TABLE OF CONTENTS

I. INTRODUCTION ........................................................................................................1

II. EXECUTIVE SUMMARY ..........................................................................................2

III. SCOPE/AUDIT PROCEDURES .............................................................................3

IV. COMPLIANCE AUDIT FINDINGS
    Category 2 – Case Management and Coordination of Care ...........5
    Category 4 – Member’s Rights .................................................................7
    Category 6 – Administrative and Organizational Capacity ..........9
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.

The Plan currently has several programs to provide medical care to its members residing in Orange County. As of February 2016, enrollment in these programs is as follows:

- **Medi-Cal**: 763,808 California's Medi-Cal recipients, since 1993
- **OneCare**: 1,377 Medicare/Medi-Cal recipients, since 2005
- **OneCare Connect**: 16,392 Medicare/Medi-Cal recipients, since 2015
- **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**: 136 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 review audit for the review period of February 1, 2015 through January 31, 2016. The onsite review was conducted from February 8, 2016 through February 19, 2016. The audit consisted of document review, verification studies, and interview with the Plan personnel.

An Exit Conference was held on April 7, 2016 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 on April 22, 2016 which is reflected in this report.

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

The summary of the findings by category is as follows:

Category 2 – Case Management and Coordination of Care

Medical record documentation for the completion of an Initial Health Assessment lacked a comprehensive office visit.

The Plan’s methodology to monitor compliance with the Initial Health Assessment requirement is inadequate.

Category 4 – Member’s Rights

The Plan did not submit the completed report of investigation to all the required DHCS personnel.

Category 6 – Administrative and Organizational Capacity

The Plan did not report a suspected fraud and abuse case to the Department of Health Care Services (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 onsite audit of CalOptima was conducted from February 8, 2016 through February 19, 2016. The audit included a review of the Plan’s contracts with DHCS, its policies for providing services, the procedures used to implement the policies, and verification studies of the implementation and effectiveness of the policies. Documents were reviewed and interviews were conducted with plan administrators and staff.

The following verification studies were conducted:

Category 1 – Utilization Management

Prior Authorization Requests: 20 medical and 16 pharmacy prior authorization requests were reviewed for timeliness, consistent application of criteria, and appropriate review by the Plan.

Appeals Procedures: 47 prior authorization appeals were reviewed for appropriate and timely adjudication.

Category 2 – Case Management and Coordination of Care

California Children’s Services (CCS): 11 medical records were reviewed for evidence of Coordination of Care between the Plan and CCS Providers.

Individual Health Assessment (IHA): 20 medical records were reviewed for completeness and timely completion.

Complex Case Management (CCM): 6 medical records listed as CCM were reviewed for a coordination of care.

Category 3 – Access and Availability of Care

Emergency Service Claims: 20 emergency service claims were reviewed for appropriate and timely adjudication.
Family Planning Claims: 20 family planning claims were reviewed for appropriate and timely adjudication.
Category 4 – Member’s Rights

Grievance Procedures: 40 grievances were reviewed for timely resolution, response to complainant, and submission to the appropriate level for review.

Category 6 – Administrative and Organizational Capacity

New Provider Training: 34 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 2 – Case Management and Coordination of Care

### 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.B

Contractor shall ensure that the IHA includes the IHEBA as described in Exhibit A, Attachment 10, Provision 8, Paragraph A using an age appropriate DHCS approved assessment tool.

Contractor shall make repeated attempts, if necessary, to contact a Member and schedule an IHA….(as required by Contract)

COHS Contract A.10.3.E

**Provision of IHAs for Members under Age 21:**

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

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:

#### 2.4.1 Initial Health Assessment Documentation.

The Plan shall cover and ensure the provision of an IHA (comprehensive history and physical examination) in conformance with California Code of Regulations (CCR), Title 22, section 53910.5(a)(1) to each new member within the required timelines (COHS Contract, Exhibit A, Attachment 10(3) (A)).

The Plan’s Policy # GG1613, Initial Health Assessment, states its Members shall receive an IHA after enrollment in the program and CalOptima shall track IHAs to ensure assessments are conducted within the timeframes specified in applicable statutes and regulations.

The medical records reviewed did not have sufficient documentation of a complete history and physical examination to reflect a comprehensive office visit.

The DHCS medical audit included a verification study of 37 medical records. Twenty-three (23) medical records reviewed did not meet the requirements for IHA completion. The medical records showed the
primary care providers (PCP) failed to document the key elements necessary to support a comprehensive history, pertinent review of systems, a physical examination, and a complete history. In addition, five (5) medical records were not submitted for review.

In the Plan’s response, no documentation to support the findings from the audit report was submitted.

