CONTRACT AND ENROLLMENT REVIEW DIVISION
SANTA ANA
AUDITS AND INVESTIGATIONS
DEPARTMENT OF HEALTH CARE SERVICES

REPORT ON THE MEDICAL AUDIT OF

Orange County Organized Health System dba CalOptima

2023

Contract Number:	08-85214
Audit Period:	February 1, 2022 Through January 31, 2023
Dates of Audit:	February 27, 2023 Through March 10, 2023
Report Issued:	August 17, 2023

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I. INTRODUCTION

Orange County Organized Health System dba CalOptima Health Plan (Plan) was founded in 1993 via a partnership with the local government, the medical community (hospitals and physicians), and health advocates. In 1995, the Plan began operation as a County Organized Health System for Orange County to provide medical care for Medi-Cal beneficiaries.

In addition, the Plan is currently governed by a Board of Directors of ten members appointed by the Orange County Board of Supervisors. The Board of Directors is comprised of Plan members, providers, business leaders, and local government representatives.

The Plan currently has several programs to provide medical care to its members residing in Orange County. As of December 31, 2022, the composition of the Plan membership was as follows:

- Medi-Cal: 927,086 Medi-Cal recipients for low-income individuals, families with children, seniors, and people with disabilities.
- OneCare (Health Maintenance Organization Special Needs Plan): 17,381 Medi-Cal and Medicare members.
- Program of All-Inclusive Care for the Elderly: 437 Medicare/Medicaid and Medi-Cal recipients aged 55 and older who live in the services area and are eligible for nursing facility services.

II. EXECUTIVE SUMMARY

This report presents the audit findings of the Department of Health Care Services (DHCS) medical review audit for the period of February 1, 2022 through January 31, 2023. The review was conducted from February 27, 2023 through March 10, 2023. The audit consisted of a document review, verification studies, and interviews with Plan personnel.

An Exit Conference with the Plan was held on July 12, 2023. The Plan was allowed 15 calendar days from the date of the Exit Conference to provide supplemental information addressing the audit report findings. The Pan did provide additional information after the Exit Conference, which DHCS reviewed.

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

The prior DHCS medical audit, for the audit period of February 1, 2020 through December 31, 2021, was issued on November 8, 2022. This audit examined documentation for compliance.

The summary of the findings by category is as follows:

Category 1 – Utilization Management

There were no findings in this category for this audit period.

Category 2 – Case Management and Coordination of Care

The Plan is required to ensure that an Initial Health Assessment (IHA) is performed by the member's assigned Primary Care Provider (PCP) and non-physician mid-level practitioners. The Plan did not ensure compliance and the provision of the Plan's contracted PCPs to perform IHA to new members.

The Plan is required to implement policies and procedures to ensure the Pediatric Risk Stratification Process (PRSP) provisions are performed to Whole Child Model (WCM). The Plan did not ensure that members who did not have medical utilization data, claims processing data history, or other assessments or surveys information available for PRSP were automatically categorized as high risk until further assessment data was gathered to make an additional risk determination.

Category 3 – Access and Availability of Care

There were no findings in this category for this audit period.

Category 4 – Member's Rights

There were no findings in this category for this audit period.

Category 5 – Quality Management

There were no findings in this category for this audit period.

Category 6 – Administrative and Organizational Capacity

There were no findings in this category for this audit period.

III. SCOPE/AUDIT PROCEDURES

SCOPE

The DHCS Contract and Enrollment Review Division conducted this audit to ascertain whether the medical services provided to Plan members comply with federal and state laws, Medi-Cal regulations and guidelines, and State Contracts.

PROCEDURE

The following verification studies were conducted from February 27, 2023 through March 10, 2023. 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 the Plan's administrators, a delegated entity, and staff.

The following verification studies were conducted:

Category 1 – Utilization Management

Prior Authorization: 29 medical prior authorization, 15 pharmacy prior authorization, and 30 delegated prior authorization were reviewed for medical necessity, consistent application of criteria, timeliness, appropriate review, and communication of results to members and providers.

Prior Authorization Appeal Procedures: 20 medical prior authorization of which eight were upheld, and 12 were overturned were reviewed to ensure that required timeframes were met and appeals were appropriately routed and adjudicated.

Category 2 – Case Management and Coordination of Care

IHA: 20 medical were reviewed for completeness and timely completion.

WCM: 20 WCM records were reviewed for appropriate care coordination.

Category 4 – Member's Rights

Exempt Grievances: Five exempt grievance cases were reviewed to verify the classification, reporting timeframes, and investigation process.

