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

REPORT ON THE MEDICAL AUDIT OF

Orange County Organized Health System
dba CalOptima

Contract Number: 08-85214

Audit Period: February 1, 2018
Through
January 31, 2019

Report Issued: June 25, 2019

TABLE OF CONTENTS

I. INTRODUCTION

CalOptima is a separate public agency founded in 1993 by the Orange County Board of Supervisors, which partners with local government, the medical community (both hospitals and physicians) and health advocates. In 1993, the Plan was established as a County Organized Health System, (COHS). The Plan is the second largest health insurer in Orange County, which provides healthcare services to more than 770,000 residents.

In addition, the Plan is currently governed by a Board of Directors made up of eleven (11) members that are appointed by the Orange County Board of supervisors. The Board of Directors is composed 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 2018, enrollment in these programs is as follows:

- **Medi-Cal:** 742,386 Medi-Cal recipients, for low-income individuals, families with children, seniors, and people with disabilities.
- **OneCare:** 1,423 Medicare/Medicaid recipients, for Medi-Cal members who also have Medicare.
- **OneCare Connect:** 14,610 Medicare/Medicaid & Medi-Cal recipients who live in Orange County for both Medicare Parts A and B and Medi-Cal, who are 21 years and older.
- **Program of All-Inclusive Care for the Elderly (PACE):** 295 Medicare/Medicaid and Medi-Cal recipients aged 55 and older who live in the service 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 audit for the period of February 1, 2018 through January 31, 2019. The onsite review was conducted from Monday, February 4, 2019 through Friday, February 15, 2019. The audit consisted of document reviews, verification studies, and interviews with Plan personnel.

An Exit Conference was held on May 22, 2019 with the Plan. The Plan was allowed 15 calendar days from the date of the Exit Conference to provide supplemental information addressing the audit report findings. The Plan submitted additional information after the exit conference that is reflected in this report.

The reduced scope audit evaluated five categories of performance; Utilization Management (UM), Case Management and Coordination of Care, Access and Availability of Care, Member's Rights, and Quality Management.

The summary of the findings by category is as follows:

Category 1 – Utilization Management

There are no findings in this category.

Category 2 – Case Management and Coordination of Care

The Plan did not ensure that Behavioral Health Treatment (BHT) services are provided based upon the member's approved treatment plan that includes direct service hours and did not take remedial action on non-compliant providers. Plan *Policy No. GG.1548: Authorization for Applied Behavioral Analysis for Autism Spectrum Disorder* does not have a procedure to monitor and ensure Applied Behavioral Analysis (ABA) providers are providing BHT services based upon an approved treatment plan that includes providing the authorized number of direct service hours.

Category 3 – Access and Availability of Care

The Plan did not comply with its written policies and procedures to ensure that members have access to Covered Services in accordance with monitoring of all primary care practitioners (PCPs) in the Plan's provider network by failing to conduct the 2018 Timely Access Survey.

Category 4 – Member's Rights

There are no findings in this category.

Category 5 – Quality Management

Contract requires the Plan to monitor, evaluate, and take effective action to address any needed improvements in the quality of care delivered by all providers rendering services. The Plan did not take effective action to ensure improvements in quality of care for Behavioral Health Treatment members when their grievances demonstrated quality problems.

III. SCOPE/AUDIT PROCEDURES

SCOPE

The 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 review was conducted from February 4, 2019 through February 15, 2019. The audit included a review of the Plan's policies for providing services, the procedures used to implement the policies, and verification studies of the implementation and effectiveness of the policies. Interviews were conducted with the Plan's administrators and staff.

The following verification studies were conducted:

Category 1 – Utilization Management

Prior Authorization: Twenty-one (21) medical and twenty (20) pharmacy prior authorization requests were reviewed for compliance with contractual requirements, including medical necessity, consistent application of criteria, and timeliness.

Appeal Procedures: Thirteen (13) medical prior authorization appeals and ten (10) pharmacy prior authorization appeals were reviewed to ensure that required timeframes were met and appeals are appropriately routed and adjudicated by appropriately qualified personnel.

