DHCS AUDITS AND INVESTIGATIONS

CONTRACT AND ENROLLMENT REVIEW DIVISION

SAN DIEGO SECTION

REPORT ON THE MEDICAL AUDIT OF ORANGE COUNTY HEALTH AUTHORITY, A PUBLIC AGENCY DBA CALOPTIMA HEALTH FISCAL YEAR 2024-25

Contract Number: 23-30235

Audit Period: February 1, 2024 — January 31, 2025

Dates of Audit: January 27, 2025 — February 7, 2025

Report Issued: May 20, 2025

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I. INTRODUCTION

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

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 members residing in Orange County. As of September 30, 2024, the composition of the Plan membership was as follows:

- Medi-Cal: 895,716 Medi-Cal members for low-income individuals, families with children, seniors, and people with disabilities.
- OneCare (Medicare Advantage Special Needs Plan): 17,282 Medi-Cal members who also have Medicare.
- Program of All-Inclusive Care for the Elderly: 503 Medicare/Medicaid and Medi-Cal members aged 55 and older who live in the service area and are eligible for nursing facility services but able to live in the community with support.

II. EXECUTIVE SUMMARY

This report presents the audit findings of the Department of Health Care Services (DHCS) medical audit for the period of February 1, 2024, through January 31, 2025. The audit was conducted from January 27, 2025, through February 7, 2025. The audit consisted of documentation review, verification studies, and interviews with the Plan's representatives.

An Exit Conference with the Plan was held on April 24, 2025. The Plan was allowed 15 calendar days from the date of the Exit Conference to provide supplemental information addressing the draft audit findings. On May 9, 2025, the Plan submitted a response after the Exit Conference. The evaluation results of the Plan's response are reflected in this report.

The audit evaluated six categories of performance: Utilization Management, Population Health Management and Coordination of Care, Network and Access to Care, Member Rights, Quality Improvement and Health Equity Transformation, and Administrative and Organizational Capacity.

The prior DHCS medical audit for the period of February 1, 2023, through February 29, 2024, was issued on August 16, 2024. This audit examined the Plan's compliance with the DHCS Contract and assessed the implementation of the prior year 2024, Corrective Action Plan except for two findings that remained open at the time of the audit.

The summary of the findings by category follows:

Category 1 – Utilization Management

The Plan is required to notify members of a decision to deny, defer, or modify requests for Prior Authorizations (PAs) in accordance with language requirements. The Plan did not provide full and immediate translation of Notice of Action (NOA) letters for members with limited English proficiency who speak threshold or concentration standard languages.

Category 2 – Population Health Management and Coordination of Care

The Plan is required to provide members with an approval letter when a Continuity of Care (COC) decision is made. The Plan did not generate and send member approval letters.

The Plan is required to develop member-facing written material about Enhanced Care Management (ECM) for use across its network of ECM providers. The written material must, at a minimum, explain that ECM participation is voluntary and can be discontinued at any time, and describe the process by which the member may choose a different ECM Lead Care Manager or ECM provider. The Plan did not develop and provide member-facing material explaining ECM participation is voluntary and can be discontinued at any time nor the process to choose a different ECM Lead Care Manager or ECM provider.

Category 3 – Network and Access to Care

There were no findings noted for this category during the audit period.

Category 4 – Member Rights

There were no findings noted for this category during the audit period.

Category 5 – Quality Improvement and Health Equity Transformation

There were no findings noted for this category during the audit period.

Category 6 – Administrative and Organizational Capacity

The Plan is required to report any potential Fraud, Waste, and Abuse (FWA) to the DHCS Program Integrity Unit (PIU) within ten working days. The Plan did not ensure that all preliminary reports of suspected FWA were reported to DHCS within ten working days.

III. SCOPE/AUDIT PROCEDURES

SCOPE

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

PROCEDURE

DHCS conducted an audit of the Plan from January 27, 2025, through February 7, 2025, for the audit period of February 1, 2024, through January 31, 2025. The audit included a review of the Plan's Contract with DHCS, policies and procedures for providing services, 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 and staff.

