Plan number instead of a direct telephone number to the decision maker or the specific unit of the UM Department responsible for adverse benefit determinations. The phone number listed on the NOA letter is a general Plan phone number requiring several prompts before members can access the UM Department.

The Plan did not provide in its NOA letters a direct telephone number that is consistent with its policies and procedures, contractual requirements, and federal regulations. During an interview, the Plan confirmed that the phone number in the NOA letter to

providers was a general phone number that required several prompts before being able to access the UM Department.

If NOAs do not include the name and the direct number of the Plan decision maker, it can limit the provider's ability to easily contact the decision maker. This can result in the delayed submission of appeals for medically necessary services and lead to poor health outcomes.

Recommendation: Revise and implement policies and procedures to ensure that NOA letters contain a direct telephone number for the decision-maker or the specific unit of the UM Department responsible for adverse benefit determinations.

1.3 PRIOR AUTHORIZATION APPEAL PROCESS

1.3.1 Member's Written Consent for Appeals Filed by a Provider

The Plan shall ensure that members, or a provider or authorized representative acting on behalf of a member and with the member's written consent, may request an appeal, with the Plan either orally or in writing. *(Contract, Exhibit A, Attachment 14(1)(A))*

Appeals filed by the provider on behalf of the member require written consent from the member*. (APL 21-011, Grievance and Appeals Requirements, Notice and Your Rights Templates)*

Finding: The Plan did not obtain written consent from a member when a provider filed an appeal on the member's behalf.

The Plan's policy MSSOP-001, *Appeals Process* (revised January 22, 2021), states that providers appealing on behalf of members require consent from the member. The policy, however, mentions that written or verbal consent is accepted and that the appeal cannot be opened until receipt of the written or verbal consent.

A verification study of 26 appeals found that nine were filed by a provider on the member's behalf. Of the nine appeals, the Plan obtained verbal consent for all nine appeals, however, only two had written member consent.

The Plan's policy improperly states that either written or verbal consent from the member must be obtained if the appeal is filed by a provider. During an interview, the Plan stated that staff documents verbal authorization of the member consenting to the provider filing an appeal on the member's behalf.

Failure to obtain written consent from a member when a provider files an appeal on the member's behalf may interfere with patient autonomy, which is the right of members to make a decision about their medical care without their health care provider's influence.

Recommendation: Revise and implement policies and procedures to ensure that written consent is obtained when a provider files an appeal on the member's behalf.

CATEGORY 2 – CASE MANAGEMENT AND COORDINATION OF CARE

2.4	CONTINUITY OF CARE

2.4.1 Member Notification of Approved Continuity of Care

Upon approval of a COC request, the Plan is required to notify the member within seven calendar days regarding the request approval, the duration of the COC arrangement, the process that will occur to transition the member's care at the end of the COC period, and the member's right to choose a different provider from the Plan's provider network. *(APL 18-008, Continuity of Care for Medi-Cal Members Who Transition Into Medi-Cal Managed Care)*

The Plan's policy MM-UM08, *Continuity of Care* (revised July 29, 2022), states that upon approval of a COC request, the Plan notifies the new member via written approval NOA letter of the following within seven calendar days: the approval of the request, the duration of the COC arrangement, the process that will occur to transition the member's care at the end of the COC period, and the member's right to choose a different provider from the Plan's provider network.

Finding: The Plan did not notify members of approved COC requests.

While the Plan's policy states that members will be notified of the approval of a COC request, the audit found no evidence of the Plan sending notification to members.

In a verification study, five of eighteen records reviewed revealed that upon approval of a COC request, the Plan did not provide notification to members of the approved request.

The Plan did not adhere to its policy of notifying members of the approved COC request. During an interview, the Plan stated that the Medical Management Department is responsible for issuance and follow-up of COC request authorizations. Although the Director of Medical Management was not hired until June 2022, the Plan had both an interim Director of Medical Management and Director of Member Services overseeing the COC process. However, the Plan lacked oversight in sending out COC-related written notifications.

Without notifying members of an approved COC request, members may not be aware of the duration to continue with their existing provider, treatment, or medication.

Recommendation: Implement policies and procedures to ensure members are notified

of the approved COC requests within seven calendar days of the approval.

