MEDICAL REVIEW - SOUTHERN SECTION II
AUDITS AND INVESTIGATIONS
DEPARTMENT OF HEALTH CARE SERVICES

Orange County Organized Health System dba CalOptima

Contract Number: 08-85214

Audit Period: July 1, 2013
Through
June 30, 2014

Report Issued: January 5, 2015

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I. INTRODUCTION

The audit report represents the findings from the medical audit of CalOptima and their implementation of their County Organized Health System (COHS) Managed Care Contract for Orange County with the State of California.

CalOptima was founded in 1993 via a partnership of local government, the medical community (both hospitals and physicians) and health advocates. Their mission is to provide members with access to quality health care services delivered in a cost-effective and compassionate manner.

The Medical Review Branch conducted a full scope review of the requirements in CalOptima's Medi-Cal contract (No. 08-85214). The purpose of the review was to determine if the Plan was in compliance with the Medi-Cal contract and other applicable laws and regulations. Evaluation of the Plan's compliance with the contract and regulations in the area of Utilization Management, Case Management and Coordination of Care, Access and Availability of Care, Member's Rights, Quality Management, and Administrative and Organizational Capacity was performed.

In addition, the Medi-Cal Managed Care Division (MMCD) requested that the Medical Review Branch review the Corrective Action Plan from the Focused Medical Review conducted in February 2014. The focus was to ensure that the Plan has developed the policies to provide services and implemented the processes to comply with the Medi-Cal contract requirements and other applicable laws and regulations.

The Plan currently has several programs to provide medical care to its members residing in Orange County. As of July 2014, enrollment in these programs is as follows:

- **Medi-Cal**: 627,661 California's Medi-Cal recipients, since 1993
- **OneCare**: 14,914 Medicare/Medi-Cal recipients, since 2005
- **Multipurpose Senior Services Program**: 435 recipients of the Medi-Cal Home and Community-based Services Program (HCBS) administered by the California Department of Aging (CDA), since 2009
- **PACE**: 51 Medicare and Medi-Cal recipients, since 2013

II. EXECUTIVE SUMMARY

This report presents the audit findings of the Department of Health Care Services (DHCS) medical audit for the period of July 1, 2013 through June 30, 2014. The on-site review was conducted from September 29, 2014 through October 10, 2014. The audit consisted of document reviews, verification studies, and interviews with Plan personnel.

An Exit Conference was held on November 24, 2014 with the Plan. The Plan was allowed 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), Case Management and Coordination of Care, Access and Availability of Care, Members' Rights, Quality Management, and Administrative and Organizational Capacity.

The summary of the findings by category is as follows:

Category 1 – Utilization Management

The Plan did not implement the reporting of utilization data that demonstrates Utilization Management and Quality Improvement integration.

The Plan and the Delegated Networks did not implement their Prior Authorization determination tools. In addition, medical and pharmacy Prior Authorizations were not resolved within the required timeframe. Furthermore, Notice of Action letters were not sent to the Members in a timely manner.

The Plan's Policies do not have a specific system to track all referrals, including open or unused referrals, as required by the Contract.

The Plan did not resolve expedited appeals within the contractual timeframe.

Category 2 – Case Management and Coordination of Care

The Plan lacked monitoring system to ensure that Members who are eligible for Case Management receive these services and that coordination of Care occurs between the Primary Care Providers and the specialty providers.

The Member's medical records lacked documentation for Coordination of Care between Primary Care Physicians and specialists for California Children's Services and Early Intervention/Developmental Disabilities Members. In addition, the Member's medical records lacked documentation for the completion of the Initial Health Assessments.

Category 3 – Access and Availability of Care

The Plan did not develop procedures to monitor waiting times in the providers' offices. In addition, the Plan written Policy, Provider Manual, and Member Handbooks did not indicate the timeframe of the initial prenatal care appointment as per the Contract. Furthermore, access to specialty services and ancillary services standards were not specified in the Plan's Policy and Member Handbooks as required by the Contract.

The Plan's Policy did not meet the contractual requirements to indicate that there has to be a designated emergency service facility within the Service Area and this designated emergency service facility will have one or more Physicians and one (1) Nurse on duty in the facility at all times. In addition, the Member Handbooks do not inform Members needing Urgent Care services and to be seen within 24 hours.

The Plan does not have a system to ensure that providers are triaging Members' telephone calls.

The Plan's Policy does not specify that the Covered Services provided to the Members for claim processing includes Emergency Service and Family Planning claims. Also, the Plan's Policy does not indicate that misdirected Family Planning claims received by the Plan will be re-directed to the appropriate payer of service within ten (10) working days.

The Plan's Policy does not describe the requirements to provide a 72-hour supply of the drugs to a Member. In addition, the Plan did not implement effective monitoring procedures to ensure that drugs are prescribed to Members in emergency circumstances and the drugs are received. Furthermore, the Plan did not have policies and procedures for Hospital Oversight to include specific language to ensure the provision of prescribed drugs in emergency situations.

Category 4 – Member's Rights

The Plan does not follow its policies and procedures which requires the Plan to maintain and process grievances in a timely manner.

The Plan's Policy does not indicate that the investigation of a security incident or breach be submitted to the DHCS Program Contract Manager, the DHCS Privacy Officer, and the DHCS Information Security Officer within 72 hours. Also the Plan's Policy does not indicate that a complete report of the investigation will be provided to the DHCS Program Contract Manager, the DHCS Privacy Officer, and the DHCS Information Security Officer within ten (10) working days of the breach discovery. In addition, the address for the DHCS Privacy Officer in the Notice of Privacy Practices issued by the Plan is incorrect and the contact information for the DHCS Information Security Officer is not included in the Notice of Privacy Practices on the CalOptima website.

Category 5 – Quality Management

The verification study of medical records indicates that providers did not maintain complete records for the Members. Also, the Plan lacked the monitoring system in maintaining record keeping. In a separate verification study of Informed Consent documentation, the findings include improper completion of the consent forms.

Category 6 – Administrative and Organizational Capacity

The Plan's Policy does not include the contractual requirement to conduct training to all new providers within the timeframe.

The Plan did not report a potential fraud and abuse case to DHCS within the required timeframe.

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 Contract.

PROCEDURE

The on-site review was conducted from September 29, 2014 through October 10, 2014. 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

Prior Authorization Requests: 11 medical and 15 pharmacy prior authorization requests were reviewed for timeliness, consistent application of criteria, and appropriate review.

Appeal Procedures: 30 medical and 30 pharmacy prior authorization appeals were reviewed for appropriate and timely adjudication.

Category 2 – Case Management and Coordination of Care

California Children's Services (CCS): 9 medical records were reviewed for evidence of coordination of care between the Plan and CCS Providers.

Early Intervention Services and Developmental Disabilities: 7 medical records were reviewed for evidence of coordination of care between the Plan and Regional Centers.

Individual Health Assessment: 31 medical records were reviewed for completeness and timely completion.

Category 3 – Access and Availability of Care

Emergency Service Claims: 30 emergency service claims were reviewed for appropriate and timely adjudication.

Family Planning Claims: 25 family planning claims were reviewed for appropriate and timely adjudication.

Category 4 – Member's Rights

Grievance Procedures: 87 grievances were reviewed for timely resolution, response to complainant, and submission to the appropriate level for review.

Category 5 – Quality Management

Medical Records: 31 medical records were reviewed for completeness.

Informed Consent: 30 informed consent records were reviewed.

Category 6 – Administrative and Organizational Capacity

New Provider Training: 25 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.