The following verification studies were conducted:

Category 1 – Utilization Management

PA Requests: Twenty-five PA requests were reviewed for timeliness, consistent application of criteria, appropriate review, and communication of results to members and providers.

Delegated PA Requests: Twenty-two PA requests were reviewed for appropriate and timely adjudication.

Category 2 – Population Health Management and Coordination of Care

Initial Health Appointment (IHA): Twenty medical records were reviewed for timeliness and completeness of IHA requirements.

California Children's Services (CCS) Whole Child Model: Eight CCS Whole Child Model records were reviewed for appropriate care coordination.

COC: Five medical records were reviewed to evaluate timeliness, appropriate determination, and notification of COC requests.

ECM: Eighteen medical records were reviewed to evaluate the provision of ECM core service components.

Category 3 – Network and Access to Care

Non-Emergency Medical Transportation (NEMT) and Non-Medical Transportation (NMT): Eleven records (five NEMT and six NMT) were reviewed to confirm compliance with transportation requirements for timeliness and appropriate adjudication.

Category 4 – Member Rights

Grievance Procedures: Twenty-seven standard grievances (21 quality of care and 6 quality of service), 5 expedited grievances, 3 exempt grievances, and 10 call inquiries were reviewed for timely resolution, response to the complainant, submission to the appropriate level for review, and translation in the member's preferred language (if applicable).

Category 5 – Quality Improvement and Health Equity Transformation

Quality Management: Eight potential quality issue cases were reviewed for timely evaluation and effective action taken to address improvements.

Category 6 – Administrative and Organizational Capacity

FWA: Twelve FWA cases were reviewed for processing and reporting requirements.

Encounter Data: Five encounter data records were reviewed for complete, accurate, reasonable, and timely encounter data submissions.

COMPLIANCE AUDIT FINDINGS

Category 1 – Utilization Management

1.2 Prior Authorizations

1.2.1 Translations of Member Notices

The Plan must notify members of a decision to deny, defer, or modify requests for PA, in accordance with Code of Federal Regulations (CFR), Title 42, section 438.210(c) and California Code of Regulations, Title 22, sections 51014.1 and 53894 by providing a NOA to members regarding any denial, deferral, or modification of a request for approval to provide a health care service. This notification must be provided in accordance with all requirements set forth in the Contract, Exhibit A, Attachment III, Subsection 4.6.4 (Notice of Action), including language requirements specified in *All Plan Letter (APL) 21-004, Standards for Determining Threshold Languages, Nondiscrimination Requirements, and Language Assistance Services*. (*Contract, Exhibit A, Attachment III, 5.1.5*)

The Plan must provide full and immediate translation of written materials for members with limited English proficiency who speak threshold or concentration standard languages, including NOA letters. (*Contract, Exhibit A, Attachment III, 5.2.10(3)(b)*)

The Plan must provide written translations of member information, including NOA letters, in the threshold and concentration languages identified in its service area. In Orange County, the Plan's service area, Chinese is one of the threshold languages. Chinese is the combination of Cantonese, Mandarin, and other Chinese language. (*APL 21-004, Standards for Determining Threshold Languages, Nondiscrimination Requirements, and Language Assistance Services*)

Where Chinese has been identified as a threshold or concentration language and the member has requested to receive translated written information in either traditional or simplified Chinese characters, the Plan must provide written information in the member's preferred characters. However, if the member has not indicated a preference for simplified or traditional Chinese characters, and the Plan does not yet have a process in place to provide written translations in Chinese, the Plan must provide translations in traditional Chinese characters. Only upon member request will the Plan be required to provide translated written information in simplified Chinese characters. *(APL 21-004, Standards for Determining Threshold Languages, Nondiscrimination Requirements, and Language Assistance Services)*

Plan policy, *DD.2002 Cultural and Linguistic Services* (revised December 1, 2023), states that the Plan will provide translated member information, including a full and immediate translation of written materials in the Plan's threshold languages, including routine and immediate translation of notices pertaining to a denial, limitation, termination, delay, or modification of benefits, and the right to file a grievance or appeal.

Finding: The Plan did not provide translations of NOAs for members with limited English proficiency who speak dialects of Chinese, a threshold language in the Plan's service area.

