

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

REPORT ON THE MEDICAL AUDIT OF

**CENCAL HEALTH PLAN**

Contract Number: 08-85212

Audit Period: November 1, 2018  
Through  
October 31, 2019

Report Issued: March 13, 2020

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## I. INTRODUCTION

The CenCal Health Plan (Plan) was established in 1983 originally as the Santa Barbara Health Initiative. The Plan has expanded its service area to cover two counties, Santa Barbara and San Luis Obispo.

The Plan is a public entity that is 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 including prescription drugs.

As of August 31, 2019, the Plan's enrollment totals for its Medi-Cal line of business was 175,598. Membership composition by county was 123,923 for Santa Barbara; 51,675 for San Luis Obispo.

## II. EXECUTIVE SUMMARY

This report presents the audit findings of the Department of Health Care Services (DHCS) medical review audit for the review period of November 1, 2018, through October 31, 2019. The on-site review was conducted from November 4, 2019 through November 15, 2019. The audit consisted of document review, verification studies, and interviews with Plan personnel.

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

During the audit period, the Plan participated 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, 2017, through October 31, 2018, was issued on April 4, 2019. The audit examined documentation for compliance and to determine to what extent the Plan has operationalized their Corrective Action Plan.

An Exit Conference with the Plan was held on February 19, 2020. 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 February 5, 2020, the Plan submitted a response after the Exit Conference. The results of the evaluation to the Plan's response are reflected in this report.

The summary of the findings by category are as follows:

### **Category 1 – Utilization Management**

The Contract requires the Plan to monitor, evaluate, and take effective action to address any needed improvements in the quality of care delivered by all providers rendering services on its behalf, in any setting. State regulations require the Plan to conduct concurrent reviews with the provision of health care services to members. The Plan did not provide oversight and concurrent reviews for beneficiaries residing in Skilled Nursing Facilities (SNFs), Intermediate Care Facilities (ICFs), and Long Term Care Facilities (LTCs) managed by a contracted entity.

The Contract requires the Plan to maintain a system to ensure accountability for delegated quality improvement activities. The Plan failed to ensure initial and ongoing assessments of their Pharmacy Benefit Manager's (PBM) sub-contracted delegated entity, responsible for the PBM's UM activities.

*APL 17-018* allows Non-Physician Medical Practitioner (NMPs) referrals to mental health providers when the condition is above their scope of practice, however the Plan's delegate's policy allows denial of mental health services if requested by NMPs.

## **Category 2 – Case Management and Coordination of Care**

CCS eligible members may receive Maintenance and Transportation reimbursement. The Plan's Maintenance and Transportation Program reimburses members below the standards as defined in CCS Numbered Letter 03-0810.

*APL 18-006* criteria for Behavioral Health Treatment (BHT) no longer requires a Comprehensive Diagnostic Evaluation (CDE) to initiate BHT services. The Plan's delegated entity still requires a CDE to initiate BHT services.

## **Category 3 – Access and Availability of Care**

The Plan is required to ensure network providers are enrolled in the Medi-Cal Program. The Plan did not ensure that contracted pharmacy providers are enrolled in the Medi-Cal program.

The Plan is required to distribute a Provider Directory and to ensure the accuracy of the information contained therein. The Plan did not maintain an accurate online and printed Provider Directory, as required by the Contract and Health and Safety Code, section 1367.27. The Plan's printed and online Provider Directories did not list behavioral and mental health providers.

## **Category 4 – Member's Rights**

The Contract requires the Plan to resolve each grievance within 30 calendar days from the date the Plan receives the grievance. The Plan's policy and procedure stated that all grievances are resolved in 45 business days.

The Plan is required to record each grievance received verbally or in writing in a grievance log. The Plan failed to document grievances received from members regarding mental health issues.

The Contract requires the Plan to report security incidents, breaches, unauthorized access, use or disclosure of Protected Health Information (PHI) or personal information (PI) to the appropriate DHCS officers within required timeframes. The Plan did not report the security incidents, breaches, unauthorized access, use or disclosure of PHI or PI to the appropriate DHCS officers within the required timeframes.

## **Category 5 – Quality Management**

No findings noted for the audit period.

**Category 6 – Administrative and Organizational Capacity**

No findings noted for the audit period.

## II. SCOPE/AUDIT PROCEDURES

### **SCOPE**

The audit was conducted by 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 contracts.

### **PROCEDURE**

DHCS conducted an on-site audit of the Plan from November 4, 2019, through November 15, 2019. 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 the Plan administrators and staff.