CATEGORY 1 - UTILIZATION MANAGEMENT

1.1	UTILIZATION MANAGEMENT PROGRAM

Utilization Management (UM) Program Requirements:
Contractor shall develop, implement, and continuously update and improve, a UM program that ensures appropriate processes are used to review and approve the provision of Medically Necessary Covered Services. Contractor is responsible to ensure that the UM program includes:

A. Qualified staff responsible for the UM program.
B. The separation of medical decisions from fiscal and administrative management to assure medical decisions will not be unduly influenced by fiscal and administrative management.
C. Allowances for a second opinion from a qualified health professional at no cost to the Member.
D. Established criteria for approving, modifying, deferring, or denying requested services. Contractor shall utilize evaluation criteria and standards to approve, modify, defer, or deny services. Contractor shall document the manner in which providers are involved in the development and or adoption of specific criteria used by the Contractor.
E. Communications to health care practitioners of the procedures and services that require prior authorization and ensure that all contracting health care practitioners are aware of the procedures and timeframes necessary to obtain prior authorization for these services.
F. An established system to track and monitor services requiring prior authorization through the Contractor. The system shall include authorized, denied, deferred, or modified prior authorizations, and the timeliness of the determination. Contractor shall ensure that all contracted health care practitioners and non-contracting specialty providers are informed of the prior authorization and referral process at the time of referral.
G. The integration of UM activities into the Quality Improvement System (QIS), including a process to integrate reports on review of the number and types of appeals, denials, deferrals, and modifications to the appropriate QIS staff.
H. Procedures for continuously reviewing the performance of health care personnel, the utilization of services and facilities, and cost.

These activities shall be done in accordance with Health and Safety Code Section 1363.5.
COHS Contract A.5.1

There is a set of written criteria or guidelines for Utilization Review that is based on sound medical evidence, is consistently applied, regularly reviewed, and updated.
COHS Contract A.5.2.B

Reference Cited:

Health and Safety Code Section 1363.5 – Regarding disclosures of the Plan's process in authorizing, modifying, and denying healthcare services.

Under- and Over-Utilization:
Contractor shall include within the UM Program mechanisms to detect both under- and over-utilization of health care services. Contractor's internal reporting mechanisms used to detect Member utilization patterns shall be reported to DHCS upon request.
COHS Contract A.5.4

❖ COMPLIANCE AUDIT FINDINGS ❖	
PLAN: CalOptima	
AUDIT PERIOD: July 1, 2013 through June 30, 2014	DATE OF AUDIT: September 29 through October 10, 2014

SUMMARY OF FINDINGS:

CalOptima has a well-described Utilization Management program with annual reviews of its program description and work plan, staff and executive leadership with clear organizational hierarchy appointed full-time to its operations, and a Prior Authorization system that utilizes accepted medical criteria and standard of care. There are established committees overseeing Utilization Management, Benefits Management, Pharmacy and Therapeutics, and Quality Improvement. However, a recent audit (2014 Focused Medical Review) found deficiencies in reporting of Under-Utilization, integration of Utilization Management and Quality Improvement, proper processing of Prior Authorizations, and oversight of Health Networks with delegated services.

In response to these findings, the plan has developed the Delegation Oversight Committee, the Audit and Oversight Department, and initiated implementation of reporting systems for Prior Authorizations and inpatient utilization (CORE reports) and QI-related utilization data (Altruista/dashboard). The Plan provided the template for the CORE reports; however, the operationalizing of these reporting systems has not been implemented as of the end of the audit period and per the Corrective Action Plan for the 2014 Focused Medical Review. Implementation of these reporting systems is needed for the Plan to demonstrate full compliance with the contractual requirements for Utilization Management and Quality Improvement integration and to detect under-utilization. [COHS Contract Reference: A.5.4]

RECOMMENDATION:

Ensure that the Plan implements and operationalizes the reporting systems for Utilization Management and Quality Improvement integration and detection of under-utilization.

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:

A. Qualified health care professionals supervise review decisions, including service reductions, and a qualified Physician will review all denials that are made, whole or in part, on the basis of medical necessity. For purposes of this provision, a qualified Physician or Contractor's Pharmacist may approve, defer, modify, or deny prior authorizations for pharmaceutical services, provided that such determinations are made under the auspices of and pursuant to criteria established by the Plan medical director, in collaboration with the Plan Pharmacy and Therapeutics Committee (PTC) or its equivalent.
B. There is a set of written criteria or guidelines for Utilization Review that is based on sound medical evidence, is consistently applied, regularly reviewed, and updated.
C. Reasons for decisions are clearly documented.
F. Decisions and appeals are made in a timely manner and are not unduly delayed for medical conditions requiring time sensitive services.
H. Records, including any Notice of Action, shall meet the retention requirements described in Exhibit E, Attachment 2, Provision 17.B. Records Retention.
I. Contractor must notify the requesting provider or Member of any decision to deny, approve, modify, or delay a service authorization request, or to authorize a service in an amount, duration, or scope that is less than requested. The notice to the provider may be orally or in writing.

COHS Contract A.5.2.A, B, C, F, H, I

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.G

Timeframes for Medical Authorization:
Pharmaceuticals: 24 hours or one (1) business day on all drugs that requires prior authorization in accordance with Welfare and Institutions Code Section 14185(a)(1).
COHS Contract A.5.3(F)

Denial, Deferral, or Modification of Prior Authorization Requests:
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, regarding any denial, deferral or modification of a request for approval to provide a health care service. 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:

CalOptima has a well-described system for processing Prior Authorizations with the appropriate staffing for front-line and supervisory functions. Services such as emergency care and family planning are provided without need for authorization as per the contract. There are well-described and accepted clinical guidelines used in the determination of medical necessity, and the Plan regularly evaluates their consistent application with Inter Rater Reliability studies. The appropriate medical professionals render decisions on all cases reviewed.

However, a recent audit (2014 Focused Medical Review) identified issues with the Prior Authorization process including: timeliness of resolutions, language and format of the Notification of Action letters, inadequate review of medical records or inappropriate citation in denial letters (particularly with the Delegated Networks). During the onsite interview with the Plan personnel, CalOptima described their corrective actions, including intensifying monitoring of Prior Authorizations at both the Plan and Delegated Entity level by the Audit and Oversight Department, developing a Prior Authorization determination audit tool, and providing additional training in denial letter review to all Delegated Networks.

A verification study was performed on a total of twenty-six (26) Prior Authorizations from January 1, 2014 to June 30, 2014, which includes eleven (11) medical services and fifteen (15) pharmacy Prior Authorizations. The following deficiencies were noted:

- 1 medical service Prior Authorization was resolved outside of the timeline for standard determinations. The Notice of Action letter was sent after 5 days.
- 7 pharmacy Prior Authorizations were resolved outside of the timeline for standard determinations (24 hours). The Notice of Action letters were sent after 24 hours.

During the review of the audit period, there was no evidence that the Prior Authorizations determination tool had been put into practice by the Plan or any Delegated Network. There is a visible increase in oversight of the Prior Authorizations process and based on the sample reviewed, there is an apparent improvement in the processing of medical Prior Authorizations (with the exception of one case with a missing Notification of Action letter). In regards to the resolution timeliness of pharmacy Prior Authorizations, the issue remains the same. The Plan does not comply with the contractual requirements.

In the Plan's response to this audit finding subsequent to the Exit Conference, the Plan asserts that CalOptima is not in violation of the Contract requirement. The pharmacy prior authorizations reviewed were deferrals and should be counted as timely in accordance with CalOptima COHS Contract – Exhibit A, Attachment 5, Provision 2.A. This section permits a Plan's pharmacist to approve, defer, or deny prior authorizations for pharmaceutical services.

However, the Plan is required by the Contract – Exhibit A, Attachment 5, 3(F) and Welfare and Institutions Code Section 14185(a)(1) to provide a response to a prior authorization request for pharmaceuticals within 24 hours.

RECOMMENDATIONS:

- Ensure that the Prior Authorization determination tool is implemented by the Plan and the Delegated Networks.
- Ensure that Members receive written Notice of Action letters for Prior Authorizations in a timely manner as required by the Contract.
- Ensure that the medical and pharmacy Prior Authorizations are resolved in a timely manner.