Category 2 – Case Management and Coordination of Care

Behavioral Health Treatment (BHT): Twenty-one (21) medical records were reviewed for evidence of coordination of care and collaboration between the provider and member. The records were also reviewed to ensure treatment plans were completed with required elements and crisis plans.

Category 3 – Access and Availability of Care

Appointment Availability Study: Five (5) primary care physicians, five (5) specialist, and five (5) obstetrician-gynecologist (OB-GYN) were selected for an access and availability survey. The survey was conducted to determine the availability of first and second appointment openings and to review the accuracy of the Plan directory.

Category 4 – Member's Rights

Grievance Procedures: Forty-one (41) grievances were reviewed for timely resolution, response to complainant, and submission to the appropriate level for review. Of the sampled grievances, twenty-two (22) were categorized as quality of care, nine (9) were categorized as quality of service, and ten (10) were categorized as access.

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

❖ COMPLIANCE AUDIT FINDINGS (CAF) ❖

PLAN: Orange County Organized Health System dba CalOptima

AUDIT PERIOD: February 1, 2018 through January 31, 2019
DATE OF AUDIT: February 4, 2019 – February 15, 2019

CATEGORY 2 – CASE MANAGEMENT AND COORDINATION OF CARE

2.3	BEHAVIORAL HEALTH TREATMENT

For Members under 21 years of age diagnosed with Autism Spectrum Disorder (ASD) or for Members under 3 years of age with a rule out or provisional diagnosis. The Plan shall cover Medically Necessary Behavioral Health Treatment, (BHT) services as defined in the federally approved State Plan, and in accordance with Health and Safety Code sections 1374.72 and 1374.73, Title 28 California Code of Regulations 1300.74.72, APL 15-019, and APL 15-025 to the extent that they are consistent with the State Plan. APLs superseding APL 15-019 and APL 15-025 that clarify the delivery of BHT services shall be incorporated herein by this reference and become part of this Contract as of their effective date.

1) The Plan shall provide Medically Necessary BHT services as stated in the Member's treatment plan and/or continuation of BHT services under continuity of care with the Member's BHT Provider.
2) For Members 3 years or older, the Plan shall require a Comprehensive Diagnostic Evaluation before Members receive BHT services.
3) BHT services must be based upon a treatment plan that is reviewed no less than every six (6) months by a qualified autism service Provider as defined by Health and Safety Code Section 1374.73(c)(3) and by the federally approved State Plan.
4) The Plan shall provide continuity of care for Members diagnosed with ASD as stated below and in accordance with this Section G.
    a) For Members who had received BHT through a regional center prior to September 15, 2014, the Plan shall not provide BHT services until such time as the Member may be safely transitioned into the Plan's Provider Network in accordance with the BHT services transition plan approved by DHCS and the Department of Developmental Services (DDS). If a Member, or a Member's parent or legal guardian, chooses to access BHT services from the Plan's Network Provider prior to the transition of regional center clients to the Plan for BHT services, the Plan shall provide Medically Necessary BHT services from the Plan's Network Provider.

2.3	BEHAVIORAL HEALTH TREATMENT

b) If Members received BHT services outside of the Plan's Network prior to September 15, 2014, and the Member or the Member's parent or legal guardian request continued access to their existing BHT Provider, the Plan shall ensure continuity of care in accordance with

APL 15-019 and APL 15-025. The Plan must offer continuity of care with an out-of-Network BHT Provider if all of the following conditions are met:

i. The Member has an existing relationship with a qualified autism service Provider. An existing relationship means the Member has seen an out-of-Network BHT Provider at least one time during the six (6) months prior to the Plan assuming responsibility of BHT services from the regional center or the date of the Member's initial enrollment with the Plan if the enrollment occurred on or after September 15, 2014;

ii. The Provider can agree to the Plan's rate or the Medi-Cal FFS rate, whichever is higher, for the appropriate BHT service;

iii. The Provider does not have any documented quality of care issues that would cause exclusion from the Plan's Network;

iv. The Provider is a qualified Provider under Health and Safety Code Section 1374.73 and the approved State Plan; and

v. The Provider supplies the Plan with all relevant treatment information, for purposes of determining medical necessity, as well as a current treatment plan, as long as it is allowable under federal and state privacy laws and regulations.