The following verification studies were conducted:

#### **Category 1 – Utilization Management**

Delegation of UM: 16 medical prior authorization files were reviewed for timeliness, consistent application of Plan's criteria, communication clarity, cultural/linguistic attentiveness, and overall regulatory adherence.

Prior authorization requests: 16 medical and 29 pharmacy prior authorization requests were reviewed for timeliness, consistent application of criteria, and appropriate review.

Appeal procedures: 29 medical and 18 pharmacy appeals were reviewed for appropriate and timely adjudication.

#### **Category 2 – Case Management and Coordination of Care**

CCS requirements: Five medical records were reviewed to evaluate coordination and performance of services and to verify the implementation of Whole Child Model Program.

BHT: Five files were reviewed for coordination, completeness, and compliance with BHT requirements.

Non-Emergency Medical Transportation: Seven claims were reviewed to confirm compliance with Non-Emergency Medical Transportation requirements.

Non-Medical Transportation: Nine claims were reviewed to confirm compliance with the Non-Medical Transportation requirements.

#### **Category 3 – Access and Availability of Care**

Appointment availability verification: Three specialists were reviewed. The third next

available appointments were used to measure access to care.

Emergency services and family planning claims: 31 emergency services and seven family planning claims were reviewed for appropriate and timely adjudication.

#### **Category 4 – Member’s Rights**

Grievance procedures: 39 grievances (24 Quality of Care, ten Quality of Service, five exempt) were reviewed for timely resolution, response to complainant, and submission to appropriate level for review.

Health Insurance Portability and Accountability Act (HIPAA): Four HIPAA cases were reviewed for appropriate reporting and proper treatment.

#### **Category 5 – Quality Management**

Provider training: 39 new provider-training records were reviewed for timely provision of Medi-Cal Managed Care program training.

#### **Category 6 – Administrative and Organizational Capacity**

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

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



**❖ COMPLIANCE AUDIT FINDINGS (CAF) ❖**

**PLAN:** CenCal Health Plan

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**CATEGORY 1 - UTILIZATION MANAGEMENT**

<b>1.1</b>	<b>• UTILIZATION MANAGEMENT PROGRAM</b>
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**1.1.1 Oversight and Concurrent Reviews of Contracted Skilled Nursing Facilities, Intermediate Care Facilities, and Long Term Care Facilities**

The Plan shall monitor, evaluate, and take effective action to address any needed improvements in the quality of care delivered by all providers rendering services on its behalf, in any setting. The Plan shall be accountable for the quality of all covered services regardless of the number of contracting and subcontracting layers between the Plan and the provider.

*(Contract, Exhibit A, Attachment 4)*

*Health and Safety Code, section 1367.01(a)* “A health care service plan and any entity with which it contracts for services that include utilization review or utilization management functions, that prospectively, retrospectively, or concurrently reviews and approves, modifies, delays, or denies, based in whole or in part on medical necessity, requests by providers prior to, retrospectively, or concurrent with the provision of health care services to enrollees, or that delegates these functions to medical groups or independent practice associations or to other contracting providers, shall comply with this section.”

According to, California Code of Regulations (CCR), Title 22, sections 51335(e) “The attending physician must recertify, at least every 60 days, the patient’s need for continued care in accordance with the procedures specified by the Director. The attending physician must comply with this requirement prior to the start of the 60 day period of stay for which the patient is being recertified.”

**Finding:** The Plan did not meet oversight and concurrent review levels for beneficiaries residing in SNF, ICF, and LTC facilities managed by a contracted entity.

Concurrent review is the evaluation of a beneficiary’s medical care while he or she is in an inpatient setting, SNF, ICF, or LTC, to ensure that appropriate and quality care is being provided at the appropriate level of service and that the continuing stay there is medically necessary.

The Plan is ultimately responsible for monitoring, evaluating, and taking corrective action for needed quality of care improvements for all medical care delivered by providers to beneficiaries on its behalf in all settings, regardless of the number of contracting and subcontracting layers between the Plan and providers.

## ❖ COMPLIANCE AUDIT FINDINGS (CAF) ❖

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The Plan's, *Policy and Procedure HS-UM-01, Concurrent Review*, described that the Plan must perform, as appropriate, concurrent utilization review to evaluate a beneficiary's care while in an inpatient setting or under outpatient observation status, with the goal being that the beneficiaries receive the right level of care at the right time. This concurrent review allows the Plan to determine if the beneficiary's status of admission to a hospital or other facility remains medically necessary i.e. meets medical necessity. During interviews, the Plan explained that they had not been performing concurrent utilization reviews for their beneficiaries in SNFs and other facilities, such as ICFs and LTCs.