A verification study revealed that in 2 of 28 PA requests, members were not sent NOAs that were translated into traditional or simplified Chinese. A review of Plan documentation shows that Mandarin was entered as the members' preferred language. Mandarin is a Chinese dialect, which has been identified as a threshold language for the Plan's service area. For members whose preferred language is Chinese or a dialect of Chinese, the Plan must provide written translations in traditional characters or if the member has requested, in simplified characters.

The review of Plan policy DD.2002, determined the policy does not mention that threshold languages include the spoken dialects of Chinese as outlined in APL 21-004. It also does not include that members who have identified Chinese as a preferred language, may also request to have written information in either traditional or simplified Chinese characters. Further, as stated in APL 21-004, if the member has not indicated a preference between the two, the Plan shall provide the member with written translations in traditional Chinese characters.

The Plan explained that due to staff error in determining the appropriate written translation for the member's preferred language, the Plan did not translate the NOA. The Plan's staff did not recognize that Mandarin is a spoken dialect of written Chinese when deciding whether a translation of the NOA was required.

If the Plan does not provide translations of member NOAs, members may not understand decisions to deny coverage of requested services and be informed of their right to appeal. Members will not be able to make informed decisions about their health care. In addition, health inequities for members with limited English proficiency may be exacerbated.

Recommendation: Implement Plan policy to ensure that translations of NOAs are provided for members with limited English proficiency who speak Chinese, a threshold language in the Plan's service area.

COMPLIANCE AUDIT FINDINGS

Category 2 – Population Health Management and Coordination of Care

2.4 Continuity of Care

2.4.1 Member Approval Letters

The Plan must allow all members to request COC in accordance with CFR, Title 42, section 438.62 and *APL 23-022, Continuity of Care for Medi-Cal Beneficiaries who Newly Enroll in Medi-Cal Managed Care from Medi-Call Fee-For-Service, on or After January 1, 2023*. *(Contract, Exhibit A, Attachment III, 5.2.12(B))*

The Plan must provide acknowledgement of COC decisions to members. A COC decision is considered complete when the Plan notifies the member of its decision via the member's preferred method of communication or telephone. The Plan must also send a notice by mail to the member within seven days of the COC decision. *(APL 23-022, Continuity of Care for Medi-Cal Beneficiaries who Newly Enroll in Medi-Cal Managed Care from Medi-Call Fee-For-Service, on or After January 1, 2023)*

For COC requests that are approved, the Plan must include in the notice a statement of the Plan's decision, the duration of the COC arrangement, the process that will occur to transition the member's care at the end of the COC period, and the member's right to choose a different network provider. *(APL 23-022, Continuity of Care for Medi-Cal Beneficiaries who Newly Enroll in Medi-Cal Managed Care from Medi-Call Fee-For-Service, on or After January 1, 2023)*

Plan policy, *GG.1325 Continuity of Care for Members Transitioning into the Plan's Health Services* (revised April 1, 2024), states that the Plan or a health network shall notify the member in writing of the outcome of the request by U.S. mail, or via the requestor's preferred method of communication or by telephone.

Finding: The Plan did not provide COC approval letters to members.

A verification study of five COC requests revealed two approvals where a letter was not generated and sent to the member informing them of this decision. The two approved COC requests only had a standard PA NOA letter that was generated and sent to the provider. A PA NOA is sent for decisions regarding a provider's request for authorization of health care services for a member, but it lacks all required COC approval notice letter

elements. A COC approval letter specifically notifies the member of a COC decision, duration of the COC arrangement, the transition of care process at the end of the COC period, and the member's right to choose a different network provider.

During the audit period, the Plan transitioned to a new medical management system that only created an auto-populated standard PA NOA instead of a COC approval letter. In an interview, the Plan explained with the new system, staff were unaware that only the standard PA NOA letter was being generated. The Plan's new system was set up to automatically populate a standard PA NOA letter for providers and did not generate a COC member approval letter.

Without a member approval letter, members may not be aware of their approved benefits. This can cause a delay in receiving medically necessary services.

Recommendation: Implement Plan policy to ensure members receive an approval letter when a COC decision is made.