1.3	REFERRAL TRACKING SYSTEM

Referral Tracking System:
Contractor is responsible to ensure that the UM program includes... An established system to track and monitor services requiring prior authorization through the Contractor. The system shall include authorized, denied, deferred, or modified prior authorizations, and the timeliness of the determination.
COHS Contract A.5.1.F

SUMMARY OF FINDINGS:

The prior audit (2014 Focused Medical Review) identified issues with the referral tracking system and processing of prior authorization at both the Plan and Delegated Network level. In response to these findings, CalOptima has increased tracking and trending of Prior Authorizations within the Utilization Management Department, and has proposed means for reporting of internal audit data to the Plan Utilization Management subcommittee meetings. There is some evidence that unused and open authorizations are being reported to the committee; however, it is not clear if Delegated-level data is being presented or that aggregate audit data is being reported to the Delegation Oversight Committee.

In their written Policy GG.1508, Authorization and Processing of Referrals, the Plan has established the procedure by which they process a request for Prior Authorization; however, it does not delineate how the Plan monitors open and unused Prior Authorization referrals or addresses deficiencies when they exist. As required by the Contract, the Plan "is responsible for an established specialty referral system to track and monitor referrals" [COHS Contract Reference: A.5.1.F]

RECOMMENDATIONS:

- Ensure that Delegated-level open and unused Prior Authorizations are being reported to the responsible committees.
- Ensure that the Plan has written policies that reflect the referral tracking mechanisms that are in place, including the tracking of open and unused referrals, and how to address identified deficiencies with the Plan level or Delegated level providers.

1.4	PRIOR AUTHORIZATION APPEAL PROCESS

Appeal Procedures:
There shall be a well-publicized appeals procedure for both providers and patients.
COHS Contract A.5.2.E

SUMMARY OF FINDINGS:

There is a well-publicized process of appeals at CalOptima, with well-described policies and procedures in place and dedicated full-time staff and supervisors to oversee the process.

The recent audit (2014 Focused Medical Review) found some issues with timeliness and Member notification of appeal decisions, which has resulted in increased internal monitoring of appeals and Notice of Action letters in the Medical and Pharmacy departments.

A total of sixty (60) appeals were reviewed, including thirty (30) standard medical appeals and thirty (30) pharmacy appeals (10 expedited and 20 standard). The review found that standard appeals were reviewed timely; however, three (3) expedited appeals were resolved outside of the contractual timeframes.

RECOMMENDATION:

Ensure that expedited appeals are resolved within contractual timeframes.

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. These services are provided through either basic or complex case management activities based on the medical needs of the member.
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.11.6

SUMMARY OF FINDINGS:

CalOptima has policies and procedures for the Coordination and Continuity of Care for the Members. 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 policies and procedures define the guidelines for Case Management of the Members by CalOptima Direct or a Health Network. The policies and procedures also define the process for monitoring Health Network compliance through monthly Case Management reports. In addition, Policy HF 2003, Out of County or Out of Network Services, defines the responsibility for Covered Services rendered to a Member outside the Member's Health Network or outside of Orange County.

The Plan submitted five (5) medical records for the review. However, Case Management notes were not included. Based on the review, following findings were disclosed:

- Four (4) records lacked documentation of Individualized Care Plan and Case Management notes; however, there was evidence of basic case management, management of acute or chronic illness by multidisciplinary teams, and collaboration such as referrals.
- Two (2) of the three (3) members were listed as CCS-eligible although they were over 21 years old as of enrollment with CalOptima.
- One (1) Member's medical record contained one encounter visit with the PCP and all other documents contained ER visits and inpatient documentation.

The Plan conducts Facility Site Reviews (FSR) with their Health Network providers. Although the FSRs determine if there is documentation for coordination of care for Members, the Plan could not provide any documentation of Case Management or monitoring for five (5) selected CalOptima Members.

Although CalOptima has written policies and procedures for provision of case management and coordination of care both within and outside the network, the Plan lacks documentation for monitoring and tracking Members who receive these services.

RECOMMENDATION:

Develop a monitoring system to ensure that Members who are eligible for Case Management receive these services and that coordination of care occurs between the Primary Care Providers and the specialty providers.

2.2	CALIFORNIA CHILDREN'S SERVICES

California Children's Services (CCS):
Upon diagnostic evidence that a Medi-Cal Member under 21 years of age may have a CCS eligible condition, Contractor shall refer the Member to the local CCS office for determination of eligibility.

A. Contractor shall develop and implement written policies and procedures for identifying and referring children with CCS eligible conditions to the local CCS program. The policies and procedures shall include, but not be limited to those which:
   1) Ensure that Contractor's providers perform appropriate baseline health assessments and diagnostic evaluations that provide sufficient clinical detail to establish, or raise a reasonable suspicion, that a Member has a CCS eligible medical condition.
   2) Assure that Contracting Providers understand that CCS reimburses only CCS paneled providers and CCS-approved hospitals within Contractor's network; and only from the date of referral.
   3) Enable initial referrals of Member's with CCS eligible conditions to be made to the local CCS program by telephone, same-day mail or FAX, if available. The initial referral shall be followed by submission of supporting medical documentation sufficient to allow for eligibility determination by the local CCS program.
   4) Ensure that Contractor continues to provide all Medically Necessary Covered Services for the Member's CCS eligible condition until CCS eligibility is confirmed.
   5) Ensure that, once eligibility for the CCS program is established for a Member, Contractor 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.
   6) If the local CCS program does not approve eligibility, Contractor remains responsible for the provision of all Medically Necessary Covered Services to the Member. If the local CCS program denies authorization for any service, Contractor remains responsible for obtaining the service, if it is Medically Necessary, and paying for the service if it has been provided.

B. Contractor shall execute a Memorandum of Understanding (MOU) with the local CCS program...for the coordination of CCS services to Members.

COHS Contract A.11.10.A, B

SUMMARY OF FINDINGS:

CalOptima has policies and procedures for identifying and referring children with CCS-eligible conditions. The Plan wants to ensure that Members who have an actual or potential CCS-eligible condition are referred appropriately to the local CCS program for evaluation and that Members continue to receive medically necessary covered services whether or not they are covered by CCS.

The Plan's policies and procedures indicate that CalOptima, a Health Network or a Practitioner identifies Members who may have a CCS-eligible condition. The Member shall be referred to CCS within twenty-four (24) hours or the next working day after determining that a Member may have a CCS eligible condition.

A Memorandum of Agreement (MOA) between California Children Services (CCS) Program and CalOptima Health Plan is in place. The parties agree and understand that responsibility for performance of certain services under the Agreement will be shared by both parties. The MOA addresses each party's responsibility.

Case Management notes and the medical records were requested for three (3) complex CCS-eligible Members to evaluate the effectiveness of the Plan's Case Management function. Based on the review, two (2) of the three (3) members were listed as CCS-eligible although they were over 21 years old as of enrollment with CalOptima and one

(1) Member's medical record contained one encounter visit with the PCP and all other documents contained ER visits and inpatient documentation.

A review of nine (9) medical records disclosed a lack of documentation which includes:

- Two (2) medical records had no documentation that identifies the Member with CCS-eligible condition.
- Eight (8) medical records lacked documentation of coordination of care between the PCP, specialty provider and the CCS program.
- Two (2) medical records lacked documentation for encounters after enrollment as a CalOptima Member.

The Plan has the responsibility to ensure that Members with CCS-eligible conditions are referred in a timely manner to the CCS program, continue to provide medically necessary covered serviced not authorized by CCS and to document Coordination of Care and Case Management between the Member's Primary Care Providers, CCS specialty provider, and the local CCS program.