In correspondence during the audit period between the Plan's Compliance Officer and DHCS subsequent to a grievance investigation of contracted entity SNFs by the Plan, it was written that the SNFs failed to maintain accurate medical records on patients and that the primary care physicians in the SNFs were not visiting beneficiaries every 60 days for recertification purposes as required by *CCR, Title 22, section 51335(e)*.

As per the, *Contracted SNF Entity Agreement, Exhibit A(4)(E)*, the attending physicians caring for SNF beneficiaries must recertify, at least every 60 days, the beneficiary's medical necessity for continued care in the facility. Because the Plan indicated in audit interviews that it had not been performing concurrent utilization reviews on the SNF beneficiaries, it was not ascertained whether or not that the SNFs were keeping accurate medical records and that the 60 day attending physician requirement was being met.

During the audit interviews, the Plan stated that it was the responsibility of the contracted entity SNFs to ensure that continuing medical care of the beneficiaries was appropriate. This is contrary to the Plan Contract, *Exhibit A, Attachment 4, Quality Improvement System*: "The Plan shall monitor, evaluate, and take effective action to address any needed improvements in the quality of care delivered by all providers rendering services on its behalf, in any setting. The Plan shall be accountable for the quality of all covered services regardless of the number of contracting and subcontracting layers between the Plan and the provider." To summarize, the Plan always has the ultimate responsibility for the quality of care delivered to all beneficiaries.

The *Contracted Entity Agreement, Compliance Section 10.1* stated that, "Facility representatives shall serve on the Plan's committees that address utilization review and quality assurance, as applicable, without compensation from the Plan." During audit interviews, the Plan stated that the contracted entity SNFs had no representatives on any of the Plan's committees, which was not aligned with the written Contract between the contracted entity SNFs and the Plan. Insufficient interaction between the Plan and the contracted entity SNF officials would make it more difficult to identify and correct utilization and quality issues as they arise.

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When the Plan does not provide adequate oversight and concurrent reviews for beneficiaries in SNF, ICF, or LTC facilities, there is an increased risk of beneficiaries not receiving appropriate medical care.

**Recommendation:** The Plan should follow its' UM policy and procedure, contracted entity SNF agreement, and applicable Contract and regulatory requirements in regards to concurrent reviews, medical record reviews, and oversight of beneficiaries at SNFs, ICFs and LTCs.

## ❖ COMPLIANCE AUDIT FINDINGS (CAF) ❖

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1.2

### • DELEGATION OF UTILIZATION MANAGEMENT

#### 1.2.1 Annual Assessment of a Sub-Delegate.

The Contract requires the Plan to maintain a system to ensure accountability for delegated quality improvement activities, that at a minimum:

- (1) Evaluates subcontractor's ability to perform the delegated activities including an initial review to assure that the subcontractor has the administrative capacity, task experience, and budgetary resources to fulfill its responsibilities.
- (2) Ensures subcontractor meets standards set forth by the Plan and DHCS.
- (3) Includes the continuous monitoring, evaluation, and approval of the delegated functions.

*(Contract, Exhibit A, Attachment 4,(6)(B))*

*APL 17-004* stated, "Regardless of the relationship that the Plan has with a subcontractor, whether direct or indirect through additional layers of contracting or delegation, the Plan has the ultimate responsibility for adhering to, and fully complying with, all terms and conditions of its Contract with DHCS."

The Plan's policy and procedure *HS-UM05, Pre-Service Review* stated, "At least annually, the Plan's UM Department will perform an oversight delegation review of entities who are delegated for UM activities."

The Plan's policy and procedure *CPL-30, Delegate Annual Audit Process* stated, "It is the responsibility of the entire management team to ensure ongoing auditing and monitoring of delegated entities is properly executed, documented, and evidenced at least annually."

**Finding:** The Contract requires the Plan to maintain a system to ensure accountability for delegated quality improvement activities. The Plan failed to conduct initial and ongoing assessments of their PBM sub-contracted delegated entity responsible for the PBM's UM activities.

The Plan conducted a pre-delegation review of their PBM. The PBM, however, contracted with another entity for its UM delegated activities according to the UM PBM 2018 Program Evaluation. The Plan never assessed the subcontracted delegated entity or ensured the PBM conducted oversight of its subcontracted delegated entity.