2.6 Enhanced Care Management

2.6.1 Enhanced Care Management Member-Facing Written Materials

The Plan must develop member-facing written material about ECM for use across its network of ECM providers. The written material must be submitted for DHCS review and approval prior to use. This material must explain that ECM participation is voluntary and can be discontinued at any time. The material must also describe the process by which the member may choose a different ECM Lead Care Manager or ECM provider. *(Contract, Exhibit A, Attachment III, 4.4.1(K)(2) & (K)(3))*

Plan policy, *GG.1353 CalAIM Enhanced Care Management Service Delivery* (revised August 1, 2024), states that an ECM provider shall ensure ECM members are able to decline or discontinue ECM upon initial outreach and engagement, or any other time.

Plan policy, *GG.1354 CalAIM Enhanced Care Management Eligibility and Outreach* (revised August 1, 2024), states members receiving ECM may request to change their ECM provider at any time by notifying the Plan by phone, in person, or by electronic means, in accordance with Plan policy, *DD.2008 Health Network and CalOptima Community Health Network Selection Process*.

Finding: The Plan did not provide member-facing ECM written material that included all minimum required elements.

The Plan's Member Handbook, Member Newsletters, and ECM flyer did not include material explaining ECM participation is voluntary and can be discontinued at any time nor did the material describe the process for a member to choose a different ECM Lead Care Manager or ECM provider. Plan policy GG.1353 did not state it would have member-facing materials to explain that ECM members are able to decline or discontinue ECM upon initial outreach and engagement, or any other time. Plan policy GG.1354 did not state that member-facing materials would be available to explain how ECM members can change their ECM provider at any time.

In a written statement, the Plan confirmed that it did not have written member-facing materials available explaining ECM is voluntary and may be discontinued at any time. It also confirmed that it did not have member-facing materials available on how to choose a different ECM Lead Care Manager or ECM provider. Instead, the Plan's Member Handbook only states that if members receive ECM services, they may opt out by notifying their ECM Lead Care Manager. The Plan left the member to interpret that participation in ECM services is voluntary, like its other benefits and services. It also left members to interpret that an ECM Lead Care Manager or ECM provider could be changed at any time, similar to requesting a primary care provider change. The Plan acknowledged it should have been more explicit with this requirement to clearly indicate the process to change an ECM Lead Care Manager or ECM provider at any time.

If the Plan does not provide members with written material explaining ECM participation is voluntary and can be discontinued at any time, the member may not be aware of their right to decline or prematurely end participation. Additionally, if a member is not provided with written material on how to choose a different ECM Lead Care Manager or ECM provider, the member may not have access to an ECM Lead Care Manager or provider who fits their needs.

Recommendation: Revise and implement Plan policy to ensure the provision of member-facing ECM written materials.

COMPLIANCE AUDIT FINDINGS

Category 6 – Administrative and Organizational Capacity

6.2 Fraud and Abuse

6.2.1 Fraud, Waste, and Abuse Reporting

The Plan is required to meet the reporting obligations in accordance with CFR, Title 42, section 438.608(a)(7), to refer, investigate, and report all FWA activities that the Plan identifies to DHCS PIU. The Plan, its subcontractors, its downstream subcontractors, and/or its network providers must file a detailed preliminary report of suspected FWA with DHCS PIU within ten working days. *(Contract, Exhibit A, Attachment III, 1.3.2)*

Plan policy, *HH.1107 Fraud, Waste, and Abuse Investigation and Reporting* (revised September 1, 2023), states the Plan is required to conduct, complete and report suspected FWA to DHCS PIU within ten business days of the date the Plan first became aware of, or is on notice of, such activity. The referral, any completed investigations, and quarterly FWA reports shall be submitted on a Medi-Cal Complaint Report (MC 609) that can be sent to DHCS PIU via secure email.

Finding: The Plan did not ensure that all preliminary reports of suspected FWA were reported to DHCS PIU within ten working days.