c) The Plan shall continue to authorize Medically Necessary BHT services in accordance with the Member's treatment plan at the time of the request for continuity of care during the continuity of care period.

d) The Plan's Network Provider may update the BHT treatment plan upon completion of the assessment and discontinue BHT services if the evaluation determines that the authorization of BHT services is not Medically Necessary.

5) The plan shall provide all necessary Member treatment information to the Member's regional center to enable care coordination, as permitted by federal and state law, APL 15-022, and this Contract.

2.3	BEHAVIORAL HEALTH TREATMENT

6) The Plan shall enter into a Memorandum of Understanding (MOU) with each local regional center in accordance with Exhibit A, Attachment 12, Provision 2 of this Contract, to facilitate the coordination of services for Members with developmental disabilities, including ASD, as permitted by federal and State law, and specified by DHCS in APL 15-022. If the Plan is unable to enter into an MOU, the Plan shall inform DHCS why agreement with the regional center was not reached and demonstrate that a good faith effort was made by the Plan to enter into an MOU with the regional center.

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

The Plan is required to cover and ensure the provision of medically necessary Behavioral Health Treatment (BHT) services to eligible Medi-Cal members under 21 years of age as required by the Early and Periodic Screening, Diagnostic and Treatment (EPSDT) mandate.

On July 1, 2018, DHCS will transition the provision of medically necessary BHT services for eligible members under 21 years of age without an Autism Spectrum Disorder (ASD) diagnosis from Regional Centers (RCs) to the MCPs. Beginning on July 1, 2018, the authorization and payment of BHT services will transition from the RCs to the MCPs.

MCPs must:

1) Inform members that EPSDT services are available for members under 21 years of age.
2) Provide access to comprehensive screening and prevention services, at designated intervals or at other intervals indicated as medically necessary, in accordance with the most current Bright Futures periodicity schedule, including but not limited to:
    a. A health and developmental history
    b. A comprehensive unclothed physical examination
    c. Appropriate immunizations
    d. Lab tests and lead toxicity screening
    e. Screening services to identify developmental issues as early as possible.

2.3	BEHAVIORAL HEALTH TREATMENT

3) Provide access to medically necessary diagnostic and treatment services, including but not limited to, BHT services based upon a recommendation of a licensed physician and surgeon or a licensed psychologist.

The provision of EPSDT services for members under 21 years of age, which includes medically necessary, evidence-based BHT services that prevent or minimize behavioral conditions and promote, to the maximum extent practicable, the functioning of a member, will become the responsibility of MCPs effective on the date of the member's transition from the RC or, for new members, upon MCP enrollment. MCPs must ensure that appropriate EPSDT services are initiated in accordance with timely access standards.

Criteria for BHT Services
In order to be eligible for BHT services, a Medi-Cal member must meet all of the following overage criteria:

1) Be under 21 years of age.
2) Have a recommendation from a licensed physician and surgeon or a licensed psychologist that evidence-based BHT services are medically necessary.
3) Be medically stable.
4) Be without a need for 24-hour medical/nursing monitoring or procedures provided in a hospital or intermediate care facility for persons with intellectual disabilities (ICF/ID).

BHT services are provided under a behavioral treatment plan that has measurable goals over a specific timeline for the specific member being treated and that has been developed by a BHT Service Provider. The behavioral treatment plan must be reviewed, revised, and/or modified no less than once every six months by a BHT Service Provider. The behavioral treatment plan may be modified if medically necessary. BHT services may be discontinued when the treatment goals are achieved, goals are not met, or services are no longer medically necessary.