Quality of Services: 21 cases were reviewed for timeliness, investigation process, and appropriate resolution.

Quality of Care: 20 standard grievances were reviewed for processing, clear and timely

response, and appropriate level of review.

Category 5 – Quality Management

Potential Quality Improvement : 12 cases were reviewed for response to the complainant and submission to the appropriate level for review.

Category 6 – Administrative and Organizational Capacity

Fraud, Waste, and Abuse: Ten cases were reviewed for proper investigative process, and timely reported to DHCS for review.

Overpayment Reporting: Ten overpayment recovery cases were reviewed for timely reporting to DHCS and annual reporting of total overpayment recoveries to DHCS.

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

CATEGORY 2 – CASE MANAGEMENT AND COORDINATION OF CARE

2.1	INITIAL HEALTH ASSESSMENT

2.1.1 Provision of Initial Health Assessment

The Plan is required to comply with all existing final Policy Letters and All Plan Letters (APL) issued by DHCS. *(COHS Contract, Exhibit E, Attachment 2(D))*

Medi-Cal Managed Care Division (MMCD) Policy Letter 08-003, requires the Plan to ensure an IHA is performed by member's PCP, perinatal care providers, and non-physician mid-level practitioners (nurse practitioners, certified nurse midwives, physician assistants, and PCPs in training).

The Plan Policy, *(# GG1613) Initial Health Assessment Initial Health Assessment* (Revised December 1, 2021), states an IHA should be performed by the member's assigned PCP, perinatal care provider during a member pregnancy, and non-physician mid-level practitioners such as nurse practitioners, certified nurse midwives, physician assistants, and PCPs in training. The policy also indicates the Plan monitors PCP IHA completion during Facility Site Review (FSR) and Medical Record Review (MRR). The Plan may issue a Corrective Action Plan (CAP) to any provider or practitioner that fails to meet the IHA documentation metrics.

Finding: The Plan did not ensure that an IHA was performed by the member's PCP, perinatal care providers, and non-physician mid-level practitioners.

The verification study identified three new members who had IHA performed by a psychiatrist or ophthalmologist.

The Plan used service codes in claims as one of the process to identify if an IHA is completed. In addition to the service codes and the dates of service, claims also listed the provider's names and specialties who performed the billed services. However, when there were an Evaluation and Management (E&M) codes such as 99202 to 99205 used to claim for a new member's visit, the Plan identified that claim as an IHA completion without checking the provider's specialty on the claim to ensure IHA was provided by a PCP, perinatal care providers, and non-physician mid-level practitioners as required.

Therefore, the three new members who had IHA performed by a psychiatrist or ophthalmologist did not have an IHA completion performed by their assigned PCPs.

During the interview, the Plan acknowledged that its used E&M code as one of the service codes to identify IHA completion, but the Plan did not check the provider specialty on the claim to ensure that a new member's IHA was performed by their selected or assigned PCP as required.

The Quality Improvement Committee (QIC) *Meeting Minutes* on March 8, 2022 showed only the review of number of MRR CAPs issued to providers during the Plan's 2021 FSR/MRR audit. The QIC did not review the IHA completion rates and ensure that a new member's IHA was performed by their selected or assigned PCP as required. The IHA and Individual Health Education Behavioral Assessment were reviewed as a criterion for the MRRs. The MRRs were completed as part of the FSR process of the Plans' PCPs. The FSR/MRR reports were submitted to QIC annually for review. The 2021 FSR/MRR report was presented to the QIC on March 8, 2022. The FSR/MRR reports contained FSR scores, MRR scores, the number of initial MRRs, the number of periodic MRRs, and the number of MRR CAPs issued to the reviewed site providers. The FSR/MRR reports did not specifically outline the IHA completion rates. In addition, the Plan did not have a process to monitor and ensure a new member's IHA was performed by their PCP, perinatal care provider, and non-physician mid-level practitioner as required.

The IHA is a comprehensive assessment that is completed during the member's initial encounter with a selected or assigned PCP. The IHA assists the member's PCP to assess and manage the member's acute, chronic, and preventive health needs. If the IHA is not performed for each new member by their PCP, the provider cannot identify and treat the member's mental, physical, psychological, and preventative health needs.

Recommendation: Revised and implement policies and procedures to ensure compliance and the provision of the Plan's contracted PCPs to perform IHA to new members.