RECOMMENDATION:

Ensure that CCS-eligible Members are monitored and tracked for Case Management and that Coordination of Care between Primary Care Providers and specialty providers occurs and is documented.

2.3	EARLY INTERVENTION SERVICES / DEVELOPMENTAL DISABILITIES

Early Intervention Services:
Contractor shall develop and implement systems to identify children under three (3) years of age who may be eligible to receive services from the Early Start Program and refer them to the local Early Start Program. These include children who have a developmental delay in either cognitive, communication, social, emotional, adaptive, physical, motor development, including vision and hearing, or a condition known to lead to developmental delay, or those in whom a significant developmental delay is suspected, or whose early health history places them at risk for delay. Contractor shall collaborate with the local Regional Center or local Early
Start Program in determining the Medically Necessary diagnostic and preventive services and treatment plans for Members participating in the Early Start Program. Contractor shall provide case management and care coordination to the Member to ensure the provision of all Medically Necessary covered diagnostic, preventive and treatment services identified in the individual family service plan developed by the Early Start Program, with Primary Care Provider participation.
COHS Contract A.11.12

Services for Persons with Developmental Disabilities:

A. Contractor shall develop and implement procedures for the identification of Members with developmental disabilities.
B. Contractor shall provide all screening, preventive, Medically Necessary, and therapeutic Covered Services to Members with developmental disabilities. Contractor shall refer Members with developmental disabilities to a Regional Center for the developmentally disabled for evaluation and for access to those non-medical services provided through the Regional Centers such as but not limited to, respite, out-of-home placement, and supportive living. Contractor shall monitor and coordinate all medical services with the Regional Center staff, which includes identification of all appropriate services, which need to be provided to the Member.
C. Services provided under the Home and Community-Based Services (HCBS) waiver programs to persons with developmental disabilities are not covered under this Contract. Contractor shall implement and maintain systems to identify Members with developmental disabilities that may meet the requirements for participation in this waiver and refer these Members to the HCBS waiver program administered by the State Department of Developmental Services (DDS).
If DDS concurs with the Contractor's assessment of the Member and there is available placement in the waiver program, the Member will receive waiver services while enrolled in the plan. Contractor shall continue to provide all Medically Necessary Covered Services.
D. Contractor shall execute a Memorandum of Understanding (MOU) with the local Regional Centers...for the coordination of services for Members with developmental disabilities.

COHS Contract A.11.11.A, B, C, D

SUMMARY OF FINDINGS:

The Plan's Policy GG.1302a, Coordination of Care for RCOC Members, defines the guidelines for Coordination of Care by CalOptima or a Heath Network for a Member who is eligible for services from the Regional Center of Orange County (RCOC). The Policy indicates that RCOC provides services to eligible individuals from birth to three years of age under Early Intervention Services (Early Start Program) and to eligible individuals three years of age and over under the Lanterman Act.

The Memorandum of Understanding between CalOptima and Regional Center of Orange County delineates the responsibilities of the Plan and the Regional Center in the coordination of services for Members with developmental disabilities.

A review of seven (7) medical records for Members with EI/DD-eligible conditions disclosed a lack of documentation which includes:

- One (1) medical record had no diagnosis or lacked documentation that identifies the Members with EI/DD eligible condition.
- Three (3) medical records identified Members as CCS-eligible in addition to being EI/DD eligible but this was not identified on the Member list.
- One (1) medical record contained only encounter visits with the specialists. There was a lack of documentation of screening, medically necessary services and therapeutic services covered by the contract.
- Two (2) medical records lacked documentation for encounters after enrollment as a CalOptima Member.

Medical records for Members with EI/DD conditions were lacking documentation for Coordination of Care and provision of medically necessary covered diagnostic, preventive and treatment services identified for its Members.

RECOMMENDATIONS:

- Develop a monitoring system to ensure that the EI/DD eligible Members receive primary care services and coordination of care occurs between Primary Care Providers and EI/DD specialists.
- Review and strengthen procedures for the identification of EI/DD eligible Members and ensure coordination of care with the regional center.

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) in conformance with Title 22 CCR Section 53851 (b)(1) and Section 53910.5(a)(1) 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.

1) Contractor shall make at least three (3) documented attempts that demonstrate Contractor's unsuccessful efforts to contact a Member and schedule an IHA. Contact methods must include at least one (1) telephone and one (1) mail notification.
2) Contractor must document all attempts to perform an IHA at subsequent office visit(s) until all components of the IHA are completed.

COHS Contract A.10.3.E

Provision of IHAs for Members under Age 21:

1) For Members under the age of 18 months, Contractor shall 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.10.5

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.10.6

SUMMARY OF FINDINGS:

The COHS Contract requires the provision of an Initial Health Assessment (IHA) for each new Member within stipulated timelines and reasonable attempts to contact a Member to schedule an IHA be made and that all attempts be documented.

The Plan's Policy GG 1613, Initial Health Assessment, states that all Members receive an Initial Health Assessment (IHA) within 120 calendar days after enrollment in the CalOptima Program unless the Primary Care Provider determines that the Member's medical record contains complete and current information to allow for an assessment of the Member's health status and health risk. The Health Network shall inform the practitioners of the need for timely IHA for all Members and shall track IHAs to ensure assessments are conducted within the timeframes.

The Plan's Policy GG.1613 further states that IHA shall include comprehensive history, preventive services for asymptomatic Members, comprehensive physical and mental status examination, diagnoses and plan of care that includes follow-up activities.

The Plan provided an Excel spreadsheet for IHA completion for each Health Network for the past three quarters. The results showed that the Plan is not meeting the target as required by the Department of Health Care Services.

For the Verification Study in this section, thirty one (31) IHA medical records were reviewed for compliance with the IHA requirements. Based on the review, three (3) medical records lacked documentation of an IHA and five (5)

medical records were completed outside the required timeframe for IHA completion. In addition, thirteen (13) medical records failed to document the 3 required attempts to contact the Members to schedule an IHA.

RECOMMENDATIONS:

- Develop a process to effectively monitor completion of Initial Health Assessments within the required timeframe.
- Develop a system to document the 3 attempted contacts with Members to schedule their Initial Health Assessment required by 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

Members must be offered appointments within the following timeframes:

c) Non-urgent primary care appointments – within ten (10) business days of request;
d) Appointment with a specialist – within 15 business days of request;
e) Non-urgent appointment for ancillary services for the diagnosis or treatment of injury, illness, or other health condition – within 15 business days of request.

COHS Contract A.9.3.A.2

Prenatal Care:
Contractor shall ensure that the first prenatal visit for a pregnant Member will be available within 10 business days upon request.
COHS Contract A.9.3.B

Monitoring of 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 (dated 1/1/13) GG.1600, Access and Availability Standards, establish appointment standards for the Plans providers and Members.

The Plan's Policy GG.1600, Provider Manual, and Member Handbooks indicate a Member's first prenatal visit should be within 2 weeks rather than 10 business days after a request as required by the Contract. [COHS Contract Reference: A.9.3.B]

The Plan indicates the timeframe for specialty services and ancillary services appointment standards is 15 days after approval for the service is received rather than 15 days after a request is made for the service. [COHS Contract Reference: A.9.3.A.2]

The Plan's Accessibility Report for 2013 indicates that the in-office wait time measures had been removed from the 2013 report as per the Plan personnel and as evidenced by the documentation submitted.

The Plan's Policy GG.1100, Primary Care Practitioner Definition, Role, and Responsibilities, indicates a PCP's responsibilities of keeping office waiting times to a maximum of forty-five (45) minutes; however, the Policy does not include the procedures for monitoring in-office wait time. The Plan is not compliant with the Contractual requirements. [COHS Contract Reference: A.9.3.C]

The Plan maintains procedures for following-up on missed appointments in the Plan's Provider Manual.