In a verification study of 12 cases, there were 3 cases where the Plan exceeded ten working days to submit MC 609 reports to DHCS PIU. The Plan reported the suspected FWA to DHCS PIU between 18 and 23 working days after the date of initial discovery. Two cases involved potential eligibility fraud, and one case encompassed inappropriate billing. The audit found noncompliance with the Plan's policy and procedures, as noted in the following examples:

- One potential fraud case alleged a member was ineligible for Medi-Cal benefits due to undisclosed income. The Plan received an anonymous letter and immediately took action to begin an analysis of the data received. Within seven working days, the FWA analyst found that the member was an active Medi-Cal member that had received benefits in the Plan's service area. However, 15 working days passed before the Plan reported the allegation to DHCS PIU. The Plan documentation noted that due to the allegation coming from an anonymous reporter, additional information could not be obtained. Additionally, the Plan noted it does not determine eligibility.

- The second potential case of fraud was submitted by a provider alleging a member did not possess legal residency and suspected the member did not meet financial qualifications for the Medi-Cal program. The Plan contacted the member's provider, and the allegations were saved in a case folder. The Plan's analyst was notified to report the case to DHCS PIU on the same day it was received. However, 22 working days passed before the Plan reported the allegation to DHCS PIU. The Plan also noted it does not determine member eligibility.
- The third potential case of fraud was submitted by the Plan's Medical Director who identified a provider submitting improper Current Procedural Terminology codes. The Plan's FWA Department assessed the case as low risk. It also confirmed the Plan is not contracted with the provider, but the provider is contracted with other health networks. However, 16 working days passed before the Plan reported the potential inappropriate billing to DHCS PIU. The Plan noted the case is ongoing.

In an interview, the Plan explained cases were reported past ten working days because its FWA analysts were unsure whether the potential eligibility fraud cases qualified for referral to DHCS PIU. For the case of inappropriate billing, the FWA analyst was unsure if there was enough information to support the referral to DHCS PIU. The Plan also confirmed that when the three FWA referrals were received, it did not have a tracking system established to monitor and oversee the age and status of cases. The audit did not find Plan documentation that showed monitoring and oversight of these FWA cases.

Review of Plan policy, *HH.1105 Fraud, Waste, and Abuse Detection* (revised September 1, 2023), found that the Plan identifies unsubstantiated declarations of eligibility and improper billing as potential circumstances where FWA may be detected. Furthermore, Plan policy HH.1107 states the Plan shall conduct preliminary research of any allegation of suspected FWA and report it to the appropriate agency in accordance with its DHCS Contract. The Plan did not align its practices with established procedures.

If the Plan does not report suspected FWA to DHCS PIU timely, it may limit the ability to track, analyze, and respond to incidents and mitigate the impact to members, providers, the Plan, and the Medi-Cal program.

Recommendation: Implement Plan policy to ensure prompt reporting of all potential FWA to DHCS PIU within ten working days of when the Plan first becomes aware of, or is in notice of, the activity.

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SAN DIEGO SECTION

REPORT ON THE MEDICAL AUDIT OF ORANGE COUNTY HEALTH AUTHORITY, A PUBLIC AGENCY DBA CALOPTIMA HEALTH FISCAL YEAR 2024-25

Contract Number: 23-30267

Contract Type: State Supported Services

Audit Period: February 1, 2024 — January 31, 2025

Dates of Audit: January 27, 2025 — February 7, 2025

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I. INTRODUCTION

This report presents the results of the audit of Orange County Health Authority, A Public Agency dba CalOptima Health (Plan) compliance and implementation of the State Supported Services contract number 23-30267 with the State of California. The State Supported Services Contract covers abortion services with the Plan.

The audit covered the period of February 1, 2024, through January 31, 2025. The audit was conducted from January 27, 2025, through February 7, 2025, which consisted of a document review and verification study with the Plan administration and staff.

An Exit Conference with the Plan was held on April 24, 2025. No deficiencies were noted during the review of the State Supported Services Contract.

COMPLIANCE AUDIT FINDINGS

State Supported Services

The Plan's policies and procedures, Provider Manual, and Member Handbook indicated that abortion service was covered, and prior authorization was not required for this service. Members may go to any Medi-Cal provider of their choice for abortion services, at any time for any reason, regardless of network affiliation.

A verification study of seven State Supported Service claims was conducted to determine appropriate and timely adjudication of claims. There were no compliance issues identified during the audit period.

Recommendation: None.