By not conducting or ensuring oversight of a subcontracted delegated entity, the Plan cannot ensure UM processes are followed according to State regulations. This lack of oversight could place members at risk of receiving services that do not meet standards set forth by the Plan and DHCS.

❖ **COMPLIANCE AUDIT FINDINGS (CAF)** ❖

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**Recommendation:** Implement policies and procedures to ensure all direct and indirect delegates and subcontractors comply with all terms and conditions of the Plan's Contract with DHCS.

## ❖ COMPLIANCE AUDIT FINDINGS (CAF) ❖

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1.5

### • MENTAL HEALTH AND SUBSTANCE ABUSE

#### 1.5.1 Outpatient Mental Health Services.

The Contract stated, “Primary care provider means a person responsible for supervising, coordinating, and providing initial and primary care to patients; for initiating referrals; and, for maintaining the continuity of patient care. A primary care provider may be a primary care physician or non-physician medical practitioner.” The Contract further stated, “Non-physician medical practitioners (Mid-Level Practitioner) means a nurse practitioner, certified nurse midwife, or physician assistant authorized to provide primary care under physician supervision.”

(Contract, Exhibit E, Attachment 1,)

APL 17-018 stated, “At any time, beneficiaries can choose to seek and obtain a mental health assessment from a licensed mental health provider within the Plan’s provider network. Each Plan is still obligated to ensure that a mental health screening of beneficiaries is conducted by network primary care provider. The APL further stated primary care provider’s must refer the beneficiary to mental health providers when condition is above his/her scope of practice.”

The Plan’s delegated entity’s policy and procedure, *Utilization Management Plan 2019* stated, “In addition to the Associate Medical Director(s) or staff psychiatrist designee, a Behavioral Health Care Advisor who is a licensed psychologist may deny non-physician requests for outpatient services.”

**Finding:** APL 17-018 allows non-physician medical practitioner referrals to mental health providers when the condition is above his/her scope of practice. The Plan’s delegate’s policies and procedures allow for improper denial of mental health services if requested by a non-physician medical practitioner.

The Plan’s delegated entity’s policies and procedures did not make a distinction between mental health and behavioral health requirements. Mental health services can be addressed by non-physician medical practitioners while behavioral health services are prescribed by a medical professional.

The Plan’s members who receive care from non-physician medical practitioners and referrals for their outpatient mental health services may be denied by the delegated entity; which could result in members not receiving needed mental health services.

**Recommendation:** Ensure mental health delegate’s materials and procedures allow for non-physician medical practitioners referrals for outpatient mental health services.

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**CATEGORY 2 – CASE MANAGEMENT & CORDINATION OF CARE**

**2.1**

**• CALIFORNIA CHILDREN’S SERVICES (CCS)**

**2.1.1 CCS Maintenance and Transportation Reimbursement**

The Contract states, “Ensure that, once eligibility for the CCS program is established for a member, the Plan shall continue to provide all Medically Necessary Covered Services that are unrelated to the CCS -eligible condition and shall monitor and ensure the coordination of services and joint case management between its primary care providers, the CCS specialty providers, and the local CCS program.”  
*(Contract, Exhibit A, Attachment 11,(10)(A)(5))*

*APL 18-023* stated, “Plans must provide and authorize the CCS Maintenance and Transportation benefit for CCS-eligible members or the member’s family seeking transportation to a medical service related to their CCS-eligible condition when the cost of Maintenance and Transportation presents a barrier to accessing authorized CCS services. Maintenance and Transportation services include meals, lodging, and other necessary costs (e.g. parking, tolls, etc.), in addition to transportation expenses, and must comply with the requirements listed in CCS N.L. 03-0810. These services include, but are not limited to, Maintenance and Transportation for out-of-county and out-of-state services.”

**Finding:** The Plan’s policies and procedures for Maintenance and Transportation reimbursement do not comply with *APL 18-023* which cites the authority of CCS Numbered Letter (N.L.) 03-0810. The Plan’s Maintenance and Transportation Program policy HS-PEDS254SOP, reimburses members below the standards set in CCS N.L. 03-0810.

- The Plan’s Meals and Lodging reimbursement covers a maximum of seven days for every 30 days; while CCS N.L. 03-0810 reads 15 days of coverage for each 30 days.
- The Plan’s Meal reimbursement is covered at maximum of \$30.00 a day per family; while the CCS N.L. 03-0810 stated \$15.00 per day/ per person.
- The Plan’s reimbursement for Lodging costs will cover a maximum of \$100.00 per night. However, the CCS N.L. 03-0810 stated that maximum covered amount is based on the State of California employee-lodging rate. CCR Title 2, section 599.619 reads that lodging in the State of California is between \$84.00 and \$140.00 in addition to tax. The out-of-state travel is based on actual lodging-expenses.