2.2	CALIFORNIA CHILDREN'S SERVICES

2.2.1 Performance of Pediatric Risk Stratification Process

The Plan is required to comply with all existing final Policy Letters and APL issued by DHCS. *(COHS Contract, Exhibit E, Attachment 2(D))*

MMCD APL 21-005 requires the Plan to have a pediatric risk stratification mechanism, or algorithm, to assess the California Children Services (CCS)-eligible member's risk level that will be used to classify members into high and low risk categories, allowing the Plan to identify members who have more complex health care needs. The Plan must complete a risk stratification within 45 days of enrollment for all members, including new CCS members enrolling in the MCP and newly CCS-eligible members by using the medical utilization and claims processing data, existing member assessment or survey data, and telephonic or in-person communications. Members with no medical utilization data, claims processing data history, or other assessments and/or survey information must be automatically categorized as high risk until further assessment data is gathered to make an additional risk determination.

Plan Policy, *(# GG1330) Case Management California Children Services Program Whole Child Model* (Revised August 18, 2022), stated the Plan identifies the health risk of each CCS-eligible member using a DHCS-approved proprietary pediatric risk stratification algorithm within 45 calendar days of the eligibility with the CCS program. The PRSP includes the review of medical utilization data, medical claims, and encounter data, existing assessment or survey data, pharmacy data, data provided by the local CCS program and DHCS, and telephonic or in-person communications, if available at the time of the risk stratification. If a member does not have the noted data available, the Plan will automatically categorize such members as high risk until the Plan is able to gather further assessment data to make an additional risk determination.

, *Whole Child Model Pediatric Risk Stratification Technical Specifications* (Revised May 27, 2021), described the business rules for WCM PRSP with the scoring algorithm: high risk is ≥ 19 points, and low risk is < 19 points.

Finding: The Plan did not ensure that members who did not have medical utilization data, claims processing data history, or other assessments or survey information available for PRSP were automatically categorized as high risk until further assessment data was gathered to make an additional risk determination.

The verification study identified eight WCM members had no medical utilization data, claims processing data history, or other assessment or survey information besides their diagnosis for PRSP. The Plan scored 14 points for the diagnosis of cancer and eight points for other diagnoses. The total points were either eight or 14 for each member. Based on the total points, the member was categorized as low risk instead of automatically high risk as required.

During an interview, the Plan acknowledged that it did not have the process to monitor PRSP performance. The Plan also acknowledged that the low risk level assigned to a member whose diagnosis was the only available data during the PRSP was incorrect.

The Plan's, *Whole Child Model Clinical Advisory Committee (CAC) (meeting dates: February 15, 2022, May 17, 2022, and August 16, 2022),* reviewed WCM measures in utilization management of Neonatal Intensive Care Unit, durable medical equipment, and emergency department; WCM grievances and resolution services; and WCM customer service inquiries. The WCM CAC did not discuss and review the WCM PRSP performance monitoring.

The Plan's, *Quality Improvement Committee (meeting dates from February 2022 through November 2022)* reviewed and approved the WCM CAC meeting minutes. There was no discussion or review of WCM PRSP performance monitoring for quality improvement.

The WCM member's risk level is used to classify members into high and low risk categories and assist the Plan in identifying members who have more complex health care needs. When a high risk WCM member is incorrectly categorized as low risk, the member's needs will not be met and consequently, the quality of care may be compromised.

Recommendation: Revise and implement policies and procedures to ensure compliance with PRSP performance to WCM members.

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REPORT ON THE MEDICAL AUDIT OF

Orange County Organized Health System dba CalOptima

2023

Contract Number:	08-85221 State Supported Services
Audit Period:	February 1, 2022 Through January 31, 2023
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I. INTRODUCTION

The audit report presents the audit findings of the contract compliance audit of Orange County Organized Health System dba CalOptima (Plan) 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 the Plan.

The review was conducted from February 27, 2023 through March 10, 2023. The audit covered the review period from February 1, 2022 through January 31, 2023. The audit consisted of a document review of materials provided by the Plan and interviews with Plan staff.

An Exit Conference with the Plan was held on July 12, 2023.

❖ COMPLIANCE AUDIT FINDINGS (CAF) ❖

PLAN: Orange County Organized Health System dba CalOptima

AUDIT PERIOD: February 1, 2022 through January 31, 2023
DATE OF AUDIT: February 27, 2023 through March 10, 2023

STATE SUPPORTED SERVICES

SUMMARY OF FINDING(S): The Plan's Provider Manual and Member Handbook indicate that members may access sensitive services, such as abortion and abortion-related services, from any qualified provider, contracted or non-contracted, without prior authorization. The Plan has policies and procedures to ensure timely and accurate claims processing.

The verification studies noted that abortion services were covered, and members did not require prior authorization for these services. There were no material findings during the audit period.

RECOMMENDATION(S): None.