Behavioral Treatment Plan
BHT services must be provided, observed, and directed under an approved behavioral treatment plan.

The approved behavioral treatment plan must meet the following criteria:

1) Be developed by a BHT Service Provider for the specific member being treated.

2.3	BEHAVIORAL HEALTH TREATMENT

2) Include a description of patient information, reason for referral, brief background information (e.g., demographics, living situation, home/school/work information), clinical interview, review of recent assessments/reports, assessment procedures and results, and evidence-based BHT services.
3) Be person-centered and based upon individualized, measureable goals and objectives over a specific timeline.
4) Delineate both the frequency of baseline behaviors and the treatment planned to address the behaviors.
5) Identify measureable long-, intermediate-, and short-term goals and objectives that are specific, behaviorally defined, developmentally appropriate, socially significant, and based upon clinical observation.
6) Include outcome measurement assessment criteria that will be used to measure achievement of behavior objectives.
7) Include the current level (baseline, behavior parent/guardian is expected to demonstrate, including condition under which it must be demonstrated and mastery criteria [the objective goal]), date of introduction, estimated date of mastery, specify plan for generalization and report goal, as met, not met, modified (include explanation).
8) Utilize evidence-based BHT services with demonstrated clinical efficacy tailored to the member.
9) Clearly identify the service type, number of hours of direct service(s), observation and direction, parent/guardian training, support and participation needed to achieve the goals and objectives, the frequency at which the member's progress is measured and reported, transition plan, crisis plan, and each individual BHT service provider responsible for delivering the services.
10) Include care coordination involving the parents or caregiver(s), school, state disability programs and others as applicable.
11) Consider the member's age, school attendance requirements, and other daily activities when determining the number of hours of medically necessary direct service and supervision.
12) Deliver BHT services in a home or community-based setting, including clinics. Any portion of medically necessary BHT services that are provided in school

must be clinically indicated as well as proportioned to the total BHT service received at home and community.

13) Include an exit plan/criteria.

All Plan Letter 18-006

SUMMARY OF FINDINGS:

2.3.1 Behavioral Health Treatment (BHT) Plan Requirements

The Plan is required to provide medically necessary Behavioral Health Treatment (BHT) services to members under 21 years of age diagnosed with Autism Spectrum Disorder (ASD), or for members under 3 years of age with a rule out or provisional diagnosis. The BHT services must be based upon the member's behavioral treatment plan developed by a qualified autism service provider and approved by Plan. *(Contract, Amendment A28, Exhibit A, Attachment 10(5)(F))*

The All Plan Letter 18-006 requires the Plan to deliver Medi-Cal covered BHT services in accordance with the member's Plan-approved behavioral treatment plan. BHT services must be provided, observed, and directed under an approved behavioral treatment plan. The approved behavioral treatment plan must clearly identify the service type, observations, directions, parent/guardian training, support and participation needed to achieve the goals and objectives, the frequency at which the member's progress is measured and reported, transition plan, and crisis plan. It must also contain number of hours of direct services (BHT authorized hours). *(All Plan Letter (APL) 18-006)*

The Plan did not ensure that BHT services are provided based upon the member's approved treatment plan that includes sufficient direct service hours.

Plan *Policy No. GG.1548: Authorization for Applied Behavioral Analysis for Autism Spectrum Disorder* describes the documentation requirements for BHT treatment plan, but does not include the direct service hours. In addition, the policy does not have a procedure to monitor and ensure Applied Behavioral Analysis (ABA) providers are providing BHT services based upon an approved treatment plan that includes providing direct service hours as authorized.

In five (5) BHT Grievances and five (5) related BHT medical records reviewed, the files revealed that the ABA providers did not provide direct service hours sufficiently as approved in the treatment plans. The Plan did not investigate the cause and assist providers in compliance with the BHT contract and APL requirements.