The Plan monitors appointment and provider access and availability through annual surveys which include an accessibility survey, an availability survey, and a member satisfaction survey. The Plan also monitors access and availability standards through grievances and Facility Site Reviews. However, the Plan does not have a system and procedures to ensure the monitoring of Member wait times in the providers' offices.

Subsequent to the Exit Conference, the Plan submitted a revised Policy, GG.1600, Access and Availability, which indicates that a Member's first prenatal visit should be within 10 business days upon request. The Plan's Policy GG.1600 is in compliance with the CalOptima COHS Contract. The Plan also made revisions to the Provider Manual and Member Handbooks.

However, the Policy, GG.1600 is pending Department of Health Care Services approval. The revisions to the Provider Manual and Member Handbooks were not available for review.

RECOMMENDATIONS:

- Update Policy GG. 1600, Access and Availability Standards, Provider Manual and Member Handbooks to indicate that a Members first prenatal visit should be with 10 business days upon request.
- Update Policy GG. 1600, Access and Availability Standards, to specify the language for specialty services and update Member Handbooks for ancillary services standards so that the timeframe for an appointment is 15 days after a request for the service.
- Develop procedures to ensure the monitoring of Member wait times in the providers' offices.

3.2	URGENT CARE / EMERGENCY CARE

Urgent Care:
Contractor shall ensure that a Member needing Urgent Care is seen within 24 hours upon request.
COHS Contract A.9.3.E

Members must be offered appointments within the following timeframes:

a) Urgent care appointment for services that do not require prior authorization – within 48 hours of a request

b) Urgent appointment for services that do require prior authorization – within 96 hours of a request

COHS Contract A.9.3.A.2

Emergency Care:
Contractor shall ensure that a Member with an Emergency Condition will be seen on an emergency basis and that Emergency Services will be available and accessible within the Service Area 24-hours a day, 7-days a week.
COHS Contract A.9.6

Contractor shall have as a minimum a designated emergency service facility within the Service Area, providing care on a 24-hours a day, 7-days a week basis. This designated emergency service facility will have one or more Physicians and one (1) Nurse on duty in the facility at all times.
COHS Contract A.6.4

SUMMARY OF FINDINGS:

The Plan's Policy (dated 1/1/13) GG.1600, Access and Availability Standards, include criteria and standards for both Urgent Care Services and Emergency Services. The Policy indicates that the standards are monitored through the Plan's Access and Availability Studies.

Although the Plan has developed and implemented the Policy GG.1600, the Policy does not indicate that there has to be a designated emergency service facility within the Service Area, providing care on a 24 hours a day, 7 days a week and the designated emergency service facility to have one or more Physicians and one (1) Nurse on duty in the facility at all times. The language in the Policy does not comply with Contractual requirements. [COHS Contract Reference: A.6.4]

The Member Handbooks informs the Plan's Members of Urgent Care and Emergency Care standards. However, the Member Handbooks do not inform the Member needing Urgent Care that they should be seen within 24 hours upon request as required by the Contract. [COHS Contract Reference: A.9.3.E]

RECOMMENDATIONS:

- Update the Policy dated 1/1/13 GG.1600, Access and Availability Standards, to include that there has to be a designated emergency service facility within the Service Area and the designated emergency service facility to ensure that there is one or more Physicians and one (1) Nurse on duty in the facility at all times as required by the Contract.
- Update the Member Handbooks to inform Member needing Urgent Care services that they should be seen within 24 hours upon request as required by the Contract.

3.3	TELEPHONE PROCEDURES / AFTER HOURS CALLS

Telephone Procedures:
Contractor shall require providers to maintain a procedure for triaging Members' telephone calls, providing telephone medical advice (if it is made available) and accessing telephone interpreters.
COHS Contract A.9.3.D

After Hours Calls:
At a minimum, Contractor shall ensure that a Physician or an appropriate licensed professional under his/her supervision is available for after-hours calls.
COHS Contract A.9.3.F

SUMMARY OF FINDINGS:

The Plan's Policy (dated 1/1/13) GG 1600, Access and Availability Standards, ensures that telephone standards and after hour calls are being monitored through the Plan's Access and Availability Studies, grievances, and Facility Site Reviews.

The Plan Policy GG 1100, Primary Care Practitioner Definition, Role, and Responsibilities, indicates that access to care shall be available 24 hour a day, 7 days a week, including accommodations for urgent care, performance of procedures, inpatient rounds, and arrangements for emergency and back-up coverage in the Primary Care Provider's absence. The Plan complies with the Contractual requirements.

Based on the review of the Plan's documents, 2013 Accessibility Report, the survey consisted of two parts: A paper survey and a phone survey covering both business hours and after-hours calls for unique phone numbers. The results of the 2013 Accessibility Report indicated that the standards were not met for both business hours and after-hours telephone calls. The Plan does not meet the contractual requirements for the providers to maintain procedures for triaging Member's telephone calls. [COHS Contract Reference: A.9.3.D]

The Plan's Policy GG 1600 requires the Health Networks to submit a Corrective Action Plan to CalOptima's QI Department within thirty (30) calendar days. The Plan sent letters to the Health Networks identifying that the standards were not met. As per the Plan personnel, no Corrective Action Plans were submitted. The Plan is not following their Access and Availability Standards Policy.

RECOMMENDATIONS:

- Implement a system to ensure that providers are triaging Members' telephone calls as required by the Contract.
- Ensure that the Plan follow their Policy which requires a Corrective Action Plan from the Health Networks for deficiencies or non-compliances noted.

3.5	EMERGENCY SERVICE PROVIDERS (CLAIMS)

Contracting & Non-Contracting Emergency Service Providers & Post-Stabilization: (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,C,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...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, unless the contracting provider and Contractor have agreed in writing to an alternate payment schedule.

A. Contractor shall comply with 42 USC Section 1396a(a)(37) and Health and Safety Code Sections 1371 through 1371.39.
B. Contractor shall pay 90 percent of all clean claims from practitioners who are in individual or group practices or who practice in shared health facilities, within 30 days of the date of receipt and 99 percent of all clean claims within 90 days. The date of receipt shall be the date Contractor receives the claim, as indicated by its date stamp on the claim. The date of payment shall be the date of the check or other form of payment.
C. Contractor shall maintain procedures for prepayment and post payment claims review, including review of data related to provider, Member and Covered Services for which payment is claimed.
D. Contractor shall maintain sufficient claims processing/tracking/payment systems capability to: comply with applicable State and Federal law, regulations and Contract requirements, determine the status of received claims, and calculate the estimate for incurred and unreported claims.
E. Contractor shall submit claims payment summary reports to DHCS on a quarterly basis as specified in Exhibit A, Attachment 2, Provision 2. Financial Audit Reports Paragraph B. 2.

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)

References Cited:
42 USC Section 1396u-2(b)(2)(D) – Emergency services furnished by non-contract providers
42 USC Section 1396a(a)(37) – Claims Payment Procedures
Health and Safety Code Sections 1371 through 1371.39 – Health Care Service Plan Claim Reimbursement
Title 28 CCR Section 1300.67(g)(1) – Scope of Basic Health Care Services

❖ COMPLIANCE AUDIT FINDINGS ❖	
PLAN: CalOptima	
AUDIT PERIOD: July 1, 2013 through June 30, 2014	DATE OF AUDIT: September 29 through October 10, 2014

SUMMARY OF FINDINGS:

The Plan's Policy FF 2001, Claims Processing for Covered Services Rendered to CalOptima Direct Members or Members Enrolled in a Shared Risk Group, outlines the procedure for claims processing to ensure timely and accurate processing of claims for Covered Services provided to CalOptima Members. Although the Policy indicates the claims processing procedures, it does not specify that the emergency services are included in the Covered Services provided to the Members as required by the Contract. [COHS Contract Reference: A.8.4]

Thirty (30) Emergency Services claims were reviewed for appropriate and timely payments. All 30 claims had the date of receipt stamped on the claims, were paid appropriately and within the required timeframe as per the Contract requirement. [COHS Contract Reference: A.8.4]

RECOMMENDATION:

Update Policy FF 2001, Claims Processing for Covered Services Rendered to CalOptima Direct Members or Members Enrolled in a Shared Risk Group, to indicate that emergency services are included in the Covered Services provided to the Members as required by the Contract.