CATEGORY 3 – ACCESS AND AVAILABILITY OF CARE

3.8	NON-EMERGENCY AND NON-MEDICAL TRANSPORTATION

3.8.1 Physician Certification Statement

The Plan shall comply with all existing final Policy Letters and APLs issued by DHCS. *(Contract, Exhibit E, Attachment 2(1)(D))*

The Plan and transportation brokers must use a DHCS-approved PCS form to determine the appropriate level of service for members. Additionally, the Plan must ensure that it or its transportation broker provides the appropriate modality prescribed by the member's provider in the PCS form. The Plan or its transportation brokers may not change the modality outlined in the PCS form, or downgrade members' level of transportation from NEMT to NMT unless multiple modalities are selected in the PCS form, in which case the managed care plan or its transportation broker then may choose the lowest-cost modality. Furthermore, the Plan must conduct monitoring activities no less than quarterly, which may include, but are not limited to, verifying the transportation broker is not modifying the level of transportation service outlined in the PCS form. *(APL 22-008, Non-Emergency Medical and Non-Medical Transportation Services and Related Travel Expenses)*

The Plan's policy MM-UM33, *Non-Emergency Medical Transportation and Non-Medical Transportation* (revised August 17, 2022), documents the Plan's protocols related to NEMT and NMT transportation services. The Plan will use a DHCS-approved PCS form to determine the appropriate level of service for members. All required fields in the PCS form must be completed by the prescribing provider. Review and approval of the PCS form is the Plan's responsibility and will not be delegated to its contracted transportation broker. The Plan will coordinate with its transportation broker regarding the approved mode of NEMT transport and dates of service to ensure provision of NEMT services.

Finding: The Plan did not ensure that PCS forms were complete and included the transportation modality to determine the appropriate level of service for members.

The audit found that there was no monitoring activity conducted by the Plan to ensure that PCS forms were complete.

A verification study found that in four of fourteen NEMT services, the PCS forms did not include information regarding transportation modality.

The Plan did not adhere to its policy of reviewing and approving the completeness of PCS forms.

Without completed PCS forms, the Plan cannot assign the best method of transportation to fit the members' needs and ensure transportation safety.

Recommendation: Implement policies and procedures to ensure that PCS forms are complete and include the transportation modality to determine the appropriate level of service for members.

3.8.2 Monitoring of Transportation Brokers

The Plan is required to monitor and oversee their transportation brokers to ensure that transportation brokers are complying with APL 22-008 requirements. The Plan must conduct monitoring activities no less than quarterly, which may include, but are not limited to, verification of the following items: (1) enrollment status of NEMT and NMT providers, (2) the transportation broker is not modifying the level of transportation service outlined in the PCS form, (3) the NEMT provider is providing door-to-door assistance for members receiving NEMT services, (4) NEMT and NMT providers are consistently arriving within 15 minutes of the scheduled time for appointments, and (5) no show rates for NEMT and NMT providers. *(APL 22-008, Non-Emergency Medical and Non-Medical Transportation Services and Related Travel Expenses)*

The Plan's policy MM-UM33, *Non-Emergency Medical Transportation and Non-Medical Transportation* (revised August 17, 2022), states that the Plan will monitor and oversee transportation brokers on a quarterly basis to ensure compliance with the requirements set forth in APL 22-008, including but not limited to: (1) enrollment of transportation providers, (2) provider no show rates, (3) provider punctuality, and (4) door-to-door assistance for members receiving NEMT services.

Finding: The Plan did not monitor no show rates of NEMT and NMT providers.

The Plan provided NEMT and NMT Trip Logs for the audit period, which showed information regarding paid and completed trips for the audit period. The logs, however, did not contain information regarding cancelled, no show, or denied trips.

The Plan did not fully adhere to the requirements and its policy of verifying no show rates for its NEMT and NMT providers. In a narrative statement, the Plan explained that its transportation broker did not have the ability to capture cancelled, no show, or denied trips in its reports to the Plan.

When the Plan does not maintain documentation to monitor cancelled, no show, or

denied transportation services, it cannot ensure that members receive medically necessary NEMT and NMT transportation services.

Recommendation: Implement policies and procedures to ensure monitoring of no show rates of NEMT and NMT providers.

❖ COMPLIANCE AUDIT FINDINGS (CAF) ❖
PLAN: Santa Barbara San Luis Obispo Regional Health Authority dba CenCal Health
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CATEGORY 4 – MEMBER'S RIGHTS

4.1	GRIEVANCE SYSTEM

4.1.1 Exempt Grievance

The Plan is required to have a Grievance System in place in accordance with California Code of Regulation (CCR), Title 28, sections 1300.68 and 1300.68.01, and Title 22, section 53858. Additionally, the Plan is required to follow Grievance and Appeal requirements, and use all notice templates included in APL 21-011, Grievance and Appeal Requirements, Notice and "Your Rights" Templates. *(Contract, Exhibit A, Attachment 14(1))*

A grievance is defined as a written or oral expression of dissatisfaction regarding the Plan and/or provider, including QOC concerns, and shall include a complaint, dispute, or request for reconsideration or appeal made by a member or the member's representative. Where the Plan is unable to distinguish between a grievance and an inquiry, it shall be considered a grievance. *(CCR, Title 28, section 1300.68(a)(1))*

A grievance received over the telephone that is not coverage disputes, disputed health care services involving medical necessity or experimental or investigational treatment, and that is resolved by the close of the next business day, is exempt from the requirement to send a written acknowledgment and response. *(CCR, Title 28, section 1300.68(d)(8))*

The Plan's policy MS-20, *Member Grievance and Appeal System* (revised August 11, 2022), states that 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.