- In one case, a member's parent complained that the ABA provider did not provide any services to member. The Plan's action was to refer the member to a new ABA provider.
- In a second case, a member's parent complained that the therapist did not follow the treatment plan. The Plan's action was assisting member's mother on locating a new ABA provider.
- In a third case, a member's parent complained that the ABA provider did not provide the services they claimed they would. The Plan's resolution letter stated there would be a follow up status letter with the member's mother in 14 days, once the Plan received a response from ABA provider. The Plan failed to send a follow-up status letter.
- In a fourth case, a member's parent complained ABA provider provided only 1-hour sessions, instead of the required 2- hour sessions due to not having enough staff. The Plan's action was to refer the member to a new ABA provider.
- In a fifth case, a member was approved for fifteen hours of therapy per week. The member's parent complained that the therapist showed up only 8 hours or less and canceled appointments without notification. The Plan's action was to track the complaint only because mother did not want to file a grievance.

The sampled medical records identified the authorized service hours along with their care plan for each member. However, only one record tracked and documented the used and unused BHT approved service hours. The tracking document showed the member used only 14% of the authorized BHT direct service hours for the period of January 2, 2018 to February 12, 2018. The Plan did not have a tracking document for the other four sampled medical records.

BHT is designed to produce socially significant improvement in human behavior. It includes the direct observation, measurement, and functional analysis of the relationship between environment and behavior. BHT services teach skills by using behavioral observation and reinforcement, or by prompting to teach each step of targeted behavior. In order to teach skills to BHT members, the individualized treatment plan includes direct service hours to guide ABA providers on how much time should be spent with members for behavioral observation and reinforcement. When the ABA

providers insufficiently deliver direct service hours, members being treated for ASD may not receive effective treatment and consequently, the quality of care may be compromised.

RECOMMENDATION:

2.3.1 Update and implement policies and procedures to monitor and ensure Applied Behavioral Analysis providers are providing Behavioral Health Treatment services based upon an approved treatment plan that includes providing direct service hours as authorized.

❖ COMPLIANCE AUDIT FINDINGS (CAF) ❖

PLAN: Orange County Organized Health System dba CalOptima

AUDIT PERIOD: February 1, 2018 through January 31, 2019
DATE OF AUDIT: February 4, 2019 – February 15, 2019

CATEGORY 3 – ACCESS AND AVAILABILITY OF CARE

3.1	APPOINTMENT PROCEDURES AND MONITORING 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;
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:

3.1.1 Appointment Wait Time Monitoring

The Plan is required to 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 subparagraph A. Appointments. (Contract, Exhibit A, Attachment 9(3)(C))

The Plan is required to provide or arrange for the provision of access to health care services in a timely manner, and establishes additional metrics for measuring and

monitoring the adequacy of the Plan's contracted provider networks to provide enrollees with timely access to needed health care services. (CCR, Title 28, Section 1300.67.2.2 (a)(4))

The Plan shall establish and maintain provider networks, policies, procedures and quality assurance monitoring systems and processes sufficient to ensure compliance with these clinical appropriateness standards. (CCR, Title 28, Section 1300.67.2.2 (c)(1))

Plan *Policy No. GG.1600* states the Plan shall analyze performance of the Plan's and Health Networks' access and availability against the standards set forth in this policy by conducting an annual Provider Access Survey (appointment availability and access during and after business hours). The Plan shall annually develop accessibility analysis (appointment availability and access during and after business hours) and availability analysis (provider/member ratio and GeoAccess) reports.

The Plan did not implement its policy and procedures to ensure that members have effective and appropriate access to Covered Services in accordance with monitoring of all primary care practitioners (PCPs) in the Plan's provider network by failing to conduct the 2018 Timely Access Survey.

The Timely Access Survey is a report that helps determine whether the Plan Members have appropriate and timely access to health care. The report determines whether health services are available to all Plan members in a timely manner. The results are compared to the Plan's standards and analyzed for the Plan as a whole and by provider type, program, and health network.

In the absence of this report, the Plan is not able to properly analyze the performance of certain standards such as appointment types, in-office wait times, telephone access, and access to specialty care. Furthermore, the Plan is also not able to process nor analyze the data collected from surveys to compare with the Plan's standards.