3.6	FAMILY PLANNING (PAYMENTS)

Non-Contracting Family Planning Providers' Reimbursement
Contractor shall reimburse non-contracting family planning providers at no less than the appropriate Medi-Cal FFS rate.... (as required by Contract)
COHS Contract A.8.8

Claims Processing—Contractor shall pay all claims submitted by contracting providers in accordance with this provision, unless the contracting provider and Contractor have agreed in writing to an alternate payment schedule.

A. Contractor shall comply with 42 USC Section 1396a(a)(37) and Health and Safety Code Sections 1371 through 1371.39.
B. Contractor shall pay 90 percent of all clean claims from practitioners who are in individual or group practices or who practice in shared health facilities, within 30 days of the date of receipt and 99 percent of all clean claims within 90 days. The date of receipt shall be the date Contractor receives the claim, as indicated by its date stamp on the claim. The date of payment shall be the date of the check or other form of payment...

COHS Contract A.8.4

Claim Filing Deadline: (ii)....The plan within ten (10) working days of the receipt of the claim incorrectly sent to the plan shall forward the claim to the appropriate capitated provider.
CCR, Title 28, Section 1300.71(b)(B)

SUMMARY OF FINDINGS:

The Plan's Policy FF 2001, Claims Processing for Covered Services Rendered to CalOptima Direct Members or Members Enrolled in a Shared Risk Group, outlines the procedure for claims processing to ensure timely and accurate processing of claims for Covered Services provided to CalOptima Members. Although the Policy indicates the claims processing procedures, it does not specify that the Family Planning services are included in the Covered Services provided to the Members as required by the Contract. [COHS Contract Reference: A.8.4]

The Plan's Policy FF 2001, Claims Processing for Covered Services Rendered to CalOptima Direct Members or Members Enrolled in a Shared Risk Group, states the claims processing procedure for misdirected claims for Emergency Services. The Policy does not indicate how the payers are informed of any misdirected Family Planning claims as required by California Code of Regulations, Title 28, section 1300.71(b).

Twenty-five (25) Family Planning claims were reviewed for appropriate and timely payment. All 25 claims had the date of receipt stamped on the claims, were paid appropriately and within the required timeframe as per the Contract requirement. [COHS Contract Reference: A.8.4]

RECOMMENDATIONS:

- Update Policy FF 2001, Claims Processing for Covered Services Rendered to CalOptima Direct Members or Members Enrolled in a Shared Risk Group, to indicate that Family Planning services are included in the Covered Services provided to the Members as required by the Contract.

- Update the language in Policy FF 2001, Claims Processing for Covered Services Rendered to CalOptima Direct Members or Members Enrolled in a Shared Risk Group, to ensure that misdirected Family Planning services claims are forwarded to the appropriate payer within ten (10) working days 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 including, but not limited to the California State Board of Pharmacy Laws and Regulations, Title 22 CCR Sections 53214 and 53854 and Title 16 CCR Sections 1707.1, 1707.2, and 1707.3. Prior authorization requirements for pharmacy services and provision of prescribed drugs must be clearly described in the Member Services Guide and provider manuals of the Contractor

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:

A. Having written policies and procedures, including, if applicable, written policies and procedures of Contractor's network hospitals' policies and procedures related to emergency medication dispensing, which describe the method(s) that are used to ensure that the emergency medication dispensing requirements are met, including, if applicable, specific language in network hospital subcontracts. Written policies and procedures must describe how Contractor and/or Contractor's network hospitals will monitor compliance with the requirements. Compliance monitoring does not require verification of receipt of medications for each and every ER visit made by Members to an emergency room which does not result in hospitalization.
B. Providing the Member, in all cases, access to at least a 72-hour supply of Medically Necessary drugs. This requirement can be met by providing a 72-hour supply of the drug to the Member, or provision of an initial dose of medication and a prescription for additional medication, which together cover the Member for the 72-hour period. Contractor's policies and procedures can describe other methods for ensuring compliance with the 72-hour requirement.
C. Having a mechanism in place for informing Members of this requirement and of their right to submit a grievance if they do not receive Medically Necessary medications in emergency situations.
D. Having a procedure for investigating and resolving Member complaints/grievances related to the failure of Contractor to provide Medically Necessary medications in emergency situations.
E. Having policies and procedures and complaint and grievance logs available for inspection during any State audit or monitoring visit, upon request.

COHS Contract A.10.8.F.1

SUMMARY OF FINDINGS:

The Plan's Policy GG.1403, Member Medication Reimbursement Process and Provision of Emergency, Disaster, Replacement, and Vacation Medication Supplies, describes the emergency medication supply procedures. However, the Policy does not describe the requirement to provide a 72-hour supply of the drugs to a Member or an initial dose of medication and a prescription for additional medication, which together cover a Member for the 72-hour period as required by the Contract. [COHS Contract Reference: A.10.8.F.1]

The Plan did not have policies and procedures for the Plan's network hospitals during the audit period. However, the Plan personnel did provide a draft Policy for Hospital Oversight dated November 2014. As per the Plan personnel, the draft policy has not been implemented yet.

The Plan is required to have written policies and procedures of Plan's network hospital which relate to emergency medication dispensing and shall describe the method(s) that are used to ensure that the emergency medication dispensing requirements are met. In addition, the Policy shall describe how the Plan and/or the Plan's network hospitals will monitor compliance with the requirements. The Plan is not compliant with the Contractual requirements. [COHS Contract Reference: A.10.8.F.1]

Based on the interview with the Plan personnel, the Plan monitors access to a 72-hour supply of a covered outpatient drug in an emergency situation by reviewing the Daily Reports, Monthly Oversight audits conducted by the Pharmacy Benefit Manager, Quarterly Meetings with P&T Committee, Yearly Reports from Providers Relations, and through pharmacy grievances and appeals. However, the Plan lacked an effective monitoring mechanism to ensure the provision of drugs prescribed in an emergency circumstance. [COHS Contract Reference: A.10.8.F.1]

RECOMMENDATIONS:

- Update Policy GG.1403, Member Medication Reimbursement Process and Provision of Emergency, Disaster, Replacement, and Vacation Medication Supplies, to include the language of providing a 72-hour supply of drugs to a Member, or an initial dose of medication and a prescription for additional medication, which together covers the Member for the 72-hour period and or other methods for ensuring compliance with the 72-hour requirement.
- Develop policies and procedures for Hospital Oversight to include specific language to ensure the provision of prescribed drugs in emergency situations.
- Develop effective monitoring procedures to ensure the provision of drugs prescribed in emergency situations.

CATEGORY 4 – MEMBER'S RIGHTS

4.1	GRIEVANCE SYSTEM

Member Grievance System and Oversight:
Member Grievance System— Contractor shall implement and maintain a Member Grievance system in accordance with Title 28 CCR Section 1300.68 (except Subdivision 1300.68(c)(g) and (h)), 1300.68.01(except Subdivision 1300.68.01(b) and (c)), Title 22 CCR Section 53858, Exhibit A, Attachment 13, Provision 4, paragraph D.13, and 42 CFR 438.420(a)(b) and (c). Contractor shall resolve each grievance and provide notice to the Member as quickly as the Member's health condition requires, within 30 calendar days from the date Contractor receives the grievance. Contractor shall notify the Member of the grievance resolution in a written member notice.
COHS Contract A.14.1

Grievance System Oversight—Contractor shall implement and maintain procedures...to monitor the Member's Grievance system and the expedited review of grievances required under Title 28 CCR Sections 1300.68 and 1300.68.01 and Title 22 CCR Section 53858.