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The Plan's reimbursement for other necessary expenses (i.e. parking, tolls) is covered at maximum of \$10.00 a day. The CCS N.L. 03-0810 identifies full coverage with the receipt.

The Plan representatives stated that price ranges in the CCS N.L. 03-0810 are outdated and do not reflect current cost.

Patients will have limited availability of resources during medical – related travel, as the Plan's reimbursement rates are lower than required in CCS N.L. 03-0810.

**Recommendation:** Revise and implement Maintenance and Transportation policy by aligning it with the CCS N.L. 03-0810.



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### 2.2 • BEHAVIORAL HEALTH TREATMENT (BHT)

#### 2.2.1 Initiating Behavioral Health Services

The Contract states, “Services for members under 21 years of age: The Plan shall cover and ensure the provision of screening, preventive, medically necessary diagnostic, and treatment services for members under 21 years of age, including Early and Periodic Screening, Diagnosis and Treatment (EPSDT) Supplemental Services. The Plan shall inform members that EPSDT services are available for members under 21 years of age, as well as how to access services.”

*(Contract, Exhibit A, Attachment 10,(5))*

*APL 18-006* stated that licensed physician and surgeon or a licensed psychologist can recommend BHT services based on medical necessity. As all members under 21 years of age that meet medical necessity criteria, even without a diagnosis of Autism Spectrum Disorder, are qualified for BHT services, differentiation of diagnosis is not necessary.

The Plan’s policy and procedure, *HS-BH300, Behavioral Health Treatment* stated, “Children identified after a developmental screening by a Plan contracted provider presenting with developmentally inappropriate behaviors will be referred immediately for diagnosis and treatment that may include BHT.”

The Plan’s mental and behavioral health delegated entity document, *Behavioral Health Treatment Annual Program Evaluation 2018* stated, “In 2018, the referral for BHT services can be depicted using the following process: When a member contacts the delegate the Behavioral Health Care Advisor will obtain a prescription from the member’s primary care physician for Applied Behavior Analysis (ABA) services. The Health Care Advisor will then authorize a CDE if one has not been completed in the last three years. Once the CDE is completed and ABA services have been recommended the member is referred for a Functional Behavioral Assessment. Upon completion of the Functional Behavioral Assessment the member will be authorized for ABA services for a six month period based on medical necessity.”

**Finding:** *APL 18-006* criteria for BHT no longer requires a CDE to initiate BHT services. The Plan’s delegated entity still requires a CDE to initiate BHT services.

The Plan stated that the CDE is needed to identify and establish diagnosis prior to treatment.

Members may experience delays in receiving BHT due to the Plan requiring the completion of unnecessary steps.

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**Recommendation:** In adherence to *APL 18-006*, revise and implement policies and procedures by removing the requirement of a CDE to initiate BHT services.

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### CATEGORY 3 – ACCESS AND AVAILABILITY OF CARE

#### 3.1 • ACCESS TO PHARMACEUTICAL SERVICES

##### 3.1.1 Enrollment of Pharmaceutical Providers

The Contract stated, “All Policy and APLs issued by DHCS Medi-Cal Managed Care Division subsequent to the effective date of this Contract shall provide clarification of the Plan’s obligations pursuant to this Contract, and/or inform and provide clarification to the Plan regarding mandated changes in state or federal law, regulations, or pursuant to judicial interpretation, but shall not add new obligations to the Contract.”

*(Contract, Exhibit E, Attachment 2,(1)(D))*

In accordance to, *Code of Federal Regulations, Title 42, section 438.608 (b)*, the State, through its contracts with a Managed Care organization entity must ensure that all network providers are enrolled with the State as Medicaid providers consistent with the provider disclosure, screening and enrollment requirements of part 455, subparts B and E of this chapter.

*APL 17-019* stated, “Plans are required to maintain contracts with their network providers and develop and implement a Managed Care provider screening and enrollment process that meets the requirements of *APL 17-019*, or direct their network providers to enroll through DHCS.”