During the access interview, the Plan stated that 2018 Timely Access Survey Report was not done due to a change in vendor and approach. The new approach was not in operation during the audit period. The Plan is working with the new survey vendor to update the survey tools and methodology to conduct the Timely Access Survey in the second quarter of 2019.

Without being able to measure member's access to care, the Plan cannot accurately evaluate the standards for timely appointments, (ex. if the next available appointment

date and time for an urgent appointment is being met with the required timeframe for compliance) nor monitor of waiting times.

RECOMMENDATION:

3.1.1 Implement policies and procedures to ensure that the Plan is analyzing the performance of the Plan's and Health Networks' access and availability against the standards set forth.

❖ COMPLIANCE AUDIT FINDINGS (CAF) ❖

PLAN: Orange County Organized Health System dba CalOptima

AUDIT PERIOD: February 1, 2018 through January 31, 2019
DATE OF AUDIT: February 4, 2019 – February 15, 2019

CATEGORY 5 – QUALITY MANAGEMENT

5.1	QUALITY IMPROVEMENT SYSTEM/ DELEGATION OF QUALITY IMPROVEMENT ACTIVITIES

General Requirements:
Contractor shall implement an effective Quality Improvement System (QIS) in accordance with the standards in Title 28 CCR Section 1300.70. Contractor shall monitor, evaluate, and take effective action to address any needed improvements in the quality of care delivered by all providers rendering services on its behalf, in any setting. Contractor shall be accountable for the quality of all Covered Services regardless of the number of contracting and subcontracting layers between Contractor and the provider.
COHS Contract A.4.1

Written Description:
Contractor shall implement and maintain a written description of its QIS that shall include the following:

A. Organizational commitment to the delivery of quality health care services as evidenced by goals and objectives which are approved by Contractor's governing body and periodically evaluated and updated.
B. Organizational chart showing the key staff and the committees and bodies responsible for Quality Improvement activities including reporting relationships of QIS committee(s), and staff within the Contractor's organization.
C. Qualifications of staff responsible for quality improvement studies and activities, including education, experience and training.
D. A description of the system for provider review of QIS findings, which at a minimum, demonstrates physician and other appropriate professional involvement and includes provisions for providing feedback to staff and providers, regarding QIS study outcomes.
E. The role, structure, and function of the quality improvement committee.
F. The processes and procedures designed to ensure that all Medically Necessary Covered Services are available and accessible to all Members…and that all Covered Services are provided in a culturally and linguistically appropriate manner.
G. A description of the mechanisms used to continuously review, evaluate, and improve access to and availability of services. The description shall include methods to ensure that members are able to obtain appointments within established standards.

❖ COMPLIANCE AUDIT FINDINGS (CAF) ❖

PLAN: Orange County Organized Health System dba CalOptima

AUDIT PERIOD: February 1, 2018 through January 31, 2019
DATE OF AUDIT: February 4, 2019 – February 15, 2019

5.1	QUALITY IMPROVEMENT SYSTEM/ DELEGATION OF QUALITY IMPROVEMENT ACTIVITIES

H. Description of the quality of clinical care services provided, including, but not limited to, preventive services for children and adults, perinatal care, primary care, specialty, emergency, inpatient, and ancillary care services.
I. Description of the activities, including activities used by Members that are Seniors and Persons with Disabilities or persons with chronic conditions, designed to assure the provision of case management, coordination and continuity of care services. Such activities shall include, but are not limited to, those designed to assure availability and access to care, clinical services and care management.

COHS Contract A.4.7.A-I

Accountability: Contractor shall maintain a system of accountability which includes the participation of the governing body of the Contractor's organization, the designation of a quality improvement committee with oversight and performance responsibility, the supervision of activities by the Medical Director, and the inclusion of contracting Physicians and Contracting Providers in the process of QIS development and performance review.
Participation of non-contracting providers is at the Contractor's discretion.
COHS Contract A.4.2

Governing Body: Contractor shall implement and maintain policies that specify the responsibilities of the governing body including at a minimum the following:

A. Approves the overall QIS and the annual report of the QIS.
B. Appoints an accountable entity or entities within Contractor's organization to provide oversight of the QIS.
C. Routinely receives written progress reports from the quality improvement committee describing actions taken, progress in meeting QIS objectives, and improvements made.
D. Directs the operational QIS to be modified on an ongoing basis, and tracks all review findings for follow-up.