A. Procedure to ensure timely acknowledgement resolution and feedback to complainant. Provide oral notice of the resolution of an expedited review...
C. Procedure to ensure that the grievance submitted is reported to an appropriate level, i.e., medical issues versus health care delivery issues...
D. Procedure to ensure the participation of individuals with authority to require corrective action. Grievances related to medical quality of care issues shall be referred to the Contractor's Medical Director.
E. Procedure to ensure that requirements of Title 22 CCR Section 51014.2, and Title 42 CFR 438.420(a)-(c) are met regarding services to Members during the grievance process.
F. Procedure to ensure that the person making the final decision for the proposed resolution of a grievance has not participated in any prior decisions related to the grievance, and is a health care professional with clinical expertise...
    1. A denial based on lack of medical necessity;
    2. A grievance regarding denial of expedited resolutions of a Contractor-level appeal; and
    3. Any grievance or Contractor-level appeal involving clinical issues
I. Procedures to ensure that Members are given a reasonable opportunity to present, in writing or in person before the individual(s) resolving the grievance, evidence, facts and law in support of their grievance. In the case of a grievance subject to expedited review, Contactor shall inform the Member of the limited time available to present evidence...comply with 42 CFR 438.406(b)(3)

COHS Contract A.14.2

Grievance Log and Quarterly Grievance Report—Contractor shall maintain, and have available for DHCS review, grievance logs, including copies of grievance logs of any sub-contracting entity delegated the responsibility to maintain and resolve grievances. Grievance logs shall include all the required information set forth in Title 22 CCR Section 53858(e).
COHS Contract A.14.3.A

SUMMARY OF FINDINGS:

CalOptima has a well-organized, efficient grievance process that contains all the elements necessary to log, review, and close out grievances. In addition, the Plan has shown evidence that it tracks and trends grievances on a regular and continuous basis, carefully evaluating cases that could be potential quality of care issues.

The Plan has Policy HH 1102, CalOptima Member Complaint, which addresses the procedures for both administrative (quality of service) and clinical (quality of care) grievances in detail.

A total of eighty-seven (87) grievances, which includes sixty (60) quality of care, twenty-one (21) quality of service, and six (6) exempt were reviewed with the following results:

- Twenty-nine (29) grievances were found to have incomplete investigations or no investigations in the grievance log, yet resolution letters were sent to the grievant. In all 29 cases, the grievance was then referred onto the Quality Improvement Department (QID) for a Potential Quality Issue (PQI) investigation. This referral occurred at or near the end of the 30 day resolution period. The language of the resolution letters does not contain conclusive elements due to the fact that most referrals to the QID for PQI are occurring late in the grievance review process.
- An improvement in the handling of exempt grievances was noted since the 2014 Focused Medical Review. The six (6) exempt grievances reviewed from the current audit period did not contain the problems found in the Focused Medical Review.

Although the Plan has policies and procedures in place to address grievances in detail, the sampled grievance logs were found to be incomplete. This does not comply with the Contract requirement. [COHS Contract Reference: A.14.2]

RECOMMENDATION:

Ensure that the Plan follows its Policy HH 1102, CalOptima Member Complaint, which requires the Plan to maintain and process grievances in a timely manner.

4.3	CONFIDENTIALITY RIGHTS

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

C. **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, uses or transmits on behalf of DHCS, in compliance with 45 CFR sections 164.308, 164.310 and 164.312, and to prevent use or disclosure of PHI other than as provided for by this Agreement...

J. **Breaches and Security Incidents.** During the term of this Agreement, Business Associate agrees to implement reasonable systems for the discovery and prompt reporting of any breach or security incident, and to take the following steps:

1. **Notice to DHCS.** (1) To notify DHCS immediately 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 security incident that involves data provided to DHCS by the Social Security Administration. (2) To notify DHCS within 24 hours by email or fax of the discovery of any suspected security incident, intrusion or unauthorized access, use or disclosure of PHI or PI in violation of this Agreement...
   Notice shall be provided to the DHCS Program Contract Manager, the DHCS Privacy Officer and the DHCS Information Security Officer...
2. **Investigation and Investigation Report.** To immediately investigate such security incident, breach, or unauthorized access, use or disclosure of PHI or PI. Within 72 hours of the discovery, Business Associate shall submit 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:
3. **Complete Report.** To 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 (10) working days of the discovery of the breach or unauthorized use or disclosure....
6. **DHCS Contact Information**. DHCS Contact Information. To direct communications to the above referenced DHCS staff, the Contractor shall initiate contact as indicated herein. DHCS reserves the right to make changes to the contact information below by giving written notice to the Contractor.

COHS Contract G.III.C, J

SUMMARY OF FINDINGS:

The Plan has an approved Policy (dated 1/1/14) HH 3020, Reporting a Breach of Data Security, Intrusion, or Unauthorized Use or Disclosure of Protected Health Information. The Plan has revised Policy HH 3020 (dated 5/1/14) and it is still pending approval from the Department of Health Care Services. Although it is a revised and draft policy, the Plan personnel indicated during the interview that the Plan has implemented the revised policy. The revised Policy (dated 5/1/14) was used to conduct the review.

The Plan's Policy HH 3020, indicates that the DHCS is notified immediately by telephone call plus email or fax upon discovery of a breach of unsecured Protected Health Information (PHI) within 24 hours and that the notice shall be provided to the DHCS Privacy Officer, the DHCS Program Contract Manager, and the DHCS Information Security Officer. In addition, the policy states that CalOptima immediately investigates the security incident, breach or unauthorized access, and use or disclosure of PHI. Within five (5) days of the initial discovery, CalOptima shall

submit an updated "DHCS Privacy Incident Report" to the DHCS Privacy Officer, the DHCS Program Contract Manager, and the DHCS Information Security Officer.

Although the Policy HH 3020 includes breach notification procedures for discovery of a breach and investigation of a security incident, it does not indicate the language stated in the Contract which is as follows:

1) CalOptima shall immediately investigate such security incident, or breach and within 72 hours, provide the "DHCS Privacy Incident Report" to the DHCS Program Contract Manager, the DHCS Privacy Officer, and the DHCS Information Security Officer. [COHS Contract Reference: Exhibit G.III.J]
2) CalOptima shall 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 (10) working days of the discovery of the breach or unauthorized use or disclosure. [COHS Contract Reference: Exhibit G.III.J]

The Plan's Policy HH 3000, Notice of Privacy Practices, indicates that the Plan provides a copy of Notice of Privacy Practice to each Member and also the Notice of Privacy Practice is posted on the CalOptima website. However, the policy does not indicate the contact information of the DHCS Privacy Officer and DHCS Information Security Officer as required by the Contract. [COHS Contract Reference: Exhibit G.III.J]

The Notice of Privacy Practices is posted on the Plan's website. The Notice of Privacy Practices does indicate the contact information of the DHCS Privacy Officer for Members to contact as an alternate means to file privacy complaints; however, the incorrect DHCS Privacy Officer's address is indicated in the Notice of Privacy Practices. Also, the contact information for the DHCS Information Security Officer is not included in the Notice of Privacy Practice as required by the Contract. [COHS Contract Reference: Exhibit G.III.J]

A total of ten (10) HIPAA breach cases were reviewed. Based on the review, nine (9) cases were not notified to any DHCS personnel within 24 hours. Also, one (1) HIPAA breach case was notified only to the DHCS Privacy Officer and it was not within 24 hours as required by the Contract. [COHS Contract Reference: Exhibit G.III.J].