Finding: The Plan did not resolve exempt grievances by the next business day.

The Plan's policy MSSOP-002, *Grievance Process Standard Operating Procedure* (revised January 22, 2021), states that when the Member Services Department receives calls regarding primary care physician reselection and other general member dissatisfaction that require 24 hours or less to resolve, the Member Service Representative specifically identifies and tracks these issues within the Plan's Call Tracking Module and are automatically coded as exempt. The Grievance and Appeal

Supervisor and the Member Services Director will periodically review the call tracking reports for these codes to verify that the issue was closed within 24 hours of the original call.

A verification study of 30 exempt grievances showed that 17 grievances involving unexpected billing were not resolved by the next business day. The Plan documented the members' dissatisfaction as an exempt grievance and instructed members to submit billing information for review, which did not result in a resolution by the next business day. These 17 grievances should have been identified as standard grievances and members given written acknowledgement.

The Plan does not have a monitoring process to ensure the proper classification of grievances. In an interview and narrative statement, the Plan explained that its Call Center automatically defaults billing issues as exempt grievance because it is identified as general member dissatisfaction that requires 24 hours or less to resolve.

By not classifying grievances correctly, member grievances may not be reviewed by appropriate staff, and the resolution may not adequately address all issues found in the grievance.

This is a repeat of the 2021 audit finding 4.1.1 – Exempt Grievance.

Recommendation: Revise and implement policies and procedures to ensure that grievances that are not resolved by the next business day are classified as standard grievances.

4.1.2 Quality of Care Resolution Letters

The Plan shall implement procedures to ensure a member may file a grievance with the Plan at any time to express dissatisfaction about any matter other than an action resulting in an NOA. *(Contract, Exhibit A, Attachment 14(2)(A))*

Resolved means that the grievance has reached a final conclusion with respect to the member's submitted grievance, and there are no pending member appeals within the Plan's grievance system, including entities with delegated authority. The Plan's written resolution must contain a clear and concise explanation of the Plan's decision. For grievances involving delay, modification or denial of services based on a determination in whole or in part that the service is not medically necessary, the Plan shall include in its written response, the reasons for its determination. The response shall clearly state the criteria, clinical guidelines or medical policies used in reaching the determination. *(CCR, Title 22, section 1300.68(a)(4), (d)(3), and (d)(4))*

Finding: The Plan's QOC grievance resolution letters did not contain a clear and concise explanation of the Plan's decisions.

The Plan's policy MS-20, *Member Grievance and Appeal System* (revised August 11, 2022), mentions that the grievance and appeal system allows the Plan opportunity to provide customer service recovery, to enable the member or their authorized representative to grieve regarding a provider, service or benefit, and to disagree with the Plan's decision regarding the authorization process. However, the policy did not include the definition of a resolved grievance, and that written resolutions must contain a clear and concise explanation of the Plan's decision.

A verification study of 28 QOC standard grievances found that all resolution letters did not have a clear and concise explanation of the Plan's decision. Instead, all resolution letters contained verbiage stating that the results of its peer review cannot be shared, even with the person requesting the grievance.

In an interview, the Plan stated that it uses a template for clinical and non-clinical resolution letters.

The absence of a clear and concise explanation in the resolution letters does not give members transparency in how their grievance is handled. Moreover, members may be discouraged from appealing the Plan's decision when there is a lack of a clear and concise explanation given.

Recommendation: Revise and implement policies and procedures to ensure that QOC grievance resolution letters contain a clear and concise explanation of the Plan's decisions.