2.4.2. Plan Methodology to Monitor IHA Compliance.

The Plan is required to ensure provision of an IHA in conformance with CCR, Title 22, section 53910.5 (a)(1) to each new member within 120 calendar days of enrollment (COHS Contract, Exhibit A, Attachment 10(3) (A)) and to have procedures to monitor IHA completion (MMCD Policy Letter No. 08-003 Initial Comprehensive Health Assessment).

The Plan’s methodology for monitoring IHA is through Facility Site Reviews (FSR) conducted every three years including Medical Record review process of reporting. Other than FSRs, no other efforts were made to monitor IHA completion.

During interviews, the Plan stated a new measure will be added in 2016. The process will evaluate the number of members that have had an IHA within 120 calendar days of enrollment and/or within the previous 12 months.

Without an effective monitoring system the Plan can not verify if the provider completed a comprehensive IHA within the required time frames on a member or maintained documentation of attempts to contact the member.

In the Plan’s response, no documentation to support the findings from the audit report was submitted. This item will be revisited in the next DHCS medical audit to permit the Plan sufficient time to implement the process and to report its measurement results.

RECOMMENDATIONS:

2.4.1 Ensure members’ medical records contain all elements of a complete Initial Health Assessment.

2.4.2 Ensure procedures for monitoring Initial Health Assessment compliance are based on validated methodologies.
## CATEGORY 4 – MEMBER’S RIGHTS

### 4.3 CONFIDENTIALITY RIGHTS

**Health Insurance Portability and Accountability Act (HIPAA) Responsibilities:**

**A. Responsibilities of Business Associate.**

2. **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. Business Associate shall implement reasonable and appropriate policies and procedures to comply with the standards, implementation specifications and other

Required by Contract

**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 and this Addendum, or potential loss of confidential data affecting this Agreement. A breach shall be treated as discovered by Business Associate as of the first day on which the breach is known, or by exercising reasonable diligence would have been known, to any person (other than the person committing the breach) who is an employee, officer or other agent of Business Associate.

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.

COHS Contract G.III.C, J
SUMMARY OF FINDINGS:

4.3.1 The Plan did not submit the completed report of investigation to all the required DHCS personnel.

The Plan 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, Exhibit G, Attachment 3(C) and (J)) and (MMCD All Plan Letter 09-014).

The Plan's Policy # HH.3020, Reporting a Breach of Data Security, Intrusion, or Unauthorized Use or Disclosure of Protected Health Information, states that within ten (10) working days of the initial discovery, CalOptima Privacy Officer or Designee shall submit a complete investigation report to the DHCS Contract Manager, DHCS Privacy Officer, and DHCS Information Security Officer.

A total of ten HIPAA breach cases were reviewed for the audit period. Based on the review, seven completed investigation reports with the Privacy Incident Report (PIR) were submitted only to the DHCS Privacy Officer and not to the DHCS Contract Manager and DHCS Information Security Officer as required in the contract.

During interviews, the Plan stated that the initial discovery of investigation reports were submitted via email to the DHCS Contract Manager, DHCS Privacy Officer and the DHCS Information Security Officer within 72 hours as required in the contract. The DHCS Privacy Officer replied to the email without including the DHCS Contract Manager and the DHCS Information Security Officer. Therefore, the Plan only sent the completed investigation reports to the DHCS Privacy Officer.

In the Plan's response, the new measures has been added which includes creating an e-mail distribution list for sending e-mail correspondence on all privacy incidents/breaches to DHCS. The email distribution includes the DHCS Privacy Officer, the DHCS Information Security Officer, the DHCS Program Contract Manager, CalOptima's Compliance Officer and CalOptima's Privacy Officer. In addition, the Plan updated the desktop procedure to include this modification to the process.

This item will be revisited in the next DHCS medical audit to permit the Plan sufficient time to implement the process and to report its measurement results.

RECOMMENDATION:

4.3.1 Ensure that the Completed Report of the investigation is submitted to the DHCS Contract Manager and the DHCS Information Security Officer along with the DHCS Privacy Officer within the required timeframe of 10 working days.
COMPLIANCE AUDIT FINDINGS

PLAN: Orange County Organized Health System dba CalOptima

DATE OF ONSITE AUDIT: February 8 – 19, 2016

CATEGORuY 6 – ADMINISTRATIVE AND ORGANIZATIONAL CAPACITY

6.3 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. Additionally, Contractor is prohibited from employing, contracting or maintaining a contract with Physicians or other health care providers that are excluded, suspended or terminated from participation in the Medicare or Medi-Cal/Medicaid programs. 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). Contractor is deemed to have knowledge of any providers on these lists. Contractor must notify the Medi-Cal Managed Care Program/Program Integrity Unit within ten (10) State working days of removing a suspended, excluded, or terminated provider from its provider network and confirm that the provider is no longer receiving payments in connection with the Medicaid program.