COHS Contract A.4.3.A-D

Provider Participation: Contractor shall ensure that contracting Physicians and other providers from the community shall be involved as an integral part of the QIS. Contractor shall maintain and implement appropriate procedures to keep contracting providers informed of the written QIS, its activities, and outcomes.
COHS Contract A.4.5

SUMMARY OF FINDINGS:

5.1.1 Quality Improvement

The Plan is required to monitor, evaluate, and take effective action to address any needed improvements in the quality of care delivered by all providers rendering services on its behalf, in any setting. (Contract, Exhibit A, Attachment 4(1))

Plan *Policy No. GG.1611: Potential Quality Issue Review Process* describes that all Plan departments, practitioners, providers, health networks, and Health Delivery Organizations (HDO) shall refer a Potential Quality Issue (PQI) to the Quality Improvement (QI) Department for review and investigation. If a Member chooses to remain anonymous, the QI staff will open PQI case and flag as confidential.

The Plan did not take effective action to ensure improvements in quality of care when case files demonstrated quality problems. The Plan failed to properly categorize BHT grievances as quality of care.

The review of five (5) Behavioral Health Treatment (BHT) Grievances (three were grievances where the member's parents did not want to file a grievance) revealed that member's parents complained that the BHT providers did not provide direct service hours sufficiently as approved in the treatment plans. The Plan action was to switch members to a new BHT provider. The Plan did not refer these BHT grievances to Potential Quality Issues (PQI) for investigations and improvements in quality of care. If the Plan sees a quality issue in an unreported grievance; the Plan should refer the issue as a PQI for investigation. The Plan categorized these BHT grievances as quality of service.

During interview, the Plan stated PQI referrals for these BHT grievance cases were not necessary, as the Plan did not identify significant provider-specific trends. The Plan said these BHT grievances are individual and unrelated cases.

Although the Plan did not identify significant provider-specific trends, these grievances were related cases as they were in the same category quality of care. When the BHT providers insufficiently deliver direct service hours, members being treated for Autism Spectrum Disorder (ASD) may not receive effective treatment and consequently, the quality of care may be compromised.

If the Plan does not follow up evidence of inadequate treatment, there is a high risk for substandard care which could result in decreased disorder improvement.

RECOMMENDATION:

5.1.1 Improve the quality of care by taking follow-up action upon discovery of poor quality of care by providers.

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

REPORT ON THE MEDICAL AUDIT OF

Orange County Organized Health System
dba CalOptima

Contract Number:	08-85221 State Supported Services
Audit Period:	February 1, 2018 Through January 31, 2019
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TABLE OF CONTENTS

I. INTRODUCTION

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

The onsite audit of the Plan was conducted from Monday, February 4, 2019 through Friday, February 15, 2019. The audit covered the review period of February 1, 2018 through January 31, 2019 and consisted of a document review of materials provided by the Plan.

An exit conference was held on May 22, 2019 with the Plan.

❖ COMPLIANCE AUDIT FINDINGS (CAF) ❖

PLAN: Orange County Organized Health System dba CalOptima

AUDIT PERIOD: February 1, 2018 through January 31, 2019
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CATEGORY 1 - UTILIZATION MANAGEMENT

STATE SUPPORTED SERVICES CONTRACT REQUIREMENTS

Abortion
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 Services' (DHS') 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.1

SUMMARY OF FINDINGS:

The provider manual, member handbook, and Plan's claims processing policies indicate that abortion services do not require prior authorization and are compliant with all contractual and regulatory requirements.

RECOMMENDATION:

None