RECOMMENDATIONS:

- Update the Plan's Policy dated (5/1/14) HH.3020, Reporting a Breach of Data Security, Intrusion, or Unauthorized Use or Disclosure of Protected Health Information, to include the contractual stipulation that:
  1) The investigation of security incident of a HIPAA breach within 72 hours be submitted to the DHCS Program Contract Manager, the DHCS Privacy Officer, and the DHCS Information Security Officer
  2) To 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 (10) working days of the discovery of the breach.
- Ensure that the 24 hour DHCS Initial Notification of Breach is submitted to the required DHCS personnel within the required timeframe.
- Ensure that the contact information of the DHCS Privacy Officer and the DHCS Information Security Officer is indicated in Policy, HH. 3000, Notice of Privacy Practices.
- Update the Notice of Privacy Practices on the CalOptima website to ensure that the correct contact information for the DHCS Privacy Officer is indicated and to include the contact information of the DHCS Information Security Officer in the Notice of Privacy Practices.

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) and Title 22 CCR Section 53861, and MMCD Policy Letter 02-02 as required and approved by CMS.

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: CalOptima	
AUDIT PERIOD: July 1, 2013 through June 30, 2014	DATE OF AUDIT: September 29 through October 10, 2014

SUMMARY OF FINDINGS:

The Plan has developed policies and procedures and established standards for documentation of care in Medical Record Maintenance for each Member as required by the Contract. In addition, the Plan has developed procedures to maintain patient medical records and to safeguard the confidentiality of information and established standards for the administration and maintenance of medical records by individual Providers to facilitate communication, coordination, and continuity of care. Furthermore, the Plan's policies and procedures describe the Plan's monitoring process of a Practitioner's compliance through medical record audits such as the Full Scope Site Review.

Facilities visited had properly secured medical records both for hard copy and electronic health records and had a designated person responsible for securing medical records.

In the Verification Study, thirty-one (31) records were reviewed according to the Contract requirements for documentation of medical services provided and continuity and coordination of care. It was noted that eight (8) medical records were missing personal/biographical information, preferred language, immunization and health maintenance and/or preventive services.

Based on the review of the Member's medical records, the Plan is not following Policy GG.1608, Full Scope Site Reviews, which requires the monitoring and tracking of the Facility Site Reviews and Medical Record Reviews.

Although the Plan has written policies and procedures for medical record maintenance, the Plan lacks internal controls for monitoring and tracking the maintenance of the Members medical records.

RECOMMENDATIONS:

- Ensure that complete medical records are maintained for each Member.
- Continue to monitor compliance with Facility Site Reviews including medical record reviews.
- Ensure that the system of monitoring record keeping is maintained.

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's Policy GG.1118, Family Planning Services, Out-of-Network, defines in the section Informed Consent for Sterilization that the Department of Health Services (DHS) Consent for Sterilization form, PM330, must be completed by the Member, witnessed and completed by the Practitioner who will perform the sterilization procedure in accordance with the regulations.

Samples of thirty (30) paid sterilization claims were reviewed for compliance. The findings for nineteen (19) of the claims are as follows:

- 19 paid claims were submitted without the required Informed Consent form (PM 330).
- Eight (8) used other forms of consent with incorrect or insufficient information.

During the interview, the Plan personnel stated that Claim Examiners ensure that the claim is completed prior to the payment. Although the Plan has the responsibility to determine that a copy of PM 330 is attached with the sterilization claims, the Plan does not have a system of monitoring compliance with the PM 330 requirement.

RECOMMENDATIONS:

- Ensure that each Member has access to sterilization procedures including alternative methods of family planning and birth control without Prior Authorization.
- Educate providers and the Claims Department on the proper completion of PM 330 and develop a system to monitor compliance with the training.

CATEGORY 6 – ADMINISTRATIVE AND ORGANIZATIONAL CAPACITY

6.4	PROVIDER TRAINING

Medi-Cal Managed Care Provider Training:
Contractor shall ensure that all Primary Care Providers receive training regarding the Medi-Cal Managed Care program in order to operate in full compliance with the Contract and all applicable Federal and State statutes and regulations. Contractor shall ensure that provider training relates to Medi-Cal Managed Care services, policies, procedures and any modifications to existing services, policies or procedures. Contractor shall conduct training for all providers no later than 10 (ten) working days after the Contractor places a newly contracted provider on active status and shall complete the training within 30 calendar days of placing on active status. Contractor shall ensure that provider training includes, but is not limited to, information on all Member rights specified in Exhibit A, Attachment 13, Member Services, including the right to full disclosure of health care information and the right to actively participate in health care decisions. Contractor shall ensure that ongoing training is conducted when deemed necessary by either the Contractor or DHCS.
COHS Contract A.7.5

SUMMARY OF FINDINGS:

The Plan's Policy EE 1103, Primary Care Practitioner (PCP), Provider, and Health Network Education and Training, indicates that CalOptima or a Health Network shall contact a newly contracted PCP within ten (10) business days from the PCP's placement on the Active Status. This Policy indicates that the Plan "shall contact" a newly contracted provider within 10 days whereas the Contract requirements states that Contractor "shall conduct training" for all the providers no later than 10 (ten) working days. [COHS Contract Reference: A.7.5]

A sample of twenty-five (25) providers from the Plan's list of newly contracted providers during the audit period were selected and reviewed to ensure that training was provided in accordance with contractual requirements. Based on the review, it was found that twenty-four (24) new providers did not initiate the training within 10 (ten) working days of being placed on active status. [COHS Contract Reference: A.7.5]

RECOMMENDATIONS:

- Update Policy EE 1103, Primary Care Practitioner (PCP), Provider, and Health Network Education and Training, to indicate that CalOptima shall conduct training for all providers no later than 10 (ten) working days after a newly contracted provider's placement on active status.
- Ensure that newly contracted providers are provided training within the required timeframe of 10 working days after the provider is placed on active status.

6.5	FRAUD AND ABUSE

Fraud and Abuse Reporting

B. Contractor shall meet the requirements set forth in 42 CFR 438.608 by establishing administrative and management arrangements or procedures, as well as a mandatory compliance plan, which are designed to guard against fraud and abuse. These requirements shall be met through the following:

4. Fraud and Abuse Reporting
   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....
5. Tracking Suspended Providers
   Contractor shall comply with Title 42 CFR Section 438.610...A list of suspended and ineligible providers is maintained in the Medi-Cal Provider Manual, which is updated monthly and available on line and in print at the DHCS Medi-Cal website (www.medi-cal.ca.gov) and by the Department of Health and Human Services, Office of Inspector General, List of Excluded Individuals and Entities (http://oig/hhs.gov)...

COHS Contract E.2.27.B

SUMMARY OF FINDINGS:

The Plan has programs, procedures, and tools that are designed to detect and examine potential fraud and/or abuse. Procedures have been implemented for the processing of potential and/or suspected non-compliant activities.

The Plan's Policy (dated 2/1/13) HH.1107A, Fraud, Waste and Abuse Investigation and Reporting, indicate that the suspected cases of Fraud and Abuse shall be reported to DHCS within ten (10) business days of the date CalOptima first becomes aware of, or is on notice of such activity.

The Plan's Policy HH. 2021, Vendor Exclusion Monitoring and Audits, indicates the monitoring sources procedures for tracking Suspended Providers. The Plan complies with the Contractual requirements.

A Sample of fourteen (14) Fraud and Abuse cases for the audit period were selected for review. Based on the review, six (6) cases did not meet contractual requirement as follows:

- Four (4) cases were not reported to the Department of Health Care Services
- Two (2) cases were reported to the Department of Health Care Services outside the required timeframe

Based on the review, the Plan failed to report the suspected fraud and abuse cases to DHCS within the timeframe of ten (10) working days to comply with the contractual requirements. [COHS Contract Reference: E.2.27.B]

RECOMMENDATION:

Ensure that all the cases of suspected Fraud or Abuse are reported to the Department of Health Care Services within the required timeframe of ten (10) working days.