SUMMARY OF FINDINGS:

6.3.1 The Plan did not report a suspected fraud and abuse case to the Department of Health Care Services (DHCS) within the required timeframe.

The Plan 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. The Plan 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 the Plan first becomes aware of, or such activity (COHS Contract, Exhibit E, Attachment 2(27) (B)).

The Plan’s Policy HH.1107, 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.

A total of twelve fraud and abuse cases were reviewed for the audit period. Based on the review, eight cases did not meet contractual requirements as they were reported to the Department of Health Care
Services outside the required 10 working days timeframe. Of these eight cases, four were reported after 100 plus days.

This is a repeat finding. In 2014 Corrective Action Plan, it was noted that the item was closed because the finding overlapped with the finding in the 2013 Focused Review. However, the 2014 Focused Review, Corrective Action Plan was not closed due to the Plan not supplying evidence of the 10 day reporting compliance.

During interviews, the Plan stated that in 2014 there were a total of 215 new cases received as compared to 433 cases received up until September 30, 2015. Therefore, the Plan is aware of not consistently reporting the preliminary investigation to DHCS within the 10 working days because of the high volume of new cases.

In the Plan’s response, CalOptima requested to revise the language in the findings. The requests were reconsidered and the findings were revised.

RECOMMENDATION:

6.3.1 Monitor to improve a system that ensures all incidents of suspected fraud and abuse cases are reported to DHCS within ten working days of the date the Plan is aware of such activity.
# TABLE OF CONTENTS

I. INTRODUCTION ........................................................................................................1

II. COMPLIANCE AUDIT FINDINGS .............................................................................2
INTRODUCTION

The audit report presents the findings of the contract compliance audit of Orange County Organized Health System dba CalOptima and its implementation of the State Supported Services contract No. 08-85221 with the State of California. The State Supported Services contract covers abortion services for CalOptima.

The onsite audit of the Plan was conducted from February 8, 2016 through February 19, 2016. The audit covered the review period from February 1, 2015 through January 31, 2016 and consisted of a document review of materials provided by the Plan.
STATE SUPPORTED SERVICES CONTRACT REQUIREMENTS

Abortion – Services to be Performed:
Contractor agrees to provide, or arrange to provide, to eligible Members the following State Supported Services:
Current Procedural Coding System Codes*: 59840 through 59857
HCFA Common Procedure Coding System Codes*: X1516, X1518, X7724, X7726, Z0336

*These codes are subject to change upon the Department of Health Care Services’ (DHCS’) implementation of the Health Insurance Portability and Accountability Act of 1996 (HIPAA) electronic transaction and code sets provisions. Such changes shall not require an amendment to this Contract.
State Supported Services Contract Exhibit A.4

SUMMARY OF FINDINGS:

The Plan Policy GG.1508, Authorization and Processing Referrals, states that elective abortion do not require prior authorization, but must be provided, as follows, to ensure that a Member is treated by a qualified provider. A Member can obtain elective abortion services from a Medi-Cal licensed practitioner and a Member requesting an elective abortion can access information about qualified practitioners by calling CalOptima’s Customer Service Department or the Member’s Health Network Member services department.

The Member Handbook informs Members that family planning services to prevent or delay pregnancy, pregnancy prevention, and abortion services are available and do not require prior authorization and that these services do not need guardian or parent consent. In addition, it states that these services are available to adults and adolescents (12 years of age or older). All Members have the right to confidentiality when obtaining these services. It also informs Members that they have the right to receive family planning services and choose a doctor or clinic not with CalOptima and that authorization from their Primary Care Physician is not needed. Furthermore, it informs Members that they may call their health network or CalOptima’s Customer Service Department if they have questions or need help finding a qualified Medi-Cal provider.

The Provider Manual informs providers that abortion is under categories of care for which no prior authorization is required. The manual references Plan Policy GG. 1118, Family Planning Services, Out-of-Network, that states Members may access family planning services on a self-referral basis to any qualified family planning practitioner, including an out-of-network practitioner, without prior authorization.

According to Plan personnel, the claims department maintains an updated list of claim codes for abortion services. The Plan monitors the code list yearly, as well as when new codes are established. Plan personnel stated that out-of-network providers are reimbursed in house. The Plan monitors weekly reports to ensure that out-of-network providers are properly reimbursed. CalOptima has guidelines to provide instructions for the billing of abortion services for participating Providers and for claims processors when paying or denying a claim with updated billing codes. The Plan is in compliance with the Contractual requirement.