*APL 19-004* stated, “The Plan network providers that have a state-level enrollment pathway must enroll in the Medi-Cal program. State-level enrollment pathways are available either through DHCS Provider Enrollment Division (PED) or another State Department with a recognized enrollment pathway. The Plan has the option to develop and implement a Managed Care provider screening and enrollment process that meets the requirements of this APL, or the Plan may direct their network providers to enroll through a state-level enrollment pathway.”

**Finding:** A review of a sample of pharmacies in the network indicated they were not enrolled in the Medi-Cal program. There is no documentation indicating that the Plan conducted oversight of the PBM to ensure the requirements outlined in the *APL 19-004* or *APL 17-019* were implemented.

Although the Plan has a process for enrolling medical providers to their network, the process did not meet the requirements outlined in APLs.

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The Plan did not have a Managed Care provider screening and enrollment process which meets *APL 19-004* requirements. Also, the Plan did not ensure that providers were individually identified and screened for enrollment in the Medi-Cal program.

Without effective screening and enrollment oversight processes, the Plan may include providers in their network who do not meet Medi-Cal program enrollment requirements.

**Recommendation:** Develop and implement a Managed Care provider screening and enrollment process to meet *APL 19-004* requirements or direct network providers to enroll through a state-level enrollment pathway.

### 3.1.2 Provider Directory

The Plan is required to distribute a Provider Directory and to ensure the accuracy of the information contained therein. The Plan did not maintain an accurate online and printed Provider Directory, as required by the Contract and *Health and Safety Code, section 1367.27*

The Contract stated, “The name, National Provider Identifier (NPI) number, address, and telephone number of each Service Location (e.g., locations of hospitals, primary care physicians, specialists, optometrists, psychologists, pharmacies, SNF, urgent care facilities, Federally Qualified Health Centers, Indian Health Programs). In the case of a medical group/foundation or independent practice association, the medical group/foundation or independent practice association name, NPI number, address, and telephone number shall appear for each provider. The hours and days when each of these facilities is open, the services and benefits available, including which, non-English languages are spoken, the telephone number to call after normal business hours, and accessibility symbols are approved by DHCS, and identification of providers that are not accepting new patients.”

*(Contract, Exhibit A, Attachment 13,(4)(D)(4))*

**Finding:** The Plan’s printed and online Provider Directories did not list behavioral and mental health providers name, address, NPI, telephone number, and hours of business.

The Plan listed the number for the behavioral and mental health delegate rather than the numbers for each behavioral and mental health provider. The Plan sought to have members go through the delegated entity to receive behavioral and mental health services.

Members may not be aware of available behavioral and mental health providers and unable to make an informed choice.

**Recommendation:** Include behavioral and mental health providers’ information in the printed and online Provider Directory as it is required in the Contract.

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### CATEGORY 4 – MEMBER’S RIGHTS

#### 4.1 • GRIEVANCE SYSTEM

##### 4.1.1 Grievance Resolution

The Contract stated, “The Plan shall resolve each grievance and provide notice to the member as quickly as the member’s health condition requires, or within 30 calendar days from the date the Plan receives the grievance.”

*(Contract, Exhibit A, Attachment 14,(1))*

*APL 17-006* stated, “Plans shall continue to comply with the State’s established timeframe of 30 calendar days for grievance resolution.”

*CCR, Title 22, section 53858(g)(1)* stated, “Member grievances shall be resolved within 30 days of the member’s submittal of a written grievance or if the grievance is made verbally, it shall be resolved within 30 days of the written record of the grievance.”

The Plan’s policy and procedure, *300-1000-M, Member Grievance System (Complaints/ Appeals)* stated, “All complaints and appeals are resolved within 30 calendar days and members are notified of the resolution in writing.”

The Plan’s policy and procedure, *MSSOP-002, Grievances Process* stated, “Final letter to be mailed by day 30 at very latest, but on the earliest day of closure.”

The Plan’s policy and procedure, *MS20, Member Grievance and Appeals System* stated, “The Member Services Grievance Coordinator notifies members, in writing that the Plan has finished its review of their grievance no later than 30 calendar days from its receipt.”

The Plan’s policy and procedure, *PS-CR07, Member Grievance and Appeals System*, stated, “All grievances are resolved within 45 business days. The policy is inconsistent with *APL 17-006*, state regulation, and the Plan’s Contract.”

The Plan’s policy and procedure, *PS-CR07, Member Grievance and Appeals System*, stated, “Receipt and Resolution of a Provider Complaint: a.) The Provider Services Department is charged with the resolution of provider complaints. The complaint may be related to: member issues, another provider’s care or treatment, a clinical or quality of care issue, aspects of the Plan’s administration of its programs, or other issues. The provider may file a complaint with the Provider Services Department via a telephone call, by fax, or through other written means.”