4.1.3 Quality of Service Resolution Letters

The Plan shall implement procedures to ensure a member may file a grievance with the Plan at any time to express dissatisfaction about any matter other than an action resulting in an NOA. *(Contract, Exhibit A, Attachment 14(2)(A))*

Resolved means that the grievance has reached a final conclusion with respect to the member's submitted grievance, and there are no pending member appeals within the Plan's grievance system, including entities with delegated authority. The Plan's written resolution must contain a clear and concise explanation of the Plan's decision. For grievances involving delay, modification, or denial of services based on a determination in whole or in part that the service is not medically necessary, the Plan shall include in its written response, the reasons for its determination. The response shall clearly state the criteria, clinical guidelines or medical policies used in reaching the determination. *(CCR,*

Title 22, section 1300.68(a)(4), (d)(3), and (d)(4))

Finding: The Plan's QOS grievance resolution letters did not contain a clear and concise explanation of the Plan's decisions.

The Plan's policy MS-20, *Member Grievance and Appeal System* (revised August 11, 2022), mentions that the grievance and appeal system allows the Plan opportunity to provide customer service recovery, to enable the member or their authorized representative to grieve regarding a provider, service or benefit, and to disagree with the Plan's decision regarding the authorization process. However, the policy did not include the definition of a resolved grievance, and that written resolutions must contain a clear and concise explanation of the Plan's decisions.

A verification study of 27 QOS standard grievances found that ten resolution letters did not have a clear and concise explanation of the Plan's decision. In an interview, the Plan stated that it uses a template for clinical and non-clinical resolution letters.

The absence of a clear and concise explanation in the resolution letters does not give members transparency in how their grievances are processed. Moreover, members may be discouraged to appeal the Plan's decision when there is a lack of a clear and concise explanation given.

Recommendation: Revise and implement policies and procedures to ensure that QOS grievance resolution letters contain a clear and concise explanation of the Plan's decisions.

CATEGORY 6 – ADMINISTRATIVE AND ORGANIZATIONAL CAPACITY

6.2	FRAUD AND ABUSE

6.2.1 Notification Regarding Changes in Member's Circumstances

The Plan must notify DHCS when the Plan receives information about changes in member's circumstances that may affect the member's eligibility, such as changes in the member's residence, changes in the member's income, and the death of a member. *(Contract, Exhibit E, Attachment 2 (27)(B)(3))*

Finding: The Plan did not ensure notification of DHCS regarding changes in a member's circumstances that may affect member eligibility.

The Plan maintains a desktop procedure MSSOP-003, *Member Services* (revised August 25, 2020), which ensures demographic updates reported by members or providers are reported on a weekly basis. Plan staff makes these changes in the Plan's health information system, then subsequently completes an excel log which are sent to Department of Social Services on a weekly basis. However, the Plan does not have a policy and the desktop procedure does not delineate steps to notify DHCS of changes in a member's circumstances.

In an interview, the Plan expressed that changes regarding a member's circumstances are reported on a weekly basis to the County's Social Services Department as required by APL 22-004, *Strategic Approaches for Use by Managed Care Plans to Maximize Continuity of Care Coverage as Normal Eligibility and Enrollment Operations Resume*. The Plan also explained that when the Fraud, Waste, and Abuse Team receives notification regarding changes to member's circumstances, the Plan reports such information to DHCS Program Integrity Unit via MC-609 within ten working days. However, the Plan did not provide policies and procedures that include steps in notifying DHCS of member changes.

It is the Plan's responsibility to guard against fraud and abuse by reporting changes in member circumstances. Failure to report to DHCS may lead to unnecessary costs resulting in compromise of the Plan and the Medi-Cal Program's fiscal integrity.

Recommendation: Develop and implement policies and procedures to ensure notification to DHCS regarding changes in a member's circumstances that may affect member eligibility.

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REPORT ON THE MEDICAL AUDIT OF

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2022

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I. INTRODUCTION

This report presents the audit findings of Santa Barbara San Luis Obispo Regional Health Authority dba CenCal Health (Plan) State Supported Services Contract No. 08-85219. The State Supported Services Contract covers abortion services for the Plan.

The audit period is from October 1, 2021 through September 30, 2022. The review was conducted from October 17, 2022 through October 28, 2022, which consisted of document review of materials provided by the Plan and interviews with the Plan's administration and staff.

An Exit Conference with the Plan was held on April 20, 2023.

❖ COMPLIANCE AUDIT FINDINGS (CAF) ❖

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

AUDIT PERIOD: October 1, 2021 through September 30, 2022
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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. *(State Supported Services Contract, Exhibit A(1))*

The Plan's policy CLM-09, *State Supported Services/Pregnancy Termination/Abortion* (revised July 22, 2022), 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.

The Member Handbook informs members that some providers may have a moral objection to abortion and have a right not to offer the service. However, the Plan instructs members to contact the Plan or their primary care provider (PCP) for assistance. Members are also informed that referrals are not needed from PCPs for abortion and abortion-related services.

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

The audit found no discrepancies in this section.

Recommendation: None.