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**Finding:** The Plan's policy *PS-CR07* read that all grievances are resolved in 45 business days. All grievances must be resolved within 30 calendar days.

The Plan stated, *Policy 400-4420, Provider/Member Treatment Authorization Request Appeals Process*, had been retired, and replaced with policy *PS-CR07*. However, policy *PS-CR07* referenced *Policy 400-4420*. Policy *PS-CR07* stated that all grievances are resolved in 45 business days. The Plan stated this only referenced provider grievances. Providers can submit grievances on behalf of members, therefore the policy is inconsistent with *APL 17-006*, state regulations, and their Contract with DHCS.

Delays in resolving grievances related to clinical or quality of care issues could adversely impact member health outcomes.

**Recommendation:** Amend policies to be consistent with the Contract and state regulation.

### 4.1.2 Recording of Grievances

The Contract stated, "Grievance logs shall include all the required information set forth in CCR, Title 22, section 53858(e)." *(Contract, Exhibit A, Attachment 14,(3)(A))*

*CCR, Title 22, section 53858(a)* stated, "Each plan in a designated region shall establish and maintain written procedures for the submittal, processing, and resolution of all member grievances and complaints. The regulation further states *(e)(1)* The recording in a grievance log of each grievance received by the Plan, either verbally or in writing."

*CCR, Title 28, section 1300.68 (a)* stated "The grievance system shall be established in writing and provide for procedures that will receive, review, and resolve grievances within 30 calendar days of receipt by the Plan, any provider, or entity with delegated authority to administer and resolve the Plan's Grievance System. The following definitions shall apply with respect to the regulations relating to Grievance Systems: (1) "Grievance" means a written or verbal expression of dissatisfaction regarding the Plan and/or provider, including quality of care concerns, and shall include a complaint, dispute, request for reconsideration, or appeal made by an enrollee or the enrollee's representative. Where the Plan is unable to distinguish between a grievance and an inquiry, it shall be considered a grievance."

*APL 17-006* stated, "Plans shall maintain a written record for each grievance and appeal received by the Plan."

## ❖ COMPLIANCE AUDIT FINDINGS (CAF) ❖

**PLAN:** CenCal Health Plan

**AUDIT PERIOD:** November 1, 2018 through October 31, 2019

**DATE OF AUDIT:** November 4, 2019 through November 15, 2019

The Plan's policy and procedure, *MS-20, Member Grievance and Appeals System*, stated, "Document all grievances and/or appeals into the Plan's online tracking system as soon as either is identified."

The Plan's policy and procedure, *300-1000, Member Grievance and Appeals System* stated, "Should a Plan member contact the Plan and express their dissatisfaction with either the mental health and behavioral health delegate's or the mental health plan of the respective county, the Plan's call centers', Member Services Representative (MSR), will offer to warm transfer the member to either the mental health and behavioral health delegate or the appropriate county mental health plan."

**Finding:** The Plan failed to document grievances received from beneficiaries regarding mental health issues.

During the on-site interviews, the Plan's interim Member Services Director stated that member grievances regarding the delegated entity were not logged into their Complaint of Grievance (COG) database. This conflicts with state regulations and their Contract with DHCS.

By not logging all grievances into their COG system, the Plan could lose track of a member's grievance. Potentially resulting in adverse health outcomes for members and impacts to their appeal rights and the ability to address the problems.

**Recommendation:** Revise and implement policies and procedures to ensure compliance with the Contract and state regulations regarding grievances.

## ❖ COMPLIANCE AUDIT FINDINGS (CAF) ❖

**PLAN:** CenCal Health Plan

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### 4.2 • CONFIDENTIALITY RIGHTS

#### 4.2.1 HIPAA Breach Reporting

The Contract stated, “the Plan agrees to implement reasonable systems for the discovery and prompt reporting of any breach or security incident, and to take the following steps:

- Notify DHCS immediately, within 24 hours, by telephone call plus email or fax upon the discovery of a breach of unsecured PHI or PI in electronic media or in any other media if the PHI or PI was, or is reasonably believed to have been, accessed or acquired by an unauthorized person, or upon the discovery of a suspected incident that involves data provided to DHCS by the Social Security Administration. Notice shall be provided to the DHCS Program Contract Manager, the DHCS Privacy Officer, and the DHCS Information Security Officer. Notice shall be made using the “DHCS Privacy Incident Report” form, including all information known at the time.
- Immediately investigate such security incident, breach, or unauthorized access, use or disclosure of PHI or PI and report within 72 hours of the discovery with an updated “DHCS Privacy Incident Report” containing the information marked with an asterisk and all other applicable information listed on the form, to the extent known at that time, to the DHCS Program Contract Manager, the DHCS Privacy Officer, and the DHCS Information Security Officer.
- Provide a complete report of the investigation to the DHCS Program Contract Manager, the DHCS Privacy Officer, and the DHCS Information Security Officer within ten working days of the discovery of the breach or unauthorized use or disclosure. The report shall be submitted on the DHCS Privacy Incident Report.”  
(Contract, Exhibit G, (3)(J)(1))

The Plan’s policy and procedure *Section II.C.2 HIPAA Privacy, Business Associates*, stated, “If the Plan discovers a Business Associate or itself breached the security of PHI, DHCS must be notified immediately.” The policy and procedure lists the contract requirements for reporting timeframes, the appropriate incident reporting form to use, and the three appropriate DHCS staff to send the incident report to.

**Finding:** The Plan did not report the security incidents, breaches, unauthorized access, use or disclosure of PHI or PI to the appropriate DHCS officers within the required timeframes.

A verification study was conducted for the four cases listed on the Plan’s HIPAA Privacy Incident Log. The cases were reported to the appropriate DHCS officers on the DHCS Privacy Incident Report form; however, three of the cases were not reported within the required timeframes of 24 hours, an updated report within 72 hours, and a final report



**❖ COMPLIANCE AUDIT FINDINGS (CAF) ❖**

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within ten working days of discovery. The final reports submitted were 58, 62, and 52 working days after discovery.

The Plan staff stated in the interview that the previous Privacy Officer retired. In the transition to the new Compliance and Privacy Officer, the Privacy Incident Reports were not filed. The new Compliance and Privacy Officer and the Compliance Investigator did not follow the Plan's policies and procedures.

The Plan provided a written statement explaining why the Privacy Incident Reports filed were not timely: "The Plan underwent a transition of the Privacy Officer in July 2019. The transition lacked proper handoff of the Privacy Office's requirements and operations. When the Plan realized there were contractual obligations to report HIPAA incidents and breaches to DHCS all HIPAA incidents were reported."

Untimely reporting of suspected security incidents and breaches to the appropriate DHCS officers may hinder DHCS's ability to immediately take appropriate action to protect member's PHI whose information potentially could have been disclosed .

This is a repeat of prior year finding 4.3.1 - Confidentiality Rights

**Recommendation:** Implement policies and procedures to ensure the Plan reports suspected security incidents and breaches to the appropriate DHCS officers within the required timeframes and develop and implement a system of controls to ensure continuity of operations and compliance.

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

REPORT ON THE MEDICAL AUDIT OF

**CENCAL HEALTH PLAN**

Contract Number: 08-85219  
State Supported Services

Audit Period: November 1, 2018  
Through  
October 31, 2019

Report Issued: March 13, 2020

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## **I. INTRODUCTION**

This report represents the recent audit of GenCal Health Plan (Plan) State Supported Services Contract No. 08-85219. The State Supported Services contract covers abortion services for the Plan.

The audit period was November 1, 2018 through October 31, 2019. The onsite audit was conducted from November 4, 2019 through November 15, 2019.

An Exit Conference with the Plan was held on February 19, 2020.

❖ **COMPLIANCE AUDIT FINDINGS (CAF)** ❖

**PLAN: CenCal Health Plan**

**AUDIT PERIOD: November 1, 2018 through October 31, 2019**

**DATE OF AUDIT: November 4, 2019 through November 15, 2019**

**STATE SUPPORTED SERVICES CONTRACT REQUIREMENTS**

The Plan agrees 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. Such changes shall not require an amendment to this Contract. *(Contract, Exhibit A, (4))*

Plan Policy No.CLM-09: *State Supported Services/Pregnancy Termination/Abortion*, The Plan has implemented procedures to ensure members can access State Supported Service without prior authorization. This applies to both contracted and non-contracted providers. Medical justification and authorization for pregnancy termination/abortion are not required. Inpatient hospitalization for the performance of an abortion requires prior authorization under the same criteria as other medical procedures.

The onsite interview confirmed the Plan provided State Supported Services to its members and all required procedure codes were verified within their billing system. There were no deficiencies noted during the audit period.